# SENATE BILL REPORT
# SB 5120

As of February 20, 2023

**Title:** An act relating to establishing 23-hour crisis relief centers in Washington state.

**Brief Description:** Establishing 23-hour crisis relief centers in Washington state.

**Sponsors:** 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 & Long Term Care: 1/13/23, 1/26/23 [DPS-WM, w/oRec]. Ways & Means: 2/21/23.

**Brief Summary of First Substitute Bill**

- Directs the Department of Health to license or certify 23-Hour Crisis Relief Centers, a new type of crisis diversion facility to serve persons regardless of behavioral health acuity.

## SENATE COMMITTEE ON HEALTH & LONG TERM CARE

**Majority Report:** That Substitute Senate Bill No. 5120 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Cleveland, Chair; Robinson, Vice Chair; Muzzall, Assistant Ranking Member; Conway, Dhingra, Randall and Van De Wege.

**Minority Report:** That it be referred without recommendation.

Signed by Senator Padden.

**Staff:** Kevin Black (786-7747)

## SENATE COMMITTEE ON WAYS & MEANS

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*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:** Corban Nemeth (786-7736)

**Background:** Crisis Diversion. A crisis diversion facility is a facility that provides a person in a behavioral health crisis with a place to go when they are in a behavioral health crisis as an alternative to a less desirable location, like an emergency room, involuntary treatment facility, or jail. Crisis diversion facilities are typically structured to receive clients dropped off by police or emergency medical personnel, and may also accept clients who walk in or who are brought by friends or family. The Washington State Department of Health (DOH) certifies two types of crisis diversion facilities which are identical in function but referred to by different names: crisis stabilization units and triage facilities. A crisis stabilization unit or triage facility is a short-term facility licensed as a residential treatment facility which can keep clients for up to three days in beds provided by the facility.

Other states such as Arizona have pioneered a somewhat different model of crisis diversion facility which employs shorter stays of less than 24 hours. This is sometimes referred to as a "living room model," because instead of beds the facilities admit the client to lazy boy recliners, using an open layout instead of individual rooms. Other features of this model include procedures to make client drop off as fast and frictionless as possible for law enforcement and other first responders.

Designated Crisis Responders. Designated crisis responders (DCRs) are individuals authorized to evaluate a person in crisis for possible involuntary commitment to a locked behavioral health facility. Involuntary commitment is a court process, and is available for individuals if the DCR determines they present a likelihood of serious harm or are gravely disabled due to a behavioral health disorder, as those terms are legally defined under the Involuntary Treatment Act.

**Summary of Bill (First Substitute):** 23-Hour Crisis Relief Centers. By January 1, 2025, DOH must license or certify 23-Hour Crisis Relief Centers (CRCs), which are defined as facilities open 24 hours a day, seven days a week, which offer access to behavioral health care to adults for no more than 23 hours 59 minutes at a time per patient, and accept all behavioral heath walk-ins and drop-offs from ambulance, fire, police, designated crisis responders, mobile rapid response crisis teams, fire department mobile integrated health and CARES teams, and individuals referred through the 988 system regardless of behavioral health acuity. A CRC must not require medical clearance for individuals dropped off by first responders, and must be structured to have a no-refusal policy for individuals dropped off by law enforcement. A CRC must be structured to accept all other admissions 90 percent of the time and track instances of refusal and the reason for that refusal, making this data available to DOH. A CRC must maintain capacity to assess physical health needs, deliver minor wound care for nonlife-threatening wounds, and provide care for most minor physical or basic health needs, with an identified pathway to transfer to more medically appropriate services if needed. A CRC must provide access to a prescriber and have the ability to dispense medications appropriate for CRCs. DOH must develop standards for the number of recliner chairs allowed in a CRC, and the appropriate variance needed to accommodate the

no-refusal policy for law enforcement. Real-time bed tracker technology under development for the 988 system must track availability of recliners in CRCs.

If a person is brought to a CRC and thereafter refuses to stay voluntarily, and the professional staff regard the person as presenting an imminent likelihood of serious harm or to be in imminent risk because of a grave disability, the staff may detain the person for sufficient time to allow a DCR to authorize further custody or transport the person to another facility for detention under the Involuntary Treatment Act, but for no longer than 12 hours from the notification to the DCR.

DOH must develop standards for determining medical stability before an emergency medical services drop-off at a CRC. The CRC must screen individuals for suicide risk and violence risk, with more comprehensive assessment available if needed. It must maintain relationships with entities capable of providing ongoing service needs of its clients, or provide sufficient aftercare services for the clients itself. An exception to the time limit of 23 hours 59 minutes is available for individuals who are waiting on a DCR evaluation or making an imminent transition to an established aftercare plan. DOH must not require a CRC to be licensed as a residential treatment facility. DOH must coordinate with the Health Care Authority (HCA) and Department of Social and Health Services to prohibit discharges or transfers to a CRC from a nursing home, assisted living facility, enhanced services facility, soldier's and veteran's home, adult family home, or hospital, unless the hospital has a formal relationship with the CRC. HCA must make CRC services eligible for Medicaid billing to the maximum extent allowed by federal law.

Other Kinds of Crisis Diversion Facilities. Language authorizing DOH to certify triage facilities is repealed. All remaining triage facilities are converted to crisis stabilization units, and references to triage facilities are removed from the RCW. Crisis stabilization units must determine an individual's need for involuntary hospitalization.

**EFFECT OF CHANGES MADE BY HEALTH & LONG TERM CARE COMMITTEE (First Substitute):**

- Specifies that CRCs must serve adults.
- Expands the definition of first responders.
- Establishes a deadline of January 1, 2025, for DOH to create rules.
- Modifies provisions related to the CRC's capacity to accept admissions, no refusal policy, treating wound care, and transition to aftercare.
- Requires CRCs to track declined admissions and make that data available to DOH.
- Requires CRCs to provide access to a prescriber and be able to dispense medications
- Requires DOH to develop standards for determining medical stability before an emergency medical services drop-off at a CRC.
- Requires establishment of rules that prohibit discharges or transfers to a CRC from nursing homes, assisted living facilities, enhanced services facilities, soldier’s and veterans’ homes, and adult family homes, and hospitals without a formal relationship

to the CRC.
- Requires real-time bed tracking technology to track the availability of recliner chairs in CRCs.

**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 Original Bill (Health & Long Term Care):** *The committee recommended a different version of the bill than what was heard.* PRO: The 988 crisis line bill passed two years ago has become a national model. Now we have to deliver the services surrounding 988. Thirty of us visited a CRC in Arizona and found all the things Washington is lacking. We require medical clearance, a huge barrier, and employ exclusionary criteria in behavioral health facilities. They don't do this. We must create a crisis system which cannot say no to individuals. In Arizona the time for law enforcement drop-off is six minutes. Jails have no exclusionary criteria, so neither should a CRC. Emergency responders have a good sense of where people belong, but they have never had an option like a CRC. We need more places for people in crisis. King County proposes to fund five CRCs. Please allow exceptions for CRCs to be licensed with exceptions to certain requirements while we build capacity in the system. Sufficient funding is needed. Community behavioral health needs are increasing. Mobile crisis response helps but we have a gap—somewhere for people to go. CRCs are the missing link. Without them, people in crisis fill emergency rooms and jails. This bill creates a tool our residents need. Please promote prevention, ensure these facilities have a safe level of staffing, and collaborate with cities to cite CRCs in the most appropriate locations. This bill is much needed. 23 hours is a short period of time for people in great crisis. A no-refusal policy without medical clearance will present implementation challenges. Please create a phased multiyear approach so this can be piloted. CRCs should be part of a crisis care campus that includes peer respite and a facility allowing for longer-term stays. Medical complications can look like behavioral health issues. Please include some type of medical stability criteria that can be implemented in the field. CRCs will provide an appropriate place to end over-reliance on involuntary treatment. Please add people with lived experience, their families, the Pharmacy Commission, and the Washington State Hospital Association to the list of folks who must be consulted in rulemaking. Law enforcement loves no refusal and no medical clearance. We need to help those who need help. Organized retail crime rings prey upon persons with behavioral health disorders; helping them in CRCs is better than sending them to jail. Exceptions to the 24-hour limit should not include transitioning to aftercare, which will lead to boarding. CRCs must be able to distribute medications and have medication rooms. Please narrow the reference to wound care. The Arizona model must be adjusted to fit Washington State. Arizona provides a continuum of services including a transitions

program where individuals can stay longer than 24 hours while waiting for the care they need. Please build in a mechanism to report when a person is denied access to a CRC. Please expand drop-offs rules to include mobile rapid response teams, DCRs, and co-responder units. My son's experiences being stuck in emergency rooms were traumatizing and killed his hope. This bill will help fulfill the 988 vision for someone to call, someone to respond, and a safe place to go for crisis care. Over six emergency room visits my daughter waited hours for medical clearance before accessing a behavioral health team. Discharge drags on long after the crisis has passed. CRCs will provide more comfort, timely treatment, and timely resolution in a less stressful environment. My daughter said she would consider to a CRC before an emergency room while she is still escalating. CRCs will give family time to catch their breath and find relief.

CON: This bill will harm people by trapping them in the psychiatric treatment system which perpetrates human rights abuses. People should get assistance in a noncoercive peer environment.

OTHER: We support the intent of this bill. Some CRC clients need more intensive treatment options. Patients transitioning to aftercare will wait longer than 24 hours. CRCs must have rapid access to prescribers. Discharge plans must be clear, and timelines adhered to faithfully with no exception but waiting for a DCR. Long-term care providers should be prohibited from inappropriately discharging residents to CRCs. I oppose involuntary treatment. Please place a time limit on how long a CRC can take to notify a DCR. There should be a client bill of rights. Please require dementia training for CRC staff.

**Persons Testifying (Health & Long Term Care):** PRO: Senator Manka Dhingra, Prime Sponsor; James McMahan, Washington Association of Sheriffs & Police Chiefs; Kelli Curtis, City of Kirkland Councilmember; Mark Johnson, Washington Retail Association; Levi Van Dyke, Volunteers of America Western Washington; Sofia Aragon, City of Burien Mayor; Sarah Chesemore; Jerri Clark, Mothers of the Mentally Ill; Gay-Lynn Beighton; Katie Kolan, Washington State Hospital Association; Michael Transue, Connections Health Solutions; Brad Banks, Behavioral Health Administrative Services Organizations, Co-Responder Outreach Alliance; Joan Miller, Washington Council for Behavioral Health; Kari Reardon, Washington Defender Association/Washington Association of Criminal Defense Lawyers; Leo Flor, King County; Todd Carlisle, Disability Rights Washington.

CON: Steven Pearce, Citizens Commission on Human Rights.

OTHER: Rebecca Faust; Brad Forbes, Alzheimers Association - WA Chapter; Patricia Hunter, Washington State Long Term Care Ombuds Program; Christie Spice, Washington State Department of Health; Keri Waterland, Washington State Health Care Authority.

**Persons Signed In To Testify But Not Testifying (Health & Long Term Care):** Bipasha Mukherjee; Thai Nguyen.