HOUSE BILL REPORT
SSB 5073

As Passed House - Amended:
April 7, 2021

Title: An act relating to improving involuntary commitment laws.

Brief Description: Concerning involuntary commitment.

Sponsors: Senate Committee on Behavioral Health Subcommittee to Health & Long Term Care (originally sponsored by Senators Dhingra, Das, Kuderer, Salomon, Warnick and Wilson, C.).

Brief History:

Committee Activity:

Civil Rights & Judiciary: 3/24/21, 3/26/21 [DP];
Appropriations: 3/31/21, 4/1/21 [DPA].

Floor Activity:

Passed House: 4/7/21, 87-10.

Brief Summary of Substitute Bill
(As Amended By House)

- Expands less restrictive alternative treatment requirements to include a substance use disorder evaluation and consultation about the formation of a mental health advance directive.
- Applies provisions related to video evaluations under the Involuntary Treatment Act to minors.
- Authorizes courts to provide periodic monitoring to patients ordered to receive involuntary outpatient treatment and to modify the terms of their commitment orders.
- Amends various provisions related to the American Indian/Alaska Native behavioral health system.

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.

HOUSE COMMITTEE ON CIVIL RIGHTS & JUDICIARY

Majority Report: Do pass. Signed by 14 members: Representatives Hansen, Chair; Simmons, Vice Chair; Gilday, Assistant Ranking Minority Member; Abbarno, Davis, Entenman, Goodman, Kirby, Orwall, Peterson, Thai, Valdez, Walen and Ybarra.

Minority Report: Do not pass. Signed by 1 member: Representative Klippert.

Minority Report: Without recommendation. Signed by 2 members: Representatives Walsh, Ranking Minority Member; Graham, Assistant Ranking Minority Member.

Staff: Ingrid Lewis (786-7289).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended. Signed by 26 members: Representatives Ormsby, Chair; Bergquist, Vice Chair; Gregerson, Vice Chair; Macri, Vice Chair; Stokesbary, Ranking Minority Member; Chambers, Assistant Ranking Minority Member; Caldier, Chopp, Cody, Dolan, Fitzgibbon, Frame, Hansen, Harris, Hoff, Johnson, J., Lekanoff, Pollet, Ryu, Schmick, Senn, Springer, Steele, Stonier, Sullivan and Tharinger.

Minority Report: Without recommendation. Signed by 7 members: Representatives Corry, Assistant Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Boehnke, Chandler, Dye, Jacobsen and Rude.

Staff: Andrew Toulon (786-7178).

Background:

Involuntary Treatment.

The Involuntary Treatment Acts (ITA) for adults and minors set forth the procedures, rights, and requirements for involuntary treatment. The provisions governing involuntary treatment of minors over the age of 13 are parallel with the adult ITA in many respects.

Under the ITA statutes, a person may be committed by a court for involuntary treatment if he or she, due to a mental health or substance use disorder, poses a likelihood of serious harm or is gravely disabled and will not consent to voluntary treatment.

Designated crisis responders (DCR) are responsible for investigating and determining whether a person may be in need of involuntary treatment. In the adult ITA statute, DCR evaluations may be conducted by video, provided that a licensed health care professional or professional person who can adequately and accurately assist with obtaining any necessary information is present with the person at the time of the evaluation.

The DCR may petition the court for initial detention at an evaluation and treatment facility (E&T), secure withdrawal management and stabilization facilities (SWMS), or approved substance use disorder treatment program for evaluation and treatment for up to 120 hours, excluding weekends and holidays if the person poses a likelihood of serious harm or is gravely disabled. An E&T specializes in treating persons with mental health disorders and a SWMS specializes in treating persons with substance use disorders. A facility may be licensed as a co-occurring disorder treatment facility specializing in treatment of all kinds of behavioral health disorders; including both mental health and substance use disorders. If following a person's commitment to an E&T or a SWMS it appears that the person would be better served by treatment at the other kind of facility, the facility may refer the person for placement at the more appropriate facility.

American Indian/Alaska Native Behavioral Health Services.

Tribes have exclusive jurisdiction over ITA services provided to American Indian and Alaska Native (AI/AN) persons within the boundary of the tribe. The tribe may consent to concurrent state jurisdiction or expressly decline to exercise exclusive jurisdiction. Involuntary commitment orders by tribal court must be recognized and enforced by Washington courts. If a DCR knows, or has reason to know, that a person under investigation for civil commitment is an AI/AN who receives medical or behavioral health services from a tribe, the DCR must notify the tribe or Indian health care provider regarding whether a petition for initial detention or involuntary outpatient treatment will be filed. Notification must be made in person or by telephonic or electronic communication to the tribal contact listed in the Health Care Authority's Tribal Crisis Coordination Plan as soon as possible and within three hours. The DCR may restrict the release of information to comply with federal substance use disorder laws related to privacy. A federally recognized Indian tribe must be allowed to file a petition for initial detention with superior court under Joel's Law when a DCR decides not to detain a person for evaluation and treatment.

Less Restrictive Alternative Treatment.

When entering an order for involuntary behavioral health treatment, if a court finds that a less restrictive alternative (LRA) to inpatient commitment is in the best interest of the person or others, the court must order an appropriate less restrictive course of treatment. Certain services are required under a LRA order, and at a minimum require:

- assignment of a care coordinator;
- an intake evaluation with the provider of the LRA treatment;
- a psychiatric evaluation;
- a schedule of regular contacts with the treatment provider;
- a transition plan addressing access to continued services at the expiration of the order;
- a crisis plan; and
- notification to the care coordinator when the person does not substantially comply with treatment requirements.

Upon request by a party, a LRA order may be modified or revoked if the person is failing to adhere to the terms and conditions of the court-ordered treatment, is substantially deteriorating or decompensating, or poses a likelihood of serious harm.

Mental Health Advance Directive.

A mental health advance directive is a legal document that a person with capacity may create to express his or her preferences and instructions about mental health treatment in the event of incapacity.

Summary of Amended Bill:

Provisions related to video ITA evaluations by DCRs are applied to minors.

A DCR must attempt to ascertain if a person being assessed for involuntary treatment has executed a mental health advance directive.

A transfer of a patient detained for involuntary treatment between an E&T or a SWMS facility may take place at any time following the patient's initial examination and evaluation. The detention period may only be for the remainder of the current commitment period without any need for further review from the court.

The minimum requirements for a LRA treatment order are expanded to include a substance use disorder evaluation and consultation about the formation of a mental health advance directive.

A court may supervise a person on a LRA treatment order or conditional release by conducting and requiring an appearance in court for periodic review of the LRA treatment, and modifying the order after considering input from the treatment provider. A care coordinator may disclose information and records related to mental health services for purposes of implementing the LRA treatment.

Language in the adult ITA relating to AI/AN behavioral health services is imported into the minor ITA. Language in the adult ITA that confers exclusive jurisdiction over the involuntary commitment of an AI/AN person to an evaluation and treatment facility located within the boundaries of the tribe is removed. A DCR is required to notify both the tribe and the Indian health care provider whether a petition for initial detention or outpatient treatment will be filed, instead of the tribe or the provider. The HCA is required to publish information on how federally recognized tribes can utilize Joel's Law and requires DCRs to inform a tribe, if a person is a member, if the DCR makes a decision not to file a petition for involuntary treatment when the tribe has requested a DCR investigation.

Technical changes and updates are made. The bill is null and void if specific funding is not

appropriated in the operating budget.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill contains multiple effective dates. However, the bill is null and void unless funded in the budget.

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

(In support) There are barriers in the implementation of Ricky's Law. This is focused on making sure that a patient gets the treatment they need as quickly as possible. This allows the seamless transfer from specialty facilities. It incorporates the use of mental health advance directives. It allows for the better sharing of treatment information with necessary parties. It allows for video assessments for minors.

Courts have the authorization to hold hearings, but they need the ability to change LRA orders as needed.

One-third of King County patients who are released from involuntary hospitalization return to the hospital in psychosis within the 90-day LRA treatment period.

(Opposed) Court supervision of a community-based LRA does not safeguard individual rights or prevent inappropriate indefinite commitment. The bill puts judges, who do not have the expertise in behavioral health issues, in a position of treatment supervisors. The statutory scheme would allow the court to enforce criminal sentences through repetitive hearings and the threat of jail. Courtrooms are not treatment facilities. This is a barrier to compliance with court orders. Many patients have a hard time keeping appointments or court hearings and increasing the amount of appearances may mean that a person misses required appointments. Other factors to consider are transportation to appearances and having to take time off of work which may jeopardize a person's livelihood.

The length of conditional release in the current statute is increased.

Sections regarding mental health advance directives do not indicate that the DCR should note its existence in the petition.

A court should have input on the transfer of patients between facilities, and the individual should be consulted.

Staff Summary of Public Testimony (Appropriations):

(In support) Provisions in the bill permit, but do not require, courts to set review hearings to

better serve patients that are leaving inpatient hospitalization. Patients who are re-hospitalized cost the state millions of dollars. This bill provides an opportunity for courts to support patients in the re-entry process and reduce or eliminate re-hospitalization. No court is required to set review hearings. The treatment costs associated with this re-entry process are paid for out of dollars that already exist and have been languishing unspent because there was no system in place to use those funds effectively. There are nominal additional court costs, and treatment for Medicaid patients is paid for by managed care organizations with Medicaid dollars.

(Opposed) The state should not be spending money and amending statutes for a program that is only being used in King County and does not benefit the rest of the state. It is concerning that there will be review hearings with no guidance as to how they will occur. There will be additional costs of allowing patients to be transferred without any input from the court. Rather than passing legislation, these issues should be studied by the involuntary treatment workgroup. The provisions regarding advanced mental health directives are positive, but there needs to be an amendment to make these provisions effective.

This legislation creates an ability for periodic court review, which means that individuals transitioning back into the community will have to make additional appearances in court. This is a punitive response to a health care issue. Increasing investments in the criminal legal system will not result in improved behavioral health outcomes. Periodic court review will increase the burden of the individual to comply with a less restrictive alternative order. The courts are not behavioral health providers and requiring individuals to appear can be triggering. If individuals do not participate in required activities, they can be revoked and sent back to inpatient treatment, incurring even more court and behavioral health costs. Increased court supervision will not lead to long-term recovery and stabilization.

Persons Testifying (Civil Rights & Judiciary): (In support) Senator Dhingra, prime sponsor; and Johanna Bender, Superior Court Judges' Association.

(Opposed) Gordon Hill, King County Department of Public Defense; Kari Reardon, Washington Defender Association and Washington Association of Criminal Defense Lawyers; Darya Farivar, Disability Rights Washington; and Steven Pearce, Citizens Commission on Human Rights.

Persons Testifying (Appropriations): (In support) Johanna Bender, Superior Court Judges Association.

(Opposed) Kari Reardon, Washington Defender Association and Washington Association of Criminal Defense Lawyers; and Darya Farivar, Disability Rights Washington.

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

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