HOUSE BILL REPORT
HB 1499

As Reported by House Committee On:
Public Safety

Title: An act relating to promoting recovery and improving public safety by providing behavioral health system responses to individuals with substance use disorder in lieu of criminalizing possession of personal use amounts of controlled substances, counterfeit substances, and legend drugs.

Brief Description: Providing behavioral health system responses to individuals with substance use disorder.

Sponsors: Representatives Davis, Harris-Talley, Ramel, Macri, Simmons, Peterson, Bateman, Fitzgibbon, Duerr, Ortiz-Self, Hackney, Slatter, Ryu, Berry, Sells, Thai, Chopp, Valdez, Pollet, Eslick, Ormsby, Morgan, Stonier and Frame.

Brief History:

Committee Activity:

Public Safety: 2/12/21, 2/15/21 [DPS].

Brief Summary of Substitute Bill

- Requires the Heath Care Authority (HCA) to establish a substance use recovery services plan to assist persons with substance use disorder in accessing treatment and recovery services.
- Requires the HCA to establish a substance use recovery services advisory committee to advise the HCA in the development and implementation of the substance use recovery services plan.
- Eliminates criminal penalties for certain violations of the Uniform Controlled Substances Act and related provisions when the amount of the substance at issue is within a "personal use amount" threshold established by the HCA.
- Expands provisions authorizing alternatives to arrest for persons with behavioral health disorders.

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

- Requires basic law enforcement training to include training on interactions with persons with substance use disorders.

HOUSE COMMITTEE ON PUBLIC SAFETY

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 7 members: Representatives Goodman, Chair; Johnson, J., Vice Chair; Davis, Hackney, Orwall, Ramos and Simmons.

Minority Report: Do not pass. Signed by 4 members: Representatives Mosbrucker, Ranking Minority Member; Klippert, Assistant Ranking Minority Member; Graham and Lovick.

Minority Report: Without recommendation. Signed by 2 members: Representatives Griffey and Young.

Staff: Omeara Harrington (786-7136).

Background:

Behavioral Health Services.
The Health Care Authority (HCA) provides medical care services to eligible low-income state residents and their families, primarily through the Medicaid program. While some clients receive services through the HCA on a fee-for-service basis, the large majority receive coverage for medical services through managed care systems. Managed care is a prepaid, comprehensive system for delivering a complete medical benefits package that is available for eligible families, children under age 19, low-income adults, certain disabled individuals, and pregnant women. Since January 1, 2020, all behavioral health services and medical care services have been fully integrated in a managed care health system for most Medicaid clients.

While most Medicaid clients receive behavioral health services through a managed health care system, behavioral health administrative service organizations administer certain behavioral health services that are not covered by the managed health care system within a specific regional service area. There are 10 behavioral health administrative service organizations in Washington. The services provided by a behavioral health administrative service organization include maintaining continuously available crisis response services, administering services related to the involuntary commitment of adults and minors, coordinating planning for persons transitioning from long-term commitments, maintaining an adequate network of evaluation and treatment services, and providing services to non-Medicaid clients in accordance with contract criteria.

Criminal Offenses Under the Uniform Controlled Substances Act and Related Provisions.
The Uniform Controlled Substances Act regulates the manufacture, distribution, and dispensation of controlled substances. It also criminalizes certain conduct related to controlled substances and counterfeit substances. The criminal penalties for violating the Uniform Controlled Substances Act depend upon the nature of the violation and the type of substance. A "controlled substance" means a drug or substance included in Schedules I through V, with some exceptions. Drugs and substances are placed on schedules based on their potential for abuse, medical use, and safety. Substances in Schedule I are the most tightly controlled, while those in Schedule V are the least tightly controlled. A "counterfeit substance" is a controlled substance which has been altered to look like a substance produced or distributed by a manufacturer, distributor, or dispenser. Related provisions regulate legend drugs (prescription drugs).

Among others, crimes contained in the Uniform Controlled Substances Act and related provisions include:

- possession of a controlled substance, unless authorized by law or obtained through a valid prescription, which is a class C felony;
- possession of 40 grams or less of marijuana, unless authorized by law, which is a misdemeanor;
- possession, manufacture, or distribution of a counterfeit substance unless authorized by law, which is a class B or class C felony depending on the substance;
- possession, sale, or delivery of any legend drug, except pursuant to a prescription, which is a class B felony if the offense involves sale, delivery, or possession with intent to deliver, or a misdemeanor for a simple possession offense; and
- use, delivery, or possession or manufacture with intent to deliver, drug paraphernalia, which is generally a misdemeanor but becomes a gross misdemeanor if the drug paraphernalia is delivered to a minor at least three years younger than the defendant.

Alternatives to Arrest for Persons with Behavioral Health Disorders.
When a police officer has reasonable cause to believe that an individual has committed a crime, and the individual is known by history or consultation with the relevant behavioral health administrative services organization, managed care organization, crisis hotline, or local crisis services providers to suffer from a mental disorder, as an alternative to arrest, the arresting officer is authorized and encouraged to take certain actions to facilitate the person receiving treatment services. The officer may take the individual to a crisis stabilization unit or triage facility, or refer the individual to a mental health professional, for evaluation for possible civil commitment proceedings. The officer may also release the individual upon the individual's agreement to voluntarily participate in outpatient treatment. The officer's decision as to whether to refer the individual to treatment in lieu of arrest must be guided by the local law enforcement diversion guidelines for behavioral health developed and mutually agreed upon with the prosecuting authority.

Basic Law Enforcement Training.
The Criminal Justice Training Commission provides basic law enforcement training and

educational programs for law enforcement, corrections officers, and other public safety professionals in Washington. Basic law enforcement officer training is required of all law enforcement personnel, with the exception of volunteers and reserve officers. The Basic Law Enforcement Academy consists of a 720-hour program covering a wide variety of subjects including: criminal law and procedures; traffic enforcement; cultural awareness; communication and writing skills; emergency vehicle operations; firearms; crisis intervention; patrol procedures; criminal investigation; and defensive tactics.

Summary of Substitute Bill:

Substance Use Disorder Services.
Development of a Substance Use Recovery Services Plan. The HCA must establish a substance use recovery services plan (plan) to implement measures that assist persons with substance use disorder in accessing treatment and recovery support services. The plan must articulate the manner in which continual, rapid, and widespread access to a comprehensive continuum of care is provided to all persons with substance use disorder, regardless of the point at which they present within the continuum of care.

The HCA's plan must consider: the manner in which persons with substance use disorder currently access and interact with the behavioral health system; the points of intersection that persons with substance use disorder have with the health care, criminal, legal, and child welfare systems; and the various locations in which persons with untreated substance use disorder congregate. Additionally, the plan must: anticipate the decriminalization of personal use amounts of controlled substances, counterfeit substances, and legend drugs; include potential new community-based care access points and strategic grants to community organizations to educate the public; include creative mechanisms for real time, peer-driven, noncoercive outreach and engagement to individuals in active substance use disorder and develop measures to enhance the effectiveness of interventions; and support diversion to community-based care for individuals who may face criminal consequences for other drug-related law violations, but for whom a response that addresses underlying needs may be more effective.

The plan must include specified substance use disorder services, including: field-based outreach and engagement; peer recovery support services; intensive case management; substance use disorder treatment; and recovery support services including housing, job training, and placement services. These services must be made available in or accessible to all jurisdictions, must be equitably distributed across urban and rural settings, and, if possible, made available on demand through 24-hours-a-day, seven-days-a-week peer recovery coach response, behavioral health triage centers, or other innovative rapid response models. Services must, at a minimum, adhere to certain specified principles.

Substance Use Recovery Services Advisory Committee. The HCA must establish a substance use recovery services advisory committee (advisory committee) to advise in the

development and implementation of the HCA's plan. The HCA must consult with the University of Washington Department of Psychiatry and Behavioral Sciences and an organization that represents the interests of people who have been directly affected by substance use and the criminal legal system in appointing members to the advisory committee who have relevant background related to the needs of persons with substance use disorder. The membership of the committee must include individuals with specified backgrounds, including, but not limited to: specified subject matter experts; persons who are currently using controlled substances without legal authority; adults and youth who are in recovery, and family members of persons with substance use disorder; substance use disorder professionals; representatives of city and county governments, law enforcement, and the legal system; a representative of fire chiefs; the Criminal Justice Training Commission; housing providers; representatives of racial justice organizations; a representative of a local health jurisdiction; and representatives of tribes.

The advisory committee must make recommendations to the HCA concerning:

- current regional capacity for existing public and private programs providing substance use disorder assessments, care, and recovery support services;
- barriers to accessing the existing health system for those populations chronically exposed to the criminal legal system, and possible innovations to improve accessibility;
- evidence-based, research-based, and promising treatment and recovery services appropriate for target populations;
- workforce needs for the behavioral health sector;
- options for leveraging existing integrated managed care, Medicaid waiver, American Indian or Alaska Native fee-for-service behavioral health benefits, and private insurance service capacity for substance use disorders;
- assistance to jurisdictions in complying with requirements relating to diversion of individuals with complex behavioral health conditions to community-based care whenever possible and appropriate;
- design of a mechanism for referring people with substance use disorder or problematic behaviors resulting from drug use into supportive services, including intercepting individuals who likely would otherwise be referred into the criminal legal system;
- design of ongoing qualitative and quantitative research about the types of services desired by people with substance use disorders and barriers they experience in accessing existing and recommended services; and
- proposing a funding framework in which resources are eventually shifted from punishment sectors to community-based care interventions such that community-based care becomes the primary strategy for addressing and resolving public order issues related to behavioral health conditions.

Plan Submission and Implementation. The HCA must submit the plan to the Governor and the Legislature by December 1, 2021, and must adopt rules and enter into contracts with providers to implement the plan by December 1, 2022. In addition to seeking public

comment, the HCA must adopt rules in accordance with the recommendations of the advisory committee. The rules must be informed by existing diversion models administered by the HCA. By November 1, 2022, the HCA must submit a readiness report to the Governor and the Legislature indicating the progress on the substance use disorder continuum of care, including availability of outreach, treatment, and recovery support services, as well as system preparedness for the decriminalization of personal use amounts of controlled substances, counterfeit substances, and legend drugs. In consultation with the advisory committee, the HCA must submit a report on the implementation of the plan to the Legislature and the Governor by December 1 of each year, beginning in 2022.

In implementing the plan, responsibility for payment of substance use disorder treatment services including outpatient treatment, withdrawal management, residential treatment, medications for opioid use disorder, and crisis stabilization services is assigned as follows:

- Payment for covered services for individuals enrolled in Medicaid managed care plans is the responsibility of the managed care plan to whom the enrollee is assigned.
- Payment for individuals enrolled in the Medicaid fee-for-service program is the responsibility of the HCA.
- Payment for covered services for individuals enrolled in private health care plans is the responsibility of the private health care plan.
- Payment for all other individuals as well as services not covered by Medicaid or private plans is the responsibility of the behavioral health administrative services organization.

Outreach and engagement services and recovery support services that are not reimbursable through insurance must be funded through a combination of: appropriations from the Recovery Pathways Account, if that account is created through legislation; targeted investments from the Federal Substance Abuse Block Grant, if permissible under the grant; funds recovered by the state through lawsuits against opioid manufacturers, if permissible; and appropriations from the State General Fund based on a calculation of the savings captured from reduced expenses for the Department of Corrections resulting from the changes in the bill.

Decriminalization of Personal Use Amounts of Controlled Substances, Counterfeit Substances, and Legend Drugs.

Effective July 1, 2023, an exception is made to certain crimes under the Uniform Controlled Substances Act and related provisions when the offense involved possession or use of a controlled substance, counterfeit substance, or legend drug at or below a personal use amount. A "personal use amount" means the maximum amount of a substance that the HCA has determined to be consistent with personal, nonprescribed use patterns of people with substance use disorder. Specifically, the crimes for which a personal use amount is decriminalized include: possession of a controlled substance; possession of 40 grams or less of marijuana; possession of a counterfeit substance; possession of a legend drug; and use of drug paraphernalia. An exception is also made to the offense of delivery, or possession or manufacture with intent to deliver, drug paraphernalia, for social services or

health care agencies distributing drug paraphernalia to others for personal use.

By April 1, 2023, the HCA, in consultation with the Department of Health and the Pharmacy Quality Assurance Commission, must adopt rules establishing maximum personal use amounts of controlled substances, counterfeit substances, and legend drugs known to be used by people for recreational or nonmedical and nonprescribed purposes. When any new recreational or nonmedical use of a substance is discovered after that date, a personal use amount must be established for that substance within one year. In establishing personal use amounts, the HCA must convene and consult with a work group including, at a minimum: persons who currently use controlled substances outside the legal authority of a prescription or valid practitioner order; persons in recovery from substance use disorder who previously used substances outside the legal authority of a prescription or valid practitioner order; representatives from law enforcement; a representative of public defenders; a representative of prosecutors; and relevant experts.

The decriminalization of personal use amounts of controlled substances, counterfeit substances, and legend drugs does not prevent any public or private employer from establishing or enforcing employment or workplace policies pertaining to use, possession, manufacture, distribution, or dispensation of such substances, regardless of whether the amount of the substance constitutes a personal use amount. This includes, for example, hiring practices, drug testing, and termination and other disciplinary actions for violations.

Alternatives to Arrest for Persons with Behavioral Health Disorders.
The provisions outlining alternatives to arrest for persons with mental health disorders are modified to also expressly apply to persons with substance use disorder. Community health providers are among those who may consult with law enforcement about a contacted individual's history. Options for the officer are changed to reference referral to a designated crisis responder for an involuntary treatment evaluation, rather than a mental health professional, and to add options to refer the individual to youth, adult, or geriatric mobile crisis response services, as appropriate, or to an available on-demand provider responsible to receive referrals in lieu of legal system involvement. The referral may be for the purpose of supportive services, in addition to treatment.

Basic Law Enforcement Training.
Beginning July 1, 2022, as part of basic law enforcement training, all law enforcement personnel must receive training on law enforcement interaction with persons with substance use disorders, including referral to treatment and recovery services. The training must also be made available to law enforcement agencies, through electronic means, for use at their convenience for internal training.

The training must be developed by the Criminal Justice Training Commission in consultation with appropriate substance use disorder recovery advocacy organizations and with other organizations and agencies that have expertise working with persons with substance use disorders. The Criminal Justice Training Commission must also examine

existing courses that relate to persons with a substance use disorder, and should draw on existing training partnerships with the Washington Association of Sheriffs and Police Chiefs.

The training must replicate field situations as much as possible and must include core instruction in:

- proper procedures for referring persons to treatment and supportive services;
- the cause and nature of substance use disorders, including the role of trauma;
- barriers to treatment engagement experienced by many with such disorders who have contact with the legal system;
- how to identify indicators of substance use disorder and respond appropriately;
- conflict resolution and de-escalation techniques for potentially dangerous situations involving persons with a substance use disorder;
- appropriate language usage when interacting with persons with a substance use disorder;
- alternatives to lethal force when interacting with potentially dangerous persons with a substance use disorder;
- principles of recovery and the multiple pathways to recovery; and
- community and state resources available to serve persons with substance use disorders.

Substitute Bill Compared to Original Bill:

The HCA must submit a readiness report to the Governor and the Legislature by November 1, 2022, that indicates progress on the substance use disorder continuum of care, including availability of outreach, treatment, and recovery support services, as well as system preparedness for the implementation of the bill's policies decriminalizing personal use amounts of controlled substances, counterfeit substances, and legend drugs.

The effective date is delayed from December 1, 2022, to July 1, 2023, for provisions decriminalizing possession of personal use amounts of controlled substances, counterfeit substances, and legend drugs, and use of paraphernalia for personal use amounts of controlled substances, as well as provisions expanding alternatives to arrest. The date by which the HCA must adopt rules establishing maximum personal use amounts of controlled substances, counterfeit substances, and legend drugs is delayed from September 1, 2022, to April 1, 2023. Provisions are removed that would have allowed persons with certain prior controlled substances convictions to vacate the record of conviction without having to meet current law requirements for vacating convictions.

Provisions are added stating that nothing in the bill prohibits public or private employers from establishing or enforcing employment or workplace policies pertaining to use, possession, manufacture, distribution, or dispensation of controlled substances, counterfeit substances, or legend drugs, regardless of whether the amount at issue is a personal use amount.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on February 15, 2021.

Effective Date of Substitute Bill: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for sections 6 through 12, 14, and 15, relating to criminal offenses and alternatives to arrest, which take effect July 1, 2023.

Staff Summary of Public Testimony:

(In support) There is nearly universal agreement that the current response to substance use disorder is inadequate. This bill proposes a paradigm shift in the state's response to untreated addiction. The state must be proactive rather than reactive, and get people help before they end up in the criminal legal system. Substance use disorder is a response to trauma. Arrest and incarceration only multiply this pain. Diagnostic criteria for substance use disorder includes continued use despite negative consequences, therefore it is implausible that criminal legal system consequences will lead to a cessation of use. Though there are some who credit their recovery to the criminal legal system, these cases are the exception. Possession charges rarely lead to treatment within the criminal system; rather, this usually happens through pretrial diversion or sentencing alternatives related to crimes against persons or property. Instead, these charges often hinder opportunities for housing and employment, which are important components in recovery. The continuum of care has three parts: outreach; treatment; and recovery support services. However, currently treatment is often all that is funded because it is covered by insurance. This bill provides the robust continuum of care that is needed.

The United States treats substance use disorder by incarcerating people. Incarceration as a treatment does not work. Jails and prisons have improved the care they provide, but a penal institution is not the right place to provide treatment for a disease. Crime may be a manifestation of the disease and the approach should be therapeutic. This bill in essence applies the Hippocratic Oath to "first, do no harm" to Washington government's management of those with substance use disorder. While there are examples of people who have benefitted from incarceration, the vast majority have been harmed. With the increasing number of countries that have adopted alternatives to criminalization, there is an increasing evidence base to show that the bill's approach has benefits. It reduces use among problematic users, reduces strain on the criminal justice system, and reduces drug deaths, without a significant increase in drug use. The most efficacious reform approach is decriminalization paired with a health response. Reflecting on the experience of Switzerland, the free choice of those who do not cause harm to others should be protected, and treatment should be provided to those who are ill. The pattern of criminalizing those who use drugs should end, and with it the false hope that criminalization will eliminate the drug market. Instead, criminalization leads to many negative consequences, like the high incarceration rates the United States is experiencing. Arrest and punishment are arbitrary and affect those who are poor and marginalized. Portugal now treats this as a health and

social issue rather than a criminal issue. In that country, in response to a significant heroin problem, punishment for possession of small amounts of drugs was made comparable to a low-level seatbelt violation, while other criminal penalties remained in place. The main goal is to address needs. There has been a decrease in the number of new problematic users, and an improvement in all indicators available.

Watching a family member struggling with addiction is devastating; children of parents with substance use disorders are extremely traumatized by the exposure. Substance use disorder is an inter-generational problem, and the bill will help stop this pattern. Recovery is not linear, and treatment is expensive. People are desperate for help with their addictions. Substance use is a major factor in chronic homelessness. Access to services leads to recovery, and criminal charges can serve as a barrier to accessing services or can break up services. Even when services are offered through the criminal justice system, often the person has many felony charges already. Criminal charges and associated court fines cause large hurdles for people, break up families, and further the guilt and shame inherent in addiction. The current system warehouses people, when it would be better to support people being productive members of society. Even those who are in recovery have consequences finding housing and employment and encounter other issues related to criminal history. People who can resist their cravings should be rewarded with a practical path forward. A lot of people recovering from addiction are leaders in the rough who need to heal so that they can help others. This bill is a holistic approach that will lead to recovery rather than recidivism.

The current response to substance use disorder does not work, and prosecuting people for possession of tiny amounts of drugs is not an effective strategy. It should be treated as the public health threat that it is so that public safety concerns can be addressed. The current inadequate allocation of resources and goodwill, extraordinary punitive consequences, disproportionate impacts on people of color, and shaming of those who are ill, have not led to more livable and safe communities. The bill does not decriminalize all crimes or take away drug courts, nor does it prevent employers from having no-drug policies. Oregon recently changed its laws to allow possession of small amounts of drugs needed for daily use. Currently, cases for possession of small amounts of drugs may take a year to resolve and involve jail time and warrants.

(Opposed) The provisions legalizing possession of a controlled substance should be removed from the bill. Community investment and improvements should not come at the expense of public safety. The criminal justice system, while not an appropriate or effective strategy to address these issues, has proven to be the only mechanism for intervention and treatment for many. This bill does not just decriminalize illicit substances, it legalizes them for everyone, including children. Substance use disorder is devastating to those who it affects and is not a victimless crime. Decriminalizing drugs may lead to a change in public perception that drugs are acceptable. While the current system is not working, there are great nonprofits that are helping with these issues. The state should be a standard setter in helping these assistance systems grow. A comprehensive and effective community-based

strategy would make the issues with criminal sanctions moot.

(Other) Counties support diversion from the criminal justice system, but there has to be clear coordination around services, sufficient funding, and available qualified clinicians. The provisions related to vacating convictions are problematic due to the huge backup in the courts due to the COVID-19 pandemic. There were 4,500 cases of this type last year alone. There are several current committees and work groups on related issues. Those groups should coordinate on these efforts going forward.

Persons Testifying: (In support) Representative Davis, prime sponsor; Steve Eisler; Michelle Horne-Richburg; Dr. Cindy Grande, Olympia Bupe Clinic; Dr. Marc Stern, University of Washington School of Public Health; Mika Watson-Cheesman, Capital Recovery Center; Keith Blocker; Adam Cornell, Snohomish County Prosecuting Attorney's Office; Dan Satterberg, King County Prosecuting Attorney's Office; João Augusto Castel-Branco Goulão, Portugal's Intervention on Addictive Behaviours and Dependencies General Directorate (SICAD); Caitlin Hughes, Flinders University, South Australia; Ruth Dreifuss, Global Commission on Drug Policy; Monte Levine; Meta Hogan, Gather Church; Meg Martin, Interfaith Works; and Linda Robertson.

(Opposed) James McMahan, Washington Association of Sheriffs and Police Chiefs; and Sarah Davenport-Smith, Family Policy Institute of Washington.

(Other) Juliana Roe, Washington State Association of Counties.

Persons Signed In To Testify But Not Testifying: Linda Gustafson, Support, Advocacy, and Resource Center; Lukas Metzner, Students for Sensible Drug Policy University of Washington; Nancy Connolly; Nichole Alexander, REACH and JustCARE Project; Carmen Pacheco-Jones, Health and Justice Recovery Alliance; Everett Maroon, Blue Mountain Heart to Heart; Dr. Chris Nguyen - University of Washington; Tanner Leo; Emi Koyama, Coalition for Rights and Safety for People in the Sex Trade; Kurtis Robinson, Better Health Together, I Did The Time, and Revive Center for Returning Citizens; Tobin Klusty; Tara Lund; Margaret Hobbs; Hawetan Adugna, Lake Washington High School; Jennifer Heine-Withee; Krystal Hoover; Jonathan Meyer, Lewis County Prosecuting Attorney's Office; and Chris Bandoli, Association of Washington Healthcare Plans.