Washington State Health Care Authority

Acute Behavioral Health & Involuntary Treatment Act

Individuals experiencing a behavioral health crisis may present as a risk to themselves or others or be unable to care for their basic needs of health and safety. A behavioral health crisis may be related to mental health and/or substance use disorder. Referrals to the crisis system help to stabilize individuals and assist with additional resources. Washington Health Care Authority (HCA) contracts with regional Behavioral Health Administrative Services Organizations (BH-ASO) to provide crisis and Involuntary Treatment Act (ITA) services throughout the state.

Terminology

Behavioral health disorder: Either a mental disorder as defined in this section, a substance use disorder as defined in this section, or a co-occurring mental disorder and substance use disorder [RCW 71.05.020(7), 71.34.020(9)]

Mental disorder: Any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions [RCW 71.05.020(38)]

An adult cannot be detained for evaluation and treatment solely because of the presence of a developmental disability, substance use disorder, or dementia alone. However, such an individual may be detained for evaluation and treatment based on such a sole condition if that condition causes the individual to be gravely disabled, or to present a likelihood of serious harm [RCW 71.05.040].

Substance use disorder (SUD): A cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using the substance despite significant substance-related problems; the diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances [RCW 71.05.020(53)]

A behavioral health crisis can be devastating, and even traumatic, for individuals, families, and our communities. Although we cannot know when a crisis may occur, we can create and maintain a system that is agile and responsive when the need arises. A strong crisis response system in Washington state minimizes delays, reduces reliance on law enforcement (LE) and emergency departments, and only uses restrictive responses when no other safe solution can be found. A new and innovative component of our state's crisis system are mobile rapid response crisis teams (MRRCT) that can be rapidly deployed to the location of the crisis and provide crisis assessment and stabilization services to anyone, anywhere, and at any time.

MRRCT services offer voluntary community-based intervention to individuals in need wherever they are including at home, work, school, juvenile courts, or anywhere else in the community where the person is experiencing a crisis. Where teams have capacity, mobile crisis services are available 24 hours a day, every day of the year and should respond to an emergent crisis within two (2) hours of the referral and within 24 hours for an urgent crisis.

The crisis service providers are required to triage all incoming requests for crisis response services. Cases are prioritized based on Emergent, Urgent, and Routine care, as well as current location. For example, an urgent case in the community might be prioritized over an emergent case in an Emergency Department (ED) due to the safety the ED provides for the individual. The crisis response services will coordinate to dispatch a team based upon the established team in the area.

Terminology

Emergent care means services provided for a person that, if not provided, would likely result in the need for crisis intervention, or hospital evaluation due to concerns of potential danger to self, others, or grave disability per RCW 71.05 and 71.34. Emergent mental health care must be provided within two (2) hours of a request for crisis mental health treatment from any source.

Urgent care means a behavioral health condition that requires attention and assessment within 24-hours, but which does not place the individual in immediate danger to self or others and the individual is able to cooperate with treatment. Urgent care must be provided within twenty-four (24) hours of a request for mental health crisis services from any source.

Community-based crisis team means a team that is part of an emergency medical services agency, a fire service agency, a public health agency, a medical facility, a nonprofit crisis response provider, or a city or county government entity, other than a law enforcement agency, that provides the on-site community-based interventions of a mobile rapid response crisis team for individuals who are experiencing a behavioral health crisis.

Mobile rapid response crisis team means a team that provides professional on-site community-based intervention such as outreach, de-escalation, stabilization, resource connection, and follow-up support for individuals who are experiencing a behavioral health crisis. These shall include certified peer counselors as a best practice to the extent practicable based on workforce availability, and meet standards for response times established by the authority.

You may call your local county crisis line to request assistance for you, a client or a friend or family member (24/7/365) regardless of insurance.

County Crisis line phone numbers

Individuals in crisis may present imminent or serious risk of harm to themselves or others or be unable to care for their basic needs of health and safety due to their behavioral health symptoms. When they are unwilling to engage in safety planning and other stabilization efforts by MRRCT team members, or there is no appropriate or available alternative that could mitigate the level of risk, the MRRCT team will make referral for a higher level of response. The MRRCT team will connect with the appropriate Designated Crisis Responder (DCR) services for an Involuntary Treatment Act (ITA) investigation. A DCR referral can be initiated by anyone who has first-hand knowledge of the person and the concerning behaviors. Referents should be aware that the request may be triaged first by less restrictive forms of crisis services.

Find designated crisis responder (DCR) offices in Washington.

View the DCR contact list

The Involuntary Treatment Act (ITA) provides the statutory framework for investigation, evaluation, detention, and civil commitment of individuals experiencing a mental disorder or a substance use disorder whose

symptoms are so acute that the individual may need to be treated on an involuntary basis in an Evaluation and Treatment facility (E&T) or Secure Withdrawal Management and Stabilization facility (SWMS).

At the time of a referral, the DCR provides information to the referent about DCR procedures and protocols. This may include informing the referent whether a face-to-face interview can be expected and what further information is needed for a face-to-face interview. A DCR may determine a situation to be emergent or non-emergent and make recommendations to ensure all less restrictive alternatives are explored.

In potentially dangerous situations where the safety of the individual or others is at risk, the DCR may issue a custody authorization for transport of the individual to a safe setting.

An ITA evaluation is performed by DCR and consists of an interview with the individual to determine if symptoms of the individual's mental disorder or substance use disorder places the individual at risk due to the likelihood of serious harm, and/or grave disability. ITA evaluations are often conducted in hospital emergency departments, or in the community.

During the evaluation, the DCR will explore voluntary treatment. To agree to voluntary treatment implies that the individual can express a good faith willingness (free of coercion) to engage with the procedures and treatment plan prescribed by a treatment provider, facility, and professional staff to whom the individual has volunteered; additionally, it requires that the individual has capacity to informed consent to care as required by RCW 7.70.060.

When the investigation concerns a patient who is not competent to provide informed consent to less restrictive treatment options, the DCR shall make reasonable efforts to determine whether the individual's health care decision maker, as identified in RCW 7.70.065, can and will consent to the less restrictive treatment on behalf of the individual.

Terminology

Designated Crisis Responder (DCR): A mental health professional appointed by the county, by an entity appointed by the county, or by the authority in consultation with a federally recognized Indian tribe or after meeting and conferring with an Indian health care provider, to perform the duties specified in this chapter. [RCW 71.05.020(16)]

Grave disability indicates that an individual's mental disorder or substance use disorder places them in danger of serious harm and is often accompanied by demonstrated failure to provide for their essential needs of health and safety. Further, there may be a severe deterioration in routine functioning evidenced by increasing loss of volitional control over their actions; this individual is not currently receiving care that is essential for their health and safety.

Imminent: The state or condition of being likely to occur at any moment or near at hand, rather than distant or remote [RCW 71.05.020(28)].

Likelihood of serious harm means a substantial risk exists that physical harm will be self-inflicted, inflicted upon another, or inflicted upon the property of others. This includes threats or attempts to commit suicide or harm oneself, or behavior that causes harm or places another person in reasonable fear that they will be harmed, or behavior that caused substantial loss or damage to the property of others.

When a DCR finds the individual meets the criteria for involuntary treatment, meaning they are gravely disabled or pose a substantial risk of serious harm, the DCR will work to find an available treatment bed. For those individuals in need of mental health treatment, if no available involuntary treatment bed can be found, the DCR will seek authorization for a Single Bed Certification (SBC) at the emergency department. SBCs cannot be

utilized for individuals needing involuntary substance use treatment. For individuals with medical or care needs that prevent acceptance at an Evaluation and Treatment (E&T) facility, they may be admitted to a hospital medical floor on a SBC. If the DCR cannot find a treatment bed or be granted a SBC, the DCR is unable to detain the individual. The DCR will complete a No Bed Report (NBR) and the emergency department will determine the course of care.

A detained individual may be moved to an Evaluation and Treatment (E&T) facility. An individual detained for substance use disorder may be detained to a Secure Withdrawal and Management Stabilization (SWMS) facility. A facility may be dually credentialed as both an E&T facility and SWMS facility.

No-bed Report (also Unavailable Detention Facilities Report): When a DCR determines an individual meets criteria for involuntary inpatient treatment but is unable to detain them due to the lack of an available bed at an evaluation and treatment (E&T) facility or secure withdrawal management and stabilization (SWMS) facility, and the individual cannot be served by the use of a Single Bed Certification, the DCR is required to make a report to HCA within 24 hours.

Single bed certification: The process for requesting an exception to be granted to allow a facility that is willing and able to provide timely and appropriate, involuntary inpatient mental health treatment when the facility (usually a hospital) is not otherwise certified as a mental health treatment facility. The single bed certification allows the person to be held for the 120-hour initial detention, detention pending a revocation proceeding, 14-day commitment, or 90 or 180-day treatment periods under an ITA order. Single bed certifications last for a for a maximum of 30 days and can be renewed. [RCW 71.05.745, WAC 182-300]

Single bed certification will not be available for individuals detained due to substance use disorder until July 1, 2026.

Evaluation & Treatment (E&T) Facility is a setting with a Behavioral Health Agency License and Certification issued by the Department of Health. E&T services can be provided in facilities licensed as Acute Care Hospitals, Private Psychiatric and Alcoholism Hospitals, or Residential Treatment Facilities.

If it is determined that involuntary criteria are met and the individual needs further inpatient care beyond the 120-hour period, and the individual is unwilling to accept treatment voluntarily, another petition for up to 14 days of involuntary treatment will be filed. A probable cause hearing will allow a judge to determine whether there is adequate evidence to support an order of commitment for up to 14 days of additional treatment.

Five possible outcomes of the 14-day hearing:

- The judge can dismiss the case and release the individual.
- The criteria for commitment is met and the individual can be held for short-term commitment (up to 14 days).
- The judge can accept the patient’s agreement to enter treatment voluntarily.
- The individual can be placed on a less restrictive order to the community, which places conditions on the individual for a period of up to 90 days.
- The case can be “continued,” with a rescheduled hearing, at the request of the Assigned Counsel.

If it is determined the individual needs further treatment beyond the 14-day commitment period, a 90-day petition will be filed with the court. At this hearing, the individual can be ordered by the court for further involuntary inpatient (restrictive) or outpatient (less restrictive) treatment.

Terminology

Detention vs. commitment: A detention is a 120-hour period of further involuntary evaluation and treatment initiated by a DCR under RCW 71.05 or 71.34; a commitment is determination and order issued by a judicial officer in response to a petition. A detention may also be called an "initial." After the initial, orders for commitment occur at 14-day, then 90-day, then at 180-day intervals.

Less restrictive alternative treatment (LRA): means a program of individualized treatment in a less restrictive setting than inpatient treatment. The program is outlined in a court order for outpatient treatment which includes services to be provided and conditions that the individual must adhere to. An LRA order may be enforced, modified, or revoked as appropriate. [RCW 71.05.320]

Types of LRAs:

Assisted Outpatient Treatment (AOT): Through AOT, community-based behavioral health treatment is available under civil commitment. The aim is to better motivate an individual who struggles with voluntary treatment adherence to engage fully with their treatment plan. AOT may be ordered by the court, if legal criteria are met, as a form of less-restrictive, alternative treatment to involuntary inpatient treatment. It may be ordered by the court as one type of less restrictive alternative treatment upon discharge from an involuntary inpatient setting. An AOT order may be enacted for up to 18 months.

Conditional release (CR): A CR is utilized when a professional at the facility providing involuntary treatment determines the individual can be appropriately served by outpatient treatment prior to or at the expiration of the period of commitment. The outpatient treatment provider agrees to assume responsibility for providing treatment. It can impose conditions on the individual, and the release may be revoked upon violation of any of its terms. A CR is often utilized in a similar way to an LRA. A CR can last up to 180 days, depending on the length of the underlying inpatient commitment order. Prior to expiration of a CR, a new LRA petition may be filed in the community to ensure continued engagement with outpatient treatment.

Least restrictive alternative/order (LRA/LRO): An LRA order for individualized treatment in a least restrictive setting than inpatient treatment includes services described in RCW 71.05.585. LRA/LRO are typically 90- or 180-days in duration but can be for up to one year if the person is discharged from a state hospital and meets certain criteria. Prior to expiration of a LRA/LRO, a new LRA/LRO petition may be filed. However, an LRA/LRO is not permissible if 36 months have passed since the last date of discharge from detention for inpatient treatment.

On occasion an individual may remain at a local acute care hospital on a Single Bed Certification due to complex medical needs or an inability to transfer to a State Hospital or HCA-contracted Long-Term Civil Commitment facility. In these circumstances, ITA hearings are still conducted. Some hospitals may ask the court to hold a review hearing to make the state transfer the individual to a psychiatric treatment or long-term care setting. Representatives of the state may have to appear to "show cause" as to why the person has not been transferred.

After a 90-day commitment order for inpatient treatment, an individual may remain at an E&T or transition to a State Hospital or Long-Term Civil Commitment facility if a placement becomes available. If involuntary inpatient treatment is to be sought beyond the 90-day stage, a petition for a 180-day commitment may be filed. Consecutive 180-day petitions can be filed until the individual is stabilized and ready for discharge. Discharge planning always begins upon admission. Individuals may be discharged into community support programs such as Home and Community Services, Foundational Community Supports, and Governor's Opportunity for Supportive Housing and to a behavioral health agency for follow up. Discharges may or may not include a court order for less restrictive alternatives (LRA/LRO, CR, or AOT).

If a designated crisis responder decides not to detain a person, immediate family members, guardians or a tribe may go directly to a superior court to ask for the individual to be detained. This can only occur if forty-eight hours have elapsed since a designated crisis responder received a request for investigation, and the designated crisis responder has detained the person. This is also known as a “Joel’s Law” petition.

Learn more about Joel’s Law

Washington Courts Administrative Office of the Courts Joel’s Law

These best practice guidelines do not override any statutes or rules and are not meant to override any agency policies or clinical judgment.

Additional resources

- 988 crisis line implementation (HB 1477) | Washington State Health Care Authority
- Assisted Outpatient Treatment Assisted outpatient treatment fact sheet (2024) (wa.gov)
- Directory of certified behavioral health providers DOH 606-019 Behavioral Health Agencies Directory (wa.gov)

More information

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