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VIA E-MAIL ONLY

Honorable Chief Justice Debra L. Stephens
and Honorable Justices of the
Washington State Supreme Court
PO Box 40929
Olympia, WA 98501
E-Mail: SUPREME@COURTS.WA.GOV

Re: Proposed Involuntary Treatment Act (ITA) Court Order

Dear Chief Justice Stephens and Justices of the Washington State Supreme Court:

We submit this letter on behalf of the Washington State Hospital Association (WSHA) in response to an order proposed by the Washington Association of Criminal Defense Lawyers (WACDL) and the Washington Defender Association (WDA) on Friday, March 27, 2020.

This Court is well aware of the perilous state of Washington's hospitals and their employees with the total number of COVID-19 cases continuing to double weekly. As the number of hospitalized patients grows, quadrupling over the last four weeks, hospitals are faced with caring for critically ill patients, lack of equipment and supplies, workforce shortages, and risks to healthcare providers, all while preparing for the unknown. There is great uncertainty about what is ahead, but the public health emergency could overwhelm the system.

Against this ominous background, the WACDL and WDA ask the Court to enter a statewide order imposing numerous obligations on the same hospitals with regard to patients involved in Involuntary Treatment Act (ITA) cases ("the defense order"). WSHA represents those hospitals. WSHA agrees that a statewide order is necessary, but with very different terms. The defense order would seriously and negatively affect the ability of hospitals to take care of their patients in a time of maximum need.

WSHA and its member hospitals fully recognize the important individual interests presented by ITA cases, but those interests can be protected with a more reasoned and flexible set of procedures. The proper order is one that calls on all stakeholders in the ITA system to do their best, not to achieve perfection in the midst of a public health crisis.

Washington hospitals have a significant interest in the ITA process

Civil commitment proceedings under the ITA involve a unique role for hospitals. This role was directly recognized by this Court not long ago in *In re Detention of D.W*., 181 Wn.2nd 201, 206 n 2 (2014) ("The hospitals' interest in intervening [in ITA cases] is clear.").

Given the limits of the state's behavioral health system, the hospital emergency department is the doorway to the ITA for most patients. It is, unfortunately, a doorway in which patients often get stuck: with scarce treatment resources at the state hospitals and in the community, patients detained and committed pursuant to the ITA often linger in hospitals for lengthy periods of time. This was addressed by the Court in *In re Detention of D.W*.

Hospitals participate directly in the ITA process. The initial 72 hour detention of a person who is dangerous to self or others, or is gravely disabled, as a result of a mental disorder, substance use disorder or both is initiated by a designated crisis responder (DCR). *See* RCW 71.05.150. The "professional staff of the facility" then decides whether additional intensive treatment for up to 14 days is needed. If so, a petition is filed either by the DCR or, more frequently, members of the hospital's professional staff. *See* RCW 71.05.230. As petitioners, those members are parties to the ITA case. Importantly, hospitals of all kinds participate in the ITA process.

If further treatment is needed beyond 14 days, a petition for long term treatment of up to 90 days is filed. *See* RCW 71.05.290. Professionals at the hospital generally are involved as petitioners, and their opinions are necessary to support petitions. Again, they are parties to the ITA case.

The interest of hospitals in the ITA process is not limited to the courtroom. It has broader system impacts, particularly for emergency departments and in being trauma ready. On any given day, dozens of ITA patients are in Washington's community hospitals, oftentimes in emergency departments.[1] Some of those hospitals have psychiatric beds, but most do not. The professionals at those hospitals provide the best care they can for ITA patients. The reality, recognized by this Court, is that many ITA patients should be elsewhere. And, the resources directed to them cannot be used for patients from the community with medical needs. Those patients now include ones suffering from COVID-19 and related illnesses.

Even in the best of times, hospitals' daily routines are challenged by the ITA process, which involves petitions, visits from DCRs, the presence of lawyers, requests for records and interviews, court testimony, transporting patients to and from court hearings, and the court hearings themselves taking place in the hospitals. The requirements in the defense order would impose

[1] It is important to note that, even under normal circumstances, Washington does not have enough bed capacity for ITA patients, which means that ITA patients are often detained in community hospitals, including emergency departments and non-psychiatric units. *See* Washington State Health Care Authority, Single Bed Certification (SBC) quarterly update, *available at* https://www.hca.wa.gov/assets/program/single-bed-certification-122019.pdf.

greater burdens on hospitals, beyond the requirements of the ITA, at a time when the resources of hospitals must be directed to the acute needs of COVID-19 patients, as well as patients who come to the hospital for other medical emergencies. The defense order also imposes **greater** obligations on hospitals than many of the emergency orders relating to ITA cases that are already in place by trial courts across the state.

Washington hospitals are facing unprecedented times during this global pandemic

Hospitals are facing an unprecedented challenge with COVID-19. In Washington, the total number of COVID-19 cases reached 4,310 this past Saturday (2,077 of which in are in King County, where approximately half of all ITA cases occur), with 189 reported deaths (including 136 in King County). According to a modeling analysis from the University of Washington's Institute for Health Metrics and Evaluation, even with strict social distancing, more than 81,000 people in the U.S., and more than 1,400 in Washington, could die from COVID-19 by July 1, 2020.

In light of this unprecedented public health emergency, Washington healthcare facilities have received regulatory flexibility to support its efforts in responding to COVID-19. After the U.S. declared a national emergency, the Department of Health and Human Services issued a nationwide waiver under Section 1135 of the Social Security Act, to waive certain requirements in Medicaid, Medicare, and the Children's Health Insurance Program. Subsequently, the Centers for Medicaid & Medicare Services (CMS) issued further blanket Section 1135 waivers of certain healthcare laws and regulations. Additionally, CMS approved two Section 1135 Medicaid waivers specifically for Washington which, among other things, allow for screening in offsite locations (for purposes of the Emergency Medical Treatment and Active Labor Act), allow expedited discharge processes to enable movement of patients among different care settings, allow care in non-hospital settings, allow practice by those whose privileges expire or have not been approved, and allow facilities to reuse personal protective equipment (PPE) so more can be saved for patient care areas. Waiver approvals are ongoing.

Washington healthcare facilities have also received support from Governor Inslee, who has issued several proclamations to preserve the state's limited healthcare supplies and protect its healthcare workers. On March 19, 2020, the Governor issued a proclamation halting elective and non-urgent surgeries (including for slow growing cancers) and dental services to preserve PPE and ensure healthcare workers would have enough protective equipment to wear as they work the front lines of the pandemic. Then, on March 26, 2020, the Governor issued a proclamation waiving various licensing and credentialing requirements for healthcare workers to allow them to focus on providing care to the community during the outbreak.

There are other state healthcare measures at work. The Department of Health is supporting enrollment and activation of emergency volunteer health practitioners. Further, the Washington Medical Commission has modified its regulatory approach to consider the difficult circumstances and choices providers are facing, and adopted emergency rules to enable retired providers, including physicians and physician assistants, to provide care during the pandemic.

The defense order imposes an unreasonable burden on hospitals that will interfere with the delivery of life saving treatment

As healthcare workers get sick or burn out, the shortage of healthcare workers increases, while at the same time, the number of patients diagnosed with COVID-19 continues to rise. In the middle of this crisis, Washington hospitals are being asked by the WDA and WACDL to take extraordinary measures to protect defense counsel and prioritize their needs.

While WSHA agrees that an order is necessary to provide guidance for ITA cases, implementing a one-size-fits-all approach will not work across the state. Rather, the order needs to consider the resources available at different hospitals in Washington, and provide hospitals with flexibility in how they operate, particularly during a time when hospitals are rapidly being forced to restructure how they deliver care as they respond to a surge in COVID-19 patients.

To understand the impact of the defense order, it is important to first understand its scope, which is broad—it would apply to all hospitals in the state, big and small, in urban and rural communities, including critical access hospitals that have 25 or fewer beds and limited resources. Many of these hospitals do not have ITA coordinators or dedicated ITA staff.

This leads to the language of the defense order, which would place unreasonable burdens on hospitals, which are already overtaxed and have a dwindling workforce, scarce supplies, and limited space. Under the defense order, DCRs would be required to conduct evaluations "as soon as possible," hospitals would be required to provide remote video access for hearings and facilitate in person meetings between defense counsel and patients unless "impossible to provide," and hospitals would be required to provide PPE for defense counsel to see patients, regardless of whether the patient had contracted or been exposed to COVID-19 (not to mention providing hand sanitizer, disposable pens, and a clean table to conduct business). The defense order also would require hospitals to "make every effort to release patients."

These proposed requirements would interfere with the delivery of life saving treatment. If implemented, hospitals would be put in the difficult position of having to re-direct critical resources. For just one example, the defense order requires hospitals to provide PPE to defense counsel, at a time when **hospitals are struggling to provide enough PPE to healthcare workers** due to a worldwide shortage. While hospitals want to ensure that ITA patients' rights are protected, it is imperative that hospitals are focusing their resources towards increased care demands and patient care.

Aside from negatively impacting the ability of hospitals to combat the virus, the defense order would also directly put in jeopardy the same patients it seeks to protect—many of whom are homeless or housing insecure and are at greater risk of contracting COVID-19. Specifically, the defense order would lead to ITA cases being dismissed based on procedural grounds due to the inability of hospitals to comply, which in turn would result in ITA patients being discharged from hospitals prematurely, only to return again to overcrowded emergency departments. If that happens, ITA patients will be at greater risk of being exposed to the virus, and it will negatively impact the availability of beds that could be used for patients with COVID-19. It bears emphasizing

that hospitals struggled to manage ITA demand in emergency departments ***before*** the current crisis.

The defense order is unnecessary and unworkable for hospitals across the state

While WSHA understands the individual interests at stake in ITA cases, there are no facts that justify issuance of the defense order. As noted in an email, WDA is concerned about "the **potential** abridgment of … civil rights," not about an actual violation that has occurred. The defense order is based on speculative and hypothetical concerns, not on any real-world need.

There are also several requirements in the defense order which are unworkable for Washington's many different hospitals. Washington has more than 100 hospitals. They range from facilities with hundreds of beds in urban areas to critical access hospitals with 25 beds or less serving rural communities. A number of these hospitals presently are treating acutely ill COVID-19 patients. Some of those already are overwhelmed. All are braced.

The state's hospitals differ widely not just in size, but also in services they can provide, ability to care for acutely ill patients, infrastructure, physical plant, workforce adequacy, internet speed, space, technology capability, and hardware. Many hospitals are financially insecure and resource strapped. 13 hospitals do not have enough cash on hand to operate through May and 5 are at imminent risk of closure as a result of impacts from COVID-19. The multiple mandatory requirements of the defense order cannot be met by many of these hospitals.

Due to inpatient demands, hospitals are moving as much patient care as possible to telehealth options. The technology that the defense order calls for hospitals to provide already is in use. The human and space resources that the order allocates to the ITA process are needed to save lives. A visit today to Washington's hospitals would show beds in hallways, tents in parking lots, and exhausted professionals (see Exhibit A).

Since the public health crisis began, hospitals have responded to court orders and stakeholder requests by creating remote processes for attorneys and hearings to the best of their facilities' capabilities.[2] While some hospitals have had success, others have not. Some hospitals do not have the equipment, software, or staff to provide remote video access, much less procedures in place to facilitate the process. Other hospitals face additional technological challenges, including the inability to transmit records electronically, which means staff are having to manually scan the records for each case.

The defense order requires PPE for defense counsel. If it can be found, however, PPE is needed for patient care and to protect frontline healthcare workers. Many hospitals are experiencing significant shortages of PPE and do not have enough for their staff. In a recent call

[2] The defense order places much emphasis on the importance of video communications. ITA defense lawyers regularly call their clients on the telephone before hearings as part of the ITA process. That does not need to change because of the COVID-19 outbreak.

with the Department of Health, hospital use of PPE was described as involving "severe conservation strategies," including reuse.

Other medical problems needing hospitalization, of course, have not stopped. As hospitals try to save COVID-19 patients, people suffering trauma, heart attacks, strokes, need for emergency surgeries, and labor and delivery, to name a few conditions, will continue to arrive.

The defense order could result in the automatic dismissal of ITA cases, which is contrary to the language and purpose of the ITA and would put ITA patients in jeopardy

WSHA is deeply concerned that the inability of hospitals to meet the onerous demands of the defense order will be used by defense counsel as a basis to seek dismissal of ITA cases. This result would be contrary to the intent of the ITA and would have negative consequences for patients, healthcare professionals, and the community.

Patients are in the ITA process because they are acutely ill and at risk, most often to themselves. They can be profoundly depressed or acutely psychotic. The purpose of the ITA is to keep them safe. An order which increases the chance of requests for dismissal is not in their interests, nor is it consistent with legislative intent behind the ITA.

RCW 71.05.010(2) provides:

> "When construing the requirements of this chapter the court must focus on the merits of the petition, except where requirements have been totally disregarded, as provided in *In re C.W.*, 147 Wn.2d 259, 281 (2002). A presumption in favor of deciding petitions on their merits furthers both public and private interests because the mental and physical well-being of individuals as well as public safety may be implicated by the decision to release an individual and discontinue his or her treatment."

The requirements of the ITA, together with an order intended to address the needs of the current public health emergency, will protect the legal interests of patients who are in the ITA process. The defense order, on the other hand, increases the chance of advocacy for dismissal of ITA cases, when exactly the opposite result is needed—and explicitly prescribed by law.

An increased rate of dismissal of ITA cases in these circumstances will not only hurt patients in need of treatment but also will, in many cases, simply start the process again. An acute psychiatric or substance abuse crisis will not be ended by dismissal of an ITA case. That patient will soon be back in the emergency department, alongside COVID-19 patients and others waiting to be seen.

Conclusion

The Court is not faced with a choice between lifesaving treatment and individual rights. The situation is not that stark or dramatic. What is needed is best efforts by all stakeholders to adapt

and function in an uncontrollable environment. For Washington's hospitals, the Court should ask that they do their best in each case to facilitate meaningful communication between patients and their defense counsel, and try to provide a basic set of records for use in ITA cases. In turn, the Court should ask ITA defense counsel to be flexible and recognize the intense circumstances under which hospitals are operating in their mission to save lives. These efforts will allow the ITA system to continue functioning, albeit differently than it did six weeks ago. In the unlikely event a defense absolutely cannot be presented in a given case, the trial court can decide on the remedy.

WSHA's proposed order is attached.

Respectfully,

/s/ Eric J. Neiman and Emma P. Pelkey

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LEWIS BRISBOIS BISGAARD & SMITH LLP

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Enclosure