HOUSE BILL REPORT
SHB 1773

As Passed Legislature

Title: An act relating to assisted outpatient treatment for persons with behavioral health disorders.

Brief Description: Concerning assisted outpatient treatment for persons with behavioral health disorders.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Taylor, Davis, Leavitt, Callan, Cody, Macri, Ormsby and Harris-Talley).

Brief History:

Committee Activity:

Civil Rights & Judiciary: 1/19/22, 1/28/22 [DP];
Appropriations: 2/5/22, 2/7/22 [DPS].

Floor Activity:

Passed House: 2/11/22, 87-8.
Senate Amended.
Passed Senate: 3/3/22, 47-1.
House Concurred.
Passed House: 3/7/22, 90-8.
Passed Legislature.

Brief Summary of Substitute Bill

- Revises the definition of "in need of assisted outpatient behavioral health treatment" under the Involuntary Treatment Act.
- Establishes a new procedure for designated persons to directly file a petition in superior court for up to 18 months of assisted outpatient treatment (AOT), and establishes requirements and procedures for the petition process.
- Requires the AOT petition to be served on the prosecutor, who must review the petition and, if the petition meets the requirements of law,

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schedule a court hearing and serve the respondent.

- Provides that less restrictive alternative (LRA) treatment may include a requirement to participate in partial hospitalization.
- Allows for revocation of an LRA order based on a person being in need of AOT on the same grounds as for other LRA orders.
- Amends the law governing behavioral health treatment for minors to allow commitments based on AOT for adolescents aged 13 to 17.

HOUSE COMMITTEE ON CIVIL RIGHTS & JUDICIARY

Majority Report: Do pass. Signed by 10 members: Representatives Hansen, Chair; Davis, Entenman, Kirby, Klippert, Orwall, Peterson, Thai, Valdez and Walen.

Minority Report: Without recommendation. Signed by 7 members: Representatives Simmons, Vice Chair; Walsh, Ranking Minority Member; Gilday, Assistant Ranking Minority Member; Graham, Assistant Ranking Minority Member; Abbarno, Goodman and Ybarra.

Staff: Edie Adams (786-7180).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 25 members: Representatives Ormsby, Chair; Bergquist, Vice Chair; Gregerson, Vice Chair; Corry, Assistant Ranking Minority Member; Boehnke, Chopp, Cody, Dolan, Dye, Fitzgibbon, Frame, Hansen, Harris, Hoff, Jacobsen, Johnson, J., Lekanoff, Pollet, Ryu, Schmick, Senn, Springer, Stonier, Sullivan and Tharinger.

Minority Report: Without recommendation. Signed by 8 members: Representatives Macri, Vice Chair; Stokesbary, Ranking Minority Member; Chambers, Assistant Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Caldier, Chandler, Rude and Steele.

Staff: Andrew Toulon (786-7178).

Background:

The Involuntary Treatment Act (ITA) sets forth the procedures, rights, and requirements for involuntary behavioral health treatment of adults. A person may be committed by a court for involuntary behavioral health treatment if he or she, due to a mental health or substance use disorder, poses a likelihood of serious harm, is gravely disabled, or is in need of assisted

outpatient behavioral health treatment (AOBHT).

A designated crisis responder (DCR) is a mental health professional responsible for investigating and determining whether a person may be in need of involuntary treatment. A person may be committed for involuntary inpatient treatment only on the basis of likelihood of serious harm or grave disability. Where the petition is based on the person being in need of AOBHT, the commitment may only be for treatment in an outpatient setting under a less restrictive alternative treatment (LRA) order. The provisions governing involuntary treatment of minors over the age of 13 are parallel with the adult ITA in many respects, but do not include provisions for involuntary commitment based on a minor being in need of AOBHT.

Assisted Outpatient Behavioral Health Treatment.
A person is in need of AOBHT if the person, as a result of a behavioral health disorder:

- has been committed by a court to detention for involuntary behavioral health treatment during the preceding 36 months;
- is unlikely to voluntarily participate in outpatient treatment without an LRA order, based on a history of nonadherence with treatment or in view of the person's current behavior;
- is likely to benefit from LRA treatment; and
- requires LRA treatment to prevent a relapse, decompensation, or deterioration that is likely to result in the person presenting a likelihood of serious harm or the person becoming gravely disabled within a reasonably short time.

In order to file a petition for AOBHT, the DCR must conduct an investigation and determine that the person meets criteria. The DCR may spend up to 48 hours to conduct the investigation. If the DCR finds that a person is in need of AOBHT, the DCR files a petition for up to 90 days of LRA treatment and must provide the person with a summons to the court hearing and serve the petition on the person and the person's attorney. The probable cause hearing must be held within five judicial days of the filing of the petition. If the court finds that the person meets criteria, the court may enter an order for 90 days of LRA treatment.

Less Restrictive Alternative Treatment.
When entering an order for involuntary treatment, if the court finds that treatment in a less restrictive alternative than detention is in the best interest of the person, the court must order an appropriate less restrictive course of treatment rather than inpatient treatment. Less restrictive alternative treatment must include specified components, including assignment of a care coordinator, an intake evaluation and psychiatric evaluation, a schedule of regular contacts with the treatment provider, a transition plan addressing access to continued services at the end of the order, and individual crisis plan. In addition, LRA treatment may include additional requirements, including a requirement to participate in medication management, psychotherapy, residential treatment, and periodic court review.

Enforcement of Less Restrictive Alternative Treatment Orders.
Either a DCR or the agency or facility providing services under an LRA order may take a number of actions if a person fails to adhere to the terms of the LRA order, if the person is suspected of experiencing substantial deterioration in functioning or substantial decompensation that can with reasonable probability be reversed, or if the person poses a likelihood of serious harm.

A DCR or the Secretary of the Department of Social and Health Services may revoke the LRA order by placing the person in detention and filing a petition for revocation. A hearing on the petition must be held within five days. Except for cases where the LRA order is based on AOBHT, the court must determine whether: the person has adhered to the terms of the LRA order; substantial deterioration in functioning has occurred; there is evidence of substantial decompensation with a reasonable probability that it can be reversed by inpatient treatment; or there is a likelihood of serious harm. If the court makes one of these findings, the court may reinstate or modify the order, or it may order a further period of detention for inpatient treatment.

If the LRA order is based solely on the person being in need of AOBHT, the court must determine whether to continue the detention for inpatient treatment or reinstate or modify the person's LRA order. To continue the detention, the court must find that the person, as a result of a behavioral health disorder, presents a likelihood of serious harm or is gravely disabled and no less restrictive alternatives to involuntary detention and treatment are in the best interest of the person or others.

Summary of Substitute Bill:

Assisted outpatient behavioral health treatment is renamed assisted outpatient treatment (AOT). New standards and procedures are established for commitments for persons who are in need of AOT.

Assisted Outpatient Treatment Criteria.
The definition of "in need of assisted outpatient treatment" is revised. A person is in need of AOT if the court finds by clear, cogent, and convincing evidence that:

- The person has a behavioral health disorder.
- Based on a clinical determination and in view of the person's treatment history and current behavior, at least one of the following is true:
    - The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.
    - The person is in need of AOT in order to prevent a relapse or deterioration that would be likely to result in grave disability or a likelihood of serious harm.
- The person has a history of lack of compliance with treatment that has:
    - at least twice within the 36 months prior to the filing of the petition, been a significant factor in necessitating the person's hospitalization or receipt of services in a forensic or other mental health unit of a state correctional facility

or local correctional facility, provided that the 36-month period must be extended by the length of any hospitalization or incarceration of the person that occurred within the 36-month period;
    - at least twice within the 36 months prior to the filing of the petition been a significant factor in: necessitating emergency medical care; necessitating hospitalization for behavioral health-related medical conditions including overdose, infected abscesses, sepsis, endocarditis, or other maladies; or behavior that resulted in the person's incarceration; or
    - resulted in one or more violent acts, threats, or attempts to cause serious physical harm to the person or another within the 48-months prior to the filing of the petition, provided that the 48-month period must be extended by the length of any hospitalization or incarceration of the person that occurred within the 48-month period.
- Participation in an AOT program would be the least restrictive alternative necessary to ensure the person's recovery and stability.
- The person will benefit from AOT.

Petition Process.
Assisted outpatient treatment is removed from the DCR investigation and petition process. Instead, a petition for up to 18 months of LRA treatment on the basis that a person is in need of AOT may be filed by:

- the director of a hospital where the person is hospitalized or the director's designee;
- the director of a behavioral health service provider providing behavioral health care or residential services to the person or the director's designee;
- the person's treating mental health professional or substance use disorder professional or one who has evaluated the person;
- a DCR;
- a release planner from a corrections facility; or
- an emergency room physician.

The petitioner must personally interview the person, unless the person refuses an interview, to determine whether the person will voluntarily receive appropriate treatment. The petitioner must allege specific facts based on personal observation, evaluation, or investigation, and must consider the reliability or credibility of any person providing information material to the petition.

The petition must include the following:

- a statement of the circumstances under which the person's condition was made known and the basis for the opinion that the person is in need of AOT;
- a declaration from a physician, physician assistant, advanced registered nurse practitioner, or the person's treating mental health professional or substance use disorder professional, who has examined the person no more than 10 days prior to the filing of the petition and who is willing to testify in support of the petition, or who alternatively has attempted to examine the person within the same period but has not

been able to obtain the person's cooperation, and who is willing to testify to the reasons they believe that the person meets AOT criteria;
- the declarations of any additional witnesses supporting the petition;
- the name of an agency, provider, or facility that agrees to provide LRA treatment; and
- if the person is detained at the time of the petition, the anticipated release date of the person and any other details needed to facilitate successful reentry and transition into the community.

The court must schedule an AOT petition for hearing three to seven days after the date of service, or as stipulated by the parties, but no later than 30 days after service. The court may conduct an AOT hearing in the respondent's absence if the respondent fails to appear and the respondent's counsel is present. The court may order detention of the respondent for an examination by a qualified professional if the respondent has refused an examination and there are reasonable grounds to believe the allegations in the petition are true.

If the petition involves a person whom the petitioner or behavioral health administrative services organization knows, or has reason to know, is an American Indian or Alaska Native who receives medical or behavioral health services from a tribe within Washington, the behavioral health administrative services organization must notify the tribe and Indian health care provider.

The Administrative Office of the Courts must develop court forms and a user's guide for preparation and filing of AOT petitions.

Less Restrictive Alternative Treatment.
Less restrictive alternative treatment, including for conditional release to LRA treatment for persons who have been civilly committed under criminal insanity laws, may include a requirement to participate in partial hospitalization or intensive outpatient treatment services, or both.

Less restrictive alternative treatment orders based on a person being in need of AOT are subject to the same standards for modification or revocation as for other LRA orders. This includes allowing the court to order the respondent to be detained for inpatient treatment if: the person has failed to adhere to the court order; experienced substantial deterioration in functioning; experienced substantial decompensation which can be reversed by inpatient treatment; or presents a likelihood of serious harm and detention for inpatient treatment is appropriate. The period of inpatient treatment following revocation of an LRA order resulting from a petition for AOT is 14 days from the date of the revocation hearing.

Other.
The law governing involuntary behavioral health treatment for minors is amended to allow a petition for LRA treatment for adolescents who are 13 to 17 years old on the basis that the adolescent is in need of AOT, under the same criteria and standards that apply for adults in need of AOT.

Behavioral health administrative services organizations must employ an AOT program coordinator to oversee system coordination and legal compliance for AOT.

The development of an individualized discharge plan for a person committed to a state hospital for 90 or 180 days must include consideration of whether a petition should be filed for LRA treatment on the basis the person is in need of AOT.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on March 7, 2022.

Effective Date: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for sections 1 and 2, relating to definitions, and section 31, relating to contingent effective dates of prior legislation, which take effect July 1, 2022; section 6, relating to petitions for initial detention, section 13 relating to hearings for petitions for 14 days of involuntary treatment, section 18, relating to court orders for long-term involuntary treatment, and section 24, relating to enforcement of less restrictive alternative treatment orders, which because of prior delayed effective dates take effect July 1, 2026; and section 27, relating to the duties of behavioral health services organizations, which takes effect October 1, 2022. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony (Civil Rights & Judiciary):

(In support) The bill is modeled after national best practices and laws in other states where AOT is being used successfully. It allows individuals to receive court-ordered services and treatment in the community with the support of family and support networks, rather than in an inpatient setting. Assisted outpatient treatment has been on the books for five years but has never been operationalized in most of the state. The current AOT process is unduly burdensome and there is insufficient funding to provide enhanced treatment and court oversight, which are the hallmarks of a successful AOT program.

There is no support or accountability in the current behavioral health system. The system should not wait to respond until people hit rock bottom and need to be hospitalized or end up in jail. Anosognosia is a condition that impairs a person's ability to understand and be aware of their illness and make reality-based decisions. It can make honest people become criminals when they do things they would never do if their brains were working correctly. Laws that ignore this condition fail to serve the most vulnerable.

The bill streamlines the AOT process and addresses several major problems with the current system. It clarifies and expands eligibility criteria and expands who is able to seek AOT care. It extends time of supervision because the current 90-day period does not work, and it allows for revocation and rehospitalization when clinically necessary. The bill establishes AOT as an option before a person has been involuntarily committed for treatment.

Assisted outpatient treatment is a model that works for serving the most vulnerable, because it puts a judge and a full care team in charge of ensuring that the patient gets needed care. To make it work well, there must be funding for wraparound care, a program coordinator to make sure that there is accountability for both patients and providers, and for court services to allow for the black robe effect, which works and is needed to engage patients on their road to recovery.

There are some improvements that should be made to the standards for AOT. It should be clarified that the look-back period excludes time spent in the most recent hospitalization or incarceration, but not the fact of the hospitalization or incarceration. Clarification is also needed regarding what it means to be an involuntary patient. The provision that says a person may not receive AOT unless they have been offered an opportunity to participate in treatment and continue to not engage should be removed.

(Opposed) Persons suffering from behavioral health issues endure agonizing emotional and physical pain and can be traumatized by forced treatment. The system is fundamentally broken but this bill does not solve the problems. The better approach is to invest valuable time and limited resources in fixing the system before passing a law that will mandate that people endure it. This bill may save some lives but it will surely harm many others.

The bill expands eligibility criteria and removes necessary safeguards in current AOT law that protect the liberty of mental health patients. It changes the standard to no longer require that the person will present a likelihood of serious harm or become gravely disabled within a reasonably short period of time, and it allows a broad range of people to petition. Some language in the AOT standard is incredibly vague which is unacceptable when liberty interests are at stake. Recovery and stability should be defined with specificity and there should be hard evidence that proposed treatment will lead to recovery and stability.

The bill strips away civil rights of the most vulnerable in the community. Currently, individuals who have an AOT order revoked may face 14 days of involuntary hospitalization. The bill would allow hospitalization for up to 18 months under a lower burden of proof than currently required. This is an arbitrary timeline that is not patient-centered, and there is no criteria for ending commitment. Lengthy hospitalizations fail to address long-term needs of those impacted by mental illness, and can put people at risk of losing their housing, breaking family ties, and facing financial collapse.

The intent of the bill is to expand access to behavioral health treatment, but it will actually result in the opposite. The behavioral health system is in crisis and cannot meet the needs of residents for even basic care, but AOT as implemented in this bill will not address the problems. It adds another complex and expensive layer of forced treatment and court process that will pull resources from already strained systems. It is expensive and unnecessary, and may have a discriminatory impact.

(Other) This is an important topic, but there are concerns that the bill may actually increase the length of time that it takes some individuals to receive services. The bill requires the prosecutor to file these petitions. Many prosecutor offices are currently short-staffed and this would add to that problem, especially in smaller counties. Prosecutors currently do not file these petitions; they represent a facility or DCR in the petition. Prosecutors are attorneys, not clinicians, but they are being asked to make quasi-clinical assessments.

Staff Summary of Public Testimony (Appropriations):

(In support) This bill is narrowly targeted at the current gap in services between inpatient involuntary treatment and optional outpatient treatment. There is currently no middle ground between these two extremes. This gap in services can be fixed by investing in assisted outpatient treatment (AOT) as a less restrictive treatment option. The changes will provide alternatives for patients before they meet the very high threshold for involuntary treatment and offer a continuity of care for those exiting involuntary hospitalization. Providing individuals with treatment sooner and keeping them in outpatient treatment longer will result in better outcomes for individuals and stop the traumatic and expensive cycle too many individuals have between emergency rooms, hospitalization, and incarceration. The bill offers a long-term solution that should reduce the reliance on the most expensive treatment options, which is both better for people with behavioral health needs and less expensive for the state.

Families desperately need this bill to pass so the state can include AOT as part of a coherent system that stops discarding the sickest individuals. Assisted outpatient treatment in other states has saved lives and supported the success and recovery of individuals where it is available. Proper funding is the key to the success of this model.

This bill provides an innovative set of tools for providing monitored outpatient treatment to community members who are most at risk for involuntary hospitalization and incarceration. The goal of this legislation is to disrupt the cycle of incarceration and hospitalization for persons with acute mental illness. This model is nationally tested, evidence-based, and is an accepted model for care. The model requires funding for both treatment and court oversight to serve this acutely ill population.

(Opposed) This is a forced treatment bill, laden with fear, trauma, and stigma. The bill is circular and fundamentally interrupts lives. Recovering from these illnesses is not linear, yet this bill attempts to place people into a cycle of almost no return. It puts people at ongoing risk to be committed by tracking them with the threat of additional commitment if anything were to go wrong which is punitive and not recovery oriented. More housing is needed to prevent even more homelessness and help consumers save or retrieve their housing after they exit forced treatment settings. Alternatives are needed to prevent the need for expensive and isolating commitment services that will only interrupt lives of consumers who could become repeat customers under this measure.

The intention behind this bill is to expand access to behavioral health treatment; however, it's unclear that this legislation will actually lead to that, and it will come at a hefty financial and human cost. The fiscal note requests $9 million, but there are many items listed as indeterminate, including the costs to behavioral health administrative service organizations, the costs to public hospitals, the costs of starting new programs in all counties but King, and the impacts on prosecutors. It is unknown how many people would be eligible or the costs associated with revoking individuals to inpatient treatment. There are far too many unknowns to proceed with an expensive program that may not be effective, results in deprivation of liberty, and raises serious legal and constitutional questions. It seems that a large portion of these funds will be used in the court system when what is needed is funding to build up the community behavioral health system so there can be interventions before individuals need forced treatment.

The bill as currently written violates the due process rights of the class members across the state. This legislation primarily addresses needs in King County without taking into account what is going on in the rest of the state. The fiscal note does not address the cost of defense counsel, and people are entitled to counsel in these hearings. Because of mandatory caseload standards, this is an area that will be greatly increased in expense. Potential 18-month hospitalizations would violate due process rights and result in costly litigation.

This bill removes necessary safeguards around involuntary treatment that are intended to protect the liberty of mental patients and will come at a huge cost to the courts, treatment providers, local governments, and the patients and their families. The state should explore collaborative models which provide community-based, trauma-informed care in the place of coercive treatments that do not put further strain on the court system. These types of programs foster and maintain the agency of mental health patients and their connections to the community, rather than forcing them into treatment that they did not consent to through an increasingly costly process.

Prosecutors have specific concerns about sections which require a prosecutor to file these petitions. This will take longer and be more costly than is necessary. Prosecutors do not currently file or schedule hearings for these petitions and there is no additional funding for prosecutors. Filing a petition in this type of case is a quasi clinical or legal assessment, and prosecutors do not necessarily have psychology degrees. Prosecutors do not have access to medical records, patient history, or information about whether an individual may be connected to or not connected to community services and are not the experts on where to receive this information. Without this type of access, it will make prosecutors either blind in these filings or take much longer to get these petitions filed.

This is a lifelong treatment bill because it will trap people in involuntary treatment indefinitely. This is in direct conflict with Involuntary Treatment Act provisions that prevent inappropriate, indefinite commitment of persons living with behavioral health disorders and eliminate legal disabilities that arise from such commitment. Legal findings required in the bill are intentionally vague and that is very unacceptable when it comes to

liberty interests of the individual.

There is a recent World Health Organization statement which says in order to successfully integrate a person-centered, recovery-oriented, and rights-based approach in mental health, countries must change and broaden mindsets, address stigmatizing attitudes, and eliminate coercive practices. Wherever psycho-social interventions occur, peer support and person-centered recovery and rights-based approaches must be looked at, and this bill does not do that.

Persons Testifying (Civil Rights & Judiciary): (In support) Representative Jamila Taylor, prime sponsor; Johanna Bender, Superior Court Judges' Association; Melanie Smith, National Alliance on Mental Illness Washington; Jerri Clark, Mothers of the Mentally Ill; Linda Wiley; Brian Stettin, Treatment Advocacy Center; and Patty Horne-Brine.

(Opposed) Kari Reardon, Washington Defender Association and Washington Association of Criminal Defense Lawyers; Kimberly Mosolf, Disability Rights Washington; Laura Van Tosh; Joshua Wallace, Peer Washington; Deepa Sivarajan, No New Washington Prisons; Rebecca Faust; and Richard Warner, Citizens Commission on Human Rights.

(Other) Russell Brown, Washington Association of Prosecuting Attorneys.

Persons Testifying (Appropriations): (In support) Melanie Smith, National Alliance on Mental Illness Washington; Jerry Clark, Mothers of the Mentally Ill; and Johanna Bender, Superior Court Judges' Association.

(Opposed) Laura Van Tosh; Darya Farivar, Disability Rights Washington; Kari Reardon, Washington Defender Association and Washington Association of Criminal Defense Lawyers; Deepa Sivarajan, No New Washington Prisons; Russell Brown, Washington Association of Prosecuting Attorneys; and Steven Pearce, Citizens Commission on Human Rights.

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

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