HOUSE BILL REPORT
ESHB 1713

As Amended by the Senate

Title: An act relating to integrating the treatment systems for mental health and chemical dependency.

Brief Description: Integrating the treatment systems for mental health and chemical dependency.

Sponsors: House Committee on Judiciary (originally sponsored by Representatives Cody, Harris, Jinkins, Moeller, Tharinger, Appleton, Ortiz-Self and Pollet).

Brief History:

Committee Activity:

Judiciary: 2/3/15, 2/19/15 [DPS];

Appropriations: 2/26/15, 2/27/15 [DPS(JUDI-A APP)].

Floor Activity:

Passed House: 3/9/15, 63-35.

Senate Amended.

Passed Senate: 4/15/15, 48-1.

Brief Summary of Engrossed Substitute Bill

- Makes certain short-term changes to the involuntary chemical dependency treatment provisions that parallel corresponding involuntary mental health treatment provisions.
- Integrates the involuntary treatment provisions and systems for chemical dependency and mental health, and integrates other provisions pertaining to minor-initiated and parent-initiated chemical dependency and mental health treatment for minors, effective April 1, 2017.
- Directs a Washington State Institute for Public Policy study to evaluate the effect of the integration of the involuntary treatment systems for chemical dependency and mental health.

HOUSE COMMITTEE ON JUDICIARY

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 7 members: Representatives Jinkins, Chair; Kilduff, Vice Chair; Goodman, Hansen, Kirby, Orwall and Walkinshaw.

Minority Report: Do not pass. Signed by 3 members: Representatives Shea, Assistant Ranking Minority Member; Haler and Klippert.

Minority Report: Without recommendation. Signed by 3 members: Representatives Rodne, Ranking Minority Member; Muri and Stokesbary.

Staff: Omeara Harrington (786-7136).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The substitute bill by Committee on Judiciary be substituted therefor and the substitute bill as amended by Committee on Appropriations do pass. Signed by 18 members: Representatives Hunter, Chair; Ormsby, Vice Chair; Carlyle, Cody, Dunshee, Hansen, Hudgins, S. Hunt, Jinkins, Kagi, Lytton, Pettigrew, Sawyer, Senn, Springer, Sullivan, Tharinger and Walkinshaw.

Minority Report: Do not pass. Signed by 14 members: Representatives Chandler, Ranking Minority Member; Parker, Assistant Ranking Minority Member; Wilcox, Assistant Ranking Minority Member; Buys, Condotta, Dent, Haler, G. Hunt, MacEwen, Magendanz, Schmick, Stokesbary, Taylor and Van Werven.

Minority Report: Without recommendation. Signed by 1 member: Representative Fagan.

Staff: Andy Toulon (786-7178).

Background:

Involuntary Mental Health Treatment.
Under the involuntary mental health systems for both minors and adults, a person may be committed for involuntary mental health treatment if he or she poses a likelihood of serious harm or is gravely disabled. The likelihood of serious harm or grave disability must be due to a mental disorder.

Adult System.
The Involuntary Treatment Act (ITA) sets forth the procedures, rights, and requirements for involuntary mental health treatment of adults. Under the ITA, designated mental health professionals (DMHPs) are responsible for investigating whether or not a person should be detained to an evaluation and treatment facility for an initial 72-hour evaluation. The professional staff of the treatment facility providing the 72-hour evaluation may petition the court to have the person committed for further mental health treatment. A petition must be signed by certain combinations of two examining professionals, including physicians, mental health professionals, and psychiatric advanced registered nurse practitioners.

Following a hearing, if the person is found by a preponderance of the evidence to pose a likelihood of serious harm or be gravely disabled, the court may order the person to be involuntarily committed for up to 14 days of additional treatment at an evaluation and treatment facility. Upon subsequent petitions and hearings, if commitment criteria are met by clear, cogent, and convincing evidence, a court may order up to an additional 90 days of commitment, followed by up to 180 days of commitment. Inpatient commitment on an order allowing up to 90 or up to 180 days of treatment takes place at a state hospital. Successive 180-day orders are permissible on the same grounds and pursuant to the same procedures as the original 180-day commitment.

When entering an order for up to 14, 90, or 180 days of treatment, if the court finds that the person poses a likelihood of serious harm or is gravely disabled, but that treatment in a less restrictive alternative (LRA) than detention in the best interest of the person or others, the court must order an appropriate less restrictive course of treatment rather than inpatient treatment. Less restrictive alternative treatment is for up to 90 days if ordered instead of a 14- or 90-day inpatient order, and is for up to 180 days if ordered instead of a 180-day inpatient order.

Involuntary Mental Health Treatment of Minors.
The provisions governing involuntary mental health treatment of minors over the age of 13 are in parallel with the ITA in most respects. A DMHP, upon a determination that commitment standards are met, may seek a minor's initial 72-hour detention. Upon subsequent petitions and court orders, a minor may be committed for an initial term of up to 14 days of treatment, followed by successive orders of up to 180 days of treatment. Initial and 14-day treatment takes place at an evaluation and treatment facility that provides treatment services for minors.

Subsequent treatment is in the custody of the Department of Social and Health Services (DSHS), or at a private facility if the minor's parents have assumed responsibility for payment. The court must order LRA treatment rather than inpatient treatment if in the best interest of the minor.

Other Common Features of the Involuntary Mental Health Treatment Systems for Adults and Minors.
Jurisdiction over involuntary mental health treatment proceedings is with the superior court. County prosecutors represent petitioners, unless the petitioner is a state facility, in which case the Attorney General provides representation.

If, after examination and evaluation, examining professionals determine that the initial needs of a person would be better served by placement in a chemical dependency treatment facility, then the person must be referred to an approved treatment program for chemical dependency treatment.

A person committed for 14, 90, or 180 days is prohibited from possessing firearms unless the right is later restored by a court.

<u>Involuntary Chemical Dependency Treatment</u>.

An adult or minor may be committed for involuntary chemical dependency treatment upon petition of a Designated Chemical Dependency Specialist (DCDS), a hearing, and a finding by clear, cogent and convincing evidence that the person, due to chemical dependency, poses a likelihood of serious harm or is gravely disabled. The petition of the DCDS must be accompanied by a certificate of a licensed physician who has examined the person within the previous five days, or documentation that the person refused an examination. A petition may only be filed, and the court may only order involuntary treatment, if placement in a chemical dependency program is available and deemed appropriate. If the DCDS finds that the initial needs of a person would be better served by placement within the mental health system, the person must be referred to a DMHP or evaluation and treatment facility.

In some cases, a person is detained prior to the DCDS filing for involuntary treatment. A person who is found to be incapacitated or gravely disabled by alcohol or other drugs at the time of or following admission to an approved treatment program may be detained for no longer than 72 hours, unless a petition is filed for involuntary commitment.

Persons committed as chemically dependent are committed for a term of 60 days, unless sooner discharged, and upon a subsequent petition and hearing, for a term of 90 days, unless sooner discharged. A treating facility may conditionally release a committed person in appropriate circumstances.

Jurisdiction over involuntary chemical dependency treatment proceedings is with the superior court, district court, or other court identified in court rule. The county prosecutor may, but is not obligated to, represent petitioners in involuntary chemical dependency treatment proceedings.

Minor-Initiated and Parent-Initiated Treatment.

Mental Health System.

In the mental health system, a minor age 13 or older may, without parental consent, admit himself or herself to an evaluation and treatment facility for inpatient treatment or request and receive outpatient treatment. The administrator of a facility to which a minor has been admitted for inpatient treatment must notify the minor's parents of the admission. The minor may only be admitted if the professional person in charge of the facility believes the minor is in need of inpatient treatment. A minor voluntarily admitted to inpatient treatment may give notice of intent to leave at any time. Parental consent is needed for inpatient or outpatient treatment of a minor under 13 years old.

A parent may bring his or her minor child to an evaluation and treatment facility and request an evaluation for inpatient treatment, or to an outpatient provider and request an examination for the need for outpatient treatment. The consent of the minor is not required, and, if admitted for medically necessary inpatient treatment, the minor may not be discharged based solely on his or her request. The minor may petition the court for release from the facility.

Chemical Dependency System.

The provisions for minor-initiated and parent-initiated chemical dependency treatment of minors are similar to those pertaining to mental health treatment. However, parental consent is required for inpatient chemical dependency treatment of a minor.

Integrated Crisis Response and Involuntary Treatment Pilot Program.
The Integrated Crisis Response and Involuntary Treatment Pilot Program (ICR), created by 2005 legislation, established an integrated crisis response system at two pilot sites. The ICR authorized involuntary detention and treatment of adults meeting the likelihood of serious harm or grave disability standard either due to a chemical dependency or a mental disorder. Detentions were performed by a "designated crisis responder" (DCR) with the authority and training to detain in either the chemical dependency or mental health system.

The ICR chapter paralleled the procedures and standards in the ITA with respect to emergency and non-emergency detentions. Additionally, the ICR created a 14-day inpatient commitment order and 90-day LRA order for chemical dependency treatment. Initial detentions and 14-day commitments for chemically dependent persons were to a "secure detoxification facility or other certified chemical dependency provider." Secure detoxification facility was defined as a publicly or privately operated facility, or program of an agency, providing acute and subacute detoxification services for intoxicated persons and that includes security measures sufficient to protect the patients, staff, and community.

In line with the ITA, prosecutors were required to represent petitioners for commitments based on chemical dependency under the ICR.

Summary of Engrossed Substitute Bill:

"Ricky Garcia's Act" is enacted.

Short-Term Changes to the Chemical Dependency Involuntary Treatment System.
Changes are made to the chemical dependency involuntary treatment system, which remain in effect until April 1, 2017.

A 14-day chemical dependency commitment order replaces the current 60-day order, and will issue upon the court's finding that commitment criteria are met by a preponderance of the evidence. The ability of the petitioner to file, and of the court to order commitment, remains subject to available space in an approved treatment program.

Upon a hearing for a 14-day or 90-day order, if the court finds that the criteria for commitment are met, but that placement in a less restrictive setting than inpatient treatment is in the best interest of the person or others, the court must enter an order for up to 90 days of LRA treatment and cannot order inpatient treatment. If the program designated to provide less restrictive treatment is different than the program providing initial involuntary treatment, the designated program must agree in writing to assume the responsibility.

The list of qualified examining professionals that may sign a petition for 14-day or 90-day treatment include licensed physicians, psychiatric advanced registered nurse practitioners, mental health professionals, and physician assistants working with a licensed mental health physician. An authorized combination of two professionals must sign the petition.

Prosecutors must represent petitioners in chemical dependency commitment proceedings.

Integrated Treatment System for Substance Use Disorders and Mental Health.

References to "chemical dependency" and related terms are changed to "substance use disorder."

The involuntary mental health and involuntary substance use disorder treatment systems for minors and adults are integrated, and the minor-initiated and parent-initiated mental health and substance use disorder treatment provisions are integrated, effective April 1, 2017.

Involuntary Treatment.
The ITA and the provisions pertaining to involuntary mental health treatment for minors are amended to include commitments for substance use disorders. Statutes governing involuntary chemical dependency commitment are repealed. Substance use disorder commitment (formerly "chemical dependency commitment") follows the same procedures, rights, requirements, and timelines as mental health commitment.

Designated mental health professionals and DCDSs are replaced by designated crisis responders DCRs. The DSHS, by rule, must combine the functions of a DMHP and DCDS by establishing a DCR who is authorized to conduct investigations, detain persons for up to 72 hours to the proper facility, and carry out other functions. To qualify as a DCR, a person must have received chemical dependency training as determined by the DSHS and be a:

- psychiatrist, psychologist, psychiatric advanced registered nurse practitioner, or social worker;
- person with a master's or further advanced degree in counseling or social science with at least two years of experience in direct treatment of persons with mental illness or emotional disturbance;
- person who meets certain waiver criteria as identified in statute, or as approved by the DSHS; or
- person who has been granted an exception of the minimum requirements of a mental health professional by the DSHS, consistent with agency rules.

The DSHS must develop a transition process for persons who are a DMHP or DCDS prior to the integration to become DCRs.

Initial detentions and 14-day commitments based on substance use disorders take place at secure detoxification facilities or approved substance use disorder treatment programs. For longer commitments, involuntary substance use disorder treatment takes place at an approved substance use disorder treatment program. Commitment to a secure detoxification facility or approved substance use disorder treatment program is contingent upon available space in the facility or program until July 1, 2019. If, after examination and evaluation, examining professionals determine that the initial needs of a person committed to an evaluation and treatment facility would be better served by placement in a substance use disorder facility, or that the initial needs of a person committed to a substance use disorder facility would be better served in an evaluation and treatment facility, then the person must be referred to the more appropriate placement. After that date, as with mental health commitment, involuntary commitment for substance use disorders is not dependent upon available facility space.

The superior court has jurisdiction over involuntary treatment proceedings for mental health and substance use disorders. Prosecutors represent all petitioners, including petitioners for

involuntary substance use disorder treatment, unless the petitioner is a state facility, in which case the Attorney General represents the petitioner.

The firearm prohibition associated with mental health commitment extends to persons committed for substance use disorder treatment under the provisions for 14, 90, or 180-day commitment if treatment is for use of a controlled substance as defined in federal law. The limitation on firearm rights associated with commitment for a substance use disorder applies only if the person would otherwise have his or her firearms rights limited under federal law.

Minor-Initiated and Parent-Initiated Treatment of Minors.
Provisions regarding minor-initiated mental health treatment and parent-initiated mental treatment of minors are amended to included minor-initiated and parent-initiated substance use disorder treatment of minors. Current statutes governing minor-initiated and parent-initiated chemical dependency treatment of minors are repealed.

Washington State Institute for Public Policy Study.
The Washington State Institute for Public Policy (WSIPP) must evaluate the effect of the integration of the involuntary treatment systems for substance use disorders and mental health. Preliminary reports are due to the Legislature by December 1, 2019, and June 30, 2020, and a final report must be submitted by June 30, 2022. The evaluation must include an assessment of whether the integrated system:

- has increased efficiency of evaluation and treatment of persons involuntarily detained for chemical dependency;
- is cost-effective, including impacts on health care, housing, employment, and criminal justice costs;
- results in better outcomes for involuntarily detained persons;
- increases the effectiveness of the crisis response system statewide;
- has an impact on commitments based upon mental disorders;
- has been sufficiently resourced; and
- has diverted a significant number of individuals from the mental health system whose risk results from substance abuse, including associated net savings.

EFFECT OF SENATE AMENDMENT(S):

All provisions of the underlying bill are removed.

An intent section is added stating that the Legislature intends to determine the best course of action for the integration of the mental health and chemical dependency involuntary treatment systems.

The WSIPP is required to update its 2007, 2008, and 2011 analyses of Washington's integrated crisis response pilots using the institute’s most recent cost benefit analysis methodology. The WSIPP is also directed to evaluate involuntary treatment systems for chemical dependency and report to the Legislature by December 31, 2015. To the extent it is not duplicative of other studies, the report must study implementation of involuntary chemical dependency treatment in other states with respect to emergency and nonemergency detentions. The study must include, but is not limited to the following:

- court processes for referral for involuntary chemical dependency treatment;

- statutory lengths of stay;
- types of professionals and required qualifications of professionals providing evaluation and referral for treatment;
- number of beds per one thousand residents;
- less restrictive alternatives to detention; and
- integration of involuntary mental health and chemical dependency treatment processes.

Provisions substantially similar to those contained in 2SHB 1916 are added, which make the following changes:

- Provisions related to the administration of local substance use disorder programs are recodified into the community mental health system administration code. The DSHS authorities related to substance use disorders are merged with its authority regarding mental health, including contracting, the use of federal funds, and coordinating behavioral health programs. Provisions related to substance use disorder programs are repealed, including the establishment of a discrete program for substance use disorders and the establishment of an interdepartmental coordinating committee.

- Elements of substance use disorder programs are made requirements of programs administered by behavioral health organizations, including required services, such as withdrawal management, residential treatment, and outpatient treatment, and optional services such as peer support, supported housing, supported employment, crisis diversion, and recovery support services. It is specified that the treatment is to be provided primarily through managed care contracts, except for services and funding provided through the Criminal Justice Treatment Account.

- The DSHS's licensing authority related to establishing minimum standards for licensed service providers is clarified to apply to behavioral health service providers, specifically, those licensed to provide mental health services, substance use disorder treatment services, or services to persons with co-occurring disorders.

Appropriation: None.

Fiscal Note: Available.

Effective Date: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except section 102 which, due to a prior delayed effective date takes effect April 1, 2016; sections 202 through 209, 211, 213 through 229, 231 through 234, 236, 237, 239 through 260, 266, 264, 266, 267, 269, 271, 272, and 275 through 280, relating to integration of the treatment systems for substance use disorders and mental health, and repealed sections, which take effect April 1, 2017; and sections 210, 212, 222, 235, 238, 261, 263, 265, 268, 270, and 273, relating to expiring the requirement that commitments to secure detoxification facilities and approved substance use disorder treatment programs are subject to available space, which take effect July 1, 2019.

Staff Summary of Public Testimony (Judiciary):

(In support) In 2014, legislation passed to integrate chemical dependency and mental health and replace Regional Support Networks with Behavioral Health Organizations. This change starts in 2016. A mental health task force has been working all summer, and the idea was brought up to combine the statutes and integrate crisis response. There was a pilot project that did something similar to what this bill does, and it saved money. This has a huge financial and human impact. The WSIPP study associated with the pilot showed results of lower psychiatric admissions, higher participation in substance abuse treatment, and higher employment rates. It more than offset the cost of secure detox.

Many people have had painful personal experiences with drug overdoses and suicide attempts related to substance use. Chemical dependency is an insidious brain disease, but it is treatable. A person at risk of harm or who is gravely disabled from mental illness can be committed, but if the risk is due chemical dependency, which is a different behavioral health disease, nothing can be done to commit them.

People have been committed in the mental health system due to lack of space in the chemical dependency system. It is more expensive and not appropriate to commit a person with a substance use disorder in the mental health system. Sometimes involuntary treatment is necessary and beneficial, but if a person with chemical dependency is committed in the mental health system, they may not get the substance abuse treatment they really need. Our system is stuck in treating diseases instead of people. This bill is aligned with the concept that more often than not persons with mental illness have concurring disorders. Substance use can make people psychotic, and they end up on psychiatric medication they do not need. Other times substance use leads to a change in brain chemistry and mental illness.

The mental health and chemical dependency systems are not equal. It is very challenging to maneuver the current fragmented system, and people have died waiting for chemical dependency beds. There is a chemical dependency commitment law, but it is not usable and funds have been taken away incrementally over the years. There is no enforcement and no ability to truly commit a person for chemical dependency. People get up and walk out of the emergency room because they are not detainable in the mental health system. Prosecutors are not required to represent petitioners in chemical dependency proceedings. There are no existing secure detoxification facilities. People working in the system are frustrated as they get called to the same locations again and again. Emergency dollars are spent. This bill recognizes that additional resources are needed to put people in the right system. King County's DMHPs report that half the cases they see are substance abuse cases, and King County is ready to open a secure detoxification facility.

This is a lengthy bill, and there has been a lot of feedback about changes. One piece that is still being worked on is what the DCR role should be, and what training should be involved so that DCRs are trained in both mental health and chemical dependency. Current DMHPs and DCDSs should be grandfathered into being DCRs. Issues should be worked on comprehensively to allay concerns about policies moving forward without resources in place.

(In support with amendment(s)) The integration of crisis response and the use of secure detoxification is a good thing. There should be caution against complete alignment unless doing so makes policy sense. There should be some fine tuning, including amendments focusing on persons who only have chemical dependency issues and do not have mental

health issues. If the evaluation indicates that the person has a substance use disorder, a chemical dependency professional should evaluate the person. Primary chemical dependency should be ruled out before admitting the person in the mental health system so that the person's substance abuse symptoms are not confused with a mental health issue. Stipulated orders should be allowed. A 14-day order may not be necessary, and should be up to 14 days. A 60-day, rather than a 90-day order is usually sufficient. The person can be discharged sooner under the bill, but it should be a 60-day order with an opportunity to recommit.

(In support with concerns) Integration is a good idea. It will require additional training for DCRs, but that is doable. Expanding capacity is a good thing. The shift away from commitment subject to available space is concerning. Unless there is successful development of additional secure detoxification facilities, there will be a boarding problem.

The DSHS is in support of the concept of integrating mental health and chemical dependency treatment. People do not fit into neat buckets. However, there are costs associated with developing the training for DCRs, creating secure detoxification capacity, and legal costs. The bill adds chemical dependency treatment for children's long-term treatment programs, and acknowledges parent-initiated treatment, so there is anticipation of significant use of that option.

(With concerns) A WSIPP study is a good idea, but this bill is ready, fire, aim. There is a need to look at more empirical data. There will be increased legal costs. Right now, almost any inpatient chemical dependency order is an agreed order. This bill will invite contested hearings. There is capital cost in creating secure detoxification. There is no agreement on dual certification for DCRs and it is unclear whether this component can be ramped up fast enough.

(Opposed) None.

Staff Summary of Public Testimony (Appropriations):

(In support) There is a big difference between the mental health and chemical dependency involuntary treatment statutes. As the systems are being integrated, it is important to align these standards.

There are individuals who risk losing their lives because they are not being involuntarily committed for chemical dependency treatment. The namesake for this bill suffered multiple overdoses and suicide attempts, several of which were nearly fatal, and resulted in multiple hospitalizations and emergency room visits. Police and firefighter resources were used to respond to these emergencies resulting in additional costs. Recovery is possible as long as family members can connect their loved ones to life-saving treatment.

The WSIPP evaluated integrated crisis response pilot projects which ran from 2006 through 2009 and allowed for involuntary detention for mental health or chemical dependency. Their report found that savings from fewer hospitalizations and avoidance of more expensive detentions to mental health facilities more than offset the cost of secure detox. Another study found that people committed involuntarily for chemical dependency treatment showed

decreases post discharge in the use of costly acute care services such as detox, psychiatric hospitalization, and mental health crisis services. Many people with chemical dependency issues end up committed to the mental health system and would be better served in less costly involuntary chemical dependency treatment services. This bill will save money and precious lives.

(With concerns) This bill helps take steps toward creating an integrated behavioral health system. The creation of secure detox will assure that individuals have access to services to meet their specific needs. However, as documented in the WSIPP study, these facilities will increase the demand for other chemical dependency services. There needs to be funding for these additional beds and services beyond the secure detox beds.

Funding for this bill is absolutely critical because people will now be required to be committed regardless of whether there are beds available. If it is not funded properly and the resources are not available, this will result in a smaller version of the mental health boarding problem in hospitals and emergency rooms where law enforcement will bring these people. Therefore, it is very important that the fiscal note does not underestimate the resources that are needed to meet the requirements of the bill.

There are concerns about some of the financial aspects and omissions in the fiscal notes that have been available to this point. If not properly funded, the involuntary commitment system that is already broken will be overwhelmed. There is a long way to go to get the facilities required operational throughout the state. The fiscal note indicates there will be minimal impact on superior court. There are already challenges meeting the current demand for involuntary commitment cases and adding 2,000 cases a year is going to add significant hardship on the system. This will require increases in prosecutors, public defenders, and defense experts that are allowed by statute.

(Opposed) This bill creates a new condition called substance abuse disorder and prohibits individuals that have been committed as a result of this condition from possessing a firearm. There is already a prohibition in law for someone who is mentally incompetent or involuntarily committed for mental health issues. There is also a prohibition for someone who is addicted to controlled substances. This goes way beyond that. There is no definition for substance or substance use and the definition for substance use disorder is very broad and does not provide standards. The bill refers to substance use, not substance abuse, and there is no need for additional firearms prohibitions beyond what is in existing law. The bill should be amended to remove this prohibition. The recidivism rate is much lower for someone who goes through substance abuse treatment. People should not have their constitutional rights to own a gun stripped from them.

Persons Testifying (Judiciary): (In support) Representative Cody, prime sponsor; Lauren Davis, King County Alcoholism and Substance Abuse Administrative Board; Enrique Garcia; Glen Kelley; Barry Antos; Jim Vollendroff, King County Mental Health, Chemical Abuse and Dependency Services; Laurie Rowland, Choices Cowlitz County; Brian Enslow, Washington State Association of Counties; and Jim Bloss, National Alliance on Mental Illness.

(In support with amendment(s)) Melissa Johnson, Association of Alcoholism and Addictions Programs; and Nick Federici, Pioneer Human Services.

(In support with concerns) Gregory Robinson, Washington Community Mental Health Council; and Jane Beyer, Department of Social and Health Services.

(With concerns) Bob Cooper, Washington Association of Criminal Defense Lawyers and Washington Defender Association.

Persons Testifying (Appropriations): (In support) Representative Cody, prime sponsor; Lauren Davis, King County Alcoholism and Substance Abuse Administrative Board; and Nick Federici, Pioneer Human Services.

(With concerns) Len McComb, Washington State Hospital Association; Mike De Felice, King County Defense and Washington Defenders Association; and Ian Goodhew, University of Washington School of Medicine and Harborview.

(Opposed) Brian Judy, National Rifle Association; Adina Hicks, Protect Our Gun Rights; and Bill Burris, Gun Owners Action League.

Persons Signed In To Testify But Not Testifying (Judiciary): None.

Persons Signed In To Testify But Not Testifying (Appropriations): None.