SENATE BILL REPORT
2SHB 1877

As of February 23, 2024

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: House Committee on Appropriations (originally sponsored by 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: Passed House: 2/9/24, 97-0.
Committee Activity: Law & Justice: 2/19/24, 2/20/24 [DP-WM].
Ways & Means: 2/23/24.

Brief Summary of Bill

- Allows county and tribal prosecuting attorneys to access closed court records under the Involuntary Treatment Act.
- Requires the Health Care Authority (HCA) to reimburse tribes for their court costs under the Involuntary Treatment Act.
- Allows tribes to intervene in Involuntary Treatment Act hearings involving tribal members.
- Enhances notification requirements to tribes and Indian health care providers when American Indians and Alaska Natives interact with the involuntary treatment system.
- Requires HCA to establish written guidelines for culturally competent involuntary treatment evaluations for American Indians and Alaska Natives.

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.

SENATE COMMITTEE ON LAW & JUSTICE

Majority Report: Do pass and be referred to Committee on Ways & Means.
Signed by Senators Dhingra, Chair; Trudeau, Vice Chair; Padden, Ranking Member; Kuderer, McCune, Pedersen, Salomon, Torres, Valdez, Wagoner and Wilson, L..

Staff: Kevin Black (786-7747)

SENATE COMMITTEE ON WAYS & MEANS

Staff: Corban Nemeth (786-7736)

Background: Involuntary Behavioral Health Treatment. The Involuntary Treatment Act sets forth the procedures, rights, and requirements for involuntary behavioral health treatment. Under this act, 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.

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 a managed care organization, or 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 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 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.

Indian Tribes in Washington. 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.

Designated Crisis Responder Protocols. 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 (BH-ASO) 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 BH-ASO may in turn seek reimbursement from the BH-ASO 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 Bill: Closed court records under the Involuntary Treatment Act must be made available to county prosecuting attorneys, tribal prosecuting attorneys, Indian health care providers, and tribes.

HCA must reimburse tribal courts for their court costs under the Involuntary Treatment Act on a quarterly basis.

A tribe may intervene in a proceeding under the Involuntary Treatment Act involving a member of their tribe, including by attending court proceedings, speaking in court, requesting copies of court documents, and submitting information to the court about tribal resources. Behavioral health agencies must accept tribal court orders on the same basis as state court orders.

Medical clearance may not be required for a person in the community before investigation by a designated crisis responder.

In a petition for involuntary treatment, a petition for revocation of an LRA treatment order, or a petition for assisted outpatient treatment, when a petitioner or BH-ASO knows or has reason to know that the person is an American Indian or Alaska Native, the petitioner or BH-ASO must notify the tribe and Indian health provider before the hearing and no later than three hours after the initial detention or LRA revocation decision is made, or 24 hours from the time an assisted outpatient treatment petition is served upon the person. Notice must include copies of relevant court documents and notice of the tribe's right to intervene. When the person is discharged, notice must be provided to the tribal contact listed in HCA's tribal crisis coordination plan, to the extent permitted by federal regulations.

A person detained under the Involuntary Treatment Act, in addition to receiving other treatment, has the right to not be denied access to treatment by cultural or spiritual means through practices in accordance with a tribal or cultural tradition.

HCA must establish written guidelines by December 31, 2024, for conducting culturally appropriate involuntary treatment evaluations for American Indians and Alaska Natives, in consultation with Indian health care providers and the American Indian Health Commission.

The Administrative Office of Courts must update court forms related to the Involuntary Treatment Act by December 1, 2024. A person summoned to an outpatient involuntary commitment evaluation may be accompanied by a traditional cultural healer. References to law enforcement are updated to include tribal law enforcement, references to prosecuting attorneys are updated to include tribal prosecuting attorneys, references to governments are updated to include tribal governments, references to courts are updated to include tribal courts, and references to public health authorities are updated to include tribal public health authorities. Behavioral health agencies who may provide medical clearance before detention for involuntary treatment must include Indian health care providers. HCA must consult with trial governments in updated designated crisis responder protocols. BH-ASOs must collaborate with tribal governments, and comply with the tribal crisis coordination plan agreed upon between HCA and tribes for coordination of crisis services.

Appropriation: The bill contains a null and void clause requiring specific funding be provided in an omnibus appropriation act.

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 (Law & Justice): PRO: This bill is one piece of a larger puzzle to improve coordination between tribes and local governments during crisis. We now have our first tribal designated crisis responder and are developing other programs including behavioral health aides, mobile crisis teams, and tribal crisis protocol plans. This bill helps with coordination. We have lost a lot of lives, but this bill gives us hope that things will go better.

Persons Testifying (Law & Justice): PRO: Vicki Lowe, American Indian Health Commission for Washington State.

Persons Signed In To Testify But Not Testifying (Law & Justice): No one.

Staff Summary of Public Testimony (Ways & Means): PRO: This bill is a small piece of a lot of work we have been doing. Tribal members are Washingtonians and have been eligible for these services since 1986. In 2019, we realized the gap in service that is creating this need. In terms of the fiscal impact of the bill, costs are matched 100 percent with federal funds when tribal providers see American Indian/Alaska Native clients under the Medicaid program, which would reduce costs.

OTHER: I have had several visits of crisis services to my own home to talk about people who use methamphetamines and act erratically. With this bill, I worry that crisis services are strapped and can't deliver on what they already need to do. It's premature to expand this into the tribal setting. We need more money for tribal services.

Persons Testifying (Ways & Means): PRO: Vicki Lowe, American Indian Health Commission for WA State.

OTHER: Nanci Watson.

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