Supreme Court No. 100716-7

IN THE SUPREME COURT OF THE STATE OF WASHINGTON

In the Matter of the Detention of D.H.; Court of Appeals No. 54865-8-II,

***Petitioners*.**

AMICUS CURIAE BRIEF OF AMERICAN CIVIL LIBERTIES UNION OF WASHINGTON, DISABILITY RIGHTS WASHINGTON, KING COUNTY DEPARTMENT OF PUBLIC DEFENSE, AND WASHINGTON DEFENDER ASSOCIATION

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Washington State Cases

Statutes

Federal Cases

Published Reports

https://www.seattletimes.com/seattle-news/mental-health/eastern-state-hospital-risks-losing-accreditation-as-staffing-woes-persist-at-state-psychiatric-facilities/ 21

Joel's Law Fact Sheet | Washington State Health Care Authority (2020), https://www.hca.wa.gov/assets/program/involuntary-treatment-act-overview.pdf 15

Kallert, T., Glöckner, M., Schützwohl, M., *Involuntary vs. Voluntary Hospital Admission. A Systematic Literature Review on Outcome Diversity*., European Archives of Psychiatry and Clinical Neuroscience (2008) 18

National Alliance on Mental Illness, *Mental Health by the Numbers* (2020), Mental Health By the Numbers | NAMI: National Alliance on Mental Illness 27

Peterson, B., *A Virginia Mental Institution for Black Patients, Opened After the Civil War, Yields a Trove of Disturbing Records*. The Washington Post (2021), https://www.washingtonpost.com/lifestyle/magazine/black-asylum-files-reveal-racism/2021/03/26/ebfb2eda-6d78-11eb-9ead-673168d5b874_story.html 7

Poon, L., Zadeh, K. & Leary, B., *Involuntary Treatment Act Court: Reentry and Court Outcomes* (2019), Available at: ita-2019.ashx (kingcounty.gov) 27, 28, 29, 30, 31

Ricky's Law: Involuntary Treatment Act | Washington State Health Care Authority, https://www.hca.wa.gov/about-hca/behavioral-

I. IDENTITY AND INTEREST OF AMICI

The identity and interest of Amici are set forth in the Motion for Leave to File, submitted contemporaneously with this brief.

II. INTRODUCTION

What is viewed as the modern practice of civil commitment in the United States began in the 1960s with the era of deinstitutionalization, resulting in the closure of many large state-run psychiatric hospitals following President John F. Kennedy signing the Community Mental Health Centers Act in 1963.[1] Prior to this, psychiatrists and doctors were the primary decision makers on whether to commit a patient for mental health treatment. With the civil rights era and deinstitutionalization came increased recognition that people living with mental disorders have personal agency and civil liberties.[2] Accordingly, the legal doctrine underlying

[1] Testa, M., & West, S. G., *Civil Commitment in the United States*, Psychiatry (Edgmont) (2010).
[2] Anfang, S. A., & Appelbaum, P. S., *Civil Commitment--the American Experience*. The Israel Journal of Psychiatry and Related Sciences (2006).

involuntary commitment shifted from parens patriae, meaning parent of the country, which permitted the state to intervene and act in the best interests of the individual, to a reliance on the state's police powers. Police powers stem from the state's responsibility to consider the welfare of all people living within its boundaries.[3] This duty to ensure general welfare allows states to write laws that may infringe on the liberty of some, when justified by the greater good.[4] Because police powers put an emphasis on public safety, the inquiry for involuntary commitment shifted following the 1975 United States Supreme Court case, *O'Connor v. Donaldson*, 422 U.S. 563, 575, 95 S.Ct. 2486, 45 L.Ed.2d 396 (1975). Rather than asking whether a person will benefit from treatment, the inquiry is now whether the person is a danger to others or themselves.[5] The "dangerousness" standard for civil commitment was first articulated in a federal statute in 1964 and by the end of the

[3] Testa & West, *supra*.
[4] *Id.*
[5] Anfang & Appelbaum, *supra*.

1970s, practically every state had revised its commitment statute to require dangerousness.[6]

The Supreme Court has noted that involuntary commitment and treatment are a "massive curtailment of liberty."[7] The rights of privacy, association, physical liberty, freedom from unreasonable searches and seizures, and the freedom of speech and belief may be seriously infringed upon by involuntary commitment. Of further concern, forcing individuals to receive involuntary inpatient treatment has a dramatically disruptive effect not only on their lives, but the lives of their families and friends, clinicians, first responders, and other community members. This is because involuntary civil commitment often results in dangerous legal and social deprivations, including the loss of custody of children, housing, employment, educational opportunities, other fundamental constitutional rights, such as the right to own a firearm, and in

[6] Substance Abuse and Mental Health Services Administration, *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice* (2019), civil-commitment-continuum-of-care.pdf (samhsa.gov).
[7] *Humphrey v. Cady*, 405 U.S. 504, 509; 92 S.Ct. 1048, 31 L.Ed.2d 394 (1972).

some states, includes the loss of voting and driving rights.[8] By providing states legal authorization to involuntarily commit and treat people in psychiatric facilities, most often on the basis of a person's danger to themselves or others, civil commitment symbolizes the fraught and contentious intersection between law, ethics, and medicine.

A. A Brief History of the Involuntary Treatment Act in Washington State.

The Involuntary Treatment Act ("ITA" or "the Act"), the statute pertaining to civil commitment proceedings in Washington State, was first adopted in 1973. As jurisdictions across the United States worked throughout the 1970s to deinstitutionalize the vast number of people unnecessarily detained in psychiatric hospitals, the Washington State legislature's intent in passing the Act aligned with this mission.

[8] Vasilogambros, Matt.; Pew Rsch. Ctr. "*Thousands Lose Right to Vote Under 'Incompetence' Laws*" (2018), Thousands Lose Right to Vote Under 'Incompetence' Laws | The Pew Charitable Trusts (pewtrusts.org).

Prior to the ITA, the process for involuntarily committing a person in Washington was dominated by the opinions of physicians and involved few procedural safeguards.[9] By passing the Act, the legislature intended, among other things, "[t]o end inappropriate, indefinite commitment of mentally disordered persons," "[t]o safeguard individual rights," and "[t]o encourage, whenever appropriate, that services be provided within the community."[10] They aimed to do this with robust procedural protections that incorporated the opinions of qualified mental health professionals with strict time limits on involuntary detention and safeguards like probable cause hearings.[11] However, amendments since 1973 have continually chipped away at the broad liberty interest originally expressed in the Act's legislative intent section.[12] This pattern of

[9] Durham, Mary L., and La Fond, John Q. "*The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*", Yale Law & Policy Review (1985), http://www.jstor.org/stable/40239196.
[10] See RCW 71.05.010.
[11] Durham & La Fond, *supra.*
[12] Durham & La Fond, *supra.*, p 408 ("[I]t is quite clear from the legislative history of the 1979 ITA that the Washington State Legislature intended to create a "wider net" for involuntary commitment.").

decreasing rights for those subject to involuntary commitment has made it easier for individuals to be committed and stay committed, more difficult to be released, and has shifted the emphasis from personal liberty and community-based care to public safety and detention.

B. An Overview on The Racial & Socioeconomic Disparities Present in The Civil Commitment System.

This Court has demonstrated a clear commitment to addressing the systemic racism and inequity that pervades legal systems in the state. The system of civil commitment is no different. Black, brown, and indigenous people continue to be disproportionately impacted by involuntary commitment today.[13] Overall, Black people are more likely to be diagnosed with schizophrenia, more likely to be hospitalized, to be

[13] Carlos, H. and Pontiff, C., American Bar Association, *Trick or Treatment?* (2019), https://www.americanbar.org/groups/litigation/committees/diversity-inclusion/articles/2019/summer2019-race-mental-health-poverty-incarceration-louisiana/; Swartz, M., *The Urgency of Racial Justice and Reducing Law Enforcement Involvement in Involuntary Civil Commitment* (2020), https://ps.psychiatryonline.org/doi/10.1176/appi.ps.711202; Rosenfield, S., *Race Differences in Involuntary Hospitalization: Psychiatric vs. Labeling Perspectives*, Journal of Health and Social Behavior (1984), https://doi.org/10.2307/2136701.

involuntarily detained in psychiatric hospitals for longer periods of time, and to be physically and chemically restrained while in the hospital.[14] Black Americans who react to racism may also be misdiagnosed as paranoid by white physicians who have not experienced victimization by racism.[15] Compared with other racial groups, Black Americans are more likely to be involuntarily committed and more likely to be referred to the commitment process by law enforcement.[16] These disparities are unsurprising, given the pervasive racial myth that characterizes Black men as violent and dangerous.[17] As the modern legal standard for involuntary commitment rests, to a large extent, on "dangerousness," Black men are particularly vulnerable to being judged a threat to others and committed

[14] Peterson, B., *A Virginia Mental Institution for Black Patients, Opened After the Civil War, Yields a Trove of Disturbing Records*, The Washington Post (2021), https://www.washingtonpost.com/lifestyle/magazine/black-asylum-files-reveal-racism/2021/03/26/ebfb2eda-6d78-11eb-9ead-673168d5b874_story.html.
[15] Peterson, *supra*.
[16] Chow, J.C.-C., Jaffee, K. & Snowden, L., *Racial/Ethnic Disparities in the Use of Mental Health Services in Poverty Areas*, American Journal of Public Health (2003), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447841/.
[17] Taylor, S., Grove, R. & Christian, T., *Study: Black Men Perceived as Physically More Dangerous*. EBONY (2018), https://www.ebony.com/news/black-men-stereotypes-profiling/.

against their will. In King County, Black people who are involuntarily committed are more likely to return once released: from 2014 through 2018, 50% of those committed once returned to the system within three years, compared to 36% percent of white and Asian people.[18] Similarly, individuals experiencing housing instability are disproportionately impacted by the civil commitment system. People experiencing housing instability are at increased risk of entering the civil commitment system, being detained for longer periods of time, and are more likely to return to the ITA system after being released.[19] These clear racial and socioeconomic disparities only reinforce the desperate need to curtail the continued expansion of civil commitment proceedings and strengthen the protections of individuals' civil liberties in Washington State.

[18] Beekman, D., *Mental-Health Detentions Have Surged in King County, With Homeless People More Likely to Return*. The Seattle Times (2021), https://www.seattletimes.com/seattle-news/politics/mental-health-detentions-have-surged-in-king-county-with-homeless-people-more-likely-to-return/.
[19] *Id.*

III. ARGUMENT

A. The Continued Expansion of the ITA, Predicated on the Focus of Public Safety, Further Erodes Individuals of Their Civil Liberties and Results in Harmful and/or Disruptive Effects on Their Lives.

1. A Brief Overview of the Civil Commitment Process.

Under the ITA, a person may generally be involuntarily committed if they are likely to pose a serious harm to themselves or others or if they are in imminent danger from a grave disability.[20] The length of time a person may be detained varies according to the level of evaluation they have received. A voluntary patient on a medical ward or in a hospital emergency room may be detained by staff "until the next judicial day" while waiting for a designated crisis responder

[20] See RCW 71.05.153; *Det. of D.W. v. Dep't of Soc. & Health Servs.*, 181 Wn. 2d 201, 332 P.3d 423 (2014).

("DCR").[21] The person may then be detained by a DCR for 120 hours of "emergency detention."[22] If the person continues to meet detention criteria, they can then be detained for an additional fourteen days for "involuntary intensive treatment," subject to a probable cause hearing in a Superior Court.[23] During these fourteen days, facility staff or the DCR may petition to keep the individual committed for an additional ninety or 180 days.[24] If such a petition is filed, the individual is entitled to a jury trial, should they request one, on the question of whether extended involuntary detention is appropriate.[25] Once a person has been committed for 180 days, facility staff may file successive 180-day petitions to renew the individual's commitment.[26]

Once detained, individuals subjected to inpatient ITA commitments are kept in locked facilities with significant

[21] See RCW 71.05.050(1).
[22] See RCW 71.05.153(1). Also see *Matter of Det. of E.S.*, 509 P.3d 871 (2022).
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.*

restrictions on their civil rights and personal freedoms, including being subjected to seclusion, mechanical and physical restraints, and potential involuntary administration of antipsychotic medication.[27]

2. How the ITA Has Expanded Over Time and The Infringement on Civil Liberties That Have Resulted.

Through several legislative changes, the focus of the ITA has shifted from protecting personal liberty and facilitating the deinstitutionalization of mental health care to committing more people over a concern for public safety. This shift is reflected in the legislative intent section of the ITA. When the legislative intent section was first drafted, it included some of the following values:

[27] See RCW 71.05.215, RCW 71.05.217.

(1) To end inappropriate, indefinite commitment of mentally disordered persons and to eliminate legal disabilities that arise from such commitment;

(2) To provide prompt evaluation and short-term treatment of persons with serious mental disorders;

(3) To safeguard individual rights;

(4) To provide continuity of care for persons with serious mental disorders;… .[28]

However, over the years, these goals shifted as the ITA became more restrictive. Provision (2), providing for "short-term treatment of persons with serious mental disorders" was changed in 1998 to provide for "timely and appropriate" treatment instead, reflecting an acknowledgement that the Act was being used to detain people for extended periods.[29] While as originally enacted, there was no mention of public safety, a

[28] See RCW 71.05.010.
[29] *Id.*

provision specifically naming public safety was added in 1998, and in 2015, it was elaborated upon. The statute now states that a goal of the ITA is to "protect the health and safety of persons suffering from mental disorders and to protect public safety through use of the parens patriae and police powers of the state." This provision was then moved to the top of the list, supplanting the previous, symbolic, first priority: "To end inappropriate, indefinite commitment."

Since the ITA was first passed, the legislature has enacted several changes that have made it easier for the state to involuntarily commit individuals. While the original 1973 statute allowed for commitment of the "gravely disabled" if that person cannot satisfy their basic needs, a 1979 amendment altered this definition to define basic needs as "health or safety" and to encompass situations when a person appears to be

decompensating after release into the community, for example by failing to take their medication.[30]

The rules evaluating symptoms and behavior have also changed since 1973 to allow more people to be committed. Since 2010, RCW 71.05.212 has stated that even if a person's symptoms and behavior are insufficient on their own for civil commitment, they may support a finding of grave disability or likelihood of serious harm which itself leads to civil commitment.[31] This section now also emphasizes past and historical behavior as a basis for such a finding.[32] For example, if a person has experienced suicidal ideations in the past, this can support a decision of commitment, even if they are not experiencing such thoughts now.[33]

Since 2015, a change known as "Joel's Law" allows an individual's family to directly petition to have them

[30] See RCW 71.05.240.
[31] See RCW 71.05.212.
[32] See RCW 71.05.214.
[33] *Id.*

committed.[34] Even if a DCR chooses not to detain a person for evaluation, or the forty-eight hours to investigate have elapsed, an immediate family member, guardian, or federally recognized Indian tribe, if applicable, may petition the Superior Court for the person's initial detention.[35] This change provides yet another avenue for people to enter the ITA system. Finally, Ricky's Law, passed in 2016, vastly expanded the ability of the state to civilly commit individuals by extending involuntary commitment to people suffering from substance use disorders.[36] Under Ricky's Law, a person who is chemically dependent can be involuntarily committed using the same process that previous applied only to individuals with mental health disorders.

As a result, unsurprisingly, the number of people detained in the Washington State ITA system has expanded

[34] *Joel's Law Fact Sheet | Washington State Health Care Authority* (2020), https://www.hca.wa.gov/assets/program/involuntary-treatment-act-overview.pdf.
[35] See RCW 71.05.201.
[36] *Ricky's Law: Involuntary Treatment Act | Washington State Health Care Authority*, https://www.hca.wa.gov/about-hca/behavioral-health-recovery/ricky-s-law-involuntary-treatment-act#the-law.

exponentially in conjunction with these significant amendments to the Act. In King County, between 2007 and 2017, the number of people detained for ITA commitments doubled to over 4,700 people.[37] Statewide, from July 2020 to June 2021, over 15,000 people were detained on involuntary inpatient ITA commitments.[38]

Since the ITA was first passed in 1973, changes to the law have also made it more difficult to be released from civil commitment. For example, the length of time an individual can be detained before the initial evaluation has increased. While originally the ITA allowed DCRs to initially detain an individual for 72 hours for evaluation and treatment, in 2020, that time was increased to 120 hours.[39] Because those 120 hours do not include holidays or weekends, a person who is initially

[37] Beekman, *supra*.
[38] *The Involuntary Treatment Act (ITA) | Washington State Health Care Authority* (2022), fact-sheet-involuntary-treatment-act-2022.pdf (wa.gov).
[39] See RCW 71.05.170, RCW 71.05.153, RCW 71.05.150.

admitted on a Friday may be detained for up to seven days before an evaluation.[40]

3. Involuntary Commitment Has Harmful, Far-Reaching Collateral Consequences on The Lives Of Impacted Individuals.

Involuntary civil commitment can have substantially detrimental and disruptive effects on not only the lives of those detained, but the lives of their families, friends, and community members. Scores of Disability Rights Washington ("DRW") constituents and individuals represented by attorneys across the state reported losing housing, employment, and in some instances, custody of their children, as a result of ITA detentions. This pattern of continued expansion of the ITA, at the expense of the liberty interests of those who might be subject to commitment, is even more harmful when examined alongside the evidence of inefficacy of involuntary commitment

[40] See RCW 71.05.180.

as well as the harm suffered by impacted individuals due to inadequate care, staffing, and risk of patient harm.[41]

Of particular concern, despite this Court's 2014 opinion and order prohibiting psychiatric boarding in *Det. D.W. v. Dep't of Soc. & Health Servs.*, 181 Wn. 2d 201 (2014), it is still regularly the case that DCRs determine that a person meets ITA commitment criteria, but there is no licensed and certified Evaluation and Treatment ("E&T") facility or private psychiatric hospital willing to accept the patient.[42] In January 2022, over 200 people were detained via "single bed certifications" on 14-, 90-, and 180-day ITA commitments in hospital emergency rooms and medical wards.[43] One typical DRW constituent was detained by a DCR and held in isolation

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[41] Kallert, T., Glöckner, M., Schützwohl, M., *Involuntary vs. Voluntary Hospital Admission. A Systematic Literature Review on Outcome Diversity*., European Archives of Psychiatry and Clinical Neuroscience (2008); (finding that patients subjected to involuntary commitments have higher rates of suicide, lower levels of social functioning, expressed more dissatisfaction with treatment than voluntary patients).

[42] *All Or Nothing - Ending Washington's Dependence On Involuntary Civil Commitment, DRW Report* (2022), https://www.disabilityrightswa.org/wp-content/uploads/2021/12/Final-Report.pdf

[43] *Single Bed Certification and Unavailable Detention Facility Report | Washington State Health Care Authority* (2022), https://www.hca.wa.gov/assets/program/single-bed-certification-quarter-1.pdf.

in mechanical restraints for days in a hospital emergency room because no licensed and certified ITA facility would agree to admit him.

Further, through their direct contacts with their constituents, DRW advocates are aware of hundreds of long-term civilly committed patients at Western State Hospital ("WSH") and Eastern State Hospital ("ESH") who have been determined ready for discharge but who remain hospitalized for months, and sometimes years, due to unnecessary discharge delays and claimed discharge barriers. One typical DRW constituent has been on the WSH discharge list since March 2022. While waiting for discharge, he has been assaulted by another patient, diagnosed with a medical condition requiring surgery that cannot be conducted while at WSH, and has received minimal programing and treatment, other than medication management.

Stories of the significant harm caused to individuals in the inpatient ITA system are not rare occurrences. These are the

too frequent, real life, detrimental impacts faced by individuals who are involuntarily committed across the state.

4. Individuals Who Are Involuntarily Committed Are At Increased Risk Due to The Unsafe And Potentially Fatal Conditions Present In Evaluation and Treatment Facilities.

There is a long and well-documented history of staffing shortages and patient health and safety violations at evaluation and treatment facilities across the state. Among the statewide 33 E&Ts and private psychiatric hospitals, which are licensed and certified to contract with the state to provide ITA detention and treatment, there are significant concerns about the conditions of confinement and the quality of mental health care provided in these settings. [44]

The largest facility for long-term ITA commitments is Western State Hospital. In 2018, after years of patient safety

[44] *All Or Nothing, supra*.

concerns and regulatory non-compliance, the U.S. Centers for Medicare and Medicaid Services terminated WSH's certification and federal funding, which totaled $53 million a year. [45] ESH is similarly at risk of losing its federal accreditation. In April 2022, Eastern State Hospital received notice after an unannounced visit by the Joint Commission on Hospital Accreditation that ESH "does not have adequate staff to support safe, quality care, treatment and services."[46]

An investigation by the Seattle Times of multiple private for-profit psychiatric hospitals that contract with the state to provide ITA care found that these facilities similarly fail to keep both patients and their own employees safe.[47] At Smokey Point Behavioral Hospital, in Marysville, state inspectors

[45] Bellisle, M., *With Patients at Risk, Western State Hospital is 'like going into hell'*. The Seattle Times (2018), https://www.seattletimes.com/seattle-news/apxap-exclusive-washington-hospital-is-like-going-into-hell-2/.
[46] Jimenez, E., *Eastern State Hospital, in Medical Lake, Risks Losing Accreditation and Funds*. The Seattle Times (2022), https://www.seattletimes.com/seattle-news/mental-health/eastern-state-hospital-risks-losing-accreditation-as-staffing-woes-persist-at-state-psychiatric-facilities/.
[47] Gilbert, D., *Public Crisis, Private Toll: Key Findings of the Seattle Times' Investigation of Private Psychiatric Hospitals in Washington*, The Seattle Times (2019), https://www.seattletimes.com/seattle-news/times-watchdog/public-crisis-private-toll-major-findings-of-the-seattle-times-investigation/.

repeatedly found inadequate staffing, while some patients with medical needs went untreated until their conditions deteriorated - in one case to the point of death.[48] At Cascade Behavioral Health Hospital in Seattle, seven patients died suddenly or suffered injuries that caused or contributed to their deaths over 19 months - an unusually high toll.[49] At six private psychiatric hospitals in Western Washington, there were at least 350 incidents in which patients or staff were assaulted, suffered an injury, attempted suicide, escaped or died suddenly from 2016 to 2018. Over the same time, the hospitals reported a combined 15 incidents to the state.[50]

One of these private psychiatric facilities, Fairfax Behavioral Health, which operates facilities in King and Snohomish Counties, is owned by Universal Health Services ("UHS"), which is one of the largest for-profit operators of inpatient behavioral health facilities in the US, with 188

[48] *Id.*
[49] *Id.*
[50] *Id.*

inpatient facilities, including psychiatric hospitals in Everett, Monroe, Spokane, and Lacey. UHS has been under investigation by the U.S. Department of Justice for a range of issues, including "admission eligibility, discharge decisions, length of stay and patient care issues."[51] In 2020, UHS paid $117 million to settle the DOJ's civil investigation.[52] But claims like those lodged against UHS are not rare occurrences and instead, illustrate the violent, and sometimes, deadly, experiences faced by those who find themselves within the ITA system.

The Washington State Department of Health ("DOH") investigates complaints of abuse and neglect at E&Ts and private psychiatric hospitals. Recent DOH investigations have found egregious health and safety violations at facilities in Western Washington. One

[51] *Universal Health Services, Inc. to Pay $117 Million to Settle False Claims Act Allegations*, The United States Department of Justice (2020), https://www.justice.gov/usao-edpa/pr/universal-health-services-inc-pay-117-million-settle-false-claims-act-allegations.
[52] *Id.*

example is at Navos, an E&T facility in West Seattle, where DOH found the medical care offered was so inadequate that it "placed patients at risk of psychological and physiological deterioration that may not be detected and risks poor patient outcomes and death."[53] Cascade Behavioral Health Hospital, in Seattle, failed to report an alleged sexual assault of a patient.[54] Wellfound Behavioral Health, a private psychiatric hospital in Tacoma, failed to prevent patient-on-patient assaults, and failed to assess patients who were victims of physical assault "which can lead to patient harm and death."[55] Fairfax Behavioral Health was found to have conducted video-recorded strip searches of patients as part of the admissions process

[53] *Statement of Deficiencies and Plan of Correction*, State of Washington Department of Health (2020), https://doh.wa.gov/sites/default/files/legacy/Documents/2800/X2020-137.pdf

[54] *Statement of Deficiencies and Plan of Correction*, State of Washington Department of Health (2020), https://doh.wa.gov/sites/default/files/legacy/Documents/2800/2020-12951.pdf.

[55] *Statement of Deficiencies and Plan of Correction*, State of Washington Department of Health (2020), https://doh.wa.gov/sites/default/files/legacy/Documents/2800/X2020-7271.pdf.

creating "a risk of psychological harm and loss of personal dignity."[56]

These all-too-common occurrences highlight the pressing and immediate need to strictly apply the procedural protections of the ITA to appropriately balance concern for public safety with adequate safeguards for the fundamental civil liberty rights of people subject to involuntary commitment.

B. Communities of Color and People Experiencing Housing Insecurity are Disproportionately Impacted by the ITA and Civil Commitment.

1. Legislative Expansions In The ITA Have Resulted In Racial And Socioeconomic Disproportionality.

Since the passage of the ITA in 1973, the standard for evaluating whether a person has a "likelihood of serious harm"

[56] Hagens Berman: *Puget Sound's Fairfax Behavioral Health Hit With New Class-Action Lawsuit Alleging Recorded Strip-Search of Teen Patients*, Business Wire (2019), https://www.businesswire.com/news/home/20190619005841/en/.

has been expanded in such a way that has resulted in gross racial and socioeconomic disparities in ITA commitments. Since 1997, police contact can now be used in evaluating whether more restrictive confinement is justified. That year, the legislative intent and findings section was amended to place special emphasis on repeated hospitalizations and repeated interactions with police.[57] It states that, in cases "with a prior history or pattern of repeated hospitalizations or law enforcement interventions due to decompensation," that prior history is relevant in determining whether the person would be subject to more or less restrictive treatment options.[58] As communities of color and individuals experiencing housing insecurities are significantly more likely to experience police contact, this reliance on past police contacts as a factor for future commitment disproportionately subjects people from

[57] See RCW 71.05.012.
[58] *Id.*

these communities to more restrictive forms of involuntary commitment.

2. The Racial Disparities Present In The Washington State ITA System.

In King County, people in the ITA system are disproportionately likely to be Black, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, or multiracial.[59] This racial disparity exists despite the fact that there are comparable rates of mental health disorders among various racial groups in the United States, with 22.6% of white adults suffering from mental disorders compared to 17.3% of Black adults, 18.7% of American Indian adults, and 18.4% of Hispanic/Latinx adults.[60] The King County Department of Community and Human Services ("DCHS") found that the population of white individuals in the ITA system has gradually decreased since 2014, making up 63 percent of all ITA cases and 60 percent of

[59] Poon, L., Zadeh, K. & Leary, B., *Involuntary Treatment Act Court: Reentry and Court Outcomes* (2019), Available at: ita-2019.ashx (kingcounty.gov).
[60] National Alliance on Mental Illness, *Mental Health by the Numbers* (2020), Mental Health By the Numbers | NAMI: National Alliance on Mental Illness.

all cases for those who had been through ITA Court more than three times; however, the white population in King County is approximately 68 percent.[61] This is in stark contrast to people DCHS identified as Black, making up 14.8 percent of all ITA cases. When a person had more than three prior ITA cases, people identified as Black made up 20 percent - this is despite being only seven percent of King County's general population.[62] DCHS further found striking similarities when examining rates of reentry to the ITA system. People who are American Indian or Alaska Native, Black, Native Hawaiian or Pacific Islander, or multiracial are more likely to return to the ITA system than people who are white or Asian.[63] 50 percent of individuals from these overrepresented racial groups returned to the ITA system within three years of leaving it, compared to 36 percent of white individuals.[64] Racial disparities in ITA Court entry are also similar to that of the criminal justice system, with

[61] Poon & Leary, *supra*.
[62] *Id.*
[63] *Id.*
[64] *Id.*

people who are Black and American Indian/Alaska Native being overrepresented in both ITA Court and King County jail bookings, as well as referrals to the ITA system from the criminal legal system.[65]

3. The Socioeconomic Disparities Present In The Washington State ITA System.

These disparities are also illustrated in populations of people experiencing housing instability. People in the ITA system are disproportionately likely to experience housing instability, particularly if they have a history of prior ITA cases. Per DCHS, 28 percent of people with cases filed in ITA Court between 2014 and 2018 were experiencing housing instability, compared to less than one percent of King County residents overall.[66] Housing instability among people in the ITA system has trended upward since 2014, with people in nearly 31 percent of cases in 2017 experiencing housing instability.[67] This

[65] *Id.*
[66] *Id.*
[67] *Id.*

difference is even more dramatic when looking at people with a history of prior cases. In 41 percent of cases involving a person who had been in more than three prior ITA cases, the person was also experiencing housing instability.[68] People experiencing housing instability are also more likely to return to the ITA system. Of the people DCHS recorded as experiencing housing instability at the time of case intake, 52 percent returned to the ITA system within three years of leaving it, compared to 36 percent of people who were not recorded as experiencing housing instability.[69] DCHS further found that people in an overrepresented racial group or who are experiencing housing instability are more likely to return to the ITA system, even when considering generally longer case histories in these groups.[70] This means that even when comparing two people who have both had more than three prior ITA cases, if one of the people was experiencing housing

[68] *Id.*
[69] *Id.*
[70] *Id.*

instability and the other was not, the person experiencing housing instability would be more likely to have a subsequent ITA case.[71] For example, a person who was white and housed would be less likely to return to the ITA system than someone who was American Indian and experiencing housing instability.[72] These disproportionalities in the ITA system may result from larger societal disparities in access to health care and other services. Discrimination, social stigma, and geographic and financial barriers may inhibit access to the use of mental health services for people from certain racial and socioeconomic groups. Understanding the reason for this disproportionality and applying that lens to cases that implicate the ITA offers this Court the opportunity to protect the rights of historically marginalized communities by strictly construing the protections in the ITA statutory scheme.

[71] *Id.*
[72] *Id.*

IV. CONCLUSION

Over recent decades, courts have begun to recognize and acknowledge the substantial harms of involuntary commitment, particularly, the poor conditions and lack of appropriate treatment in many facilities, the disparate impact on communities of color and individuals experiencing housing instability, and the collateral consequences on civil rights. The inpatient involuntary mental health system is, at present, broken. As courts and legislatures take critical looks at these systems across the country, we must center the constitutional liberty rights guaranteed to those who stand to lose the most.

RAP 18.17 Certification

Undersigned counsel certifies that, pursuant to RAP 18.17(b), this brief contains 4,811 words, exclusive of words contained in the appendices, title sheet, table of contents, table of authorities, certificates of compliance and signature blocks, and pictorial images, and therefore meets the word count limitation of 5,000 words for amicus briefs as required by RAP 18.17(c)(6).

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on August 25, 2022, I filed the foregoing motion via the Washington Court Appellate Portal, which will serve one copy of the foregoing document by email on all attorneys of record.

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