SENATE BILL REPORT
SHB 1773

As Reported by Senate Committee On:
Health & Long Term Care, February 16, 2022
Behavioral Health Subcommittee to Health & Long Term Care, February 24, 2022
Ways & Means, February 28, 2022

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: Passed House: 2/11/22, 87-8.
Committee Activity: Health & Long Term Care: 2/16/22 [w/oRec-BH].
Behavioral Health Subcommittee to Health & Long Term Care: 2/16/22, 2/24/22 [DPA-WM].
Ways & Means: 2/26/22, 2/28/22 [DPA, DNP, w/oRec].

Brief Summary of Amended Bill

- Amends criteria for a court to order assisted outpatient behavioral health treatment, and changes terminology to assisted outpatient treatment (AOT).
- Allows additional entities to file an AOT petition requesting an order for involuntary outpatient treatment, and changes procedures for filing the petition.
- Increases the duration of an AOT order from up to 90 days to up to 18 months.
- Expands AOT to include adolescents aged 13 to 17.
- Amends procedures for revocation of an AOT order.

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.

- Allows a court to impose partial hospitalization and intensive outpatient treatment as conditions of a less restrictive alternative treatment order.

SENATE COMMITTEE ON BEHAVIORAL HEALTH SUBCOMMITTEE TO HEALTH & LONG TERM CARE

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Frockt, Chair; Wagoner, Ranking Member; Nobles and Warnick.

Staff: Kevin Black (786-7747)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass as amended.
Signed by Senators Rolfes, Chair; Frockt, Vice Chair, Capital; Robinson, Vice Chair, Operating & Revenue; Billig, Carlyle, Conway, Dhingra, Hunt, Keiser, Mullet, Pedersen, Van De Wege, Wagoner and Wellman.

Minority Report: Do not pass.
Signed by Senator Braun.

Minority Report: That it be referred without recommendation.
Signed by Senators Wilson, L., Ranking Member; Brown, Assistant Ranking Member, Operating; Schoesler, Assistant Ranking Member, Capital; Honeyford, Ranking Minority Member, Capital; Gildon, Hasegawa, Muzzall, Rivers and Warnick.

Staff: Corban Nemeth (786-7736)

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.

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. LRA 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 Amended Bill: AOBHT is replaced with the term assisted outpatient treatment (AOT). Existing criteria for AOBHT are replaced with the following criteria, which allow a court to impose an AOT order if it finds the following circumstances are proven by clear, cogent, and convincing evidence:

- the person has a behavioral health disorder;
- based on a clinical determination, 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; or
    - 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 to the person or to others;
- the person has a history of lack of compliance with treatment for their behavioral health disorder that has:
    - at least twice within the 36-month period preceding filing of the petition been a substantial factor in necessitating 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 which occurred during the 36-month period;
    - at least twice within the last 36 months been a substantial factor in necessitating emergency medical care or behavioral health-related medical conditions including overdose, infected abcesses, sepsis, endocarditis, or other maladies, or a substantial factor resulting in the person's incarceration in a state or local correctional facility; or
    - resulted in one or more violent acts, threats, or attempts to cause serious physical harm to themselves or another within the 48-month period preceding filing of the petition, provided that this 48-month period shall be extended by the length of any hospitalization or incarceration which occurred during the 48-month period;
- participation in an AOT program would be the least restrictive alternative necessary to ensure the person's recovery and stability; and
- the person will benefit from AOT.

The individuals who may file a petition for AOT are expanded. An AOT petition may be filed by any of the following individuals:

- the director of a hospital where the person is hospitalized or the director's designee;
- the director of a behavioral health service provider providing 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 designated crisis responder;
- a release planner from a correctional facility; or
- an emergency room physician.

The length of an initial AOT order is increased from up to 90 days to up to 18 months. Existing requirements for filing an AOT petition are replaced, and instead an AOT petition must include a declaration from a physician, physician assistant, advanced registered nurse practitioner, or the person's treating mental health disorder professional or substance use disorder professional certifying they are willing to testify in support of the petition and that they have examined the person no more than ten days prior to the submission of the petition, or alternatively that they have made appropriate attempts to examine the person within that time period but were not successful in obtaining the person's cooperation. A declaration by a treating mental health disorder professional or substance use disorder professional must be co-signed by a supervising physician, physician assistant, or advanced registered nurse practitioner who certifies that they have reviewed the declaration. If the person is detained at the time the petition is filed, the petition must include the person's anticipated release date and other details needed to facilitate successful reentry and transition to 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 is represented by counsel. The court may order a mental examination of the respondent if the responded previously refused to be examined by a qualified professional.

AOT is expanded to include adolescents aged 13 to 17.

The Administrative Office of the Courts must develop court forms and a User's Guide for filing an AOT petition.

A discharge plan from a hospital where a person is detained for long-term involuntary treatment must include consideration of whether to file an AOT petition.

The options for less restrictive alternative treatment, including less restrictive alternative treatment on the basis that a person is in need of AOT, are expanded to allow a court to order the respondent to participate in partial hospitalization and/or intensive outpatient treatment services.

Procedures and standards for revocation of an AOT order are merged and aligned with the standards for revocation of other less restrictive alternative treatment orders. An agency, facility, or designated crisis responder may request assistance from a peace officer to temporarily detain a person subject to a less restrictive alternative treatment order for up to 12 hours for an evaluation for the purposes of determining whether to file a petition to revoke a less restrictive alternative treatment order. A petition for revocation must be filed within 24 hours and served upon the person, their guardian if any, and their attorney. If the court revokes the AOT order, the period of detention is for 14 days. The court must consider the following issues when determining whether to revoke a less restrictive alternative order:

- whether the person has adhered to the terms and conditions of the order;
- whether substantial deterioration in the person's functioning has occurred;
- whether there is evidence of substantial decompensation with a reasonable probability that the decompensation can be reversed by further inpatient treatment;
- whether there is a likelihood of serious harm; and
- whether, if any of the above conditions apply, it is appropriate for the court to reinstate or modify the person's less restrictive alternative treatment order or to order the person's detention for inpatient treatment.

A behavioral heath administrative services organization is required to employ an AOT program coordinator to oversee system coordination and legal compliance related to AOT.

A peace officer's obligation to provide assistance and use de-escalation tactics as part of an involuntary commitment process must include:

- taking a person into custody at request of a DCR;
- taking a person into custody if the peace office has reasonable cause to believe the person may have a behavioral health disorder and present an imminent likelihood of serious harm or be in imminent danger due to being gravely disabled;
- executing and enforcing civil orders or civil warrants to detain or apprehend a person for activities related to involuntary treatment; and
- supporting the safety of a crisis intervention team, DCR, or other behavioral health professional responding to an incident or performing other duties relating to involuntary commitment.

EFFECT OF WAYS & MEANS COMMITTEE AMENDMENT(S):

- Separates partial hospitalization from intensive outpatient treatment so that a court may require participation in both services as part of a less restrictive alternative order or conditional release order.
- Requires the Behavioral Health Administrative Services Organization, instead of the prosecutor, to provide notice to the tribe and Indian health care provider regarding the filing of an assistant outpatient treatment petition concerning a person who is an American Indian or Alaska Native who receives medical or behavioral health services

from a tribe within the state of Washington.

EFFECT OF BEHAVIORAL HEALTH SUBCOMMITTEE TO HEALTH & LONG TERM CARE COMMITTEE AMENDMENT(S):

- Amends criteria used to find that a person is in need of assisted outpatient treatment (AOT).
- Allows an AOT petition to be filed by the designee of the director of a hospital or behavioral health service provider.
- Eliminates review of AOT petition by the prosecutor and the obligation of the prosecutor to serve the AOT petition and schedule an AOT hearing and instead requires the court to fix a hearing date three to seven days after the date of service, or as stipulated by the parties, but no later than 30 days.
- Allows the court to conduct an AOT hearing in the respondent's absence if the respondent fails to appear and is represented by counsel.
- Allows the court to order a mental examination of the respondent if the respondent previously refused to be examined by a qualified professional.
- Requires the Administrative Office of the Courts to develop court forms and a User's Guide for filing an AOT petition.
- Clarifies a peace officer's obligation to provide assistance and use de-escalation tactics as part of an involuntary commitment process must include:
    - taking a person into custody at request of a DCR;
    - taking a person into custody if the peace office has reasonable cause to believe the person may have a behavioral health disorder and present an imminent likelihood of serious harm or be in imminent danger due to being gravely disabled;
    - executing and enforcing civil orders or civil warrants to detain or apprehend a person for activities related to involuntary treatment; and
    - supporting the safety of a crisis intervention team, DCR, or other behavioral health professional responding to an incident or performing other duties relating to involuntary commitment.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Substitute House Bill (Behavioral Health Subcommittee to Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: This is a critically important bill to move away from a law enforcement response for mental health and substance use disorders. AOT

helps people who need assistance making decisions due to mental illness. When the efforts of family have been frustrated, sometimes judicial oversight is needed to create accountability. As a court petition process, AOT takes civil liberties into consideration. AOT reduces dependence on law enforcement, reduces use of emergency rooms, and reduces burdens for DCRs. We cannot have any wrong doors. Please make minor amendments to language creating eligibility criteria. This bill clarifies and expands eligibility for AOT, expands who is able to seek AOT on behalf of a person in crisis, allows for rehospitalization when clinically necessary, and extends the time because we know that 90 days is too short to meet a person's needs. AOT is an evidence-based, patient-centered, trauma-informed treatment model. The funding is a crucial part of making this effective. Our families desperately need you to pass this bill to stop the system from discarding the sickest individuals. People who repeatedly cycle through the system lack insight into their illnesses and cannot see how treatment will help them. Not all people can self-manage within a voluntary system. My son needed assisted care; AOT could have saved him. LRA treatment orders do not provide the same support and therefore fail many. AOT helps people caught in the revolving door of the mental health system avoid hospitalization and jail and find a path towards treatment engagement and recovery. More people will be able to be served. AOT will reduce the strain on DCRs and emergency services. In New York, studies find that AOT dramatically reduced homelessness, hospitalizations, arrests, and incarcerations. AOT fills in the gaps by providing wraparound services and establishing relationships with a treatment team. Please study whether AOT meets the needs of youth before including youth in the bill. Allowing people to get treatment in their own community, rather than in an inpatient setting, will help them recover. AOT provides a much-needed middle option, an evidence-based model that many other states have used. There is a role for compelled treatment in our mental health system, and there should be an option for it to occur before more destabilizing inpatient hospitalization. My 28-year-old son with mental illness is currently in jail and was given treatment as part of a sentence. What if he could have gotten an order for treatment without criminal involvement? Our family's anguish motivates me to support AOT. My son's illness prevented him from having any insight into his disease and he refused treatment despite experiencing crisis at least once per week. An effective AOT program could have begun his recovery after one year instead of four years.

CON: This is a cloaked nuisance law, really an excuse to clear the streets of disproportionately BIPOC populations. We should have an opportunity to have a public dialog on this issue. This is a forced treatment bill laden with fear, trauma, and stigma. The threat of revocation is punitive and does not create recovery. Knowing that homosexuality used to be considered a psychiatric disorder makes me suspicious of involuntary commitment and forced treatment. The patients I saw improve as a psychologist were those who were able to establish a trusting therapeutic relationship with their therapist or caseworker, which is not likely to happen under coercive conditions. Since behavioral health services are underfunded this bill will take resources away from people who are prepared to establish productive therapeutic relationships. This policy is not person-centered or peer-informed. It pours millions into courts and not care, erodes civil rights,

and does not acknowledge that buy-in is essential to recovery. As a mom I used to want this kind of thing but the result was my daughter being placed in a traumatic situation and developing lasting distrust for medical providers. Please invest in access and instead work with peers to make sure that care is responsive to the individual. LRAs already cannot meet the needs of people under court orders; we should address that problem and not add to the demands. Research data around the value of AOT are unclear. The benefit of AOT is in access to robust evidence-based treatment and supports, not in a coercive court process. The court components of this bill cost $35 million; with that funding 2600 more clients could be served in assertive community treatment programs. AOT has a racially discriminatory impact. AOT does not fit with the plan for 988, adding involuntary orders and court time rather than resources to help people achieve stability. The money set aside for court process should be directed towards housing, quick access to prescription services, in-home care, triage facilities, and low-barrier access to substance use disorder treatment. AOT will increase involuntary treatment, not prevent it. This program works by taking away civil liberties and civil rights. Forcing people does not help them. We don't have enough treatment providers in this state and this bill doesn't create any. This bill strengthens punitive systems instead of empowering communities to care for each other. This will lead to more surveillance of the marginalized and less trust in mental health providers. I was hospitalized 11 times but never received support for housing, peer support, or reentry support. The experience was traumatizing and I was threatened with incarceration if I did not meet other peoples' standards. This bill could trap a person. Coercion in psychology violates patient rights. Prosecutors do not oppose AOT but ask for amendments so that prosecutors do not receive and file the petitions; instead please use a process similar to Joel's Law.

Persons Testifying (Behavioral Health Subcommittee to Health & Long Term Care): PRO: Representative Jamila Taylor, Prime Sponsor; Judge Johanna Bender, Superior Court Judges Association; Jerri Clark, MOMI--Mothers of the Mentally Ill; Brian Stettin, Treatment Advocacy Center; Jaimie Flores, Comprehensive Life Resources; Melanie Smith, NAMI Washington; Linda Wiley; Preston Horne-Brine.

CON: Laura Van Tosh; Marsha Cutting; Ramona Hattendorf, The Arc of King County; Kimberly Mosolf, Disability Rights Washington; Jessica Shook, Washington Association of Designated Crisis Responders; Kari Reardon, Washington Defender Association, Washington Association of Criminal Defense Lawyers; Meredith Ruff, No New Washington Prisons; Carmen Pacheco Jones, Health and Justice Recovery Alliance; Kathleen Wedemeyer; Russell Brown, Washington Association of Prosecuting Attorneys.

Persons Signed In To Testify But Not Testifying (Behavioral Health Subcommittee to Health & Long Term Care): No one.

Staff Summary of Public Testimony on Bill as Amended by Behavioral Health Subcommittee to Health & Long Term Care (Ways & Means): *The committee recommended a different version of the bill than what was heard.* PRO: There are

currently very few options on the scale between involuntary inpatient commitment and voluntary outpatient treatment. By allowing individuals to receive court ordered outpatient treatment in the community, people can avoid traumatic inpatient treatment that often occurs far from home. This bill will be beneficial by keeping individuals in outpatient treatment longer and thereby keeping individuals out of emergency rooms and the criminal justice system.

CON: This is an expensive program that may not be effective, results in a deprivation of liberty, and raises serious legal and constitutional questions. The court costs alone estimated by the Health Care Authority are $11 million a year. This bill comes at a large fiscal and human rights cost. This bill is a punitive measure. We should be creating services consumers want, rather than forcing consumers into services they don't want. I myself was subject to court ordered treatment and it was not a good experience. This bill pushes community mental health in the wrong direction. We need to look beyond the forced aspect of treatment and offer real alternatives, including looking at physical health conditions. None of this funding promotes monitoring and improving people's health.

Persons Testifying (Ways & Means): PRO: Melanie Smith, NAMI Washington.

CON: Darya Farivar, Disability Rights Washington; Laura Van Tosh, Retired; Steven Pearce, CCHR Seattle.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.