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NO. 90110-4

SUPREME COURT OF THE STATE OF WASHINGTON

IN RE THE DETENTION OF:
D.W., G.K., S.B., E.S., M.H., S.P., L.W., J.P., D.C., M.P.,

Respondents.

**RESPONSE TO AMICUS BRIEFS
BY DEPARTMENT OF SOCIAL AND HEALTH SERVICES AND
PIERCE COUNTY DESIGNATED MENTAL HEALTH
PROFESSIONALS**

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 ORIGINAL

TABLE OF CONTENTS

I. INTRODUCTION1

 A. The Amicus Briefs Illustrate That The Lower Court Ruling Addressed Significant Policy And Legal Questions Without Notice To Proper Parties And In A Proceeding That Does Not Create A Record Appropriate To Such Questions3

 B. The Amicus Briefs, Like The Record, Show That Hospital Beds Can Provide Constitutionally Sufficient Care During Initial Involuntary Commitment6

 1. Amici Contradict This Court’s Holding In *In re Detention of J.S.*7

 2. Amici Cite Distinguishable Cases That Do Not Suggest That Hospital Care Violates Substantive Due Process10

 3. The Hospital Association Confirms That Hospital Emergency Departments And Hospital Beds Allow Patients To Receive Meaningful Professional Care12

 C. Amici Show No Basis For Declaring That Certification Of Single Hospital Beds Violates The Involuntary Treatment Act16

 D. The Court Should Not Address New Issues Raised By Amici.....19

II. CONCLUSION20

TABLE OF AUTHORITIES

Cases

<i>Burt v. Dep't of Corrections</i> 168 Wn.2d 828, 231 P.3d 191 (2010).....	4
<i>Campbell v. Dep't of Soc. & Health Servs.</i> 150 Wn.2d 881, 83 P.3d 999 (2004).....	17
<i>In re Detention of J.S.</i> 124 Wn.2d 689, 880 P.2d 976 (1994).....	7, 8, 10, 19
<i>In re Detention of Turay</i> 139 Wn.2d 379, 986 P.2d 790 (1999).....	1, 5, 6
<i>Johnson v. Cont'l W., Inc.</i> 99 Wn.2d 555, 663 P.2d 482 (1983).....	19
<i>Nw. Sportfishing Indus. Ass'n v. Dep't of Ecology</i> 172 Wn. App. 72, 288 P.3d 677 (2012).....	5
<i>Ohlinger v. Watson</i> 652 F.2d 775 (9th Cir. 1980).....	11
<i>Oregon Advocacy Center v. Mink</i> 322 F.3d 1101 (9th Cir. 2003).....	10, 11
<i>Pierce County v. State</i> 144 Wn. App. 783, 185 P.3d 594 (2008).....	3
<i>Sharp v. Weston</i> 233 F.3d 1166 (9th Cir. 2000).....	11
<i>State v. Schaler</i> 169 Wn.2d 274, 236 P.3d 858 (2010).....	9
<i>Youngberg v. Romeo</i> 457 U.S. 307, 102 S. Ct. 2452, 73 L. Ed. 2d 28 (1982).....	8, 10

Rules

CR 19(a)..... 4
CR 19(b)..... 4

Constitutional Provisions

Const. art. XIII, § 1 16

Statutes

Laws of 2013, 2d Sp. Sess., ch. 4, § 204(1)..... 15
Laws of 2013, 2d Sp. Sess., ch. 19, § 1071 14, 15
Laws of 2014, ch. 221, § 204(1)..... 15
RCW 34.05.330(1)..... 5
RCW 34.05.510 3
RCW 34.05.570(1)(a) 9
RCW 34.05.570(2)..... 5
RCW 71.05 5, 16, 20
RCW 71.05.010(2)..... 18
RCW 71.05.010(4)..... 18
RCW 71.05.137 6
RCW 71.05.560 17
RCW 71.24.300(6)(a) 3
RCW 71.24.300(6)(c) 3
RCW 75.05.130 5

Other Authorities

The Joint Commission, Hospital Accreditation Program
Standard LD.04.03.11, *available at*
[http://www.jointcommission.org/assets/1/18/Pre_Publicati
on_EDO_HAP.pdf](http://www.jointcommission.org/assets/1/18/Pre_Publicati
on_EDO_HAP.pdf)..... 14

The Joint Commission, Hospital Accreditation Program
Standard PC.01.01.01, *R³ Report I, available at*
[http://www.jointcommission.org/assets/1/18/R3_Report_Is
sue_4.pdf](http://www.jointcommission.org/assets/1/18/R3_Report_Is
sue_4.pdf)..... 13, 14

I. INTRODUCTION

The amicus briefs filed in support of Respondents demonstrate just how inappropriate it was for the lower court to turn commitment proceedings into an ad-hoc, one-sided mini-trial on the constitutional validity of single bed certification. This Court has made clear that the trier of fact's role in an involuntary commitment proceeding is to determine whether the person meets criteria for commitment, "*not* to evaluate the potential conditions of confinement." *See In re Detention of Turay*, 139 Wn.2d 379, 404, 986 P.2d 790 (1999). The lower court ignored this rule. Moreover, the evidence it considered and that amici seek to add provides no basis to conclude that the DSHS rule violates substantive due process or statute.

The amicus briefs of Disability Rights Washington, et al. (DRW) and the Washington State Hospital Association, et al. (Hospital Association) attempt to make up for the absence of meaningful evidence by offering new evidence and suggesting DSHS should contest or correct those facts here—in an appellate forum. Rather than support the trial court's erroneous decision, these arguments and factual claims confirm that these cases fundamentally and improperly transformed from evaluating individual commitments into review of the validity of a rule and practice without a sufficient record. The hearing below, moreover,

did not demonstrate the facts asserted by amici to claim unconstitutionality or unlawfulness of hospital care. That short hearing involved five unprepared witnesses who briefly explained how single bed certifications arose. CP at 112-82. The witnesses barely explored the actual treatment in hospitals, or the myriad factors that affect availability of evaluation and treatment locations. *See* CP at 162-64.

There were many ways individuals could have properly challenged single bed certifications. At the least, the relief endorsed by amici required a lawsuit against indispensable parties—DSHS and the Regional Support Networks (RSN). The lower court's approach was uniquely inappropriate and denied this Court a reliable or useful record. Indispensable parties did not have notice of claims or meaningful opportunity to be heard; they were invited to an afternoon inquest by the mental health commissioner, where he explored the issue of single bed certifications, notwithstanding that respondents were withdrawing any motions for dismissal or specific relief. CP at 99.

Putting aside the lack of a fair proceeding or meaningful record, the amicus briefs show no legal basis for the declarations. The DSHS rule does not violate constitutional or statutory rights simply by authorizing a community hospital bed during initial evaluation and care of involuntarily committed mental health patients. The lower court relied on a mistaken

understanding of constitutional principles and the facts to issue a ruling that, if not reversed, increases the risk that people with severe mental illness will be returned to the streets in times of crisis, rather than receive care and treatment in a hospital setting.

A. The Amicus Briefs Illustrate That The Lower Court Ruling Addressed Significant Policy And Legal Questions Without Notice To Proper Parties And In A Proceeding That Does Not Create A Record Appropriate To Such Questions

Both amicus briefs ignore the elephant in the room. There was no complaint, action, or claim against DSHS asserting that its rule was invalid. Respondents made no claims, no third party claims, and did not seek to join DSHS or any other party. Respondents served no pleading against DSHS claiming it was acting illegally, or seeking judicial review of the rule under the exclusive provisions of the Administrative Procedure Act, RCW 34.05.510, or under any other statute or legal theory. Respondents filed no claims against the RSN Optum, the independent entity (CP at 239) that pays for the single hospital beds (CP at 164) and is responsible for short-term involuntary commitments during the first 17 days. RCW 71.24.300(6)(a), (c); *Pierce County v. State*, 144 Wn. App. 783, 809, 185 P.3d 594 (2008). CP at 239.

There can be little doubt that DSHS and the RSNs are indispensable when a party seeks relief concerning the validity of a DSHS

rule, and challenges use of hospital beds during mental health commitment. *See* CR 19(a), (b); *Burt v. Dep't of Corrections*, 168 Wn.2d 828, 837, 231 P.3d 191 (2010) (failure to join party “requires that the judgment be vacated and the case remanded for proper joinder”). Respondents’ counsel who originally sought dismissal, like the Commissioner who held the hearing, recognized there were “players . . . who need to be present.” CP at 97; *see also* CP at 93, 96, 100-01. But rather than acting on this recognition in legally acceptable ways, such as filing suit against the parties, the Commissioner proceeded in an informal, ad-hoc manner by inviting DSHS to provide comments. DSHS then appeared as an amicus to answer the mental health commissioner’s questions; it became a party only after the revision court ruled, to pursue this appeal. CP at 290-92.

Not surprisingly, amici do not claim that this process involved proper parties or a meaningful notice and opportunity to be heard. And, they ignore the remarkable fact that not one person from a hospital testified about how patients are evaluated and treated in a community hospital. Rather, they rely indirectly on the comments of witnesses who generally explained that hospital beds provide less optimal treatment in a more restrictive setting than an evaluation and treatment center. This general comparison between hospital care and an evaluation and treatment

center does not give substantial evidence about the evaluation and treatment in hospitals. It does not support amici or respondents' assumption that there is no treatment, evaluation, or assistance for patients in hospital beds.

The Hospital Association brief implicitly concedes that this record is insufficient to evaluate care at hospitals. Shunning the record, they offer facts and details about hospital care from outside the record. Of course, such facts could have been developed in a constitutional claim between adverse parties, or in a petition for rulemaking (which is subject to judicial review). See RCW 34.05.330(1); *Nw. Sportfishing Indus. Ass'n v. Dep't of Ecology*, 172 Wn. App. 72, 90, 288 P.3d 677 (2012) (“petition for rulemaking is eligible for judicial review and relief under RCW 34.05.570(4)(c)”). They could seek review of the rule at any time under RCW 34.05.570(2). They could help an individual patient bring a test case. But the commitment proceeding under RCW 71.05 is no place for a digression into the care and treatment modalities. The commitment proceeding parties are limited to the mental health professionals who evaluated an individual and the respondent individual. RCW 75.05.130.

These factors highlight why this Court has previously forbidden what happened here. In *In re Detention of Turay*, an accused sexually violent predator assigned error to the trial court's refusal to admit evidence

about inadequate treatment at the Special Commitment Center. This Court held that an involuntary commitment proceeding determines whether the person meets criteria for commitment and “*it is not* to evaluate the potential conditions of confinement.” *In re Detention of Turay*, 139 Wn.2d at 404. As in *In re Detention of Turay*, these commitment proceedings should not have been commandeered by the health commissioner to challenge treatment or conditions of confinement. See RCW 71.05.137 (authority of mental health commissioner limited to “applications, petitions, and proceedings . . . under this chapter”).

For all these reasons, the amicus briefs illustrate why this Court should hold that this case is inappropriate for review of declarations about the validity of the rule certifying use of hospital beds.

B. The Amicus Briefs, Like The Record, Show That Hospital Beds Can Provide Constitutionally Sufficient Care During Initial Involuntary Commitment

DRW argues that the lower court properly declared the DSHS rule violates a substantive due process right to treatment by authorizing involuntary commitment in a community hospital bed. DRW Amicus Br. at 5. They argue “the lack of adequate treatment” “is clear” and precludes any detention in community hospital beds during 72-hour or 14-day commitments. DRW Amicus Br. at 6. The Hospital Association agrees, citing facts about hospitals and general approaches to emergency

care—facts not in the record. These constitutional arguments do not withstand scrutiny.

1. Amici Contradict This Court’s Holding In *In re Detention of J.S.*

Amici’s arguments ignore the proper constitutional standard. Like the lower court, amici’s constitutional analysis focuses on whether hospitals are “optimum treatment” and whether “less restrictive” or additional care might occur at an evaluation and treatment center. While these limited facts reflect the testimony elicited by the Commissioner, it is a superficial comparison that ignores the constitutional standard for substantive due process and does not demonstrate a violation of substantive due process rights.¹

In *In re Detention of J.S.*, this Court examined the substantive due process requirements for a person involuntarily committed because of a mental health problem. *In re Detention of J.S.*, 124 Wn.2d 689, 880 P.2d 976 (1994). The Court found statutory authority to uphold a lower court order requiring treatment in a less restrictive environment than Western State Hospital, but also held that “we do not agree that such less restrictive treatment is constitutionally or statutorily required as Respondents

¹ See FF 4 (CP at 299), relying on testimony that “the hospitals do the best job they can to try and provide treatment, um, but it’s really outside their scope of practice. . . . [Patients] are getting less care than they could if they were in an evaluation and treatment center. Uh, it’s actually a more restrictive environment” See FF 6 (CP at 300), relying on testimony that a hospital bed is “not optimum treatment.”

argue.” *In re Detention of J.S.*, 124 Wn.2d at 699. The ruling examined and followed *Youngberg v. Romeo*, 457 U.S. 307, 102 S. Ct. 2452, 73 L. Ed. 2d 28 (1982). Based on *Youngberg*, and courts that have applied *Youngberg*, this Court held that showing less than optimal or more restrictive treatment does not show a violation of substantive due process.

[T]he constitutionally significant issue *is not whether the optimal course of treatment* must be followed, but whether a course of treatment is adequate and *reasonably based on professional judgment*. In each of the cases on appeal here, the testifying medical professionals found that the Respondents could be better cared for in a less restrictive setting but nonetheless recommended continued treatment in Western State would be appropriate for each of the Respondents given their conditions, their need for treatment, and the *unavailability of less restrictive alternatives*.

In re Detention of J.S., 124 Wn.2d at 700 (emphases added). Relevant to the single bed certification rule, a professional determination considers practicalities including the availability of treatment and costs:

A reasonable consideration must necessarily incorporate a cost analysis. A professional determination that excludes all considerations of costs and available resources could easily become impossible for a state to implement within justifiable budgetary limitations.

Id. (quoting *Jackson v. Fort Stanton Hosp. & Training Sch.*, 964 F.2d 980, 992 (10th Cir. 1992)).

Amici’s position fails because it depends on the lower court’s use of two witnesses who commented on the relative advantages of evaluation

and treatment centers. The witnesses did not examine the constitutionally significant issue because those same professionals supported using hospital beds for care under the circumstances. CP at 131, 181. Moreover, the court did not have evidence to overcome the fact that patients in hospital beds are evaluated and stabilized during psychiatric emergencies, that hospital professionals work in conjunction with mental health professionals during detention and care, and patients receive medication, observation, and nursing care from the hospital.²

The burden to demonstrate invalidity is on respondents. RCW 34.05.570(1)(a). This Court reviews constitutional issues *de novo*. *E.g., State v. Schaler*, 169 Wn.2d 274, 282, 236 P.3d 858 (2010). If the Court does not reverse based on the illegal procedure, it should hold that respondents and their amici did not show a substantive due process violation. Such a claim cannot rest on conclusory statements that a hospital bed is not optimum or is more restrictive, nor by general comparisons to other treatment at evaluation and treatment centers. Under

² The record provides significant proof that hospital beds result in care that is professional and meaningful. CP at 124 (“hospitals do the best job they can to try and provide treatment”); CP at 125 (hospitals provide “one-to-one” monitoring); CP at 127 (during 14-day detentions, mental health professional staff are very conscientious regarding patients in single bed certifications); CP at 131 (emphasizing that although hospital services are different than E&T centers, they provide assistance that is better than releasing the patient); CP at 161 (RSN does daily monitoring of all involuntary patients to move people to optimal placement as soon as possible); CP at 174 (hospitals can alleviate single bed certifications by increasing inpatient psychiatric care); CP at 182 (emergency departments provide some RCW 71.05 evaluations and provide some psychiatric treatment).

Youngberg and *In re Detention of J.S.*, the burden is to show that hospital care is not based on professional judgment and not rationally related to helping the involuntarily detained person. This record does not allow this Court to conclude that hospital care violates constitutional rights. Instead, the record confirms that patients in hospital beds can receive professional care meeting the requirements of substantive due process.

2. Amici Cite Distinguishable Cases That Do Not Suggest That Hospital Care Violates Substantive Due Process

DRW relies on distinguishable cases to argue that detention in a hospital bed, even for a few days at the beginning of an involuntary commitment, *per se* violates substantive due process. For example, DRW relies on *Oregon Advocacy Center v. Mink*, 322 F.3d 1101 (9th Cir. 2003). But *Mink* involved long-term detentions *in jails* pending transfer to Oregon State Hospital. The detentions averaged a month and went up to five months, where individuals were in jail cells for up to 23 hours a day. *Mink*, 322 F.3d at 1106-07. There is no factual basis for comparing hospital care under the DSHS rule to the jail cells in *Mink*. But, even if comparable, the final order in *Mink* authorized seven days in jail detentions before transfer to a mental health institution. This refutes the lower court's declaration banning any use of a hospital bed absent a separate medical need.

Similarly, amici rely on general statements in *Ohlinger v. Watson*, 652 F.2d 775 (9th Cir. 1980). In that case, individuals faced indeterminate prison sentences based on sex offender status, and the state provided no treatment to facilitate release. That is not comparable to hospital care during the initial days of involuntary commitment. The case of *Sharp v. Weston*, 233 F.3d 1166 (9th Cir. 2000), is distinguishable for the same reason. That court did not evaluate hospital care and instead dealt with the inadequate long-term treatment programs for sexual offenders who were facing indeterminate detention.

The general statements in *Ohlinger* and *Sharp*, or *Mink*, do not blindly condemn use of hospital beds for initial care. These cases do not examine how a hospital is used under the DSHS rule, where mental health professionals explore five local options for evaluation and treatment before seeking a single bed certification. CP at 118. These cases do not consider how a hospital emergency department is where these patients are first evaluated by emergency room physicians and/or authorized mental health professionals (CP at 182), how the hospital care is professionally supervised, and how the hospital beds allow for treatment for patients with mental health issues serious enough to require involuntary commitment. Hospital care is simply not comparable to the cases cited by amici.

3. The Hospital Association Confirms That Hospital Emergency Departments And Hospital Beds Allow Patients To Receive Meaningful Professional Care

The Hospital Association discusses hospital care at length. In doing so, it confirms that hospital beds are within the options a state may use during initial detention, particularly combined with plans to transfer patients to evaluation and treatment centers or other facilities.

The Hospital Association emphasizes that a hospital bed is not optimum treatment. As discussed above, that argument avoids the constitutional standard. However, when describing the care and the burdens it places on their systems, amici concede several points showing why this Court should reject respondents' claim that care in a hospital bed cannot meet the constitutional minimums. These points include:

- Community hospitals are accredited, and accreditation certifies that their emergency departments can screen, diagnose, and identify psychiatric emergencies. Hosp. Ass'n Amicus Br. at 7-8.
- Community hospitals can consult with designated mental health professionals and emergency department physicians during psychiatric emergencies, addressing the requirements of the Involuntary Treatment Act, RCW 71.05. Hosp. Ass'n Amicus Br. at 9.
- Community hospitals provide significant care pending transfers to evaluation and treatment centers. Hosp. Ass'n Amicus Br. at 10.
- Community hospitals will do "their best" awaiting transfer, and that includes hospital rooms, nursing care, physicians,

oversight by mental health professionals, and “one-to-one care, around the clock care” when required. Hosp. Ass’n Amicus Br. at 12, 16.

To further understand the discussion by the Hospital Association, this Court should examine the accreditation standards they reference, such as the revised standards of The Joint Commission, Hospital Accreditation Program Standard PC.01.01.01. *R³ Report I*, available at http://www.jointcommission.org/assets/1/18/R3_Report_Issue_4.pdf. Element 4 of that standard requires that hospitals without psychiatric services must operate under a written plan for “care, treatment, and services or the referral process for patients” with psychiatric emergencies:

Hospitals that do not primarily provide psychiatric or substance abuse services *have a written plan that defines the care, treatment, and services or the referral process for patients who are emotionally ill* or who suffer the effects of alcoholism or substance abuse.

R³ Report I, at 2 (emphasis added). Element 24 of that same Standard provides:

If a patient is boarded while awaiting care for emotional illness and/or the effects of alcoholism or substance abuse, the hospital does the following:

- Provides for a *location for the patient that is safe, monitored*, and clear of items that the patient could use to harm himself or herself or others. (See also LD.04.03.11, EP 6; NPSG.15.01.01, EPs 1 and 2)
- Provides *orientation and training* to any clinical and non-clinical staff caring for such patients in

effective and safe care, treatment, and services (for example, medication protocols, de-escalation techniques). (See also HR.01.05.03, EP 13; HR.01.06.01, EP 1)

- Conducts assessments and reassessments, and provides care consistent with the patient's identified needs. (See also PC.01.02.01, EP 23)

R³ Report I, at 2 (emphases added).³

The fact that most community hospitals opt out of inpatient psychiatric departments is no basis for concluding that such hospitals are placed in an inappropriate position. First, the legislature recently provided \$5 million in state funding to assist with capacity for community psychiatric care (although few community hospitals accepted that responsibility). See Laws of 2013, 2d Sp. Sess., ch. 19, § 1071 (funding for grants “to establish new community hospital inpatient psychiatric beds, free-standing evaluation and treatment facilities, enhanced services facilities, triage facilities, or crisis stabilization facilities with sixteen or fewer beds for the purpose of providing short term detention services through the publicly funded mental health systems”). And emergency

³ The Joint Commission, Hospital Accreditation Standard LD.04.03.11, only sets an aspirational goal of four hours before transfer. Standard LD.04.03.11, at 1, available at http://www.jointcommission.org/assets/1/18/Pre_Publication_EDO_HAP.pdf. The accreditation makes it clear that this is *not* a performance standard, and must account for the realistic needs in the area. Thus, accredited hospitals are expected to “communicate with behavioral health care providers and/or authorities serving the community to foster coordination of care for this population.” Standard PC.01.01.01, EP 9, at 2. This is, of course, exactly what is currently happening in Washington.

departments may increase psychiatric care with consulting relationships— as they do for other subjects.⁴

The Hospital Association brief is like one side of a legislative-type argument, but it does not realistically evaluate the options facing the public. Rather than prematurely judge legal and policy options, the Court should demand a proper case. For example, a case with proper parties would create a record disputing the Hospital Association’s claims about lack of funding and show how funding has increased for a number of community care options, many of which treat people *before* their condition necessitates involuntary treatment. Laws of 2013, 2d Sp. Sess., ch. 19, § 1071 (described above); Laws of 2013, 2d Sp. Sess., ch. 4, § 204(1) (appropriating nearly \$27.7 million (state and federal combined) to implement new law enhancing RSN community programs); Laws of 2014, ch. 221, § 204(1) (appropriating nearly \$12 million for enhancement of community mental health services). It would explore the complex options for reducing the number of single bed certifications and for providing care to patients in certified hospital beds. CP at 173-75. It

⁴ The amicus briefs may have relied on respondents’ conclusion that hospital care involves only the “bare necessities that the state must provide . . . a convicted criminal.” Br. Resp’ts at 17. That hyperbole is not supported by the record. Respondents leapt from the fact that evaluation and treatment centers provide additional treatment to the unsupported conclusion that hospital care for psychiatric emergencies provides no professional evaluation, care, and treatment. Even the sparse record in this case indicated that this is an overstatement. *See supra* note 3.

would address the effect of the 16 new evaluation and treatment beds opening in Pierce County in July 2014. Reply Br. Pierce County at 16.

This Court should reject the argument that substantive due process requires that patients with serious mental illness be returned to their last residence. Hospital beds can provide care that meets constitutional minimums per their accreditations, by dealing with individualized patient needs, and by consulting with designated mental health professionals to evaluate and initiate care of patients. The hospital care that occurs under the DSHS rule is designed to contribute to a patient's opportunity for recovery—unlike a ride home.

C. Amici Show No Basis For Declaring That Certification Of Single Hospital Beds Violates The Involuntary Treatment Act

DRW also supports the lower court's declaration that certification of hospital beds violated RCW 71.05, the Involuntary Treatment Act. That argument relies on their claim that the record demonstrated that hospital emergency departments are incapable of providing “‘appropriate inpatient care to persons suffering from a mental disorder.’” DRW Amicus Br. at 7 (quoting RCW 71.05.020(16) (definition of “evaluation and treatment”)).⁵

⁵ Neither the amici nor the respondent parties have briefed or supported the lower court's passing reference to article XIII, section 1 of the Washington Constitution, which authorizes the state to provide care for people with mental illness. Accordingly,

DRW's statutory argument suffers the same shortcomings as its constitutional argument. First, there is no reliable record to show that hospital care provides inappropriate care, because DSHS was not a party, and the lower court did not apply the Administrative Procedures Act to evaluate the meaning of the rule, or the record supporting its adoption. Even ignoring the duty to examine the rulemaking record, DRW's factual assertions were not tested by an adversarial process involving parties affected. The Commissioner, who asked many questions of the witnesses, did not elicit details about hospital care beyond the witnesses that provided a general comparison between hospital beds and evaluation and treatment centers.

DSHS has broad authority to adopt "such rules *as may be necessary* to effectuate the intent and purposes of this chapter, which shall include . . . procedures and standards for certification and other action relevant to evaluation and treatment facilities." RCW 71.05.560 (emphasis added). A rule authorized by such a statute is presumptively valid when reviewed, and should be upheld if "reasonably consistent with the statute being implemented." *E.g., Campbell v. Dep't of Soc. & Health Servs.*, 150 Wn.2d 881, 892, 83 P.3d 999 (2004). Single bed certification

there is no basis for this Court to evaluate whether that constitutional provision affects the validity of the DSHS rule or compels some other government action.

effectuates the intent and purposes of the chapter by authorizing evaluation and treatment capacity when full-time centers are full. DRW suggests people be sent home, but this rule provides certification of beds where there is “prompt evaluation” and “appropriate treatment,” two of the purposes of the Involuntary Treatment Act. RCW 71.05.010(2). Moreover, hospital care pending a transfer to a full-time evaluation and treatment center promotes “continuity of care.” RCW 71.05.010(4).

DRW also has no basis for claiming the state is seeking “to prolong” use of single beds. As discussed in the prior briefing, a new evaluation and treatment center opens in Pierce County this July. As discussed above, the state is funding a variety of tools to reduce single bed certifications and provide community-based treatment. Amici can advocate for additional spending, but the fact remains that the legislature has provided significant money and resources to increase mental health care during the last two fiscal years.

The Hospital Association, in passing, suggests the case can end by construing the DSHS rule to deny certifying hospital beds based on lack of evaluation and treatment space. Hosp. Ass’n Amicus Br. at 18 n.17. But neither the text of the rule, nor a rulemaking record, supports this argument. And the only witness cited by the lower court in support of this point expressly disavowed that mistaken view of the rule. CP at 180

(DSHS witness stating that the rule is applicable based on lack of space in evaluation and treatment centers). Moreover, the one person's understanding about the rule is an unsound basis for re-defining the rule's meaning. *Cf. Johnson v. Cont'l W., Inc.*, 99 Wn.2d 555, 560-61, 663 P.2d 482 (1983) ("affidavits or comments of individual legislators" are immaterial to legislative intent).

D. The Court Should Not Address New Issues Raised By Amici

Amici raise several new issues that the Court should decline to address. DRW discusses the "integration mandate" of the Americans with Disabilities Act (ADA). The lower court and parties did not raise the ADA. This Court "do[es] not generally consider issues raised first and only by amicus." *In re Detention of J.S.*, 124 Wn.2d at 702 (rejecting an ADA issue raised by amicus). On a related note, DRW suggests that the commitment process does not show that DSHS or the courts considered alternatives less restrictive than a commitment. DRW Amicus Br. at 11. DRW is incorrect. Every petition expressly considered whether there would be a less restrictive alternative. *E.g.*, CP at 604, 611 (petitioner attesting that the respondent is not suited for a less restrictive alternative).

The Hospital Association amicus brief claims that providing emergency care to a psychiatric patient would be inconsistent with their licenses. Hosp. Ass'n Amicus Br. at 17-18. No such claim was raised

during the lower court's investigation of single bed certifications and it should not be introduced now. The Hospital Association also claims that hospital use is limited to six hours. Hosp. Ass'n Amicus Br. at 19. Again, that relief was not sought by the parties and should not be considered by this Court.

II. CONCLUSION

In the real world, hospital beds are invaluable to patients who require immediate care before they can be transferred to evaluation and treatment centers. The suggestion that those beds should be declared unlawful based on a short hearing during an involuntary commitment proceeding under RCW 71.05 will hurt the people who benefit from such care. This Court should reverse and hold that a proceeding under RCW 71.05 cannot fairly address the validity of an agency rule or the conditions of treatment.

RESPECTFULLY SUBMITTED this 12th day of June 2014.

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CERTIFICATE OF SERVICE

I certify, under penalty of perjury under the laws of the state of Washington, that on this date I have caused a true and correct copy of Response To Amicus Briefs By Department Of Social And Health Services And Pierce County Designated Mental health Professionals to be served on the following via e-mail:

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DATED at Olympia, Washington this 12th day of June 2014.

//s//

Wendy R. Scharber
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Sent on behalf of: Jay D. Geck, Deputy Solicitor General WSBA 17916
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In re The Detention Of: D.W., G.K., S.B., E.S., M.H., S.P., L.W., J.P., D.C., M.P.
(single bed certification)

Cause No. 90110-4

Response To Amicus Briefs By Department Of Social And Health Services And Pierce County
Designated Mental Health Professionals