SENATE BILL REPORT
SB 5397

As of February 5, 2021

Title: An act relating to improving access to behavioral health treatment in certified crisis facilities.

Brief Description: Improving access to behavioral health treatment in certified crisis facilities.

Sponsors: Senators Randall, Dhingra, Kuderer, Lovelett, Nguyen, Nobles, Saldaña and Wilson, C..

Brief History:
Committee Activity: Health & Long Term Care: 2/03/21 [w/oRec-BH].
Behavioral Health Subcommittee to Health & Long Term Care: 2/05/21.

Brief Summary of Bill

- Requires an evaluation and treatment facility or secure withdrawal management and stabilization facility that has treatment capacity to admit a person detained for involuntary treatment, or who is applying for transfer from a single-bed certification facility, unless an exception applies.
- Requires managed care organizations and behavioral health administrative services organizations to secure a safe placement or safe discharge for a person who is detained for involuntary treatment if no other placement is available.
- Requires crisis facilities to provide medically necessary co-occurring disorder treatment to persons receiving involuntary treatment by July 1, 2022.

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

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: Kevin Black (786-7747)

Background: Involuntary Commitment for Behavioral Health. A person may be detained for involuntary treatment under the Involuntary Treatment Act (ITA) during a period of crisis if an investigation by a designated crisis responder (DCR) determines that the person has a mental disorder or substance use disorder (SUD) that causes them to present a likelihood of serious harm or to be gravely disabled.

Likelihood of serious harm means:

- a substantial risk the person will inflict physical harm upon themself or others, evidenced by threats or attempts to commit suicide, cause physical harm, or place another person in reasonable fear of sustaining such harm;
- a substantial risk the person will inflict physical harm on the property of others, evidenced by behavior which has caused substantial loss or damage; or
- the person has threatened the physical safety of another and has a history of one or more violent acts.

Gravely disabled means:

- being in danger of serious physical harm resulting from failure to provide for the person's essential human needs of health or safety; or
- experiencing severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control and the person is not receiving care essential to their health or safety.

A peace officer or other entity, at the request of a DCR, may detain a person in an emergency room, triage facility, crisis stabilization unit, evaluation and treatment facility (E&T), or secure withdrawal management and stabilization facility (SWMS) for up to 12 hours for a DCR investigation, or up to 6 hours if the person self-presents to the facility or is brought to the facility and refuses voluntary admission. If the DCR determines further detention for treatment is appropriate, the DCR must detain the person within the 6 or 12-hour period to an E&T, SWMS, or facility willing to provide treatment pursuant to a single-bed certification. Continued detention may occur for 120 hours excluding weekends and holidays and triggers a number of rights on behalf of the detained person, including the right to counsel and the right to a court hearing if detention continues beyond the 120-hour period. Detention may continue with court authorization for renewable periods of 14, 90, or 180 days, or the court may dismiss the petition for additional treatment or order treatment in the community as a less restrictive alternative.

Certified Involuntary Treatment Facilities. An E&T is a facility certified to provide involuntary treatment to a person with a mental health disorder. E&Ts may be embedded in community hospitals that provide a wide range of medical services in different areas of the facility, or may be provided in standalone facilities with limited resources to address a patient's physical care needs. A SWMS is a facility certified to provide involuntary treatment based on an SUD.

Single-Bed Certifications. The Health Care Authority (HCA) may authorize a single-bed certification to a facility willing and able to provide timely and effective mental health services to a person detained for involuntary commitment. A single bed certification is a 30-day authorization specific to the patient that may be requested for a number of reasons, including when a person needs medical services that are not available in a certified facility, to facilitate continuity of care, to allow a person to receive treatment close to their home community, and to extend the resources available for people detained in the ITA system. A facility must agree to provide services under a single-bed certification. Data from HCA indicates an average of 931 single-bed certifications per month were authorized in the first half of 2020, up from 865 per month during calendar year 2019.

No Bed Reports. When a DCR is unable to find a placement for a person who meets detention criteria under the ITA in an E&T, SWMS, or single-bed certification within the 6 or 12-hour investigation period, and the person cannot be served on a less restrictive alternative, the DCR must end the involuntary commitment investigation and file a no bed report with HCA. The DCR report must be filed within 24 hours, including specified information such as a list of facilities that refused to admit the person. HCA must promptly notify the Medicaid managed care organization (MCO) or behavioral health administrative services organization (BH-ASO) responsible for providing community behavioral health services to the person, and the MCO or BH-ASO must attempt to engage the person in appropriate services and report back to HCA within seven days. Data from HCA indicates it received an average of 46 no bed reports in the first six months of 2020, down from 64 no bed reports per month during calendar year 2019.

Summary of Bill: An E&T or SWMS that has treatment capacity must admit a person to the facility at the request of the DCR who has been detained for involuntary inpatient care unless:

- the person requires medical services not generally available at a certified involuntary treatment facility;
- a more appropriate facility exists to serve the specific needs of the person that has agreed to admit the person;
- unusual reasons specific to the person or their prior relationship with the facility exist that make the facility unable to admit the person; or
- the services offered by the facility are targeted for a specific population and the person is not among that specific population and therefore is not appropriate for admission.

The E&T or SWMS must also admit a person who is receiving temporary involuntary treatment services pursuant to a single-bed certification if it has treatment capacity upon application for transfer by the single-bed certification facility if the attending physician considers the person to be medically stable, unless a similar exception applies.

An E&T or SWMS that declines to admit a person under the above circumstances must

document the request for admission and the reason for declining admission in its records, and immediately provide a copy to the requesting DCR or single-bed certification facility. The E&T or SWMS with capacity must determine whether to admit the person at the request of a DCR within two hours of receiving the DCR's admission request.

When a DCR or single-bed certification facility determines they are unable to find a placement for a person who meets ITA detention criteria, and the DCR or facility has received at least two denials of admission from an E&T or SWMS, the DCR or facility must immediately transmit notification to the MCO responsible for the cost of the person's care, or the BH-ASO if the person is not enrolled in Medicaid, of the need for emergency intervention to secure access to crisis services for the person. The MCO or BH-ASO must obtain a safe placement or safe discharge for the person within 24 hours. If the person is being held for initial evaluation by a DCR, the initial evaluation hold is extended during this 24-hour emergency period. The DCR must serve notice of the emergency hold period on the person, and the person must be provided access to a mental health professional during the 24-hour period.

If an MCO or BH-ASO is unable to find a safe placement or safe discharge for the person during the 24-hour period, the hold dissolves and the MCO or BH-ASO must file a no bed report to HCA. The obligation of the DCR to make a no bed report is eliminated. The MCO or BH-ASO is responsible for the cost of care for the person during the 24-hour emergency hold period, unless coverage is provided by another entity.

Effective July 1, 2022, an E&T must provide medically necessary SUD services to a person admitted to the E&T who has a co-occurring SUD, and a SWMS must provide medically necessary mental health services to a person admitted to the SWMS who has a co-occurring mental health disorder.

DOH must review denials of admission requests by E&Ts and SWMS under this act during its regular facility licensure inspections and analyze the denials to determine if there are means for the facility to improve its availability to provide services to persons in crisis, including the receipt of technical assistance from DOH or other entities.

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: PRO: This bill responds to the challenges in our system. Detained crisis patients so often struggle to obtain information to certified crisis facilities. Patients are sometimes turned away even when there are empty beds available.

Most often it is the patients with the most complex needs who are denied. We have made huge strides in accessibility and equity but we have so much further to go. Let us move closer to a Washington that is able to meet the needs of individuals in crisis so the crises do not escalate. As a father to a son with mental illness I see this as a helpful improvement to the mental health law. My son was detained in a single-bed certification for over four months because he would not be accepted in a certified facility. Why should a provider of treatment have the discretion to refuse it? When we lived in Hawaii, he was hospitalized several times and but never refused treatment. This bill will help eliminate glitches and short circuits in the mental health system, and provide oversight to make the system better.

CON: We appreciate the goal to facilitate timely care for individuals in behavioral health crisis. The bill should require a medical evaluation before detention in a freestanding E&T, which can not treat all medical conditions. Delays in care can lead to fatal outcomes. This bill will not work the way it thinks it will. There is a lack of system capacity and it is about to get worse. The requirement to hold patients in emergency rooms is in conflict with a supreme court ruling prohibiting emergency room boarding. The workforce is insufficient to provide co-occurring disorder services in crisis facilities. Please allow us time to collect data and develop recommendations with input from stakeholders. Emergency rooms are the safety net for patients in crisis. Holding patients for an extra 24 hours will overwhelm emergency departments, especially in critical access hospitals. Patients will feel marginalized. This is a band aid on a system which is hemorrhaging. The 24-hour emergency hold extension would deprive the person of liberty in a setting which does not have the training or expertise to help them. We keep our E&T full but we need the ability to refuse patients on a case-by-case basis to preserve the safety of patients and staff. An E&T might disagree with a hospital about medical clearance. We will never have enough inpatient beds without investing in upstream, preventative behavioral health treatment. Language in the bill stigmatizes persons with mental illness. Antipsychotic medication is the problem; we should find nontoxic, preventive solutions. The system does not deal well with people who want alternatives and would respond to noncoercive methods.

OTHER: We have received many reports of persons with complex needs being stuck in emergency rooms after being turned down by E&Ts which have beds to serve them. This fuels the reliance on single bed certifications which are more restrictive and incapable of providing adequate care and treatment. We are very supportive of requiring facilities to document the reason why they are refusing admission to certain individuals. The reasons allowed for refusal in this bill are too broad and may create loopholes. We are unclear why an additional 24-hour hold is needed just for systems communication issues. Please fix the communication issues without lengthening detention. Persons with developmental disabilities are shut out of E&Ts frequently. We support involving MCOs and BH-ASOs in working for a safe discharge. The impact of this bill will be limited without fixing the flaws in the crisis system as a whole. Transferring persons to certified beds from single-bed certifications would be a positive step, and also increasing capacity to treat persons with co-occurring disorders. Please provide notifications to MCOs early; they can not act if they do not receive information. Increasing MCO functions would be a big administrative lift.

MCOs do not work on weekends to submit reports. Please do not require the DCRs to serve notice of the 24 hour hold and take them away from other cases. Large rural regions have limited staffing and would struggle to implement this bill. We oppose allowing patients to be discharged when no placement can be located for them.

Persons Testifying: PRO: Senator Emily Randall, Prime Sponsor; Donald Bremner, citizen.

CON: Kari Reardon, Washington Defender Association, Washington Association of Criminal Defense Attorneys; Dimitry Davydow, Comprehensive Life Resources; Jaclyn Greenberg, Washington State Hospital Association; Dr. Ryan Keay, Academy College of Emergency Physicians; Steven Pearce, Citizens Commission on Human Rights; Angie Naylor, MultiCare, Washington Council for Behavioral Health.

OTHER: James McMahan, Washington Association of Sheriffs & Police Chiefs; Darya Farivar, Disability Rights Washington; Chris Bandoli, Association of Washington Healthcare Plans; Noah Seidel, Office of Developmental Disabilities Ombuds; Brad Banks, Behavioral Health Administrative Services Organizations—County Administered.

Persons Signed In To Testify But Not Testifying: No one.