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## Committed to Commitment: The Problem with Washington State's Involuntary Treatment Act

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# COMMITTED TO COMMITMENT: THE PROBLEM WITH WASHINGTON STATE'S INVOLUNTARY TREATMENT ACT

Hannah Garland\*

*Abstract:* Washington State utilizes the Involuntary Treatment Act (ITA) to civilly commit individuals experiencing behavioral health crises. Although civil commitment involves stripping away fundamental rights, it receives less attention than criminal incarceration. The ITA is meant to protect not just the general community, but also the rights of people with behavioral health disorders who utilize the ITA system. Yet, its implementation tells a different story. Individuals in King County are detained and committed repeatedly, without receiving consistent care. Furthermore, the ITA disproportionately impacts unhoused individuals and Black individuals. As the ITA continues to grow both in utilization and expense, other community-based behavioral health interventions are unable to thrive. This is not just a social services issue: the implementation of the ITA in King County does not comply with the Americans with Disabilities Act or Washington's constitutional duty to foster and support institutions for individuals who are "mentally ill." Implementation of civil commitment law in King County is ethically and legally questionable, and raises disturbing questions about civil commitment statewide. This Comment suggests that federal litigation may be necessary to persuade state and local governments to alter how they implement the ITA and to bring that implementation into alignment with state and federal disability law.

## INTRODUCTION

In 2019, Michael's<sup>1</sup> mother took the stand to testify that she thought her son should be involuntarily committed. She was tearful as she explained that she could not care for her son, did not feel safe around him, and felt she had no other options to keep him safe. This testimony was not new for Michael's mother—in the five years prior, her son experienced

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Prior to entering law school, I worked for the King County Prosecuting Attorney's Office in the Involuntary Treatment Court unit as a family advocate. During my second year of law school, including the time when I started drafting this Comment, I worked as a legal intern for Disability Rights Washington. Both of these professional experiences impacted the formulation of this Comment. I am no longer employed by either the Prosecuting Attorney's Office or Disability Rights Washington.

1. Name changed for privacy.

worsening behavioral health<sup>2</sup> symptoms. He was involuntarily committed over a dozen times, and she was often the only person testifying at the hearing who was not a medical professional. Typically, the judge would order her son to be detained for treatment and Michael would receive short-term stabilizing care before being discharged back into her care, where the cycle would restart.

The Involuntary Treatment Act (ITA)<sup>3</sup> governs civil commitment in Washington. The stated legislative intent of the ITA is protecting those experiencing behavioral health crises and the general community.<sup>4</sup> The ITA also intends to safeguard individual rights and ensure treatment within the community whenever possible.<sup>5</sup> However, the implementation of the ITA tells a different story. Implementation is expensive,<sup>6</sup> and people detained for treatment under the ITA—disproportionately Black and Brown individuals<sup>7</sup>—become increasingly likely to cycle back through the system with each detention.<sup>8</sup> This indicates that the ITA fails to treat people in a manner that achieves longer term stability.

In the United States and Washington, legislative safeguards exist to protect disabled individuals<sup>9</sup> from discrimination, but over-reliance on involuntary treatment as a system to deliver care suggests those safeguards are not working. This Comment explores the unethical and unlawful implementation of involuntary treatment in Washington’s most populous county, King County.<sup>10</sup>

Part I of this Comment outlines the historical trends of involuntary commitment in the United States, highlighting the disturbing history of

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2. In this Comment, I primarily utilize “behavioral health” as opposed to “mental health” to be in alignment with the language used in Washington’s Involuntary Treatment Act. WASH. REV. CODE § 71.05 (2020). Additionally, I utilize “behavioral health” due to the understanding that behavioral health is an umbrella term that includes mental health and mental health disorders, and thus is most applicable to this Comment.

3. WASH. REV. CODE § 71.05 (2020).

4. *Id.* § 71.05.010(1).

5. *Id.*

6. KING CNTY. BEHAVIORAL HEALTH & RECOVERY DIV., BEHAVIORAL HEALTH AND RECOVERY SERVICES PROPOSED BUDGET 2021–2022 1–2 [hereinafter BUDGET PROPOSAL].

7. LAINA POON, KAYVON ZADEH & BROOKE LEARY, INVOLUNTARY TREATMENT ACT COURT: REENTRY AND COURT OUTCOMES 7 (2019).

8. *Id.* at 6.

9. The disability community continues to discuss whether person-first language (“person with disability”) or identity-first language (“disabled person”) is more appropriate. The disability community is not a monolith, and unsurprisingly there are strong and valid feelings on both sides of the discussion. The best practice is typically considered utilizing whichever form of language is preferred by the specific person you are speaking about or with. In this Comment, I utilize both person-first and identity-first language depending on the situation.

10. Anneliese Vance-Sherman, *King County Profile*, EMP. SEC. DEP’T (Jan. 2021), <https://esd.wa.gov/labormarketinfo/county-profiles/king> [https://perma.cc/ER2D-S3GX].

how disabled individuals have been treated and stripped of their autonomy, rights, and freedom. Part II dives deep into Washington State’s civil commitment law, exploring the legislation and its implementation and impact. Part III offers an overview of applicable federal and state disability law, focusing primarily on the Americans with Disabilities Act, the Supreme Court’s pivotal holding in *Olmstead v. L.C.*,<sup>11</sup> and the text of the Washington State Constitution. Part IV connects the prior sections, using King County as an example to show that its implementation of the ITA is unlawful. Lastly, Part V addresses actions the state must take to both ensure lawful treatment of people with behavioral health disorders and to fulfill the stated intent of the ITA.

## I. HISTORICAL TRENDS OF INVOLUNTARY COMMITMENT IN THE UNITED STATES

Part I of this Comment provides historical information about civil commitment law, its creation, and why it matters. This section covers three time periods: early America through the nineteenth century, the twentieth century, and modern times.

Civil commitment is the court ordered institutionalization of a person for reasons related to behavioral health.<sup>12</sup> This Comment discusses civil commitment as it pertains to people who fit state-specific criteria for commitment based on behavioral health symptoms.<sup>13</sup> Although the civil commitment process in the United States did not look as it does now until the mid-twentieth century, civil commitment is not a new concept.<sup>14</sup>

### A. *Civil Commitment Through the Nineteenth Century*

Early Greek and Roman law both recognized the existence of behavioral health conditions and recommended a deprivation of liberty in response, typically through guardianship by family members.<sup>15</sup> English law in the thirteenth century allowed for the property of “lunatics” and “idiots” to be seized by the King, who used the profit to provide for the individual and their family.<sup>16</sup> Throughout pre- and early United States history, behavioral health was not considered a legal issue. Instead, it was

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11. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

12. SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., *CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW AND PRACTICE 1* (2019) [hereinafter *CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM*].

13. *Id.*

14. *Id.* at 2.

15. *Id.*

16. *Id.*

common for the state to imprison people experiencing behavioral health crises or place them into almshouses—public institutions for homeless people.<sup>17</sup> Neither placement offered behavioral health treatment.<sup>18</sup> In response to overcrowding in prisons and almshouses, colonial America slowly developed poorly regulated psychiatric facilities, with the first known admission occurring in 1752.<sup>19</sup>

Throughout the eighteenth century, few legal protections existed for individuals undergoing civil commitment. Although increased state-funded institutions required implementing additional state legislation, the process of admission was still fairly simple and typically entrusted to kin and medical professionals.<sup>20</sup> The only recourse available to a person who objected to their commitment was through a writ of habeas corpus.<sup>21</sup>

The writ of habeas corpus is a constitutional right that determines whether detention or imprisonment is proper.<sup>22</sup> In 1845, Josiah Oakes unsuccessfully utilized a writ of habeas corpus to argue against his detention.<sup>23</sup> In a hearing before the Massachusetts Supreme Judicial Court, the court heard a wide range of testimony before ordering that Mr. Oakes “be remanded to the McLean Asylum to remain there until further action on the subject.”<sup>24</sup>

About fifteen years after Mr. Oakes argued for his release, a Mr. Packard urged for the involuntary treatment of his wife, Elizabeth Packard.<sup>25</sup> Mr. Packard, a member of the clergy, believed his wife was insane because she expressed religious views counter to his.<sup>26</sup> At the time,

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17. See Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 PSYCHIATRY 30, 32 (2010); CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM, *supra* note 12, at 3; Paul S. Appelbaum, *Civil Mental Health Law: Its History and Its Future*, 20 MENTAL AND PHYSICAL DISABILITY L. REP. 599, 599 (1966).

18. See Testa & West, *supra* note 17, at 3; CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM, *supra* note 12, at 3; Appelbaum, *supra* note 17.

19. Stuart A. Anfang & Paul S. Appelbaum, *Civil Commitment—The American Experience*, ISR. J. PSYCHIATRY & RELATED SCIS. 209, 210 (2006).

20. *Id.*

21. CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM, *supra* note 12, at 3.

22. *What You Should Know About Habeas Corpus*, THE AM. CIV. LIBERTIES UNION, <https://www.aclu.org/other/what-you-should-know-about-habeas-corpus> [https://perma.cc/FMR6-JVKU].

23. JOSIAH OAKES, MATTERS OF JOSIAH OAKES, SEN’R: FOUR YEARS WRONGFULLY IMPRISONED IN THE MCLEAN ASYLUM, THROUGH AN ILLEGAL GUARDIANSHIP, BY MEANS OF BRIBERY AND FALSE SWEARING 1, 2 (1850).

24. *Id.* at 12–15.

25. Mariana Brandman, *Elizabeth Packard*, NAT’L WOMEN’S HIST. MUSEUM (2021), <https://www.womenshistory.org/education-resources/biographies/elizabeth-packard> [https://perma.cc/DUY9-773Y].

26. *Id.*

the Packard's home state of Illinois allowed for the institutionalization of married women upon their husband's request, "without the evidence of insanity or distraction required in other cases."<sup>27</sup> After three years of detainment, the state released Ms. Packard to her husband because they deemed her incurably insane.<sup>28</sup> Mr. Packard continued to detain Ms. Packard in their home until a friend of Ms. Packard appealed to Judge Charles Starr, who issued a writ of habeas corpus, and a jury found Ms. Packard to be sane.<sup>29</sup>

During the mid-nineteenth century, the creation of private and public institutions became more commonplace.<sup>30</sup> Communities largely saw these institutions as places to provide long-term housing for patients experiencing chronic behavioral health concerns.<sup>31</sup> Furthermore, society began to consider psychiatric institutions as a more humane approach for the detention of people with behavioral health conditions due to the lack of treatment and poor conditions in non-psychiatric alternatives.<sup>32</sup>

Many credit the famous activist Dorothea Dix with the widespread documentation of how prisons and jails treated incarcerated individuals, particularly individuals with behavioral health conditions.<sup>33</sup> As a direct result of Dix's activism, governments began funding state mental hospitals.<sup>34</sup> Throughout the mid-1800s, state-funded mental hospitals became more widespread throughout the United States.<sup>35</sup>

## B. *Civil Commitment Law in the Twentieth Century*

Throughout the twentieth century, civil commitment slowly shifted from a process driven primarily by family members and medical

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27. THE STATUTES OF ILLINOIS 178 (Samuel H. Treat et al. eds., Chicago, D.B. Cooke & Co. 1858).

28. Brandman, *supra* note 25.

29. *Id.*

30. *See* Testa & West, *supra* note 17.

31. *See id.*

32. *See id.*; CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM, *supra* note 12, at 3.

33. *See Dorothea Lynde Dix*, HIST. (Aug. 21, 2018), <https://www.history.com/topics/womens-history/dorothea-lynde-dix> [<https://perma.cc/Q9DY-2MG6>].

34. *Id.*

35. Anfang & Appelbaum, *supra* note 19. The first public psychiatric institution in Washington State, the Insane Asylum of Washington Territory, opened in 1871 on the grounds of a former military post. The hospital was renamed to Western Washington Hospital for the Insane in 1889 when Washington became a state. Today, the facility continues to operate and is known as Western State Hospital. *History of Western State Hospital*, WASH. STATE DEP'T OF SOC. & HEALTH SERVS., <https://www.dshs.wa.gov/bha/division-state-hospitals/history-western-state-hospital> [<https://perma.cc/S535-YPQA>].

professionals to one that included legal systems.<sup>36</sup> This was due in part to the prevalence of wrongful commitment throughout the nineteenth century, investigative journalism that exposed abuse and neglect in psychiatric facilities,<sup>37</sup> and the advocacy that followed. It became more common for states to require judicial proceedings and representation by an attorney prior to commitment, providing a minimal barrier to wrongful commitment.<sup>38</sup> Although intended to improve legal protections for those being committed, this new system of civil commitment led to longer incarceration periods without any treatment, while patients waited for their court hearings.<sup>39</sup>

In 1951, the National Institute of Mental Health published guidance related to civil commitment entitled *Draft Act Governing Hospitalization of the Mentally Ill*.<sup>40</sup> The *Draft Act* proposed allowing involuntary hospitalization only when two physicians opined that a patient was “in need of care or treatment in a mental hospital, and because of his illness, lacks sufficient insight or capacity to make responsible application therefore.”<sup>41</sup> This criteria was broad. “Capacity” referred simply to whether somebody had the necessary insight to request assistance through psychiatric inpatient care, i.e., ask for inpatient care.<sup>42</sup>

Although the *Draft Act* addressed some of the medical concerns around involuntary commitment and highlighted the civil rights of committed

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36. See Testa & West, *supra* note 17; CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM, *supra* note 12, at 3.

37. Perhaps the most well-known example is *Ten Days in a Mad-House*, a series of articles written for the New York World in 1887 by Elizabeth Cochrane Seaman (more commonly known by her pen name, Nellie Bly). Bly mimicked behavioral health symptoms to be involuntarily committed to investigate conditions of a psychiatric institution. After declared insane by the court, Bly was sent to the New York City Lunatic Asylum on Blackwell’s Island. There, through observation and interviews with other patients, she quickly realized that many of her fellow patients seemed to be completely sane. Bly wrote extensively about the neglectful conditions of the institution, including invasions of privacy, threats and use of physical abuse, and lack of treatment. Howard Markel, *How Nellie Bly Went Undercover to Expose Abuse of the Mentally Ill*, PBS (May 5, 2018, 12:17 PM), <https://www.pbs.org/newshour/nation/how-nellie-bly-went-undercover-to-expose-abuse-of-the-mentally-ill> [https://perma.cc/YP5S-UJ8E].

38. See Testa & West, *supra* note 17; CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM, *supra* note 12, at 3.

39. See Testa & West, *supra* note 17; CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM, *supra* note 12, at 3; Paul S. Appelbaum, *The Draft Act Governing Hospitalization of the Mentally Ill: Its Genesis and Its Legacy*, 51 PSYCHIATRIC SERVS. 190, 190 (2000) [hereinafter *Draft Act Genesis*].

40. See *Draft Act Genesis*, *supra* note 39.

41. *Id.* at 191.

42. *Id.* Capacity today is broadly understood to refer to “[t]he mental ability to understand the nature and effect of one’s acts.” *Capacity*, BLACK’S LAW DICTIONARY (11th ed. 2019).

patients, it allowed for indefinite involuntary commitment.<sup>43</sup> It also only offered judicial review when requested by a patient who desired discharge.<sup>44</sup> The *Draft Act* was influential: some states adopted the *Act* in its complete or near-complete form while others used it as a guide for reforming civil commitment laws.<sup>45</sup>

As the United States entered the latter half of the twentieth century, the push for de-institutionalization increased, due to both the increasing prevalence of antipsychotic medications<sup>46</sup> and continued, widespread criticism psychiatric facilities conditions.<sup>47</sup> In 1963, President John F. Kennedy signed the Community Mental Health Act (CMHA), shifting the focus of behavioral health treatment from purely asylum-based to community-based care.<sup>48</sup> Community mental health care includes housing, crisis support, and ongoing mental health treatment in a non-institutional setting.<sup>49</sup> The CMHA called for developing 1,500 community behavioral health centers and was funded by \$150 million in federal grant payments.<sup>50</sup> The goal was to provide five essential services of the behavioral health system: consultation and education, inpatient facilities, outpatient clinics, emergency response, and partial hospitalization.<sup>51</sup> The success of the CHMA is questionable.<sup>52</sup> State governments only built about half of the intended 1,500 centers,<sup>53</sup> in part due to the states retaining discretion in how to spend the grant money and a lack of federal

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43. *Draft Act Genesis*, *supra* note 39, at 191.

44. *Id.*

45. *Id.* Before the *Draft Act*, Washington already required two medical examiners to perform a physical and mental examination and supply a report stating, “the condition of the person examined is such as to require care and treatment in an institution for the mentally ill.” 1949 Wash. Sess. Laws 606–07 (repealed). After the *Draft Act*, the language was changed only slightly, and required that two licensed physicians examine the individual and report whether the individual was mentally ill. 1959 Wash. Sess. Laws 85 (repealed).

46. See Testa & West, *supra* note 17, at 33.

47. *Id.*

48. *Reflecting on JFK’s Legacy of Community-Based Care*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/jfks-legacy-community-based-care> [<https://perma.cc/MN7R-KBB9>] (Mar. 18, 2021).

49. Shekhar Saxena & Pratap Sharan, *Mental Health Resources and Services*, in 4 INTERNATIONAL ENCYCLOPEDIA OF PUBLIC HEALTH 418, 428 (Kris Heggenhougen & Stella Quah eds., 2008).

50. Blake Erickson, *Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963*, PSYCHIATRYONLINE (June 11, 2021), <https://psychiatryonline.org/doi/10.1176/appi.ajp-rj.2021.160404> [<https://perma.cc/58FJ-DCD5>].

51. *Id.*

52. See Shannon Bradford, *The History of Community Mental Health Care*, CHI. POL’Y REV. (Mar. 12, 2021), <https://chicagopolicyreview.org/2021/03/12/community-mental-health-care-lessons-from-history/> [<https://perma.cc/QYD6-5U8M>].

53. *Id.*



enforcement of spending priorities.<sup>54</sup> But states also defunded inpatient programs they were typically responsible for paying for,<sup>55</sup> leading to plummeting rates of institutionalization over the next fifty years.<sup>56</sup> By the 1990s, there were about five percent as many people in psychiatric inpatient facilities as there were in the 1950s.<sup>57</sup>

Alongside de-institutionalization, civil commitment law in the twentieth century was marked by shifting standards and procedures for commitment.<sup>58</sup> The old “need for treatment” standard moved towards the more modern “dangerousness” standard.<sup>59</sup> The “need for treatment” standard was based upon the idea of caring for those who could not care for themselves.<sup>60</sup> The “dangerousness” standard focused on risk of imminent harm to self or others.<sup>61</sup>

Legislation adopted by the District of Columbia and California in 1964 and 1969, respectively, modeled the imminent danger standard that other states later adopted.<sup>62</sup> Further, the Supreme Court judicially supported the shift away from “need for treatment” in *O'Connor v. Donaldson*,<sup>63</sup> holding that “[a] finding of ‘mental illness’ alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in simple custodial confinement,”<sup>64</sup> and “a State cannot constitutionally confine without more a nondangerous individual.”<sup>65</sup>

### C. *Modern Day Civil Commitment Law in the United States*

Currently, involuntary commitment laws exist in every state.<sup>66</sup> These laws focus primarily on dangerousness and grave disability, which implicates one’s inability to satisfy their basic needs.<sup>67</sup> The shift to a “dangerousness” standard was important for protecting the rights of

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54. *Id.*

55. *Id.*

56. *See* Testa & West, *supra* note 17, at 33.

57. *Id.*

58. CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM, *supra* note 12, at 3.

59. Anfang & Appelbaum, *supra* note 19.

60. *Id.*

61. *Id.* at 211.

62. *Id.*; CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM, *supra* note 12, at 4; *see* Testa & West, *supra* note 17, at 33.

63. 422 U.S. 563 (1975).

64. *Id.* at 575.

65. *Id.* at 576.

66. CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM, *supra* note 12, at 1.

67. *Id.* at 9.

individuals with behavioral health conditions.<sup>68</sup> But this shift also created a gap in behavioral health services for people who no longer qualified for involuntary commitment.<sup>69</sup> Additionally, because the dangerousness standard is not well defined, it can lead to varying interpretations, even by behavioral health professionals.<sup>70</sup> In *O'Connor*, the Supreme Court defined dangerousness as “dangerous to himself or others” and considered whether the patient had committed dangerous acts or been suicidal.<sup>71</sup> Yet this definition is circular in nature: finding “dangerousness” when there are “dangerous act[s],” without stating what “dangerous acts” are, leads to a lack of clarity in determining whether a person is “dangerous” or not.

Modern civil commitment also shifted from a purely medical issue to an issue uniquely situated at the intersection of the medical field and the legal field. Two concepts provide the legal basis for civil commitment: (1) police power of the state; and (2) *parens patriae*.<sup>72</sup>

Police powers are difficult to define,<sup>73</sup> but they generally refer to a state’s ability to regulate people’s activity in a way that betters or protects society, including in areas of law related to public safety and public health.<sup>74</sup> Civil commitment falls under the umbrella of public health concerns legislated under the authority of police powers, and legal scholars consider it a “legitimate societal goal.”<sup>75</sup>

The doctrine of *parens patriae* (translated as parent of the people) allows the government to utilize its authority to protect citizens otherwise unable to care for themselves. However, some courts question whether vague standards for civil commitment, based upon inability to care for oneself, can truly be supported by the *parens patriae* doctrine.<sup>76</sup> They argue that *parens patriae* authority is still subject to substantive due process review, and that the vague nature of most civil commitment laws is not sufficient to withstand a substantive due process analysis.<sup>77</sup> Whether civil commitment should be considered a deprivation of physical freedom,

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68. See Testa & West, *supra* note 17, at 34.

69. *Id.*

70. See Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness*, 66 CASE W. RES. L. REV. 657, 673 (2016).

71. *O'Connor*, 422 U.S. at 567–68.

72. THOMAS L. HAGEL, REPRESENTING THE MENTALLY ILL: CIVIL COMMITMENT PROCEEDINGS 9 (1979); *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1209, 1222 (1974).

73. *Berman v. Parker*, 348 U.S. 26, 32 (1954).

74. *Id.*

75. HAGEL, *supra* note 72; *Developments in the Law: Civil Commitment of the Mentally Ill*, *supra* note 72, at 1222.

76. HAGEL, *supra* note 72, at 10.

77. *Developments in the Law: Civil Commitment of the Mentally Ill*, *supra* note 72, at 1210.

and thus subject to strict scrutiny by courts, is a valid inquiry that is beyond the scope of this Comment.<sup>78</sup>

The scope and application of civil commitment changed throughout history. Starting as a primarily familial and medical issue, civil commitment is now firmly rooted in the legal sphere. The history of civil commitment and institutionalization in the United States provides reason to think critically about the ITA and its implementation. Understanding Washington's civil commitment laws is vital as this Comment begins to shift focus towards how civil commitment impacts individuals with disabilities.

## II. WASHINGTON STATE CIVIL COMMITMENT LAW: THE INVOLUNTARY TREATMENT ACT

Washington State civil commitment law is complex, involving numerous steps that depend upon various criteria. Consistent with the history outlined above, Washington State shifted its implementation of civil commitment, both narrowing and expanding its application.<sup>79</sup> Additionally, framing current civil commitment laws by considering the broader history of civil commitment in the United States is important when analyzing the implementation and impact of the ITA.

Understanding how civil commitment is meant to work in Washington is paramount to understanding its failures. By looking closely at the laws that govern civil commitment and analyzing their implementation and effects, a clearer picture of the impact of civil commitment in Washington State begins to take shape.

Section II.A in this Part explains what the Involuntary Treatment Act is and what its stated intent is. Section II.B describes how the Involuntary Treatment Act works. Section II.C examines the Act's impact, looking at both general trends and specific populations. Lastly, section II.D looks at guidelines made by behavioral health experts that better align with the intent of the Involuntary Treatment Act and could lead to its more effective implementation.

### A. *What Is the Involuntary Treatment Act and What Is the Intent?*

In Washington State, civil commitment law is known as the Involuntary Treatment Act (ITA) and is codified in the Revised Code of Washington

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78. See generally Eric S. Janus, *Beyond Strict Scrutiny: Forbidden Purpose and the "Civil Commitment" Power*, 21 NEW CRIM. L. REV. 345 (2018) (arguing that civil commitment should be analyzed under the forbidden purpose construct rather than the typical three-tier scrutiny analysis).

79. *History and Overview of Involuntary Treatment in Washington State*, WASH. ASS'N OF DESIGNATED CRISIS RESPONDERS, <https://wadcr.org/history.html> [<https://perma.cc/SVE5-95YU>].

(RCW) section 71.05.<sup>80</sup> Washington’s legislature enacted the ITA in 1973 and has since revised it a number of times.<sup>81</sup> The legislative intent of the ITA is explicitly named in the legislation. In addition to protecting the health and safety of people in behavioral health crises<sup>82</sup> and protecting the public,<sup>83</sup> the legislation’s named intent is “[t]o prevent inappropriate, indefinite commitment of persons living with behavioral health disorders and to eliminate legal disabilities that arise from such commitment”;<sup>84</sup> “[t]o safeguard individual rights”;<sup>85</sup> “[t]o provide continuity of care”;<sup>86</sup> and “[t]o encourage, whenever appropriate, that services be provided within the community.”<sup>87</sup>

The Washington State legislature reaffirmed the ITA’s intent in 1998, stating: “[i]t is the intent of the legislature to: . . . provide additional opportunities for mental health treatment for persons whose conduct threatens himself or herself or threatens public safety and has led to contact with the criminal justice system.”<sup>88</sup> These statements of intent demonstrate what a properly functioning ITA would accomplish.

#### *B. How Does the Involuntary Treatment Act Work?*

The civil commitment process includes four stages: evaluation, initial detention, hearing, and commitment.<sup>89</sup> In Washington, a Designated Crisis Responder (DCR) evaluates people who are undergoing a behavioral health crisis.<sup>90</sup> A DCR can provide evaluation in an emergency room or non-emergency room setting.<sup>91</sup>

Through evaluation and a brief investigation—which frequently includes speaking to law enforcement, family, friends, or other witnesses present for the evaluation—the DCR decides whether the individual meets

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80. WASH. REV. CODE § 71.05 (1973).

81. WASH. STATE INST. FOR PUB. POL’Y, INVOLUNTARY TREATMENT ACT FOR SUBSTANCE USE DISORDERS IN WASHINGTON STATE: FIRST PRELIMINARY REPORT 5 (2020).

82. WASH. REV. CODE § 71.05.010(1)(a) (2020).

83. *Id.*

84. *Id.* § 71.05.010(1)(b).

85. *Id.* § 71.05.010(1)(d).

86. *Id.* § 71.05.010(1)(e).

87. *Id.* § 71.05.010(1)(g).

88. 1998 Wash. Sess. Laws 1547.

89. WASH. REV. CODE § 71.05 (1973).

90. WASH. REV. CODE § 71.05.020(16) (2021).

91. *Designated Crisis Responders (DCR)*, WASH. STATE HEALTH CARE AUTH., <https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/designated-crisis-responders-dcr> [<https://perma.cc/WRW5-NQJQ>].

the legal threshold for initial involuntary detention.<sup>92</sup> This legal threshold requires the individual to be gravely disabled, meaning they cannot care for their own basic needs, or at risk of harming themselves, others, or property.<sup>93</sup>

If the DCR decides that initial detention is appropriate, they prepare and file a petition for initial detention and attempt to find the individual an available inpatient bed at an evaluation and treatment facility (E&T).<sup>94</sup> If placement at an E&T is not available within the county the individual is in, they may be transferred to an E&T in another county.<sup>95</sup> If a placement in an E&T bed is not available at all, the DCR can apply for a single bed certification (SBC), where the individual will be held until an E&T bed becomes available.<sup>96</sup> These placements are often in non-psychiatric emergency room beds. If neither an E&T nor an SBC is available, the DCR will file a No Bed Report, and the individual can no longer be legally held under Washington's civil commitment laws.<sup>97</sup> There is no court hearing involved in the initial evaluation process.

After the DCR files an initial petition for detention, an individual can be held at an E&T or on an SBC for up to 120 hours, excluding weekends and holidays.<sup>98</sup> If the detaining facility believes the individual warrants detention beyond the initial 120 hours, they must file a petition with the court for fourteen days of involuntary treatment.<sup>99</sup> The fourteen-day petition must be signed by two medical professionals.<sup>100</sup> The individual must be assigned an attorney before the court hearing which determines the fourteen-day commitment.<sup>101</sup>

During the fourteen-day probable cause hearing, a deputy prosecuting attorney from the county where the individual is detained represents the detaining facility and generally advocates for commitment of the

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92. *Id.*

93. *Id.*

94. WASH. REV. CODE § 71.05.160 (2020).

95. *Id.* § 71.05.160(2)(b).

96. WASH. REV. CODE § 71.05.745 (2018).

97. WASH. REV. CODE § 71.05.750 (2020). State law requires an adequate follow-up plan to be created for individuals discharged after a No Bed Report (NBR) is filed. Research by Disability Rights Washington indicates that often this requirement is not satisfied, and individual discharged on NBRs were not offered support after discharge. KIMBERLY MOSOLF & HANNAH GARLAND, ALL OR NOTHING: ENDING WASHINGTON'S DEPENDENCE ON INVOLUNTARY CIVIL COMMITMENT 7 (2021).

98. WASH. REV. CODE § 71.05.180 (2020).

99. *Id.* § 71.05.230.

100. *Id.* § 71.05.230(4)(a)(i) (“(A) One physician, physician assistant, or psychiatric advanced registered nurse practitioner; and (B) One physician, physician assistant, psychiatric advanced registered nurse practitioner, or mental health professional.”).

101. *Id.* § 71.05.230(6).

individual.<sup>102</sup> Similar to a criminal case, the prosecuting attorney has a considerable amount of power in deciding whether and how to move forward with the case.<sup>103</sup> If the treatment facility recommends commitment, but the prosecuting attorney does not believe the legal threshold for commitment is met, the prosecuting attorney may advocate for a less restrictive order<sup>104</sup> or attempt to negotiate an alternative agreement with the individual's assigned defense attorney.<sup>105</sup>

The prosecuting attorney almost always utilizes expert testimony from a behavioral health professional who previously met and reviewed the treatment notes of the individual.<sup>106</sup> The prosecuting attorney may also utilize testimony from subpoenaed witnesses, typically the same people the DCR interviewed during the initial detention process.<sup>107</sup>

The assigned defense counsel represents the wishes of the individual facing civil commitment. Because the individual has the right to postpone their hearing through a continuance<sup>108</sup>—essentially agreeing to extend the timeframe of their initial petition—a fourteen-day hearing only occurs when an individual wishes to be discharged and the treating facility opposes discharge.<sup>109</sup> Before the start of the fourteen-day hearing, if an individual alleges they have in “good faith volunteered for [appropriate] treatment,” then the prosecuting attorney must show the patient has *not* done so.<sup>110</sup> The evidentiary standard for a good faith volunteer defense is by a preponderance of the evidence.<sup>111</sup> A good faith volunteer is someone who “abide[s] by procedures and a treatment plan as prescribed by a treatment facility and professional staff.”<sup>112</sup> In practice this standard is hard to reach. The very fact that an individual was initially detained, and

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102. *ITA – Information for Participants*, KING CNTY., <https://kingcounty.gov/depts/prosecutor/criminal-overview/ita-more-information.aspx> (Nov. 13, 2019) (last visited Dec. 6, 2022).

103. See, e.g., Jordan A. Sklansky, *The Nature and Function of Prosecutorial Power*, 106 J. CRIM. L. & CRIMINOLOGY 473, 474 (2016) (pointing out that prosecutorial power is increasing in the United States and globally); Angela J. Davis, *The Power and Discretion of the American Prosecutor*, 49 DROIT ET CULTURES 55, 55 (2005) (describing prosecutorial power as “vast and unrestrained” with minimal or ineffective accountability).

104. WASH. REV. CODE § 71.05.240(4)(c), (d) (2021).

105. *ITA – Information for Participants*, *supra* note 102.

106. *Id.*

107. *Id.*

108. WASH. REV. CODE § 71.05.236 (2020).

109. *Id.* § 71.05.230(2) (2020).

110. *Id.* § 71.05.240(3) (2021).

111. *Id.* Preponderance of the evidence is generally understood to mean whichever party presents stronger evidence “however slight the edge may be.” *Preponderance of the Evidence*, BLACK’S LAW DICTIONARY (11th ed. 2019).

112. WASH. REV. CODE § 71.05.240(3) (2021).

continues to be held against their will, indicates an unwillingness to abide by the procedures and plans the treatment team believes are in the individual's best interest.

The judge then determines whether a person is gravely disabled and/or presents a likelihood of serious harm, utilizing "all available evidence concerning the respondent's historical behavior."<sup>113</sup> If the judge finds the legal threshold for involuntary treatment is met, the individual will remain in the treatment facility for up to fourteen days from the date of the hearing.<sup>114</sup> The evidentiary standard for this stage of the hearing is also preponderance of the evidence.<sup>115</sup>

Detainment facilities can discharge individuals at any point, even after a judge decides they meet the legal threshold for detention.<sup>116</sup> If an individual remains in the treating facility at the end of the fourteen days, and the facility believes they require further involuntary care, the petition and hearing process repeats.<sup>117</sup> The individual then faces civil commitment for ninety days.<sup>118</sup> The evidentiary standard is raised to clear and convincing for this longer detention and any hearing that occurs thereafter.<sup>119</sup>

The ITA also allows for involuntary outpatient treatment, often court ordered through a less-restrictive order (sometimes referred to as a "less-restrictive alternative").<sup>120</sup> This procedure closely mirrors that of involuntary inpatient treatment.<sup>121</sup> As discussed above, an individual may be ordered a less-restrictive alternative at the time of the fourteen-day

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113. Symptoms that may otherwise not justify civil commitment may do so when they are "closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts," those symptoms indicate a "marked and concerning change" from the individual's baseline behavior, and it is probable the individual would continue to deteriorate if not provided with treatment. WASH. REV. CODE §§ 71.05.245(2)(a), (b) (2022). Furthermore, determination of likelihood of serious harm can include evidence of recent violent acts or recent civil commitment based on serious harm in Washington or another state. Prior acts of violence and/or prior civil commitments, although given "great weight," are not sufficient alone to determine likelihood of serious harm. WASH. REV. CODE §§ 71.05.245(1)–(3) (2022).

114. *Id.* § 71.05.230 (2020).

115. *Id.* § 71.05.240(4)(a) (2021).

116. *Id.* § 71.05.260 (1997).

117. *Id.* § 71.05.280 (2020).

118. *Id.* § 71.05.320(1)(a) (2022).

119. *Id.* § 71.05.310 (2020). Clear and convincing evidence refers to evidence that "indicat[es] that the thing to be proved is highly probable or reasonably certain." *Evidence*, BLACK'S LAW DICTIONARY (11th ed. 2019). Clear and convincing is a higher evidentiary standard than preponderance of the evidence, and a lower evidentiary standard than beyond a reasonable doubt. *Id.*

120. WASH. REV. CODE § 71.05.148 (2019).

121. *Id.*

hearing.<sup>122</sup> Alternatively, a facility may discharge a person on a less-restrictive order at any point, if that order is agreed upon by the facility and the patient.<sup>123</sup> Violation of a less-restrictive order may lead to a return to involuntary inpatient treatment.<sup>124</sup>

The ITA is complex, even for legal scholars, and is even less accessible and clear to those who are most impacted by it: the people being detained and forced into treatment. Laws other than the ITA also impact the civil commitment process—for example, those laws that govern what happens when a DCR decides not to detain someone,<sup>125</sup> and the laws governing minors. Those laws are beyond the scope of this Comment.<sup>126</sup>

### C. *What Is the Impact of the Implementation of the Involuntary Treatment Act?*

How states implement legislation is equally, if not more, important than how they write it. Because human actors administer the ITA, there is the possibility of significant variation and inconsistency in its interpretation and application. This inconsistency, combined with lack of oversight,<sup>127</sup> leads to concern for how disabled individuals are treated within the context of involuntary treatment. Additionally, as discussed above, the historical roots of civil commitment should make society particularly wary about the implementation and impact of the ITA, and the reliance on ITA as a primary source of behavioral health treatment.

#### 1. *Behavioral Health and Washington State*

Statewide trends for behavioral health provide important information

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122. *Id.* § 71.05.240(4)(c) (2021).

123. Referred to as an “agreed order,” the patient may at any time agree to an order for more restrictive or less restrictive care. *ITA Court Forms*, KING CNTY., <https://kingcounty.gov/courts/superior-court/ita/ita-court-forms.aspx> (Mar. 31, 2020) (last visited Dec. 6, 2022).

124. A new petition can be filed against a person living in the community on a less-restrictive order if that person continues to be gravely disabled, or if they threaten, attempt, or actually inflict harm on another, or substantially damage the property of another; and if that person continues to present a likelihood of serious harm as result of a behavioral health disorder or developmental disability. In situations where a new petition is filed, and the legal threshold as outlined is met, the court may revoke the original less-restrictive order in lieu of more-restrictive (inpatient) care, and the individual can be held for up to the time remaining on their less-restrictive order. For instance, if an individual has successfully completed seventy days of a ninety day less-restrictive order, they can be held in more-restrictive care for the remaining twenty days after a hearing has been held and a judge has decided the legal threshold has been satisfied. WASH. REV. CODE §§ 71.05.320(2), (6) (2021).

125. *Id.* § 71.05.201.

126. *Id.* § 71.34.

127. MOSOLF & GARLAND, *supra* note 97, at 6.



about the current status of care in Washington State, including involuntary treatment. According to Mental Health America (MHA), a non-profit organization that “promote[s] mental health as a critical part of overall wellness,”<sup>128</sup> Washington ranked 32nd in the nation for its state of mental health in 2022.<sup>129</sup> This ranking considered the prevalence of mental illness in the state, as well as access to treatment.<sup>130</sup> Recent findings by the state legislature echo the need for increased and improved behavioral health care in Washington. A finding in the 2021 Washington session laws, which established crisis call center hubs in the state, found that one in five Washington residents live with a behavioral health disorder.<sup>131</sup> Furthermore, deaths by suicide increased statewide by 36% over the last decade.<sup>132</sup> For young people aged ten to twenty-four, suicide is now the leading cause of death in Washington.<sup>133</sup>

*The Seattle Times* also recently reported that one in five Washington residents have a diagnosable mental illness and that the percentage of adults reporting serious thoughts of suicide in Washington ranks seventh-highest in the country.<sup>134</sup> Washington also has a higher than average percentage of adults with unmet treatment needs,<sup>135</sup> with rural communities more at risk for unmet need.<sup>136</sup> Dr. Jürgen Unützer, chair of the University of Washington’s Psychiatry and Behavioral Sciences Department, identified “high-intensity inpatient and community-based care” as one way to expand access to behavioral health treatment.<sup>137</sup>

Unfortunately, early behavioral health intervention is not always available to people experiencing behavioral health conditions or crises. Jim Vollendroff, former director of the King County Behavioral Health and Recovery Division, noted that “we wait until people are at the equivalent of stage 4 cancer, and then we try to intervene and we try to

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128. *About Mental Health America*, MENTAL HEALTH AM., <https://www.mhanational.org/about> [<https://perma.cc/T33R-3PAT>].

129. *Ranking the States 2022*, MENTAL HEALTH AM., <https://www.mhanational.org/issues/2022/ranking-states> [<https://perma.cc/J6YP-AV22>].

130. *Id.*

131. 2021 Wash. Sess. Laws 2408.

132. *Id.*

133. *Id.*

134. Hannah Furfaro, *Here Are the Basic Facts About Mental Health and Treatment in Washington State*, SEATTLE TIMES (Sept. 19, 2021), <https://www.seattletimes.com/seattle-news/mental-health/here-are-the-basic-facts-about-mental-health-and-treatment-in-washington-state/> [<https://perma.cc/R7XZ-P7YV>].

135. *Id.*

136. *Id.*

137. *Id.*

offer them all of this support.”<sup>138</sup> Even advocates for expansion of the ITA, such as Jerri Clark, whose son Calvin died by suicide after not meeting the threshold for civil commitment, believe that lack of appropriate access to care is at least partially to blame.<sup>139</sup> Ms. Clark explained how she and her husband contacted thirty psychiatrists shortly after the onset of Calvin’s symptoms, and only one had an appointment available in the next nine months.<sup>140</sup> Unfortunately, civil commitment did not save Calvin’s life. Despite “a series of hospitalizations,” Calvin did not receive the care he needed.<sup>141</sup>

It is clear that there is a need for behavioral health care in Washington. However, it is vital to look carefully at whether civil commitment is meeting that need, or conversely, whether the impact of civil commitment causes harm to the population it aims to serve.

## 2. *Who Is Being Impacted?*

This Comment focuses on the implementation of the ITA in King County. One county’s utilization of involuntary treatment provides insights about statewide trends. Furthermore, because King County is Washington State’s most populous county,<sup>142</sup> and includes urban, suburban, and rural communities, it provides insights into ITA implementation. Two 2019 King County reports analyzed local implementation of the ITA. The Auditor’s Report examined the ITA,<sup>143</sup> while the Behavior Health and Recovery Division Report (Facility Report) examined treatment facilities.<sup>144</sup>

The Auditor’s Report focused on reentry and outcomes in ITA court proceedings.<sup>145</sup> This report found an alarming rate of recidivism<sup>146</sup> in the involuntary treatment system, with 57% of involuntary court cases

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138. Anna Patrick, *Becoming Homeless in Seattle Helped Him Find Psychiatric Help. His Mom Says It Shouldn’t Have Taken That Long*, SEATTLE TIMES (July 25, 2021), <https://www.seattletimes.com/seattle-news/homeless/one-family-s-journey-through-was-mental-health-system/> [<https://perma.cc/W3F9-L3CW>].

139. *Id.*

140. *Id.*

141. *Id.*

142. Vance-Sherman, *supra* note 10.

143. See POON ET AL., *supra* note 7.

144. MARIA YANG, KING CNTY. BEHAV. HEALTH & RECOVERY DIV., 2019 KING COUNTY E&T DECLINE REPORT (2019).

145. See POON ET AL., *supra* note 7.

146. Recidivism in the context of criminal law “is measured by criminal acts that resulted in rearrest, reconviction or return to prison. . . .” *Recidivism*, NAT’L INST. OF JUST., <https://nij.ojp.gov/topics/corrections/recidivism> [<https://perma.cc/X6HM-XU49>]. In the context of the ITA, recidivism refers to an individual’s repeated return to civil commitment.

involving people with at least one prior ITA proceeding.<sup>147</sup> Of that number, almost a quarter involved individuals with more than three prior ITA cases, and 7% involved individuals with ten or more prior cases.<sup>148</sup> Less than half of those brought into court under the ITA were there for the first time.<sup>149</sup> Almost three-quarters of people with more than three ITA cases returned to involuntary treatment within a three-year period of their most recent case.<sup>150</sup>

According to the Auditor's Report, participation in involuntary treatment is also linked to disproportionate rates of housing insecurity. As compared to 1% of King County residents overall who experience housing instability, 28% of individuals connected to involuntary treatment experienced housing instability.<sup>151</sup> This percentage only grows as frequency of involuntary treatment increases, with housing instability experienced by 41% of individuals with more than three prior ITA cases.<sup>152</sup>

The Auditor's Report also focused on factors associated with return to the ITA system. The report noted that the ITA system's high rate of recidivism could indicate insufficient use of voluntary treatment.<sup>153</sup> The report also highlighted the trauma the ITA system engenders in committed individuals who lose their rights.<sup>154</sup> As discussed above, the most significant personal characteristic factor associated with ITA recidivism was the existence of one or more prior commitments.<sup>155</sup> Other factors correlated with likely recidivism included gender identity, race, and housing status.<sup>156</sup>

Of particular importance is the relationship between race and involvement in the ITA system. Alarming, 14.8% of all ITA cases involved Black individuals.<sup>157</sup> This is true despite Black individuals making up only 7% of the King County population. This overrepresentation contrasts starkly with the same breakdown for white individuals: 63% of ITA cases as compared to 68% of the general

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147. See POON ET AL., *supra* note 7, at 6.

148. *Id.*

149. *Id.*

150. *Id.* at 12.

151. *Id.* at 6.

152. *Id.* at 6–7.

153. *Id.* at 10.

154. *Id.*

155. *Id.* at 12.

156. *Id.* at 13.

157. *Id.* at 7.

population in King County.<sup>158</sup>

Further, the Facility Report found Black individuals more likely to be referred for involuntary detention by a DCR.<sup>159</sup> In 2017 and 2018, between 13% and 15% of referrals for involuntary detention were Black individuals, despite making up only 7% of the county's general population.<sup>160</sup> Indigenous and mixed-race individuals were also more likely to be referred for involuntary detention.<sup>161</sup>

The correlation between involuntary treatment in King County and race signifies a larger and troubling history of racism within the fields of psychology and psychiatry. Notably, both the American Psychological Association and the American Psychiatric Association issued apologies based on the relationship between racism and psychological and psychiatric care.<sup>162</sup>

Studies also show that racial stereotypes result in people perceiving Black individuals as more violent or dangerous, which is a key factor in determining whether to detain someone under the ITA.<sup>163</sup> One study, which utilized a “shooter bias” videogame,<sup>164</sup> found that the racial

158. *Id.*

159. Yang, *supra* note 144, at 11.

160. *Id.*

161. *Id.* Native American individuals represent approximately 1% of the King County population but 2% of ITA referrals. Individuals of two or more races represent approximately 5% of the King County population and up to 8% of ITA referrals.

162. In October 2021, the American Psychological Association issued an official apology based on its role in “promoting, perpetuating, and failing to challenge racism, and the harms that have been inflicted on communities of color as a result” in the United States. The American Psychological Association outlined a clear history of discrimination, including the fact that psychologists have “established, participated in, and disseminated scientific models and approaches rooted in scientific racism” including “tests and instruments that have been used to disadvantage many communities of color.” The American Psychological Association also recognized that methods of diagnosis have not successfully taken into account “the contextual and lived experiences of people of color” that influence behavioral health. *Apology to People of Color for APA's Role in Promoting, Perpetuating, and Failing to Challenge Racism, Racial Discrimination, and Human Hierarchy in U.S.*, AM. PSYCH. ASS'N (Oct. 29, 2021), <https://www.apa.org/about/policy/racism-apology> [<https://perma.cc/LU59-CZRC>]. In January 2021, the American Psychiatric Association issued its own apology, stating that “early psychiatric practices laid the groundwork for the inequities in clinical treatment” and recognizing that “race-based discrepancies” still exist “as evidenced by the variations in schizophrenia diagnosis between white and BIPOC patients.” The American Psychiatric Association also acknowledged that the impact of systematic racism in the psychiatric field is “ingrained in the structure of psychiatric practice” and continues to cause harm. *APA's Apology to Black, Indigenous and People of Color for Its Support of Structural Racism in Psychiatry*, AM. PSYCHIATRIC ASS'N (Jan. 18, 2021), <https://www.psychiatry.org/newsroom/apa-apology-for-its-support-of-structural-racism-in-psychiatry> [<https://perma.cc/LQ5T-8MMM>].

163. Kimberly Barsamian Kahn & Paul G. Davies, *Differentially Dangerous? Phenotypic Racial Stereotypicality Increases Implicit Bias Among Ingroup and Outgroup Members*, 14 GRP. PROCESSES & INTERGROUP RELS. 569 (2010). See discussion of ITA factors *supra* section II.C.2.

164. Kahn & Davies, *supra* note 163, at 570.

stereotyping of Black individuals led to “increased implicit stereotyping of Black targets.”<sup>165</sup> When comparing Black and white targets, participants saw Black targets as more dangerous.<sup>166</sup> In a different study, no difference was seen between psychiatric admission rates of Black and white individuals in emergency departments.<sup>167</sup> However, the authors noted that how race factors into medical decision-making is complex, and that bias “may be specific to situation and diagnosis,” therefore making trends harder to identify in non-specific studies.<sup>168</sup> The authors identified the determination of risk of imminent violence or dangerousness as one such instance.<sup>169</sup>

This is an important bias to be aware of, particularly as it relates to the ambiguous dangerousness standard utilized for civil commitment. Characteristic biases should be analyzed in conjunction with factors relating to the implementation of the ITA in order to gain a full picture of how involuntary treatment is being implemented.

### 3. *Other Factors Related to the Implementation of the ITA at Play*

In addition to personal characteristic factors, the Auditor’s Report identified other factors impacting ITA implementation. For instance, the Auditor’s Report found that people were less likely to return to involuntary treatment if they primarily received their care at an Evaluation and Treatment (E&T) facility.<sup>170</sup> E&T facilities are specifically and specially licensed to provide involuntary treatment in Washington, but people often cannot access them. Instead, they receive involuntary treatment in hospital emergency rooms and other less specialized settings. The Auditor’s Report suggested that its findings could be utilized to “create a system that addresses these contributing factors and works to avoid repeated cycling through the system.”<sup>171</sup>

The reasons why E&Ts refuse admittance to those requiring involuntary treatment compound the variation in treatment between E&T and non-E&T beds. Troublingly, the two leading reasons E&Ts refuse

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165. *Id.* at 577.

166. *Id.* at 576.

167. Jeffrey Kerner, Bridget McCoy, Nadia Gilbo, Mary Colavita, Mimi Kim, Lisa Zaval & Merrill Rotter, *Racial Disparity in the Clinical Risk Assessment*, 56 CMTY. MENTAL HEALTH J. 586, 589 (2020).

168. *Id.* at 590.

169. *Id.*

170. See Poon et al., *supra* note 7, at 17.

171. See *id.* at 38.

admissions are medical and behavioral reasons.<sup>172</sup> The umbrella of behavioral reasons includes “acuity,”<sup>173</sup> a term that refers to the severity and intensity of a patient’s condition, and how those factors impact their need for care.<sup>174</sup> Ironically, E&Ts decline admission to the state’s licensed, specialized involuntary care setting because, in the E&T’s estimation, the person is too sick.

Data showing that E&Ts are declining patients due to acuity is not unique. In a report written by Disability Rights Washington, Washington’s disability protection and advocacy agency,<sup>175</sup> data indicated that over one-third of patients denied an involuntary treatment bed were denied due to symptom acuity or presence of dementia, bipolar disorder, or a developmental disability.<sup>176</sup>

When considering the fact that individuals are less likely be involuntarily committed for a second time if they receive treatment at an E&T, it is concerning that E&T facilities decline patients because they are perceived to be too acute. Involuntary inpatient psychiatric care is the most restrictive form of behavioral health care, intended only for those most intensely in need of such care. Unfortunately, the very people who may benefit the most from emergency stabilizing care are being denied access.

#### 4. *Involuntary Treatment, Homelessness, and Incarceration*

Involuntary treatment does not exist in a vacuum. As discussed above, people committed under the ITA also experience disproportionately high rates of housing insecurity. According to the United States Interagency Council on Homelessness, in Washington State, approximately 22,923 people were experiencing homelessness per day, as of January 2020.<sup>177</sup> A *Seattle Times* article last updated in April 2021 reported that at 6.2%, Washington saw the third largest increase in people experiencing homelessness from 2019 to 2020.<sup>178</sup> The City of Seattle’s official website

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172. Yang, *supra* note 144, at 3. Medical and behavioral reasons were the top two reasons that E&Ts declined admissions from 2016 to 2018. *Id.*

173. *Id.* at 5.

174. MOSOLF & GARLAND, *supra* note 97, at 15 n.xxxiii.

175. *About Us*, DISABILITY RTS. WASH., <https://www.disabilityrightswa.org/about-us/> [<https://perma.cc/KY3D-3NRA>].

176. MOSOLF & GARLAND, *supra* note 97, at 6.

177. *Washington Homelessness Statistics*, U.S. INTERAGENCY COUNCIL ON HOMELESSNESS, <https://www.usich.gov/homelessness-statistics/wa/> [<https://perma.cc/QX7A-EZ5G>].

178. *See* Sydney Brownstone, *Washington State’s Rise in Homelessness Outpaced the Nation’s, According to Report*, SEATTLE TIMES (Apr. 9, 2021), <https://www.seattletimes.com/seattle->

lists mental health and addiction as two of the root causes of Seattle's homelessness crisis.<sup>179</sup>

Experts believe that homelessness impacts behavioral health and behavioral health impacts homelessness.<sup>180</sup> For example, the experience of homelessness is linked to increased behavioral health symptoms.<sup>181</sup> An article in *Psychiatric Times*, aptly and distressingly titled "The Never-Ending Loop: Homelessness, Psychiatric Disorder, and Mortality," concluded that "mental health conditions are highly prevalent in homeless populations" and that "homeless individuals have [a] higher mortality related to many causes."<sup>182</sup>

Due to a lack of available data, it is challenging to know the connection between involuntary treatment and criminal incarceration. However, some local data indicate a relationship between incarceration and involuntary treatment. For example, data presented in *Trueblood v. Washington State Department of Social & Health Services*,<sup>183</sup> a class action lawsuit that found the Department of Health and Human Services violated the class's constitutional right to timely competency evaluation and restoration services,<sup>184</sup> showed that the majority of surveyed class members had a history of involvement with behavioral health crisis services.<sup>185</sup>

Additionally, data indicates that a high percentage of people experiencing incarceration also experience behavioral health symptoms. A 2017 report showed that 37% of people in state and federal prisons were diagnosed with a behavioral health condition between 2011 and 2012, and that a staggering 44% of people in local jails were diagnosed with a behavioral health condition.<sup>186</sup> A National Research Council report

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news/homeless/washington-states-rise-in-homelessness-outpaced-the-nations-according-to-report/  
[<https://perma.cc/R7XZ-W97T>].

179. *The Roots of Seattle's Homelessness Crisis*, CITY OF SEATTLE, <https://www.seattle.gov/homelessness/the-roots-of-the-crisis> [<https://perma.cc/W973-88HC>].

180. *Homelessness and Mental Illness: A Challenge to Our Society*, BRAIN & BEHAV. RSCH. FOUND. (Nov. 19, 2018), <https://www.bbrfoundation.org/blog/homelessness-and-mental-illness-challenge-our-society> [<https://perma.cc/77MK-AES3>].

181. *Id.*

182. Lilanthi Balasuriya, Eliza Buelt & Jack Tsai, *The Never-Ending Loop: Homelessness, Psychiatric Disorder, and Mortality*, 37 *PSYCHIATRIC TIMES* 12, 14 (2020).

183. No. C14-1178-MJP, 2016 WL 4268933 (W.D. Wash. Aug. 15, 2016).

184. *AB v. DSHS (Trueblood): Reforming Washington's Forensic Mental Health System*, DISABILITY RTS. WASH. (Aug. 4, 2014), <https://www.disabilityrightswa.org/cases/trueblood/#How> [<https://perma.cc/4EMN-SGWZ>].

185. *Trueblood Diversion Plan Ex. A* at 7-8, *Trueblood v. Wash. State Dep't of Soc. & Health Servs.*, No. C14-1178 MJP (W.D. Wash. Aug. 19, 2016).

186. Jennifer Bronson & Marcus Berzofsky, *Indicators of Mental Health Problems Reported by*

published in 2014 found similar numbers, with people who reported behavioral health concerns accounting for 65% of people in jails, 54% of people in state prisons, and 45% of people in federal prisons.<sup>187</sup> June Tangney, a researcher of offender rehabilitation, stated that “[p]art of what’s really swelled our jail and prison population, especially our jail population, is our inability to deal with the mental health crisis that we’re facing in this country.”<sup>188</sup> Additionally, Washington State’s legislature acknowledged that “crisis response [has] placed marginalized communities, including those experiencing behavioral health crises, at disproportionate risk of poor outcomes and criminal justice involvement.”<sup>189</sup>

Despite a lack of current data, there is little doubt that behavioral health, homelessness, and incarceration are all linked. The people who experience involuntary treatment likely also experience homelessness and/or incarceration at a higher rate than the general population.

#### *D. Guidelines for More Effective Implementation of Involuntary Treatment*

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides guidelines to assist policy makers in reforming civil commitment, built around the goal of “taking account of the competing interests at stake in civil commitment and considering the inherent ethical concerns.”<sup>190</sup> There are three initial guidelines outlined by SAMHSA:

- (1) Civil commitment, whether inpatient or outpatient, should be reserved for those reliably diagnosed with a serious mental illness for which there is available treatment that is likely to be effective . . . ;
- (2) If the person is willing and able to engage with services voluntarily, he or she should not be committed . . . ;
- (3) A person should not be subject to inpatient commitment unless, without a hospital level of care, the person will be at significant risk, in the foreseeable future, of behaving in a way, actively or passively, that brings harm to the person or others.<sup>191</sup>

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*Prisoners and Jail Inmates 2011–12*, BUREAU OF JUST. STATS. (June 22, 2017), <https://bjs.ojp.gov/content/pub/pdf/imhprpji1112.pdf> [<https://perma.cc/7N6V-FD54>].

187. Lorna Collier, *Incarceration Nation*, AM. PSYCH. ASS’N (Oct. 2014), <https://www.apa.org/monitor/2014/10/incarceration> [<https://perma.cc/M6DX-QSQX>].

188. *Id.*

189. WASH. REV. CODE § 71.24.890(2)(a)(iii) (2021).

190. CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM, *supra* note 12, at 32.

191. *Id.*



All three guidelines imply that there should be other care available to people who do not meet the threshold for civil commitment or who would voluntarily engage in care. This raises the question: Is ethical utilization of civil commitment possible if there are insufficient viable options for less restrictive treatment available?

In 2020, SAMHSA published the “National Guidelines for Behavioral Health Crisis Care,” which make clear that “short-term, inadequate crisis care is shortsighted.”<sup>192</sup> The SAMHSA guidelines analogize “limited and fragmented approaches” such as dependence on emergency rooms as “akin to plugging a hole in a dike with a finger.”<sup>193</sup> One particular area of the SAMHSA guidelines is worth emphasizing: the importance of crisis receiving and stabilization services.<sup>194</sup> SAMHSA explains that “it is important to fund these facility-based programs so they can deliver on the commitment of never rejecting a first responder or walk-in referral in order to realize actual emergency department and justice system diversion.”<sup>195</sup>

In New York City, the Frequent Users Services Enhancement (FUSE) initiative provided eligible participants with subsidized permanent supportive housing.<sup>196</sup> The FUSE initiative succeeded, with participants reducing their use of homeless shelters as well as reducing time spent incarcerated.<sup>197</sup> The data shows that FUSE participants, on average, spent almost half as many days hospitalized for psychiatric reasons as non-participants.<sup>198</sup> FUSE’s success is not an anomaly: a 2006 study examining how permanent supportive housing impacts homeless individuals with behavioral health, substance abuse, or other disabilities<sup>199</sup> found overall decreases in both emergency department visits (56% decrease) and inpatient admissions (45% decrease).<sup>200</sup>

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192. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE—A BEST PRACTICE TOOLKIT 1, 10 (2020), <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf> [<https://perma.cc/UT4S-2FBT>].

193. *Id.*

194. *Id.* at 22.

195. *Id.*

196. Angela A. Aidala, William McAllister, Maiko Yomogida & Virginia Shubert, *Frequent Users Service Enhancement ‘FUSE’ Initiative*, COLUMBIA UNIV. MAILMAN SCH. OF PUB. HEALTH i, ii–iii (2013), [https://www.csh.org/wp-content/uploads/2014/01/FUSE-Eval-Report-Final\\_Linked.pdf](https://www.csh.org/wp-content/uploads/2014/01/FUSE-Eval-Report-Final_Linked.pdf) [<https://perma.cc/2QS8-9FCB>].

197. *Id.* at v.

198. *Id.* at vi.

199. Tia E. Martinez & Martha R. Burt, *Impact of Permanent Supportive Housing on the Use of Acute Care Health Services by Homeless Adults*, 57 PSYCHIATRIC SERVS. 992, 992 (2006).

200. *Id.* at 995.

Crisis receiving and stabilization services would provide intensive, twenty-four/seven, voluntary care to those most at risk of being involuntarily committed. SAMHSA’s vision of crisis receiving and stabilization services includes a diverse staff prepared to meet the needs of various levels of crisis. Specifically, the existence of the crisis receiving and stabilization services SAMHSA outlines would allow people who do not require hospital-level care to access intensive care that meets their behavioral health needs.

In 2018, a report by the Washington Office of Financial Management found that Washington had only 346 crisis beds, including beds “in triage facilities, crisis stabilization units, and crisis respite facilities.”<sup>201</sup> Despite recommendations that the statewide bed numbers rise to 808,<sup>202</sup> Washington added less than 100 additional beds since 2018.<sup>203</sup> That need may be even higher now.

Downtown Emergency Service Center (DESC), an organization based in King County, operates the Crisis Solutions Center in Seattle—currently the only crisis receiving and stabilization facility in King County.<sup>204</sup> The County plans to build two additional sixteen-bed crisis facilities.<sup>205</sup> The construction of these facilities is made possible due to contempt settlement funds from *Trueblood*.<sup>206</sup> DESC continues emphasizing its view that crisis response needs to be expanded.<sup>207</sup> In late 2021, the Seattle City Council passed a budget that will help fund the expansion of crisis services.<sup>208</sup> This is a positive development for the greater Seattle area, but this sort of budgetary support may not be available in more rural parts of the state.

Involuntary treatment and civil commitment are narrow areas of law that are governed more broadly by state and federal disability law. In order to analyze Washington’s implementation of the ITA, it is necessary to understand existing protections for persons with disabilities.

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201. MOSOLF & GARLAND, *supra* note 97, at 15 n.xxvii.

202. *See id.*

203. *Id.* at 4.

204. *Crisis Response*, DOWNTOWN EMERGENCY SERV. CTR., <https://www.desc.org/what-we-do/crisis-response/> [<https://perma.cc/5EUN-SQWZ>].

205. Tyler Hemstreet, *Trueblood Phase 2 Implementation Begins in King County*, DEP’T OF SOC. & HEALTH SERVS. (July 20, 2021), <https://dshswa.medium.com/trueblood-phase-2-implementation-begins-in-king-county-511a6026eee3> [<https://perma.cc/6H33-F9EG>].

206. *Id.*

207. Daniel Malone, *DESC Led Call to Increase Crisis Response*, DOWNTOWN EMERGENCY SERV. CTR. (Dec. 3, 2021), <https://www.desc.org/desc-led-call-to-increase-crisis-response/> [<https://perma.cc/3C7H-XM98>].

208. *Id.*

### III. FEDERAL AND STATE DISABILITY LAW

State and federal law prohibit discrimination against individuals with disabilities. Discriminatory actions can include over-use of institutionalization and exclusion from the community. Discussion of the laws protecting individuals with disabilities is applicable to this Comment because the population impacted by civil commitment—those with behavioral health disorders—are considered individuals with disabilities. Thus, the history of civil commitment, as discussed in Part I, and modern day civil commitment law in Washington State, as discussed in Part II, are inherently linked to the discussion of what protections individuals with disabilities are offered.

#### A. *Disability Law in Washington State*

Washington State’s antidiscrimination legislation<sup>209</sup> protects not only those with physical disabilities, but also those with “sensory” or “mental” disabilities.<sup>210</sup> Furthermore, article XIII of the Washington State Constitution details the duties Washington owes its “mentally ill” or developmentally disabled citizens:

Educational, reformatory, and penal institutions; those for the benefit of youth who are blind or deaf or otherwise disabled; for persons who are mentally ill or developmentally disabled; and such other institutions as the public good may require, *shall be fostered and supported by the state*, subject to such regulations as may be provided by law.<sup>211</sup>

Approved by a wide margin in 1889, the original text of article XIII included language describing persons with disabilities that is now considered derogatory.<sup>212</sup> In 1988, the legislature updated the amendment to its current form.<sup>213</sup> Article XIII laid the groundwork to create social institutions that better served the community.<sup>214</sup>

Article XIII likely confers on Washington State an affirmative duty to protect disabled individuals. Under article I, section 29 of the Washington State Constitution, the “provisions of th[e] Constitution are mandatory,

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209. WASH. REV. CODE § 49.60.030(a) (2020).

210. *Id.*

211. WASH. CONST. art. XIII (emphasis added).

212. ROBERT F. UTTER & HUGH D. SPITZER, THE WASHINGTON STATE CONSTITUTION 214 (G. Alan Tarr ed., Oxford Univ. Press 2d ed. 2013).

213. *Id.*

214. *Id.* at 213.

unless by express words they are declared to be otherwise.”<sup>215</sup> The Supreme Court of Washington confirmed this in *Seattle School District No. 1 of King County v. State*,<sup>216</sup> where it found the language of article IX to be mandatory and judicially enforceable.<sup>217</sup> Article IX states that “[i]t is the paramount duty of the state to make ample provision for the education of all children residing within its borders, without distinction or preference on account of race, color, caste, or sex.”<sup>218</sup> The phrase “ample provision” has repeatedly been held to create an affirmative duty of the state and corresponding right for students, in cases such as *Seattle School District*<sup>219</sup> and *McCleary v. State*.<sup>220</sup>

Other sections of the Washington State Constitution have also been read by the judiciary with wide latitude and held to create an affirmative duty. Recently, in *Martinez-Cuevas v. DeRuyter Bros. Dairy, Inc.*,<sup>221</sup> the Supreme Court of Washington once again put great weight on the language of the Washington State Constitution.<sup>222</sup> Article II, section 35 of the constitution states: “The legislature shall pass necessary laws for the protection of persons working in mines, factories and other employments dangerous to life or deleterious to health; and fix pains and penalties for the enforcement of the same.”<sup>223</sup> The Court held that by using the word “shall,” article II, section 35 established a “fundamental right of Washington workers to health and safety protection.”<sup>224</sup>

Washington State recognizes the need to prevent discrimination against disabled individuals, and the need to create state systems that support care for disabled individuals, through both state legislation and the state constitution. Further, the Supreme Court of Washington consistently reads the language of the Washington State Constitution to create fundamental rights on behalf of the specified parties. Although courts have not yet granted fundamental rights to individuals with disabilities through article XII, the court’s article IX and article II jurisprudence support such an application. Furthermore, federal legislation specifies the need for prevention of discrimination against disabled individuals and supports this requirement through case law.

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215. WASH. CONST. art. I, § 29.

216. 90 Wash. 2d 476, 585 P.2d 71 (1978).

217. *Id.* at 499, 500 n.5, 585 P.2d at 85, 86 n.5.

218. WASH. CONST. art. IX, § 1.

219. *Seattle Sch. Dist.*, 90 Wash. 2d at 499, 500 n.5, 501–02, 585 P.2d at 85, 86–87, 86 n.5.

220. 173 Wash. 2d 477, 485, 269 P.3d 227, 232 (2012).

221. 196 Wash. 2d 506, 475 P.3d 164 (2020).

222. *Id.* at 519–20, 475 P.3d at 171.

223. WASH. CONST. art. II, § 35.

224. *Martinez-Cuevas*, 196 Wash. 2d at 519–20, 475 P.3d at 171.

B. *Disability Law in the United States*

The United States' historical treatment of persons with disabilities is troubling. During the country's early history, society saw persons with disabilities as problems to be solved.<sup>225</sup> Accordingly, early treatment focused on community stability rather than individual care.<sup>226</sup> It was not until after World War I, when the United States government began providing services to disabled veterans, that the idea that the government owed a duty to care for and improve the lives of persons with disabilities emerged.<sup>227</sup> Focus on disabilities grew again after World War II, when disabled veterans advocated for treatment and training.<sup>228</sup> Unfortunately, this focus did not eliminate longstanding systematic discrimination against disabled people.<sup>229</sup>

Not until the 1970s, and after decades of advocacy from disabled and non-disabled people, did federal legislation significantly protect disabled individuals.<sup>230</sup> In 1973, the Rehabilitation Act became the first federal legislation to protect the civil rights of persons with disabilities.<sup>231</sup> In 1984, the Fifth Circuit acknowledged that people with intellectual disabilities "have been subjected to a history of unfair and often grotesque mistreatment."<sup>232</sup> Additional legislation relating to the rights of persons with disabilities passed throughout the 1970s and 1980s. This trend culminated in 1990 with the passage of the Americans with Disabilities Act (ADA).<sup>233</sup> The ADA represents a significant win for the disability community and should not be understated.<sup>234</sup> However, similar to the passage of the Civil Rights Act of 1964, the ADA alone could not eradicate the centuries of systemic discrimination against disabled people built into the United States.

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225. See, e.g., *A Brief History of the Disability Rights Movement*, ANTI-DEFAMATION LEAGUE (May 3, 2022), <https://www.adl.org/education/resources/backgrounders/disability-rights-movement> [<https://perma.cc/L3QC-3TVT>] (highlighting the historical bias against persons with disabilities).

226. See *supra* Part I; Laura I. Appleman, *Deviancy, Dependency, and Disability: The Forgotten History of Eugenics and Mass Incarceration*, 68 DUKE L.J. 417, 424 (2018).

227. ANTI-DEFAMATION LEAGUE, *supra* note 225.

228. *Id.*

229. *Id.*

230. *Id.*

231. *Id.*

232. *Cleburne Living Ctr., Inc. v. City of Cleburne*, 726 F.2d 191, 197 (5th Cir. 1984), *aff'd in part, vacated in part*, 473 U.S. 432 (1985).

233. ANTI-DEFAMATION LEAGUE, *supra* note 225.

234. Abigail Abrams, *30 Years After a Landmark Disability Law, the Fight for Access and Equality Continues*, TIME (July 23, 2020), <https://time.com/5870468/americans-with-disabilities-act-coronavirus/> [<https://perma.cc/XD4Q-62SA>].

The ADA prohibits excluding a person from public services, programs, or activities, based upon their disability.<sup>235</sup> This is referred to as the integration mandate of the ADA. Congress tasked the Attorney General with creating regulations to implement the ADA.<sup>236</sup> Under the Code of Federal Regulations section entitled “Nondiscrimination on the Basis of Disability in State and Local Government Services,” public entities must administer “services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”<sup>237</sup> Public entities must also accommodate disabled individuals by making “reasonable modifications in policies, practices, or procedures” to avoid discrimination based upon disability, unless those modifications would fundamentally alter the entities’ policies, practices, or procedures.<sup>238</sup>

Soon after the ADA’s passage, the United States Supreme Court faced the question of whether the Act’s ban on discrimination would in some circumstances require community, rather than institutional, placements for people with behavioral health disabilities.<sup>239</sup> In 1999, the Court answered with a “qualified yes.”<sup>240</sup> In *Olmstead v. L.C.*,<sup>241</sup> two women diagnosed with co-occurring behavioral health conditions and intellectual and developmental disabilities (IDD) remained in voluntary psychiatric institutional settings even after their treatment team found they could be treated in a less restrictive community setting.<sup>242</sup> The Court held that unjustified isolation of persons with disabilities is a form of discrimination.<sup>243</sup> The Court further held that the analysis of when and how the state must provide community-based care includes a number of factors: “the cost of providing community-based care . . . the range of services the State provides others with mental disabilities, and the State’s obligation to mete out those services equitably.”<sup>244</sup>

The Court interpreted “discrimination” in the ADA broadly, and supported its decision with the strong language from the Developmentally Disabled Assistance and Bill of Rights Act and the Rehabilitation Act.<sup>245</sup>

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235. 42 U.S.C. § 12132.

236. *Id.* § 12134(a).

237. 28 CFR § 35.130(d).

238. *Id.* § 35.130(b)(7)(i).

239. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 587 (1999).

240. *Id.*

241. *Olmstead*, 527 U.S. 581.

242. *Id.* at 587.

243. *Id.* at 597.

244. *Id.*

245. *Id.* at 599–600.

The Court also found support for its interpretation in the text of the ADA itself, which states in part that “historically, society has tended to isolate and segregate individuals with disabilities, and . . . such forms of discrimination . . . continue to be a serious and pervasive social problem.”<sup>246</sup> The Court noted that unjustifiable institutionalization both perpetuates stereotypes about disabled people being unable to engage in community life, and “severely diminishes” the life of disabled individuals.<sup>247</sup> Lastly, the Court emphasized that its findings were specific to disabled people able to manage and benefit from community placement.<sup>248</sup>

Regarding the reasonable-modifications standard, the Supreme Court was not as clear with its guidance. Whereas the Court of Appeals for the Eleventh Circuit offered a view on reasonable modifications that would be exceedingly difficult for a state to overcome,<sup>249</sup> the Court in *Olmstead* instead provided the state with more flexibility.<sup>250</sup> Justice Ruth Bader Ginsburg offered the following example as guidance:

If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State’s endeavors to keep its institutions fully populated, the reasonable-modification standard would be met.<sup>251</sup>

There is a rich history of applying *Olmstead* to cases involving disability and disabled people.<sup>252</sup> In 2012, the Ninth Circuit found that “a plaintiff need only show that the challenged state action creates a serious risk of institutionalization” under the integration mandate of the ADA.<sup>253</sup> The court supported its finding with a statement of interest the Department of Justice (DOJ) filed in the district court, which emphasized that “elimination of services that have enabled Plaintiffs to remain in the community violates the ADA, regardless of whether it causes them to enter an institution immediately, or whether it causes them to decline in

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246. *Id.* at 581, 600; 42 U.S.C. § 12101(a)(2).

247. *Olmstead*, 527 U.S. at 601.

248. *Id.* at 601–02 (“We emphasize that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings.”).

249. The Eleventh Circuit allowed a cost-based defense from the state in “only in the most limited of circumstances.” *Id.* at 595.

250. *Id.* at 605–06.

251. *Id.*

252. *Olmstead Enforcement—Cases by Issue*, U.S. DEP’T OF JUST. CIV. RTS. DIV., [https://www.ada.gov/olmstead/olmstead\\_cases\\_by\\_issue.htm](https://www.ada.gov/olmstead/olmstead_cases_by_issue.htm) [<https://perma.cc/8XZ7-BE9N>].

253. *M.R. v. Dreyfus*, 697 F.3d 706, 734 (9th Cir. 2012).

health over time and eventually enter an institution in order to seek necessary care.”<sup>254</sup>

In 2019, the Southern District of Mississippi held that the practical application of Mississippi’s “array of appropriate community-based services” was lacking.<sup>255</sup> The court held the hospital-centered nature of the behavioral health system resulted in exclusion of adults with serious behavioral health conditions from communities, and that this exclusion violated the ADA.<sup>256</sup> Although this holding is not binding on Washington, other federal courts, or the Ninth Circuit, it is helpful in understanding how other courts have interpreted *Olmstead* in relation to community-based care.

Federal legislation and regulations, and the way courts interpret them, make clear that disabled people should not be discriminated against by the use of institutionalization and exclusion from community. Despite this, surprisingly little litigation challenges civil commitment as an *Olmstead* violation. Recently, Disability Rights California (DRC) sued the County of Alameda, challenging the implementation of its civil commitment laws.<sup>257</sup> DRC alleged “discrimination against adults with serious mental health disabilities” based upon the repeated cycling in and out of inpatient care.<sup>258</sup> DRC also alleged that Alameda County failed to provide the community based behavioral health care necessary to prevent civil commitment.<sup>259</sup> DRC provided concrete examples of individuals experiencing the traumatic cycling in and out of institutionalization, and the lack of care available to them in the community.<sup>260</sup> Importantly, DRC also drew a connection between institutionalization and race by highlighting the experience of three Black individuals the county civilly committed.<sup>261</sup>

In April 2021, the Department of Justice Civil Rights Division published a letter concluding “there is reasonable cause to believe that . . . Alameda County violates the ADA as interpreted by *Olmstead v.*

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254. *Id.* at 734–35 (quoting Pamela S. Karlan, NOTICE REGARDING INVESTIGATION OF ALAMEDA COUNTY, JOHN GEORGE PSYCHIATRIC HOSPITAL, AND SANTA RITA JAIL 2 (Apr. 22, 2021)).

255. *United States v. Mississippi*, 400 F. Supp. 3d 546, 549 (S.D. Miss. 2019).

256. *Id.*

257. Amended Complaint, *Disability Rts. Cal. v. Cnty. of Alameda*, No. 5:20-CV-05256-CRB (N.D. Cal. Jan. 21, 2021).

258. *Id.* at 1.

259. *Id.* at 2.

260. *Id.* at 6–9.

261. *Id.*



*L.C.*”<sup>262</sup> In an investigative report that accompanied the letter, the DOJ specified that Alameda County “relies unnecessarily on segregated psychiatric institutions” and that such facilities “isolate and segregate people with mental health disabilities.”<sup>263</sup> The DOJ letter and investigation made clear that “lack of community-based behavioral health crisis services” increased the risk of institutionalization.<sup>264</sup> The DRC case is ongoing and may serve as a useful roadmap for future *Olmstead* litigation around involuntary treatment.

As the prevalence of behavioral health conditions and the need for behavioral health care increase, so must community-based care. The state and federal governments make clear that discrimination against disabled individuals is unlawful, despite implementing legislation that furthers that discrimination. Thus, it is imperative to analyze the lawfulness of the Involuntary Treatment Act (ITA) through the lens of discrimination.

#### IV. CURRENT IMPLEMENTATION OF THE INVOLUNTARY TREATMENT ACT IN KING COUNTY FAILS UNDER STATE AND FEDERAL DISABILITY LAW

Through legislation and case law, the United States federal government makes clear that public entities must provide community-based services to disabled individuals.<sup>265</sup> Under the Washington State Constitution, the state must foster and support institutions for persons who are “mentally ill” or developmentally disabled.<sup>266</sup> Taking both of these duties into account, this Comment argues that the current implementation of the ITA in King County fails under state and federal law.

##### A. *The Involuntary Treatment Act Is in Conflict with the ADA, and the Holding in Olmstead*

Based upon the empirical data available, King County fails to meet the standard set in *Olmstead* and thus violates the ADA. The residents of Washington State—especially those who have experienced involuntary treatment multiple times—are not having their behavioral health needs

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262. Letter from Pamela S. Karlan, Principal Deputy Assistant Att’y Gen., Civ. Rights Div., U.S. Dep’t of Just., to Keith Carson, Gregory J. Ahern & Mark Fratze, Alameda Cnty. (Apr. 22, 2021) (on file with author).

263. U.S. DEP’T OF JUST., CIV. RTS. DIV., INVESTIGATION OF ALAMEDA COUNTY, JOHN GEORGE PSYCHIATRIC HOSPITAL, AND SANTA RITA JAIL 7 (Apr. 22, 2021).

264. *Id.* at 10.

265. *See supra* section III.B.

266. WASH. CONST. art. XIII.

met,<sup>267</sup> and certainly not in the least restrictive setting possible. Individuals cycle in and out of involuntary treatment repeatedly.<sup>268</sup> This indicates the state's failure to provide community-based care sufficient to maintain individuals' health and stability and prevent recidivism.

The current involuntary treatment system simply triages those in the throes of a behavioral health crisis who cannot be assisted in another less-restrictive way. The legislative intent of the ITA is to "provide continuity of care for persons with serious behavioral health disorders."<sup>269</sup> Continuity of care cannot exist when people are forced into treatment, held until stabilized, discharged with minimal support, and left to decompensate into crisis and repeat the cycle. When treatment beds and other resources are denied based on "acuity" or other underlying diagnoses, involuntary treatment becomes inaccessible to those who need it most and the entire premise for involuntary treatment begins to crumble.

It is also important to think critically about who involuntary treatment impacts most and what that disproportionate impact indicates about the ITA. The data available shows that involuntary commitment disproportionately impacts people of color, both in who is being referred for initial detention and who ends up having an ITA court case.<sup>270</sup> Considering the history of racism within the fields of psychology and psychiatry,<sup>271</sup> and recent data that suggests Black individuals may be viewed as more dangerous than non-Black individuals,<sup>272</sup> one can conclude that systemic discrimination against disabled people of color, and particularly disabled Black individuals, exists in the ITA system. In its case against Alameda County, Disability Rights California emphasized the relationship between forced institutionalization and race by highlighting the involuntary treatment of three Black individuals.<sup>273</sup>

When the Supreme Court held in *Olmstead* that in some circumstances

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267. This is reflected in Washington's Mental Health America ranking, *Ranking the States 2022*, MENTAL HEALTH AM., <https://www.mhanational.org/issues/2022/ranking-states> [<https://perma.cc/J6YP-AV22>]. It is also supported by the statistics published by state legislation that refer to the number of people living with a behavioral health disorder and the drastic increase in death by suicide in the last ten years. WASH. REV. CODE § 71.24.890, Official Note § 1(a), (b), (d) (2021).

268. See POON ET AL., *supra* note 7, at 6.

269. WASH. REV. CODE § 71.05.010(e) (2020).

270. See POON ET AL., *supra* note 7, at 7; Yang, *supra* note 144, at 11.

271. See *Apology to People of Color for APA's Role in Promoting, Perpetuating, and Failing to Challenge Racism, Racial Discrimination, and Human Hierarchy in U.S.*, *supra* note 162; *APA's Apology to Black, Indigenous and People of Color for Its Support of Structural Racism in Psychiatry*, *supra* note 162.

272. See Barsamian & Davies, *supra* note 163, at 576.

273. Amended Complaint at 6–9, *Disability Rts. Cal. v. Cnty. of Alameda*, No. 5:20-CV-05256-CRB (N.D. Cal. 2021).

the ADA requires community placement for individuals with behavioral health conditions, it meant individuals who were voluntarily in psychiatric facilities, since this was the population represented in the case.<sup>274</sup> However, the leap from voluntary to involuntary is not a difficult one to make. The reasonable-modification standard under the ADA allows public entities some flexibility by excepting modifications that would “fundamentally alter” the service being provided.<sup>275</sup> The factors related to the reasonable-modification standard considered in *Olmstead*—cost of community-based care, range of services provided for others with behavioral health disabilities, and the state’s obligation to mete those services equitably<sup>276</sup>—also apply in the context of civil commitment.

Through state legislation<sup>277</sup> and local budget allocation,<sup>278</sup> state and local entities have acknowledged that there is a greater need for community-based care. However, the example offered by Justice Ginsburg, in which a state would satisfy the reasonable-modification standard if it was able to demonstrate a “comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings,”<sup>279</sup> is not borne out in Washington. In fact, the most recent amendment to the ITA *increased* the amount of time a person could be detained before their fourteen-day hearing from 72 to 120 hours,<sup>280</sup> thus relying on involuntary treatment to resolve a problem it was never built to solve. Increasing reliance on involuntary treatment threatens to negatively impact community-based treatment and overall access to care,<sup>281</sup> potentially leading to an elimination of services.

Eliminating services may indicate an ADA violation. The Department of Justice statement of interest in *M.R. v. Dreyfus*<sup>282</sup> emphasized that elimination of services violates the ADA if those services would have enabled an individual to stay in the community.<sup>283</sup> This is true even if

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274. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 593 (1999).

275. 28 C.F.R. § 35.130(b)(7).

276. *Olmstead*, 527 U.S. at 597.

277. WASH. REV. CODE § 71.24.890, Official Note § 1(d) (2021).

278. *DESC Led Call to Increase Crisis Response*, DOWNTOWN EMERGENCY SERV. CTR. (Dec. 3, 2021), <https://www.desc.org/led-call-to-increase-crisis-response/> [<https://perma.cc/3C7H-XM98>].

279. *Olmstead*, 527 U.S. at 605–06.

280. *Bulletin: Changes to the Involuntary Treatment Act (ITA) – Part 1 – Key Changes*, WASH. STATE HOSP. ASS’N (May 21, 2020), <https://www.wsha.org/articles/bulletin-changes-to-the-involuntary-treatment-act-ita-part-1-key-changes/> [<https://perma.cc/L6XC-AMLU>].

281. *See* BUDGET PROPOSAL, *supra* note 6, at 1.

282. 697 F.3d 706 (9th Cir. 2012).

283. *Id.* at 734–35 (quoting Pamela S. Karlan, NOTICE REGARDING INVESTIGATION OF ALAMEDA COUNTY, JOHN GEORGE PSYCHIATRIC HOSPITAL, AND SANTA RITA JAIL 2 (Apr. 22, 2021)).

institutionalization is not immediate, but rather is the result of a slow decline in health that results in a need for institutionalization.<sup>284</sup> A Mississippi case provides additional guidance on the community care requirement by emphasizing that practical application of behavioral health care systems should be considered in addition to whether those systems exist.<sup>285</sup> In Washington, the services never existed at a level sufficient to make community care a viable option. Families and loved ones of people experiencing a behavioral health crisis, whether temporary or long-term, are forced to turn to involuntary treatment because they cannot find or afford other options.

The primary argument against applying the *Olmstead* standard to cases involving involuntary treatment is based on Justice Ginsburg's statement in *Olmstead*, which emphasizes that neither the ADA nor its implementing regulations require community placement for those unable to "handle or benefit" from it.<sup>286</sup> However, when Justice Ginsburg's statement is read together with the Ninth Circuit decision in *Dreyfus*, it becomes clear that in order to decide whether an individual can "handle" community care, there must be sufficient functioning community care available. Forcing people to cycle through involuntary treatment because the state fails to provide sufficient, accessible community-based care is not proof that those individuals could not benefit from community care if it was made available to them. In fact, data shows that community-based services like permanent supportive housing successfully reduce emergency department visits and inpatient hospitalizations.<sup>287</sup>

One of the fundamental problems with the current implementation of the ITA in King County is its use as a catch-all for people with behavioral health needs. Much like the way law enforcement is over utilized as a response to a range of non-criminal issues,<sup>288</sup> civil commitment is being used as a one-size-fits all, highly restrictive, and ineffective safety net to catch any and all behavioral health needs. Civil commitment is a temporary, vastly insufficient, and potentially unlawful "solution" to a much larger problem.

King County must shift its focus away from reliance on civil

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284. *Id.*

285. *United States v. Mississippi*, 400 F. Supp. 3d 546, 549 (S.D. Miss. 2019).

286. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 601 (1999).

287. *Martinez & Burt, supra* note 199, at 992. When permanent supportive housing has been funded, it has been successful at decreasing hospitalization due to psychiatric reasons. *See AIDALA ET AL., supra* note 196, at vi; *Martinez & Burt, supra* note 199, at 995.

288. *Are We Asking Police to Do Too Much? 7 Experts Debate the Role Cops Should Play in Today's Society*, PHILA. INQUIRER (Feb. 28, 2019), <https://www.inquirer.com/opinion/commentary/role-of-police-law-enforcement-expert-opinion-20190228.html> [<https://perma.cc/XT72-YYZ4>].

commitment and towards providing community-based care to people with behavioral health needs. Under the standards set by the Supreme Court in *Olmstead*, and expanded by the Ninth Circuit in *Dreyfus*, implementation of the ITA in King County violates the ADA.

*B. The Involuntary Treatment Act Is in Conflict with the Washington State Constitution*

Washington’s constitution, which provides guidelines for how the state must support individuals living with behavioral health conditions, further supports the argument that King County must invest in community-based behavioral health care. Under article XIII of the Washington State Constitution, the state must foster and support institutions for persons who are “mentally ill” or developmentally disabled.<sup>289</sup> This provision is mandatory, as detailed in article I, section 29 of the state constitution.<sup>290</sup>

Multiple sections of the state constitution create an affirmative duty, including article IX<sup>291</sup> and article II.<sup>292</sup> The decision of the Washington State Supreme Court in *Martinez-Cuevas* is particularly persuasive, holding that through the use of “shall,” a fundamental right was established.<sup>293</sup> Article XIII’s similar language—“shall be fostered and supported by the state”<sup>294</sup>—also creates an affirmative duty and fundamental right. The question is: what is that duty?

Although the article XIII language of “foster [ ]and support[ ]”<sup>295</sup> is not as strong as the language of “paramount duty . . . to make ample provision”<sup>296</sup> found in article IX, it is not without weight. The general understanding of to “foster” is “to promote the growth or development of.”<sup>297</sup> *Black’s Law Dictionary* echoes this definition, defining to “foster” as “[t]o give care to or promote the growth and development (of something or someone).”<sup>298</sup> Central to the understanding of “to foster” is the promotion of growth and development.

What it means “to support” is less clear. Support can be viewed as

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289. WASH. CONST. art. XIII.

290. *Id.* art. I, § 29.

291. Seattle Sch. Dist. No. 1 of King Cnty. v. State, 90 Wash. 2d 476, 501–04, 585 P.2d 71, 86–87 (1978); McCleary v. State, 173 Wash. 2d 477, 485–86, 269 P.3d 227, 232 (2012).

292. *Martinez-Cuevas v. DeRuyter Bros. Dairy, Inc.*, 196 Wash. 2d 506, 475 P.3d 164 (2020).

293. *Id.* at 519–20, 475 P.3d at 171.

294. WASH. CONST. art. XIII.

295. *Id.*

296. *Id.* art. IX.

297. *Foster*, MERRIAM-WEBSTER, <https://www.merriam-webster.com/dictionary/foster> [<https://perma.cc/XWQ8-HGMF>].

298. *Foster*, BLACK’S LAW DICTIONARY (11th ed. 2019).

“promot[ing] the interests or cause of,”<sup>299</sup> to “pay the costs of,”<sup>300</sup> or even more generally “to keep (something) going.”<sup>301</sup> *Black’s Law Dictionary* provides similarly scant guidance, only defining “support” in the context of required monetary payments such as child support, providing structural support such as in the context of property, or more generally the “[s]ustenance or maintenance” required for one to live in their accustomed degree of comfort.<sup>302</sup> Placing these general definitions into the context of behavioral health, as the writers of article XIII of the Washington State Constitution did, leads to a general understanding that “to support” indicates promotion of the stated cause, and likely also financial support of that cause.<sup>303</sup>

The use of the word “institutions” in article XIII may also cause confusion, especially in the context of this Comment.<sup>304</sup> Although phrases such as “psychiatric institution,” “institutionalized,” and “deinstitutionalize” are used in conversations about behavioral health, the use of the word “institution” in article XIII should be read broadly. The varied use of the word “institution” throughout the Washington State Constitution supports this broad reading: “public institutions,”<sup>305</sup> “various state institutions, departments, bureaus, and agencies,”<sup>306</sup> and “institutions of higher education.”<sup>307</sup>

In common English, “institution” can be defined as both “an established organization or corporation . . . especially of a public character” and “a facility or establishment in which people (such as the sick or needy) live and receive care typically in a confined setting and often without individual consent.”<sup>308</sup> *Black’s Law Dictionary* utilizes a similar definition: “An established organization, esp. one of a public character, such as a facility for the treatment of mentally disabled

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299. *Support*, MERRIAM-WEBSTER, <https://www.merriam-webster.com/dictionary/support> [<https://perma.cc/J3U8-CS2Z>].

300. *Id.*

301. *Id.*

302. *Support*, BLACK’S LAW DICTIONARY (11th ed. 2019).

303. In a recent case, the Washington State Supreme Court held that state legislation should be given discretion in deciding how and how much financial support should be provided, but did indicate it is the state’s responsibility to provide financial support. *In re Williams*, 198 Wash. 2d 342, 361, 496 P.3d 289, 300 (2021).

304. WASH. CONST. art. XIII.

305. *Id.* art. II, § 1(b).

306. *Id.* art. VIII, § 1(k).

307. *Id.* art. XVI, § 6.

308. *Institution*, MERRIAM-WEBSTER, <https://www.merriam-webster.com/dictionary/institution> [<https://perma.cc/RWV4-PK6F>].

persons.—Also termed *public institution*.”<sup>309</sup>

Based upon context, both in article XIII and throughout the Washington State Constitution, the common English and legal definitions provided, and the historical context behind article XIII, it is logical to apply an inclusive understanding of what “institution” means as well as a strong duty to “foster and support.”

As detailed above, there are significant gaps in the behavioral health care provided to Washington State citizens. The King County 2021–2022 proposed budget noted that King County faces a “funding crisis for behavioral health services” and that “state and federal funding have long been inadequate.”<sup>310</sup> The proposed budget also specifically calls out the ITA, noting that its “steady growth . . . dramatically increased” costs and “threaten[s] to jeopardize community treatment and access to care.”<sup>311</sup> Particularly insightful is the following passage:

[N]on-Medicaid backed expenditures, including ITA Court legal costs, have continued to grow faster than non-Medicaid revenues over time. In 2021–2022, King County can no longer afford to fill this gap with local funds. Additionally, *this gap may continue to widen without legislative changes or changes to ITA Court operations.*<sup>312</sup>

Given this information, it is nearly impossible to claim that behavioral health care, other than that related to civil commitment, is being fostered and supported. The implementation of the ITA in King County eats up significant funds that would otherwise be available for community behavioral health services. All the while, people who are in crisis remain without the care they need. Thus, the only thing being fostered or supported is a failing system. When combined with serious questions about whether implementation of the ITA meets federal legal standards, King County’s lack of funding and support for behavioral health care is especially damning.

## V. LOOKING FORWARD: FUTURE IMPLEMENTATION OF THE INVOLUNTARY TREATMENT ACT

Those that created and work to implement the Involuntary Treatment Act are not villains. The question of whether the ITA needs to be razed and rebuilt is beyond the scope of this Comment. However, legal and

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309. *Institution*, BLACK’S LAW DICTIONARY (11th ed. 2019).

310. See BUDGET PROPOSAL, *supra* note 6, at 1.

311. *Id.*

312. *Id.* (emphasis added).

behavioral health professionals must think creatively and critically about how to ensure that it functions in an infrequent and careful manner, and only as a last resort, as it was intended.

The historical trends of involuntary commitment in the United States make clear that changes in law and function are usually reactionary: from primarily family-based care, to a reliance on institutionalization, to a focus on deinstitutionalization. These changing trends were not inherently malevolent and were often brought about by advocacy for better treatment of disabled individuals. As society's understanding and education surrounding disability and behavioral health grew, so did the methods of care provided.

Lessening the negative impact of civil commitment includes short-term and long-term goals: increasing the oversight and accountability within the ITA system and increasing funding and focus on community-based care. Shifting resources away from more restrictive forms of care such as civil commitment, to less restrictive forms of care such as supportive housing and community-based care, will take time. During that time, there must be increased oversight and accountability within the ITA system. For example, judicial officials who rule on these cases must have specialized training in behavioral health that includes people subjected to involuntary treatment orders.

The state should also better enforce statewide protocols to ensure consistency in how involuntary treatment law applies across jurisdictions. Other examples of policy shifts include making it harder for facilities to deny involuntary patients based on acuity, and easier to provide intensive, voluntary case management to patients at risk of cycling in and out of civil commitment.<sup>313</sup> Finally, and importantly, state legislation must halt the expansion of involuntary treatment in order to fully commit and shift to a new system.

The long-term solution for ensuring infrequent and lawful involuntary treatment is to increase funding and support for community-based behavioral health care. Previous attempts at deinstitutionalization were not fully realized because deinstitutionalized systems were not supported, leaving gaps in behavioral health care throughout the 20th and 21st centuries that led to the behavioral health crisis communities in the United

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313. Case management as part of settlement is not unprecedented: the *Trueblood* settlement included the creation of the Forensic Projects for Assistance in Transition from Homelessness (PATH) program, which provides individuals most at risk of referral for competency restoration with intensive case management. DEP'T OF SOC. & HEALTH SERVS., FORENSIC PATH (2019), <https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Trueblood/2020Trueblood/Forensic%20PATH%20One%20Pager%20v2.pdf> [<https://perma.cc/4AHH-EUVE>].



States are now facing.<sup>314</sup> Practitioners and researchers in the behavioral health field are increasingly aware that behavioral health support must be community centered. Dr. Thomas Insel—the head of the National Institute of Mental Health from 2002 to 2015—recently stated that “the person to call, the people to come and the place to go need to be part of our crisis response system going forward,” and acknowledged that many states do not understand how essential it is to have a continuum of care.<sup>315</sup>

The importance of this continuum is backed up by data. As noted above, programs such as supportive housing can dramatically reduce emergency department visits and inpatient admissions.<sup>316</sup> This means both more effective and less-restrictive care for individuals with behavioral health conditions and a decrease in costs related to funding most-restrictive care.

Conversations surrounding state funding are complex and contentious, but are imperative in Washington State. Funding is vitally important to the federal duty to provide community-based care for disabled individuals and the state duty to foster and support care for people who experience behavioral health conditions or are developmentally disabled. The state must increase funding to the kinds of behavioral health treatment that will ensure compliance with the ADA and the Washington State Constitution.

Effective solutions to legal problems often require multidisciplinary collaboration. Although changes to legislation may at times be necessary, the scope of this Comment focuses on the *implementation* of the Involuntary Treatment Act and urges Washington State and King County to shift that implementation through changes to funding and practical application. If they are unwilling to do so, it may be necessary to engage in federal litigation.

Engaging in federal litigation could lead to mandated changes to bring current ITA practice into alignment with the ADA, and those changes are likely to be the same or similar to those outlined above. The utilization of the federal court systems to force changes in how systems work has been successful in the past. In Washington, *Trueblood* is an excellent example of federal litigation being used to not just improve the system of competency restoration, but also to “emphasize[] arrest diversion and community-based supports” as a means to better support individuals with

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314. See Erickson, *supra* note 50.

315. Rhitu Chatterjee, *In ‘Healing,’ A Doctor Calls for an Overhaul of the Mental Health Care System*, NPR (Mar. 1, 2022), <https://www.npr.org/sections/health-shots/2022/03/01/1082993901/in-healing-a-doctor-calls-for-an-overhaul-of-the-mental-health-care-system> [<https://perma.cc/TZ8Y-8C7W>].

316. See AIDALA ET AL., *supra* note 196, at v–vi; Martinez & Burt, *supra* note 199, at 995.

behavioral health conditions.<sup>317</sup> That being said, a state cannot generally follow court mandated changes without buying into the need for those changes and proactively undertaking them.

Changes to how the Involuntary Treatment Act is implemented will not be easy, but are necessary. While systems are built in order to lessen the reliance on civil commitment, thus better serving disabled individuals and the community as a whole, it is vital for the involuntary treatment system to be held to high standards of accountability and oversight. To do any less represents the continued violation of state and federal disability protections.

## CONCLUSION

The Involuntary Treatment Act is not working. The history of civil commitment and the abhorrent treatment of persons with disabilities leaves little room to give failing systems the benefit of the doubt, particularly when those systems perpetuate discrimination and do not meet their stated purpose. The Involuntary Treatment Act may be lawful on its face, but its implementation allows Washington to funnel financial and legislative support into an already failing system, at the expense of other systems that could provide much needed behavioral health care. The Involuntary Treatment Act is being applied inconsistently, and, in King County, it is taking up far too much space in the field of behavioral health. In order for King County to comply with federal legislation such as the Americans with Disability Act and federal case law such as *Olmstead v. L.C.*, it must invest in community-based care in a meaningful way. Federal litigation may be necessary to force this shift. Washington's commitment to civil commitment as a fix for an increasingly failing behavioral health system is not only misguided, but also unlawful.

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317. A.B. v. DSHS (Trueblood): *Reforming Washington's Forensic Mental Health System*, *supra* note 184.

