HOUSE BILL REPORT
2SSB 5120

As Reported by House Committee On:
Health Care & Wellness
Appropriations

Title: An act relating to establishing crisis relief centers in Washington state.

Brief Description: Establishing crisis relief centers in Washington state.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Dhingra, Wagoner, Braun, Frame, Hasegawa, Keiser, Kuderer, Nguyen, Nobles, Pedersen, Randall, Saldaña, Shewmake, Stanford, Warnick, Wellman and Wilson, C.).

Brief History:
Committee Activity:
Health Care & Wellness: 3/15/23, 3/22/23 [DP];
Appropriations: 3/31/23, 4/3/23 [DP].

Brief Summary of Second Substitute Bill

- Establishes 23-hour crisis relief centers as a new category of behavioral health facility to provide services to voluntary clients, clients being brought in by first responders, and clients referred by the 988 behavioral health crisis system.
- Eliminates triage facilities as a category of behavioral health facility and converts existing triage facilities into crisis stabilization units.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 16 members: Representatives Riccelli, Chair; Bateman, Vice Chair; Schmick, Ranking Minority Member; Hutchins, Assistant Ranking Minority Member; Barnard, Bronoske, Davis, Graham, Harris, Macri, Mosbrucker, Orwall, Simmons, Stonier, Thai and Tharinger.

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.

Staff: Christopher Blake (786-7392).

Background:

Crisis mental health services are intended to stabilize a person in mental health crisis to prevent further deterioration, provide immediate treatment and intervention, and provide treatment services in the least restrictive environment available. Mental health crisis services include: crisis telephone support, crisis outreach services, crisis stabilization services, crisis peer support services, and emergency involuntary detention services.

The Department of Health (Department) certifies crisis stabilization units and triage facilities which are two types of facilities that provide behavioral health crisis services. Both types of facilities are short-term facilities that are either independent or part of larger facilities and are designed to assess, diagnose, stabilize, and treat individuals experiencing an acute crisis. In addition, triage facilities may determine the need for involuntary commitment of an individual. The Department's certification regulations for both types of facilities share many common requirements, including that a mental health professional be on-site at least eight hours per day, seven days per week, and accessible 24 hours per day, seven days per week. In addition, both types of facilities must ensure that a mental health professional assesses an individual within three hours of arrival at the facility.

Triage facilities provide inpatient services while crisis stabilization units may provide either inpatient beds or outpatient recliners. Both facilities are designed to accommodate voluntary admissions and the inpatient facilities may also detain a person for up to 12 hours at the direction of designated crisis responders or certain other participants in the civil commitment system.

Summary of Bill:

23-Hour Crisis Relief Centers.

Credentialing Standards.
A new category of behavioral health facility is established, known as a "23-hour crisis relief center" (crisis relief center). Crisis relief centers are community-based facilities, or portions of facilities, that offer access to behavioral health care to adults for less than 24 hours and are open 24 hours per day, seven days per week. Crisis relief centers must accept all clients in behavioral health crisis who arrive voluntarily, are brought in by first responders, or are referred through the 988 behavioral health crisis system, regardless of the acuity of the person's behavioral health condition. The term "first responder" includes ambulance services, fire services, mobile rapid response crisis teams, co-responder teams, designated crisis responders, fire department mobile integrated health teams, community assistance referral and education services programs, and law enforcement personnel.

Crisis relief centers are licensed or certified by the Department of Health (Department). By January 1, 2024, the Department, in consultation with the Health Care Authority, must adopt rules to require crisis relief centers to:

- offer, without medical clearance requirements, walk-in options, drop-off options for first responders, and drop-off options for persons referred through the 988 system. Crisis relief centers must be capable of accepting admissions 90 percent of the time when the facility is not at full capacity and must maintain a no-refusal policy for law enforcement. Crisis relief centers must track instances of declined admissions and the reasons for the denials and make the information available to the Department;
- provide services for mental health conditions and substance use disorder issues;
- maintain the capacity to screen for physical health needs, deliver minor wound care, and provide care for most minor physical or basic health needs, with a pathway to transfer the person to more medically appropriate services, if needed. The rules must develop standards for determining medical stability before accepting a patient from emergency medical services;
- be staffed 24 hours per day, seven days per week with a multidisciplinary team, including a prescribing provider, that is capable of meeting the needs of individuals experiencing all levels of crisis and the ability to dispense medications;
- screen all individuals for suicide risk and engage in comprehensive suicide risk assessment and planning;
- screen all individuals for violence risk and engage in comprehensive violence risk assessment and planning;
- limit patients stays to less than 24 hours, except for patients waiting for a designated crisis responder evaluation or an imminent transition to another setting as part of an established aftercare plan;
- maintain relationships with entities capable of providing for ongoing service needs, unless the licensee provides those services; and
- coordinate connection to ongoing care, when appropriate.

The Department must establish standards for the maximum number of recliner chairs that a crisis relief center may operate, including variances to account for the no-refusal policy for law enforcement. The Department's standards must also address physical environment standards that are responsive to the types of interventions that may be used by crisis relief centers for patients of different acuity levels.

When engaging in rulemaking related to crisis relief centers, the Department must consult with identified stakeholders, including medical behavioral health providers and facilities, family members who have cared for a person in behavioral health crisis, behavioral health administrative services organizations, designated crisis responders, law enforcement representatives, and emergency medical services representatives.

The Health Care Authority must make crisis relief center services eligible for Medicaid billing to the maximum extent allowed by federal law.

Interactions with the Behavioral Health System.
The real-time bed tracking technology established for the 988 behavioral health crisis system must also track the availability of recliner chairs at crisis relief centers.

If a person at a crisis relief center refuses to stay voluntarily, the staff may detain the person for sufficient time to allow a designated crisis responder to complete an evaluation if the professional staff believe that the person either presents an imminent likelihood of serious harm due to a behavioral health disorder or presents an imminent danger because of grave disability. If involuntary commitment criteria are met, the person may be held in custody or transferred to an appropriate facility within 12 hours of notifying the designated crisis responder.

In addition to other listed facilities:

- designated crisis responders may send a person to crisis relief centers for evaluation and treatment if they voluntarily agree;
- when a person is subject to emergency custody for a behavioral health condition, a peace officer may deliver the person to a crisis relief center where they may be held for up to 12 hours;
- agencies or facilities that are monitoring persons under a less restrictive alternative treatment order or conditional release order, or a designated crisis responder, may detain a person at a crisis relief center for up to 12 hours for evaluation when enforcing, modifying, or revoking an order; and
- police officers may take a person with a behavioral health condition who is believed to have committed a crime to a crisis relief center where the person may be held for up to 12 hours.

Assisted living facilities, nursing homes, adult family homes, veteran's homes, and enhanced services facilities are prohibited from discharging or transferring residents to a crisis relief center. Hospitals are prohibited from discharging or transferring patients to a crisis relief center unless it has a formal relationship with the crisis relief center.

Other Behavioral Health Facilities.

Triage facilities are eliminated as a category of behavioral health facility licensed or certified by the Department. The Department must convert existing triage facilities into crisis stabilization units at the beginning of the facilities' next certification cycle. The definition of a "crisis stabilization unit" is expanded to include activities related to determining the need for involuntary commitment of an individual. The option for crisis stabilization units to operate as outpatient facilities is eliminated.

It is specified that the requirement that a person be examined by a behavioral health professional within three hours of arrival at a facility only applies to emergency departments.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill contains multiple effective dates. Please see the bill.

Staff Summary of Public Testimony:

(In support) From 2006 to 2017 suicide in Washington increased by an average of 2.5 percent annually and with these rising cases the state can only benefit from increased access to behavioral health services. This bill continues the work that many have done around creating the 988 system. The crisis relief centers established in the bill will not shut their doors and will not require medical clearance. People need someone to call, someone to respond, and somewhere to go to get better and this bill provides that place to go. This bill provides an alternative to emergency departments and jails for persons experiencing behavioral health disorders.

Jail is a terrible place for someone having a mental health crisis, yet that is the status quo for people with poorly treated severe mental illness. Law enforcement and crisis responders can take people to the crisis relief centers which ensure that there is no wrong door for the population. Law enforcement supports the no-refusal policy for law enforcement, the suicide risk assessment, the no medical clearance policy, and the continuous hours of operation.

Communities are ready and eager to offer these essential facilities to provide neighbors in need with a place to go when they are experiencing a behavioral health crisis. This bill aligns with an upcoming crisis care center levy in King County. Crisis relief centers should be built in rural areas where there is a higher suicide rate than in populated areas because of fewer people to interact with and fewer resources. This bill is important because Native Americans are disproportionately affected by a lack of resources and accessibility. Access to these centers is very important for low-income persons and teenagers who have dangerous home lives. This bill is a critical component of upgrading the entire crisis response infrastructure. This bill will ensure that the components of the most efficient and effective model for these facilities will be in place in Washington. This bill opens a closed door to many people for getting alternative services in the community as close to home as possible. People living with dementia have unique needs and are best served in settings where staff have specific training on meeting those needs.

While many students use free school counseling services, it can interfere with learning time and some schools do not have such specialists, but crisis relief centers can provide easy access to resources that would prevent the stories that too many teenagers are used to hearing.

Organized retail crime syndicates prey on persons suffering from addiction and use them to

commit their crimes and this bill is a good step in breaking that cycle and providing them with the necessary treatment.

(Opposed) None.

Persons Testifying: Senator Manka Dhingra, prime sponsor; Sarah Perry, King County; Mark Johnson, Washington Retail Association; Jerri Clark, Mothers of the Mentally Ill; James McMahan, Washington Association of Sheriffs and Police Chiefs; Neal Black, City of Kirkland; Brad Forbes, Alzheimer's Association; Nicole Haberl, Arjun Rao, and Grace Ross, Lake Washington High School; Katie Kolan, Washington State Hospital Association; Todd Carlisle, Disability Rights Washington; Laura Van Tosh; and Michael Transue, Connections Health Solutions.

Persons Signed In To Testify But Not Testifying: None.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass. Signed by 29 members: Representatives Ormsby, Chair; Bergquist, Vice Chair; Gregerson, Vice Chair; Macri, Vice Chair; Stokesbary, Ranking Minority Member; Chambers, Assistant Ranking Minority Member; Corry, Assistant Ranking Minority Member; Berg, Chopp, Connors, Davis, Dye, Fitzgibbon, Hansen, Harris, Lekanoff, Pollet, Riccelli, Rude, Ryu, Sandlin, Schmick, Senn, Simmons, Slatter, Springer, Steele, Stonier and Tharinger.

Staff: Lily Smith (786-7175).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Health Care & Wellness:

No new changes were recommended.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill contains multiple effective dates. Please see the bill.

Staff Summary of Public Testimony:

(In support) Other states have implemented this new facility type with success. The requirements that these facilities be open 24 hours, combined with the no-refusal policy and the services provided, will all help the people that need this kind of help. The Legislature should fund this new facility type so that there are as many of these facilities available as there are gas stations.

(Opposed) Additional options for mental health treatment are good, but not additional treatment that can be forced on individuals. There remains a concern with the fact that this bill ties into the Involuntary Treatment Act. The timeframe under the bill for holding someone involuntarily only begins when the designated mental health professional is called. This timeframe should instead begin as soon as the individual asks to leave.

Persons Testifying: (In support) James McMahan, Washington Association of Sheriffs and Police Chiefs; and Michael Transue, Connections Health Solutions.

(Opposed) Rebecca Faust.

Persons Signed In To Testify But Not Testifying: None.