HOUSE BILL REPORT
HB 1877

As Reported by House Committee On:
Civil Rights & Judiciary
Appropriations

Title: An act relating to improving the Washington state behavioral health system for better coordination and recognition with the Indian behavioral health system.

Brief Description: Improving the Washington state behavioral health system for better coordination and recognition with the Indian behavioral health system.

Sponsors: Representatives Lekanoff, Stearns, Ortiz-Self, Ramel, Ramos, Cortes, Reed, Ormsby, Macri, Street, Paul, Gregerson, Doglio, Callan, Orwall, Mena, Wylie, Reeves, Pollet, Davis and Shavers.

Brief History:

Committee Activity:

Civil Rights & Judiciary: 1/23/24, 1/30/24 [DPS];
Appropriations: 2/3/24, 2/5/24 [DP2S(w/o sub CRJ)].

Brief Summary of Second Substitute Bill

- Includes tribes, Indian health care providers, and tribal entities in processes under the Involuntary Treatment Act (ITA), including: providing tribes with notice and a limited right to intervene when a member is subject to ITA proceedings, requiring designated crisis responders (DCRs) to collaborate with tribal law enforcement, and requiring behavioral health service providers to accept tribal court orders from tribes in Washington.
- Requires the Health Care Authority (HCA) to develop guidelines for culturally appropriate evaluations of American Indians and Alaska Natives and consult with tribal governments on DCR protocols.
- Allows tribes to seek reimbursement from the HCA for judicial costs of civil commitment proceedings, and allows the HCA to make grants or

---

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.

purchase services from tribes for community behavioral health programs.

- Adds tribal entities and Indian health care providers to provisions allowing disclosure of mental health information and records of court proceedings for specified purposes.

HOUSE COMMITTEE ON CIVIL RIGHTS & JUDICIARY

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 11 members: Representatives Taylor, Chair; Farivar, Vice Chair; Walsh, Ranking Minority Member; Graham, Assistant Ranking Minority Member; Abbarno, Cheney, Entenman, Goodman, Peterson, Thai and Walen.

Staff: Edie Adams (786-7180).

Background:

The Involuntary Treatment Act (ITA) sets forth the procedures, rights, and requirements for involuntary behavioral health treatment for adults. In 2020 legislation was enacted that incorporated tribes, tribal entities, and Indian health care providers within the processes and requirements of the ITA. There are 29 federally recognized Indian tribes in Washington. Health care on tribal lands is provided through an Indian health care delivery system that is supported by the federal Indian Health Service and provides care in urban and rural areas. Behavioral health services are provided by Indian health care providers and Urban Indian Health Programs, and include outpatient mental health, outpatient substance use disorder, and inpatient substance use disorder programs.

Under the ITA, a person may be committed by a court for involuntary behavioral health treatment if the person, 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 treatment. The provisions governing involuntary treatment of minors over the age of 13 are parallel with the adult ITA in many respects.

Designated crisis responders (DCRs) are responsible for investigating and determining whether a person may be in need of involuntary treatment. A DCR may be a mental health professional appointed by the Health Care Authority (HCA) in consultation with a federally recognized Indian tribe or after meeting and conferring with an Indian health care provider.

If the DCR finds a basis for commitment, the DCR may detain or petition a court to order detention for the person for up to 120 hours, excluding weekends and holidays, to an evaluation and treatment facility, secure detoxification facility, or approved substance use disorder treatment facility. After the initial 120-hour detention, the facility providing treatment may petition the court to have the person committed for further behavioral health

treatment for 14 days. Upon subsequent petitions and hearings, a court may order up to an additional 90 days of commitment at a state hospital, followed by successive terms of up to 180 days of commitment. When entering an order for involuntary treatment at any stage, the court must order an appropriate less restrictive alternative (LRA) course of treatment rather than inpatient treatment if the court finds that LRA treatment is in the best interest of the person.

When a DCR conducts an investigation or evaluation of a person for potential initial detention or involuntary outpatient treatment and the DCR knows the person is an American Indian or Alaska Native from a tribe in Washington, the DCR must notify the tribe or Indian health care provider as to whether or not a petition will be filed. The notification must occur within three hours and be made to the tribal contact identified in the HCA's tribal crisis coordination plan. A facility discharging a person who is an American Indian or Alaska Native from a tribe in Washington and who has been subject to an involuntary commitment order must provide notice of the discharge to the federally recognized tribe or Indian health care provider if the DCR has been appointed by the HCA.

If a DCR decides not to detain a person for evaluation and treatment or if 48 hours have passed since a DCR received a request for investigation and the DCR has not taken action to have the person detained, an immediate family member or guardian or conservator of the person, or a federally recognized Indian tribe if the person is a member of the tribe, may petition the superior court for initial detention.

Tribal court orders for involuntary commitment are to be recognized and enforced according to superior court rules governing tribal court jurisdiction.

Designated Crisis Responder Protocols.
The HCA is responsible for developing and updating statewide protocols to be used by DCRs and professional persons in administration of the involuntary treatment laws for adults and minors. The protocols must provide for uniform development and application criteria in evaluation and commitment recommendations relating to persons who may have behavioral health disorders. The protocols must be developed and updated in consultation with DCRs, the Department of Social and Health Services, local government, law enforcement, county and city prosecutors, public defenders, and groups concerned with behavioral health disorders.

Confidentiality of Health Care Information.
The state Uniform Health Care Information Act (UHCIA) governs the disclosure of health care information by health care providers and their agents or employees. The UHCIA provides that a health care provider may not disclose health care information about a patient unless there is a statutory exception or a written authorization by the patient. With respect to records relating to mental health services, 2020 legislation explicitly included Indian health care providers among qualified professional persons who may share information and records related to mental health and civil commitment services, included tribal courts

among courts who may interact with information and records related to mental health services, and allowed mental health information sharing by Indian health care providers for the purpose of care coordination.

Reimbursement of Judicial Costs.
A county may apply to its behavioral health administrative services organization (BHASO) on a quarterly basis for reimbursement of its costs in providing judicial services for civil commitment cases. Reimbursement per commitment case is based on an independent assessment of the county's actual direct costs. In counties where there is no significant history of similar cases, the reimbursement rate must be 80 percent of the median reimbursement rate of counties included in the independent assessment. The BHASO may in turn seek reimbursement from the BHASO that serves the county of residence of the individual who is the subject of the commitment case.

Tribal-State Crisis Coordination Plans.
The HCA and Indian tribes develop and agree on protocols for coordinating behavioral health crisis services, care coordination, and discharge and transition planning for tribal members. The plans address requirements and procedures relating to access to tribal lands by DCRs and mobile crisis teams, notice and coordination with Indian health care providers during and after crisis services, including involuntary commitments, and transportation of tribal members for evaluation and treatment services. Behavioral health administrative services organizations, under their contract with the HCA, are required to comply with tribal-state crisis coordination plans.

Summary of Substitute Bill:

Involuntary Treatment Act provisions governing adults and minors are revised to further incorporate tribes, Indian health care providers, and tribal entities in ITA processes and requirements.

"Behavioral health service provider" includes entities with a tribal attestation that they meet minimum standards or licensed or certified behavioral health agencies, and correctional facilities operated by tribal governments. The definition of "medical clearance" is revised to specifically include determinations by Indian health care providers and to state that, for a person presenting in the community, medical clearance is not required prior to investigation by a DCR. "Tribe" means a federally recognized Indian tribe.

A tribe has the right to intervene in civil commitment court proceedings. The "right to intervene" means that the tribe may:

- attend court proceeding and speak in court;
- request copies of petitions filed and orders issued by the court;
- submit information to the court, including information about available tribal resources to coordinate services; and

- petition for initial detention of a person when a DCR has, after investigation, determined not to detain the person.

An agency, facility, or DCR must notify the tribe and Indian health care provider regarding any action that will be taken to enforce, modify, or revoke an LRA order or conditional release order for a person who is an American Indian or Alaska Native who receives medical or behavioral health services from a tribe in Washington. The notice must be provided as soon as possible, but no later than three hours from the time the decision to take action is made. If proceedings for initial detention, involuntary outpatient treatment, or enforcement action for an LRA order are taken, the agency, facility, or DCR must provide the tribe and Indian health care provider with a copy of the petition, together with any orders issued by the court and a notice of the tribe's right to intervene, as soon as possible but before any hearing and no later than 24 hours from the time the petition is served upon the person. The court clerk must provide copies of any court orders necessary for an agency, facility, or DCR to provide required notices to a tribe or Indian health care provider.

When a facility providing involuntary treatment services discharges a person who the facility knows or has reason to know is an American Indian or Alaska Native who receives medical or behavioral health services from a tribe in Washington, the facility must provide notice of the person's discharge to the tribal contact listed in the HCA's crisis coordination plan. A facility providing substance use disorder services must attempt to obtain a release of information before discharge to meet the notice requirement.

Behavioral health service providers are required to accept tribal court orders from tribes located within the state on the same basis as state court orders issued under the ITA. Provisions stating that tribal court orders for involuntary commitments must be recognized and enforced in accordance with court rule are removed. Nothing in the involuntary treatment laws governing adults and minors may be read as an assertion of state jurisdiction or regulatory authority over a tribe.

Designated crisis responders must respond to referrals from tribal law enforcement officers and tribal law enforcement agencies and must collaborate and coordinate with tribal law enforcement regarding apprehensions and detentions when a court enters an initial detention order in a proceeding brought by a tribe if the person is a member of the tribe. Each person detained or committed for evaluation or treatment under the ITA has the right to treatment by cultural or spiritual means through practices that are in accordance with a tribal or cultural tradition.

The HCA, in consultation with tribes and in coordination with the Indian health care providers and the American Indian Health Commission for Washington State, must establish written guidelines for conducting culturally appropriate evaluations of American Indians or Alaska Natives by December 31, 2024. The HCA must consult with tribal governments when developing and updating statewide protocols for use by DCRs and

professional persons.

Files and records of court proceedings under the involuntary treatment laws for adults and minors are accessible to a tribal prosecuting attorney, and to a tribe or Indian health care provider who has the right to intervene and receive copies of court orders issued in civil commitment proceedings. State health information privacy laws are amended to explicitly include Indian health care providers, tribal courts, tribal prosecutors, tribal law enforcement, and tribal public health officers in exemptions allowing disclosure of mental health information for specified purposes to qualified professionals and state and local courts, prosecutors, law enforcement, and public health officers.

A tribe may apply to the HCA on a quarterly basis for reimbursement of its direct costs in providing judicial services for civil commitment cases. The director of the HCA may make grants and/or purchase services from tribes to establish and operate community behavioral health programs.

Behavioral health administrative services organizations must comply with, and ensure their contractors comply with, tribal crisis coordination plans agreed upon by the HCA and tribes for coordination of crisis services, care coordination, and discharge and transition planning with tribes and Indian health care providers applicable to their regional service areas.

The Administrative Office of the Courts (AOC), in consultation with the HCA, must develop and update court forms for use by DCRs by December 1, 2024, and superior courts must allow tribal DCRs to use court forms developed by AOC by January 1, 2025.

Substitute Bill Compared to Original Bill:

The substitute bill removes the requirement that the court forms developed by the AOC for use by DCRs be model forms.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available.

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

Staff Summary of Public Testimony:

(In support) This bill represents a great opportunity for Washington to remove barriers to collaboration and recognition of tribal governments as sovereign nations in the behavioral health system. Tribal programs and services are staffed by highly qualified providers who have unique knowledge and understanding of the complex factors that contribute to tribal

peoples' histories, behavioral health experiences, and challenges, and they are at a level of sophistication to be able to engage collectively with the state system.

Tribal communities experience higher rates of behavioral health problems, especially post-traumatic stress disorder, suicide, and substance use disorders. So many tribal members have been lost to drug and opioid-related impacts, which has been devastating to tribal communities. Crisis response services need to be delivered in a tribal-centric way and according to culturally unique approaches and practices, with no gaps, no barriers, and no delays. The bill recognizes this as well as tribal sovereignty and authority over tribal courts, and improves effective coordination of the respective systems to benefit tribal communities.

This bill is a continuation of improvements made in the 2020 Indian Behavioral Health Act to try to find and address gaps and barriers in the system. Current barriers make it hard for tribes to seek involuntary treatment or follow their tribal members who are involved with the state's crisis system. This bill was developed in partnership with tribes, DCRs, and the HCA, with input from the Governor's Office, the Attorney General's Office, and others. This bill is very important and will result in beneficial impacts for tribal communities. It will ensure the inclusion of tribes, Indian health care providers, and various tribal entities within the system, and provide tribes with notice and a limited right to intervene when a member is subject to a civil commitment proceeding. It also provides for the development of guidelines for culturally appropriate evaluations of American Indians and Alaska Natives and requires consultation with tribal governments on DCR protocols.

(Opposed) None.

(Other) The HCA is generally supportive of the goals of this bill, recognizing that the state's ITA system is complex and difficult for tribes to navigate, but it will require additional resources for the HCA to implement. The bill makes critical adjustments to the role tribes play in the ITA for tribal members, including delineating the roles of cultural healing, tribal courts, crisis response, and tribal intervention in actions that impact American Indians and Alaska Natives.

Persons Testifying: (In support) Representative Debra Lekanoff, prime sponsor; Misty Napeahi, Tulalip Tribes of Washington; Vicki Lowe, American Indian Health Commission and Washington State Women's Commission; and Rosalee Revey-Jacobs, Lummi Nation.

(Other) Aren Sparck, Health Care Authority.

Persons Signed In To Testify But Not Testifying: None.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second

substitute bill do pass and do not pass the substitute bill by Committee on Civil Rights & Judiciary. Signed by 30 members: Representatives Ormsby, Chair; Bergquist, Vice Chair; Gregerson, Vice Chair; Macri, Vice Chair; Corry, Ranking Minority Member; Chambers, Assistant Ranking Minority Member; Connors, Assistant Ranking Minority Member; Couture, Assistant Ranking Minority Member; Berg, Callan, Chopp, Davis, Dye, Fitzgibbon, Harris, Lekanoff, Pollet, Riccelli, Rude, Ryu, Sandlin, Schmick, Senn, Simmons, Slatter, Springer, Stokesbary, Stonier, Tharinger and Wilcox.

Staff: Andy Toulon (786-7178).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Civil Rights & Judiciary:

The Appropriations Committee added a clause making the bill null and void unless funded in the budget.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available.

Effective Date of Second Substitute Bill: The bill contains multiple effective dates. Please see the bill. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony:

(In support) The opioid and fentanyl crisis is racing through tribal households and communities. The bill provides a great opportunity for collaboration on policy at the tribal, state, local, and federal levels. It removes barriers, acknowledges tribal sovereignty, and provides an opportunity to save lives.

(Opposed) None.

Persons Testifying: Representative Debra Lekanoff, prime sponsor.

Persons Signed In To Testify But Not Testifying: Vicki Lowe, American Indian Health Commission and Washington State Women's Commission.