Title 71

BEHAVIORAL HEALTH

(Formerly: Mental illness)

Chapters

Alcoholism, intoxication, and drug addiction treatment: Chapter 70.96 RCW.

Center for research and training in intellectual and developmental disabilities: RCW 28B.20.410 through 28B.20.414.

County hospitals: Chapter 36.62 RCW.

Harrison Memorial Hospital: RCW 72.29.010.

Interstate compact on mental health: Chapter 72.27 RCW.

Jurisdiction over Indians concerning mental illness: Chapter 37.12 RCW.

Mental health: Chapter 72.06 RCW.

Nonresident individuals with mental illness, sexual psychopaths, and psychopathic delinquents: Chapter 72.25 RCW.

State hospitals for individuals with mental illness: Chapter 72.23 RCW.

Chapter 71.02 RCW
REIMBURSEMENT OF COSTS FOR TREATMENT

Sections

Commitment to veterans' administration or other federal agency: RCW 73.36.165.

Criminally insane—Procedures, rights, and responsibilities: Chapter 10.77 RCW.

Mental illness: Chapter 71.05 RCW.

State hospitals for individuals with mental illness: Chapter 72.23 RCW.

Voluntary patients: RCW 72.23.080 through 72.23.120.

71.02.490 Authority over patient—Federal agencies, private establishments. The United States veterans' administration, or other United States government agency, or the chief officer of a private facility shall have the same powers as are conferred upon the superintendent of a state hospital with reference to retention, transfer, parole, or discharge of mentally ill persons ordered hospitalized in their facilities. [1959 c 25 § 71.02.490. Prior: 1951 c 139 § 26.]

Commitment to veterans' administration or other federal agency: RCW 73.36.165.

71.02.900 Construction and purpose—1959 c 25. The provisions of this chapter shall be liberally construed so that persons who are in need of care and treatment for mental illness shall receive humane care and treatment and be restored to normal mental condition as rapidly as possible with an avoidance of loss of civil rights where not necessary, and with as little formality as possible, still preserving all rights and all privileges of the person as guaranteed by the Constitution. [1959 c 25 § 71.02.900. Prior: 1951 c 139 § 1; 1949 c 198 § 1; Rem. Supp. 1949 § 6953-1.]

Chapter 71.05 RCW
BEHAVIORAL HEALTH DISORDERS

(Formerly: Mental illness)

Sections

Rules of court: *Cf. Superior Court Mental Proceedings Rules (MPR).*

Council for children and families: Chapter 43.121 RCW.

Minors—Mental health services, commitment: Chapter 71.34 RCW.

71.05.010 Legislative intent. (1) The provisions of this chapter apply to persons who are eighteen years of age or older and are intended by the legislature:

(a) To protect the health and safety of persons suffering from behavioral health disorders and to protect public safety through use of the parens patriae and police powers of the state;

(b) To prevent inappropriate, indefinite commitment of persons living with behavioral health disorders and to eliminate legal disabilities that arise from such commitment;

(c) To provide prompt evaluation and timely and appropriate treatment of persons with serious behavioral health disorders;

(d) To safeguard individual rights;

(e) To provide continuity of care for persons with serious behavioral health disorders;

(f) To encourage the full use of all existing agencies, professional personnel, and public funds to prevent duplication of services and unnecessary expenditures; and

(g) To encourage, whenever appropriate, that services be provided within the community.

(2) When construing the requirements of this chapter the court must focus on the merits of the petition, except where requirements have been totally disregarded, as provided in *In re C.W.*, 147 Wn.2d 259, 281 (2002). A presumption in favor of deciding petitions on their merits furthers both public and private interests because the mental and physical well-being of individuals as well as public safety may be implicated by the decision to release an individual and discontinue his or her treatment. [2020 c 302 § 1; 2016 sp.s. c 29 § 203; 2015 c 269 § 1; 1998 c 297 § 2; 1997 c 112 § 2; 1989 c 120 § 1; 1973 1st ex.s. c 142 § 6.]

Short title—2016 sp.s. c 29: "This act may be known and cited as Ricky Garcia's act." [2016 sp.s. c 29 § 801.]

Right of action—2016 sp.s. c 29: "This act does not create any new entitlement or cause of action related to civil commitment under this chapter,

and cannot form the basis for a private right of action." [2016 sp.s. c 29 § 802.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Effective date—2015 c 269 §§ 1-9 and 11-13: "Sections 1 through 9 and 11 through 13 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect immediately [May 14, 2015]." [2015 c 269 § 20.]

Intent—1998 c 297: "It is the intent of the legislature to: (1) Clarify that it is the nature of a person's current conduct, current mental condition, history, and likelihood of committing future acts that pose a threat to public safety or himself or herself, rather than simple categorization of offenses, that should determine treatment procedures and level; (2) improve and clarify the sharing of information between the mental health and criminal justice systems; and (3) provide additional opportunities for mental health treatment for persons whose conduct threatens himself or herself or threatens public safety and has led to contact with the criminal justice system.

The legislature recognizes that a person can be incompetent to stand trial, but may not be gravely disabled or may not present a likelihood of serious harm. The legislature does not intend to create a presumption that a person who is found incompetent to stand trial is gravely disabled or presents a likelihood of serious harm requiring civil commitment." [1998 c 297 § 1.]

Additional notes found at www.leg.wa.gov

71.05.012 Legislative intent and finding. It is the intent of the legislature to enhance continuity of care for persons with serious behavioral health disorders that can be controlled or stabilized in a less restrictive alternative commitment. Within the guidelines stated in *In re LaBelle* 107 Wn. 2d 196 (1986), the legislature intends to encourage appropriate interventions at a point when there is the best opportunity to restore the person to or maintain satisfactory functioning.

For persons with a prior history or pattern of repeated hospitalizations or law enforcement interventions due to decompensation, the consideration of prior history is particularly relevant in determining whether the person would receive, if released, such care as is essential for his or her health or safety.

Therefore, the legislature finds that for persons who are currently under a commitment order, a prior history of decompensation leading to repeated hospitalizations or law enforcement interventions should be given great weight in determining whether a new less restrictive alternative commitment should be ordered. [2020 c 302 § 2; 1997 c 112 § 1.]

71.05.020 Definitions. ***(Contingent expiration date.)*** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Admission" or "admit" means a decision by a physician, physician assistant, or psychiatric advanced registered nurse practitioner that a person should be examined or treated as a patient in a hospital;

(2) "Alcoholism" means a disease, characterized by a dependency on alcoholic beverages, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued, and impairment of health or disruption of social or economic functioning;

(3) "Antipsychotic medications" means that class of drugs primarily used to treat serious manifestations of mental illness associated with thought disorders, which includes, but is not limited to atypical antipsychotic medications;

(4) "Approved substance use disorder treatment program" means a program for persons with a substance use disorder provided by a treatment program certified by the department as meeting standards adopted under chapter 71.24 RCW;

(5) "Attending staff" means any person on the staff of a public or private agency having responsibility for the care and treatment of a patient;

(6) "Authority" means the Washington state health care authority;

(7) "Behavioral health disorder" means either a mental disorder as defined in this section, a substance use disorder as defined in this section, or a co-occurring mental disorder and substance use disorder;

(8) "Behavioral health service provider" means a public or private agency that provides mental health, substance use disorder, or co-occurring disorder services to persons with behavioral health disorders as defined under this section and receives funding from public sources. This includes, but is not limited to: Hospitals licensed under chapter 70.41 RCW; evaluation and treatment facilities as defined in this section; community mental health service delivery systems or community behavioral health programs as defined in RCW 71.24.025; licensed or certified behavioral health agencies under RCW 71.24.037; facilities conducting competency evaluations and restoration under chapter 10.77 RCW; approved substance use disorder treatment programs as defined in this section; secure withdrawal management and stabilization facilities as defined in this section; and correctional facilities operated by state and local governments;

(9) "Co-occurring disorder specialist" means an individual possessing an enhancement granted by the department of health under chapter 18.205 RCW that certifies the individual to provide substance use disorder counseling subject to the practice limitations under RCW 18.205.105;

(10) "Commitment" means the determination by a court that a person should be detained for a period of either evaluation or treatment, or both, in an inpatient or a less restrictive setting;

(11) "Community behavioral health agency" has the same meaning as "licensed or certified behavioral health agency" defined in RCW 71.24.025;

(12) "Conditional release" means a revocable modification of a commitment, which may be revoked upon violation of any of its terms;

(13) "Crisis stabilization unit" means a short-term facility or a portion of a facility licensed or certified by the department, such as an evaluation and treatment facility or a hospital, which has been designed to assess, diagnose, and treat individuals experiencing an acute crisis without the use of long-term hospitalization;

(14) "Custody" means involuntary detention under the provisions of this chapter or chapter 10.77 RCW, uninterrupted by any period of unconditional release from commitment from a facility providing involuntary care and treatment;

(15) "Department" means the department of health;

(16) "Designated crisis responder" means a mental health professional appointed by the county, by an entity appointed by the county, or by the authority in consultation with a federally recognized Indian tribe or after meeting and conferring with an Indian health care provider, to perform the duties specified in this chapter;

(17) "Detention" or "detain" means the lawful confinement of a person, under the provisions of this chapter;

(18) "Developmental disabilities professional" means a person who has specialized training and three years of experience in directly treating or working with persons with developmental disabilities and is a psychiatrist, physician assistant working with a supervising psychiatrist, psychologist, psychiatric advanced registered nurse practitioner, or social worker, and such other developmental disabilities professionals as may be defined by rules adopted by the secretary of the department of social and health services;

(19) "Developmental disability" means that condition defined in *RCW 71A.10.020(5);

(20) "Director" means the director of the authority;

(21) "Discharge" means the termination of hospital medical authority. The commitment may remain in place, be terminated, or be amended by court order;

(22) "Drug addiction" means a disease, characterized by a dependency on psychoactive chemicals, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued, and impairment of health or disruption of social or economic functioning;

(23) "Evaluation and treatment facility" means any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the department. The authority may certify single beds as temporary evaluation and treatment beds under RCW 71.05.745. A physically separate and separately operated portion of a state hospital may be designated as an evaluation and treatment facility. A facility which is part of, or operated by, the department of social and health services or any federal agency will not require certification. No correctional institution or facility, or jail, shall be an evaluation and treatment facility within the meaning of this chapter;

(24) "Gravely disabled" means a condition in which a person, as a result of a behavioral health disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety;

(25) "Habilitative services" means those services provided by program personnel to assist persons in acquiring and maintaining life skills and in raising their levels of physical, mental, social, and vocational functioning. Habilitative services include education, training for employment, and therapy. The habilitative process shall be undertaken with recognition of the risk to the public safety presented by the person being assisted as manifested by prior charged criminal conduct;

(26) "Hearing" means any proceeding conducted in open court that conforms to the requirements of RCW 71.05.820;

(27) "History of one or more violent acts" refers to the period of time ten years prior to the filing of a petition under this chapter, excluding any time spent, but not any violent acts committed, in a behavioral health facility, or in confinement as a result of a criminal conviction;

(28) "Imminent" means the state or condition of being likely to occur at any moment or near at hand, rather than distant or remote;

(29) "In need of assisted outpatient treatment" refers to a person who meets the criteria for assisted outpatient treatment established under RCW 71.05.148;

(30) "Individualized service plan" means a plan prepared by a developmental disabilities professional with other professionals as a team, for a person with developmental disabilities, which shall state:

(a) The nature of the person's specific problems, prior charged criminal behavior, and habilitation needs;

(b) The conditions and strategies necessary to achieve the purposes of habilitation;

(c) The intermediate and long-range goals of the habilitation program, with a projected timetable for the attainment;

(d) The rationale for using this plan of habilitation to achieve those intermediate and long-range goals;

(e) The staff responsible for carrying out the plan;

(f) Where relevant in light of past criminal behavior and due consideration for public safety, the criteria for proposed movement to less-restrictive settings, criteria for proposed eventual discharge or release, and a projected possible date for discharge or release; and

(g) The type of residence immediately anticipated for the person and possible future types of residences;

(31) "Intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol or other psychoactive chemicals;

(32) "Judicial commitment" means a commitment by a court pursuant to the provisions of this chapter;

(33) "Legal counsel" means attorneys and staff employed by county prosecutor offices or the state attorney general acting in their capacity as legal representatives of public behavioral health service providers under RCW 71.05.130;

(34) "Less restrictive alternative treatment" means a program of individualized treatment in a less restrictive setting than inpatient treatment that includes the services described in RCW 71.05.585. This term includes: Treatment pursuant to a less restrictive alternative treatment order under RCW 71.05.240 or 71.05.320; treatment pursuant to a conditional release under RCW 71.05.340; and treatment pursuant to an assisted outpatient treatment order under RCW 71.05.148;

(35) "Licensed physician" means a person licensed to practice medicine or osteopathic medicine and surgery in the state of Washington;

(36) "Likelihood of serious harm" means:

(a) A substantial risk that: (i) Physical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by a person upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or (iii) physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or

(b) The person has threatened the physical safety of another and has a history of one or more violent acts;

(37) "Medical clearance" means a physician or other health care provider has determined that a person is medically stable and ready for referral to the designated crisis responder;

(38) "Mental disorder" means any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions;

(39) "Mental health professional" means a psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or social worker, and such other mental health professionals as may be defined by rules adopted by the secretary pursuant to the provisions of this chapter;

(40) "Peace officer" means a law enforcement official of a public agency or governmental unit, and includes persons specifically given peace officer powers by any state law, local ordinance, or judicial order of appointment;

(41) "Physician assistant" means a person licensed as a physician assistant under chapter 18.71A RCW;

(42) "Private agency" means any person, partnership, corporation, or association that is not a public agency, whether or not financed in whole or in part by public funds, which constitutes an evaluation and treatment facility or private institution, or hospital, or approved substance use disorder treatment program, which is conducted for, or includes a department or ward conducted for, the care and treatment of persons with behavioral health disorders;

(43) "Professional person" means a mental health professional, substance use disorder professional, or designated crisis responder and shall also mean a physician, physician assistant, psychiatric advanced registered nurse practitioner, registered nurse, and such others as may be defined by rules adopted by the secretary pursuant to the provisions of this chapter;

(44) "Psychiatric advanced registered nurse practitioner" means a person who is licensed as an advanced registered nurse practitioner pursuant to chapter 18.79 RCW; and who is board certified in advanced practice psychiatric and mental health nursing;

(45) "Psychiatrist" means a person having a license as a physician and surgeon in this state who has in addition completed three years of graduate training in psychiatry in a program approved by the American medical association or the American osteopathic association and is certified or eligible to be certified by the American board of psychiatry and neurology;

(46) "Psychologist" means a person who has been licensed as a psychologist pursuant to chapter 18.83 RCW;

(47) "Public agency" means any evaluation and treatment facility or institution, secure withdrawal management and stabilization facility, approved substance use disorder treatment program, or hospital which is conducted for, or includes a department or ward conducted for, the care and treatment of persons with behavioral health disorders, if the agency is operated directly by federal, state, county, or municipal government, or a combination of such governments;

(48) "Release" means legal termination of the commitment under the provisions of this chapter;

(49) "Resource management services" has the meaning given in chapter 71.24 RCW;

(50) "Secretary" means the secretary of the department of health, or his or her designee;

(51) "Secure withdrawal management and stabilization facility" means a facility operated by either a public or private agency or by the program of an agency which provides care to voluntary individuals and individuals involuntarily detained and committed under this chapter for whom there is a likelihood of serious harm or who are gravely disabled due to the presence of a substance use disorder. Secure withdrawal management and stabilization facilities must:

(a) Provide the following services:

(i) Assessment and treatment, provided by certified substance use disorder professionals or co-occurring disorder specialists;

(ii) Clinical stabilization services;

(iii) Acute or subacute detoxification services for intoxicated individuals; and

(iv) Discharge assistance provided by certified substance use disorder professionals or co-occurring disorder specialists, including facilitating transitions to appropriate voluntary or involuntary inpatient services or to less restrictive alternatives as appropriate for the individual;

(b) Include security measures sufficient to protect the patients, staff, and community; and

(c) Be licensed or certified as such by the department of health;

(52) "Social worker" means a person with a master's or further advanced degree from a social work educational program accredited and approved as provided in RCW 18.320.010;

(53) "Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using the substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances;

(54) "Substance use disorder professional" means a person certified as a substance use disorder professional by the department of health under chapter 18.205 RCW;

(55) "Therapeutic court personnel" means the staff of a mental health court or other therapeutic court which has jurisdiction over defendants who are dually diagnosed with mental disorders, including court personnel, probation officers, a court monitor, prosecuting attorney, or defense counsel acting within the scope of therapeutic court duties;

(56) "Treatment records" include registration and all other records concerning persons who are receiving or who at any time have received services for behavioral health disorders, which are maintained by the department of social and health services, the department, the authority, behavioral health administrative services organizations and their staffs, managed care organizations and their staffs, and by treatment facilities. Treatment records include mental health information contained in a medical bill including but not limited to mental health drugs, a mental health diagnosis, provider name, and dates of service stemming from a medical service. Treatment records do not include notes or records maintained

for personal use by a person providing treatment services for the department of social and health services, the department, the authority, behavioral health administrative services organizations, managed care organizations, or a treatment facility if the notes or records are not available to others;

(57) "Triage facility" means a short-term facility or a portion of a facility licensed or certified by the department, which is designed as a facility to assess and stabilize an individual or determine the need for involuntary commitment of an individual, and must meet department residential treatment facility standards. A triage facility may be structured as a voluntary or involuntary placement facility;

(58) "Video," unless the context clearly indicates otherwise, means the delivery of behavioral health services through the use of interactive audio and video technology, permitting real-time communication between a person and a designated crisis responder, for the purpose of evaluation. "Video" does not include the use of audio-only telephone, facsimile, email, or store and forward technology. "Store and forward technology" means use of an asynchronous transmission of a person's medical information from a mental health service provider to the designated crisis responder which results in medical diagnosis, consultation, or treatment;

(59) "Violent act" means behavior that resulted in homicide, attempted suicide, injury, or substantial loss or damage to property. [2022 c 210 § 1. Prior: 2021 c 264 § 21; (2021 c 264 § 20 expired July 1, 2022); 2021 c 263 § 12; (2021 c 263 § 11 expired July 1, 2022); prior: 2020 c 302 § 3; 2020 c 256 § 301; 2020 c 80 § 51; 2020 c 5 § 1; prior: 2019 c 446 § 2; 2019 c 444 § 16; 2019 c 325 § 3001; prior: 2018 c 305 § 1; 2018 c 291 § 1; 2018 c 201 § 3001; 2017 3rd sp.s. c 14 § 14; prior: 2016 sp.s. c 29 § 204; 2016 c 155 § 1; prior: 2015 c 269 § 14; (2015 c 269 § 13 expired April 1, 2016); 2015 c 250 § 2; (2015 c 250 § 1 expired April 1, 2016); prior: 2014 c 225 § 79; prior: 2011 c 148 § 1; 2011 c 89 § 14; prior: 2009 c 320 § 1; 2009 c 217 § 20; 2008 c 156 § 1; prior: 2007 c 375 § 6; 2007 c 191 § 2; 2005 c 504 § 104; 2000 c 94 § 1; 1999 c 13 § 5; 1998 c 297 § 3; 1997 c 112 § 3; prior: 1989 c 420 § 13; 1989 c 205 § 8; 1989 c 120 § 2; 1979 ex.s. c 215 § 5; 1973 1st ex.s. c 142 § 7.]

***Reviser's note:** RCW 71A.10.020 was amended by 2022 c 277 § 2, changing subsection (5) to subsection (6).

Effective date—2022 c 210 §§ 1, 2, and 31: "Sections 1, 2, and 31 of this act take effect July 1, 2022." [2022 c 210 § 30.]

Effective date—2021 c 264 §§ 21 and 26: "Sections 21 and 26 of this act take effect July 1, 2022." [2021 c 264 § 38.]

Expiration date—2021 c 264 §§ 20 and 25: "Sections 20 and 25 of this act expire July 1, 2022." [2021 c 264 § 37.]

Effective date—2021 c 263 §§ 12 and 14: "Sections 12 and 14 of this act take effect July 1, 2022." [2021 c 263 § 25.]

Expiration date—2021 c 263 §§ 11 and 13: "Sections 11 and 13 of this act expire July 1, 2022." [2021 c 263 § 24.]

Application—2021 c 263: See note following RCW 10.77.150.

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective date—2018 c 291 §§ 1-4, 6, 7, 9, 11, 12, 13, and 15: "Sections 1 through 4, 6, 7, 9, 11, 12, 13, and 15 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect April 1, 2018." [2018 c 291 § 18.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2017 3rd sp.s. c 14 §§ 9, 12, 14, 15, and 17-21: See note following RCW 71.05.590.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2015 c 269 §§ 10 and 14: See note following RCW 71.24.300.

Expiration dates—2015 c 269 §§ 9, 13, and 15: See note following RCW 71.24.300.

Effective date—2015 c 269 §§ 1-9 and 11-13: See note following RCW 71.05.010.

Effective date—2015 c 250 §§ 2, 15, and 19: "Sections 2, 15, and 19 of this act take effect April 1, 2016." [2015 c 250 § 23.]

Expiration date—2015 c 250 §§ 1, 14, and 18: "Sections 1, 14, and 18 of this act expire April 1, 2016." [2015 c 250 § 22.]

Effective date—2014 c 225: See note following RCW 71.24.016.

Findings—2011 c 89: See RCW 18.320.005.

Findings—Purpose—Construction—Severability—2007 c 375: See notes following RCW 10.31.110.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Purpose—Construction—1999 c 13: See note following RCW 10.77.010.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.05.020 Definitions. *(Contingent effective date.)*

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Admission" or "admit" means a decision by a physician, physician assistant, or psychiatric advanced registered nurse practitioner that a person should be examined or treated as a patient in a hospital;

(2) "Alcoholism" means a disease, characterized by a dependency on alcoholic beverages, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued, and impairment of health or disruption of social or economic functioning;

(3) "Antipsychotic medications" means that class of drugs primarily used to treat serious manifestations of mental illness associated with thought disorders, which includes, but is not limited to atypical antipsychotic medications;

(4) "Approved substance use disorder treatment program" means a program for persons with a substance use disorder provided by a treatment program certified by the department as meeting standards adopted under chapter 71.24 RCW;

(5) "Attending staff" means any person on the staff of a public or private agency having responsibility for the care and treatment of a patient;

(6) "Authority" means the Washington state health care authority;

(7) "Behavioral health disorder" means either a mental disorder as defined in this section, a substance use disorder as defined in this section, or a co-occurring mental disorder and substance use disorder;

(8) "Behavioral health service provider" means a public or private agency that provides mental health, substance use disorder, or co-occurring disorder services to persons with behavioral health disorders as defined under this section and receives funding from public sources. This includes, but is not limited to: Hospitals licensed under chapter 70.41 RCW; evaluation and treatment facilities as defined in this section; community mental health service delivery systems or community behavioral health programs as defined in RCW 71.24.025; licensed or certified behavioral health agencies under RCW 71.24.037; facilities conducting competency evaluations and restoration under chapter 10.77 RCW; approved substance use disorder treatment programs as defined in this section; secure withdrawal management and stabilization facilities as defined in this section; and correctional facilities operated by state and local governments;

(9) "Co-occurring disorder specialist" means an individual possessing an enhancement granted by the department of health under chapter 18.205 RCW that certifies the individual to provide substance use disorder counseling subject to the practice limitations under RCW 18.205.105;

(10) "Commitment" means the determination by a court that a person should be detained for a period of either evaluation or treatment, or both, in an inpatient or a less restrictive setting;

(11) "Community behavioral health agency" has the same meaning as "licensed or certified behavioral health agency" defined in RCW 71.24.025;

(12) "Conditional release" means a revocable modification of a commitment, which may be revoked upon violation of any of its terms;

(13) "Crisis stabilization unit" means a short-term facility or a portion of a facility licensed or certified by the department, such as an evaluation and treatment facility or a hospital, which has been designed to assess, diagnose, and treat individuals experiencing an acute crisis without the use of long-term hospitalization;

(14) "Custody" means involuntary detention under the provisions of this chapter or chapter 10.77 RCW, uninterrupted by any period of unconditional release from commitment from a facility providing involuntary care and treatment;

(15) "Department" means the department of health;

(16) "Designated crisis responder" means a mental health professional appointed by the county, by an entity appointed by the county, or by the authority in consultation with a federally recognized Indian tribe or after meeting and conferring with an Indian health care provider, to perform the duties specified in this chapter;

(17) "Detention" or "detain" means the lawful confinement of a person, under the provisions of this chapter;

(18) "Developmental disabilities professional" means a person who has specialized training and three years of experience in directly treating or working with persons with developmental disabilities and is a psychiatrist, physician assistant working with a supervising psychiatrist, psychologist, psychiatric advanced registered nurse practitioner, or social worker, and such other developmental disabilities professionals as may be defined by rules adopted by the secretary of the department of social and health services;

(19) "Developmental disability" means that condition defined in *RCW 71A.10.020(5);

(20) "Director" means the director of the authority;

(21) "Discharge" means the termination of hospital medical authority. The commitment may remain in place, be terminated, or be amended by court order;

(22) "Drug addiction" means a disease, characterized by a dependency on psychoactive chemicals, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued, and impairment of health or disruption of social or economic functioning;

(23) "Evaluation and treatment facility" means any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the department. The authority may certify single beds as temporary evaluation and treatment beds under RCW 71.05.745. A physically separate and separately operated portion of a state hospital may be designated as an evaluation and treatment facility. A facility which is part of, or operated by, the department of social and health services or any federal agency will not require certification. No correctional institution or facility, or jail, shall be an evaluation and treatment facility within the meaning of this chapter;

(24) "Gravely disabled" means a condition in which a person, as a result of a behavioral health disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration from safe behavior evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety;

(25) "Habilitative services" means those services provided by program personnel to assist persons in acquiring and maintaining life skills and in raising their levels of physical, mental, social, and vocational functioning. Habilitative services include education, training for employment, and therapy. The habilitative process shall be undertaken with recognition of the risk to the public safety presented by the person being assisted as manifested by prior charged criminal conduct;

(26) "Hearing" means any proceeding conducted in open court that conforms to the requirements of RCW 71.05.820;

(27) "History of one or more violent acts" refers to the period of time ten years prior to the filing of a petition under this chapter, excluding any time spent, but not any violent acts committed, in a behavioral health facility, or in confinement as a result of a criminal conviction;

(28) "Imminent" means the state or condition of being likely to occur at any moment or near at hand, rather than distant or remote;

(29) "In need of assisted outpatient treatment" refers to a person who meets the criteria for assisted outpatient treatment established under RCW 71.05.148;

(30) "Individualized service plan" means a plan prepared by a developmental disabilities professional with other professionals as a team, for a person with developmental disabilities, which shall state:

(a) The nature of the person's specific problems, prior charged criminal behavior, and habilitation needs;

(b) The conditions and strategies necessary to achieve the purposes of habilitation;

(c) The intermediate and long-range goals of the habilitation program, with a projected timetable for the attainment;

(d) The rationale for using this plan of habilitation to achieve those intermediate and long-range goals;

(e) The staff responsible for carrying out the plan;

(f) Where relevant in light of past criminal behavior and due consideration for public safety, the criteria for proposed movement to less-restrictive settings, criteria for proposed eventual discharge or release, and a projected possible date for discharge or release; and

(g) The type of residence immediately anticipated for the person and possible future types of residences;

(31) "Intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol or other psychoactive chemicals;

(32) "Judicial commitment" means a commitment by a court pursuant to the provisions of this chapter;

(33) "Legal counsel" means attorneys and staff employed by county prosecutor offices or the state attorney general acting in their capacity as legal representatives of public behavioral health service providers under RCW 71.05.130;

(34) "Less restrictive alternative treatment" means a program of individualized treatment in a less restrictive setting than inpatient treatment that includes the services described in RCW 71.05.585. This term includes: Treatment pursuant to a less restrictive alternative treatment order under RCW 71.05.240 or 71.05.320; treatment pursuant to a conditional release under RCW 71.05.340; and treatment pursuant to an assisted outpatient treatment order under RCW 71.05.148;

(35) "Licensed physician" means a person licensed to practice medicine or osteopathic medicine and surgery in the state of Washington;

(36) "Likelihood of serious harm" means:

(a) A substantial risk that: (i) Physical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by a person upon another, as evidenced by behavior which has caused harm, substantial pain, or which places another person or persons in reasonable fear of harm to themselves or others; or (iii) physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or

(b) The person has threatened the physical safety of another and has a history of one or more violent acts;

(37) "Medical clearance" means a physician or other health care provider has determined that a person is medically stable and ready for referral to the designated crisis responder;

(38) "Mental disorder" means any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions;

(39) "Mental health professional" means a psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or social worker, and such other mental health professionals as may be defined by rules adopted by the secretary pursuant to the provisions of this chapter;

(40) "Peace officer" means a law enforcement official of a public agency or governmental unit, and includes persons specifically given peace officer powers by any state law, local ordinance, or judicial order of appointment;

(41) "Physician assistant" means a person licensed as a physician assistant under chapter 18.71A RCW;

(42) "Private agency" means any person, partnership, corporation, or association that is not a public agency, whether or not financed in whole or in part by public funds, which constitutes an evaluation and treatment facility or private institution, or hospital, or approved substance use disorder treatment program, which is conducted for, or includes a department or ward conducted for, the care and treatment of persons with behavioral health disorders;

(43) "Professional person" means a mental health professional, substance use disorder professional, or designated crisis responder and shall also mean a physician, physician assistant, psychiatric advanced registered nurse practitioner, registered nurse, and such others as may be defined by rules adopted by the secretary pursuant to the provisions of this chapter;

(44) "Psychiatric advanced registered nurse practitioner" means a person who is licensed as an advanced registered nurse practitioner pursuant to chapter 18.79 RCW; and who is board certified in advanced practice psychiatric and mental health nursing;

(45) "Psychiatrist" means a person having a license as a physician and surgeon in this state who has in addition completed three years of graduate training in psychiatry in a program approved by the American medical association or the American osteopathic association and is certified or eligible to be certified by the American board of psychiatry and neurology;

(46) "Psychologist" means a person who has been licensed as a psychologist pursuant to chapter 18.83 RCW;

(47) "Public agency" means any evaluation and treatment facility or institution, secure withdrawal management and stabilization facility, approved substance use disorder treatment program, or hospital which is conducted for, or includes a department or ward conducted for, the care and treatment of persons with behavioral health disorders, if the agency is operated directly by federal, state, county, or municipal government, or a combination of such governments;

(48) "Release" means legal termination of the commitment under the provisions of this chapter;

(49) "Resource management services" has the meaning given in chapter 71.24 RCW;

(50) "Secretary" means the secretary of the department of health, or his or her designee;

(51) "Secure withdrawal management and stabilization facility" means a facility operated by either a public or private agency or by the program of an agency which provides care to voluntary individuals and individuals involuntarily detained and committed under this chapter for whom there is a likelihood of serious harm or who are gravely disabled due

to the presence of a substance use disorder. Secure withdrawal management and stabilization facilities must:

(a) Provide the following services:

(i) Assessment and treatment, provided by certified substance use disorder professionals or co-occurring disorder specialists;

(ii) Clinical stabilization services;

(iii) Acute or subacute detoxification services for intoxicated individuals; and

(iv) Discharge assistance provided by certified substance use disorder professionals or co-occurring disorder specialists, including facilitating transitions to appropriate voluntary or involuntary inpatient services or to less restrictive alternatives as appropriate for the individual;

(b) Include security measures sufficient to protect the patients, staff, and community; and

(c) Be licensed or certified as such by the department of health;

(52) "Severe deterioration from safe behavior" means that a person will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior;

(53) "Social worker" means a person with a master's or further advanced degree from a social work educational program accredited and approved as provided in RCW 18.320.010;

(54) "Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using the substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances;

(55) "Substance use disorder professional" means a person certified as a substance use disorder professional by the department of health under chapter 18.205 RCW;

(56) "Therapeutic court personnel" means the staff of a mental health court or other therapeutic court which has jurisdiction over defendants who are dually diagnosed with mental disorders, including court personnel, probation officers, a court monitor, prosecuting attorney, or defense counsel acting within the scope of therapeutic court duties;

(57) "Treatment records" include registration and all other records concerning persons who are receiving or who at any time have received services for behavioral health disorders, which are maintained by the department of social and health services, the department, the authority, behavioral health administrative services organizations and their staffs, managed care organizations and their staffs, and by treatment facilities. Treatment records include mental health information contained in a medical bill including but not limited to mental health drugs, a mental health diagnosis, provider name, and dates of service stemming from a medical service. Treatment records do not include notes or records maintained for personal use by a person providing treatment services for the department of social and health services, the department, the authority, behavioral health administrative services organizations, managed care organizations, or a treatment facility if the notes or records are not available to others;

(58) "Triage facility" means a short-term facility or a portion of a facility licensed or certified by the department, which is designed as a facility to assess and stabilize an individual or determine the need for involuntary commitment of an individual, and must meet department residential treatment facility standards. A triage facility may be structured as a voluntary or involuntary placement facility;

(59) "Video," unless the context clearly indicates otherwise, means the delivery of behavioral health services through the use of interactive audio and video technology, permitting real-time communication between a person and a designated crisis responder, for the purpose of evaluation. "Video" does not include the use of audio-only telephone, facsimile, email, or store and forward technology. "Store and forward technology" means use of an asynchronous transmission of a person's medical information from a mental health service provider to the designated crisis responder which results in medical diagnosis, consultation, or treatment;

(60) "Violent act" means behavior that resulted in homicide, attempted suicide, injury, or substantial loss or damage to property. [2022 c 210 § 2. Prior: 2021 c 264 § 23; 2021 c 264 § 22; 2021 c 263 § 14; (2021 c 263 § 13 expired July 1, 2022); prior: 2020 c 302 § 4; 2020 c 302 § 3; 2020 c 256 § 301; 2020 c 80 § 51; 2020 c 5 § 1; prior: 2019 c 446 § 2; 2019 c 444 § 16; 2019 c 325 § 3001; prior: 2018 c 305 § 1; 2018 c 291 § 1; 2018 c 201 § 3001; 2017 3rd sp.s. c 14 § 14; prior: 2016 sp.s. c 29 § 204; 2016 c 155 § 1; prior: 2015 c 269 § 14; (2015 c 269 § 13 expired April 1, 2016); 2015 c 250 § 2; (2015 c 250 § 1 expired April 1, 2016); prior: 2014 c 225 § 79; prior: 2011 c 148 § 1; 2011 c 89 § 14; prior: 2009 c 320 § 1; 2009 c 217 § 20; 2008 c 156 § 1; prior: 2007 c 375 § 6; 2007 c 191 § 2; 2005 c 504 § 104; 2000 c 94 § 1; 1999 c 13 § 5; 1998 c 297 § 3; 1997 c 112 § 3; prior: 1989 c 420 § 13; 1989 c 205 § 8; 1989 c 120 § 2; 1979 ex.s. c 215 § 5; 1973 1st ex.s. c 142 § 7.]

***Reviser's note:** RCW 71A.10.020 was amended by 2022 c 277 § 2, changing subsection (5) to subsection (6).

Effective date—2022 c 210 §§ 1, 2, and 31: See note following RCW 71.05.020.

Contingent effective date—2022 c 210 §§ 2 and 10; 2021 c 264 §§ 22 and 23; 2021 c 263 §§ 13 and 14; 2020 c 302 §§ 4 and 28: "(1) Sections 4 and 28, chapter 302, Laws of 2020, sections 13 and 14, chapter 263, Laws of 2021, section 23, chapter 264, Laws of 2021, and sections 2 and 10, chapter 210, Laws of 2022 take effect when monthly single-bed certifications authorized under RCW 71.05.745 fall below 200 reports for 3 consecutive months.

(2) The health care authority must provide written notice of the effective date of sections 4 and 28, chapter 302, Laws of 2020, sections 13 and 14, chapter 263, Laws of 2021, section 23, chapter 264, Laws of 2021, and sections 2 and 10, chapter 210, Laws of 2022 to affected parties, the chief clerk of the house of representatives, the secretary of the senate, the office of the code reviser, and others as deemed appropriate by the authority." [2022 c 210 § 31. Prior: 2021 c 264 § 24; 2021 c 263 § 21; 2020 c 302 § 110.]

Effective date—2021 c 263 §§ 12 and 14: "Sections 12 and 14 of this act take effect July 1, 2022." [2021 c 263 § 25.]

Expiration date—2021 c 263 §§ 11 and 13: "Sections 11 and 13 of this act expire July 1, 2022." [2021 c 263 § 24.]

Application—2021 c 263: See note following RCW 10.77.150.

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective date—2018 c 291 §§ 1-4, 6, 7, 9, 11, 12, 13, and 15: "Sections 1 through 4, 6, 7, 9, 11, 12, 13, and 15 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect April 1, 2018." [2018 c 291 § 18.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2017 3rd sp.s. c 14 §§ 9, 12, 14, 15, and 17-21: See note following RCW 71.05.590.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2015 c 269 §§ 10 and 14: See note following RCW 71.24.300.

Expiration dates—2015 c 269 §§ 9, 13, and 15: See note following RCW 71.24.300.

Effective date—2015 c 269 §§ 1-9 and 11-13: See note following RCW 71.05.010.

Effective date—2015 c 250 §§ 2, 15, and 19: "Sections 2, 15, and 19 of this act take effect April 1, 2016." [2015 c 250 § 23.]

Expiration date—2015 c 250 §§ 1, 14, and 18: "Sections 1, 14, and 18 of this act expire April 1, 2016." [2015 c 250 § 22.]

Effective date—2014 c 225: See note following RCW 71.24.016.

Findings—2011 c 89: See RCW 18.320.005.

Findings—Purpose—Construction—Severability—2007 c 375: See notes following RCW 10.31.110.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Purpose—Construction—1999 c 13: See note following RCW 10.77.010.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.05.025 Integration with chapter 71.24 RCW—Behavioral health administrative services organizations—Duty to institute procedures for timely consultation with resource management services. The legislature intends that the procedures and services authorized in this chapter be integrated with those in chapter 71.24 RCW to the maximum extent necessary to assure an appropriate continuum of care for persons with behavioral health disorders, as defined in either or both this chapter and chapter 71.24 RCW. To this end, behavioral health administrative services organizations established in accordance with chapter 71.24 RCW shall institute procedures which require timely consultation with resource management services by designated crisis responders, managed care organizations, evaluation and treatment facilities, secure withdrawal management and stabilization facilities, and approved substance use disorder treatment programs to assure that determinations to admit, detain, commit, treat, discharge, or release persons with behavioral health disorders under this chapter are made only after appropriate information regarding such person's treatment history and current treatment plan has been sought from resource management services. [2020 c 302 § 5; 2019 c 325 § 3002; 2016 sp.s. c 29 § 205; 2014 c 225 § 80; 2000 c 94 § 2; 1989 c 205 § 9.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2014 c 225: See note following RCW 71.24.016.

Additional notes found at www.leg.wa.gov

71.05.026 Behavioral health services contracts—Limitation on state liability. (1) Except for monetary damage claims which have been reduced to final judgment by a superior court, this section applies to all claims against the state, state agencies, state officials, or state employees that exist on or arise after March 29, 2006.

(2) Except as expressly provided in contracts entered into by the authority, the entities identified in subsection (3) of this section shall have no claim for declaratory relief, injunctive relief, judicial review under chapter 34.05 RCW, or civil liability against the state or state agencies for actions or inactions performed pursuant to the administration of this chapter with regard to the following: (a) The allocation or payment of federal or state funds; (b) the use or allocation of state hospital beds; or (c) financial responsibility for the provision of inpatient behavioral health disorder treatment and care.

(3) This section applies to counties, behavioral health administrative services organizations, managed care organizations, and entities which contract to provide behavioral health services and their subcontractors, agents, or employees. [2020 c 302 § 6; 2019 c 325 § 3003; 2018 c 201 § 3002; 2016 sp.s. c 29 § 206; 2014 c 225 § 81; 2006 c 333 § 301.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2014 c 225: See note following RCW 71.24.016.

Finding—Purpose—Intent—Severability—Part headings not law—Effective dates—2006 c 333: See notes following RCW 71.24.016.

71.05.027 Integrated comprehensive screening and assessment process for substance use and mental disorders. All persons providing treatment under this chapter shall also provide an integrated comprehensive screening and assessment process for substance use disorders and mental disorders adopted pursuant to RCW 71.24.630. [2019 c 325 § 3004; 2018 c 201 § 3003; 2014 c 225 § 82; 2005 c 504 § 103.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

Findings—Intent—2005 c 504: "The legislature finds that persons with mental disorders, chemical dependency disorders, or co-occurring mental and substance abuse disorders are disproportionately more likely to be confined in a correctional institution, become homeless, become involved with child protective services or involved in a dependency proceeding, or lose those state and federal benefits to which they may be entitled as a result of their disorders. The legislature finds that prior state policy of addressing mental health and chemical dependency in isolation from each other has not been cost-effective and has often resulted in longer-term, more costly treatment that may be less effective over time. The legislature finds that a substantial number of persons have co-occurring mental and substance abuse disorders and that identification and integrated treatment of co-occurring disorders is critical to successful outcomes and recovery. Consequently, the legislature intends, to the extent of available funding, to:

(1) Establish a process for determining which persons with mental disorders and substance abuse disorders have co-occurring disorders;

(2) Reduce the gap between available chemical dependency treatment and the documented need for treatment;

(3) Improve treatment outcomes by shifting treatment, where possible, to evidence-based, research-based, and consensus-based treatment practices and by removing barriers to the use of those practices;

(4) Expand the authority for and use of therapeutic courts including drug courts, mental health courts, and therapeutic courts for dependency proceedings;

(5) Improve access to treatment for persons who are not enrolled in medicaid by improving and creating consistency in the application processes, and by minimizing the numbers of eligible confined persons who leave confinement without medical assistance;

(6) Improve access to inpatient treatment by creating expanded services facilities for persons needing intensive treatment in a secure setting who do not need inpatient care, but are unable to access treatment under current licensing restrictions in other settings;

(7) Establish secure detoxification centers for persons involuntarily detained as gravely disabled or presenting a likelihood of serious harm due to chemical dependency and authorize combined crisis responders for both mental disorders and chemical dependency disorders on a pilot basis and study the outcomes;

(8) Slow or stop the loss of inpatient and intensive residential beds and children's long-term inpatient placements and refine the balance of state hospital and community inpatient and residential beds;

(9) Improve cross-system collaboration including collaboration with first responders and hospital emergency rooms, schools, primary care, developmental disabilities, law enforcement and corrections, and federally funded and licensed programs;

(10) Following the receipt of outcomes from the pilot programs in Part II of this act, if directed by future legislative enactment, implement a single, comprehensive, involuntary treatment act with a unified set of standards, rights, obligations, and procedures for adults and children with mental disorders, chemical dependency disorders, and co-occurring disorders; and

(11) Amend existing state law to address organizational and structural barriers to effective use of state funds for treating persons with mental and substance abuse disorders, minimize internal inconsistencies, clarify policy and requirements, and maximize the opportunity for effective and cost-effective outcomes." [2005 c 504 § 101.]

Additional notes found at www.leg.wa.gov

71.05.030 Commitment laws applicable. Persons suffering from a behavioral health disorder may not be involuntarily committed for treatment of such disorder except pursuant to provisions of this chapter, chapter 10.77 RCW, chapter 71.06 RCW, chapter 71.34 RCW, transfer pursuant to RCW 72.68.031 through 72.68.037, or pursuant to court ordered evaluation and treatment not to exceed ninety days pending a criminal trial or sentencing. [2020 c 302 § 7; 1998 c 297 § 4; 1985 c 354 § 31; 1983 c 3 § 179; 1974 ex.s. c 145 § 4; 1973 2nd ex.s. c 24 § 2; 1973 1st ex.s. c 142 § 8.]

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.040 Detention or judicial commitment of persons with developmental disabilities, impaired by substance use disorder, or suffering from dementia. Persons with developmental disabilities, impaired by substance use disorder, or suffering from dementia shall not be detained for evaluation and treatment or judicially committed solely by reason of that condition unless such condition causes a person to be gravely disabled or to present a likelihood of serious harm. However, persons with developmental disabilities, impaired by substance use disorder, or suffering from dementia and who otherwise meet the criteria for detention or judicial commitment are not ineligible for detention or commitment based on this condition alone. [2020 c 302 § 8; 2018 c 201 § 3004; 2004 c 166 § 2; 1997 c 112 § 4; 1987 c 439 § 1; 1977 ex.s. c 80 § 41; 1975 1st ex.s. c 199 § 1; 1974 ex.s. c 145 § 5; 1973 1st ex.s. c 142 § 9.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Purpose—Intent—Severability—1977 ex.s. c 80: See notes following RCW 4.16.190.

Additional notes found at www.leg.wa.gov

71.05.050 Voluntary application for treatment of a behavioral health disorder—Rights—Review of condition and status—Detention—Person refusing voluntary admission, temporary detention. (1) Nothing in this chapter shall be construed to limit the right of any person to apply voluntarily to any public or private agency or practitioner for treatment of a behavioral health disorder, either by direct application or by referral. Any person voluntarily admitted for inpatient treatment to any public or private agency shall be released immediately upon his or her request. Any person voluntarily admitted for inpatient treatment to any public or private agency shall orally be advised of the right to immediate discharge, and further advised of such rights in writing as are secured to them pursuant to this chapter and their rights of access to attorneys, courts, and other legal redress. Their condition and status shall be reviewed at least once each one hundred eighty days for evaluation as to the need for further treatment or possible discharge, at which time they shall again be advised of their right to discharge upon request.

(2) If the professional staff of any public or private agency or hospital regards a person voluntarily admitted who requests discharge as presenting, as a result of a behavioral health disorder, an imminent likelihood of serious harm, or is gravely disabled, they may detain such person for sufficient time to notify the designated crisis responder of such person's condition to enable the designated crisis responder to authorize such person being further held in custody or transported to an evaluation and treatment center, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program pursuant to the provisions of this chapter, which shall in ordinary circumstances be no later than the next judicial day.

(3) If a person is brought to the emergency room of a public or private agency or hospital for observation or treatment, the person refuses voluntary admission, and the professional staff of the public or private agency or hospital regard such person as presenting as a result of a behavioral health disorder an imminent likelihood of serious harm, or as presenting an imminent danger because of grave disability, they may detain such person for sufficient time to notify the designated crisis responder of such person's condition to enable the designated crisis responder to authorize such person being further held in custody or transported to an evaluation treatment center, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program pursuant to the conditions in this chapter, but which time shall be no more than six hours from the time the professional staff notify the designated crisis responder of the need for evaluation, not counting time periods prior to medical clearance.

(4) Dismissal of a commitment petition is not the appropriate remedy for a violation of the timeliness requirements of this section based on the intent of this chapter under RCW 71.05.010 except in the few cases where the facility staff or designated crisis responder has totally disregarded the

requirements of this section. [2020 c 302 § 9; 2019 c 446 § 3; 2016 sp.s. c 29 § 207; 2015 c 269 § 5; 2000 c 94 § 3; 1998 c 297 § 6; 1997 c 112 § 5; 1979 ex.s. c 215 § 6; 1975 1st ex.s. c 199 § 2; 1974 ex.s. c 145 § 6; 1973 1st ex.s. c 142 § 10.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2015 c 269 §§ 1-9 and 11-13: See note following RCW 71.05.010.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.100 Financial responsibility. In addition to the responsibility provided for by RCW 43.20B.330, any person, or his or her estate, or his or her spouse, who is involuntarily detained pursuant to this chapter for the purpose of treatment and evaluation outside of a facility maintained and operated by the department of social and health services shall be responsible for the cost of such care and treatment. In the event that an individual is unable to pay for such treatment or in the event payment would result in a substantial hardship upon the individual or his or her family, then the county of residence of such person shall be responsible for such costs. If it is not possible to determine the county of residence of the person, the cost shall be borne by the county where the person was originally detained. The department of social and health services, or the authority, as appropriate, shall, pursuant to chapter 34.05 RCW, adopt standards as to (1) inability to pay in whole or in part, (2) a definition of substantial hardship, and (3) appropriate payment schedules. Financial responsibility with respect to services and facilities of the department of social and health services shall continue to be as provided in RCW 43.20B.320 through 43.20B.360 and 43.20B.370. [2020 c 302 § 10; 2018 c 201 § 3005; 1997 c 112 § 6; 1987 c 75 § 18; 1973 2nd ex.s. c 24 § 4; 1973 1st ex.s. c 142 § 15.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Additional notes found at www.leg.wa.gov

71.05.110 Compensation of appointed counsel. Attorneys appointed for persons pursuant to this chapter shall be compensated for their services as follows: (1) The person for whom an attorney is appointed shall, if he or she is financially able pursuant to standards as to financial capability and indigency set by the superior court of the county in which the proceeding is held, bear the costs of such legal services; (2) if such person is indigent pursuant to such standards, the behavioral health administrative services organization shall reimburse the county in which the proceeding is held for the direct costs of such legal services, as provided in RCW 71.05.730. [2019 c 325 § 3005; 2014 c 225 § 83; 2011 c 343 § 5; 1997 c 112 § 7; 1973 1st ex.s. c 142 § 16.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective date—2014 c 225: See note following RCW 71.24.016.

Intent—Effective date—2011 c 343: See notes following RCW 71.05.730.

71.05.120 Exemptions from liability. (1) No officer of a public or private agency, nor the superintendent, professional person in charge, his or her professional designee, or attending staff of any such agency, nor any public official performing functions necessary to the administration of this chapter, nor peace officer responsible for detaining a person pursuant to this chapter, nor any designated crisis responder, nor the state, a unit of local government, an evaluation and treatment facility, a secure withdrawal management and stabilization facility, or an approved substance use disorder treatment program shall be civilly or criminally liable for performing duties pursuant to this chapter with regard to the decision of whether to admit, discharge, release, administer antipsychotic medications, or detain a person for evaluation and treatment: PROVIDED, That such duties were performed in good faith and without gross negligence.

(2) Peace officers and their employing agencies are not liable for the referral of a person, or the failure to refer a person, to a behavioral health agency pursuant to a policy adopted pursuant to RCW 71.05.457 if such action or inaction is taken in good faith and without gross negligence.

(3) This section does not relieve a person from giving the required notices under RCW 71.05.330(2) or 71.05.340(1)(b), or the duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims. The duty to warn or to take reasonable precautions to provide protection from violent behavior is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel. [2020 c 302 § 11; 2019 c 446 § 22. Prior: 2016 sp.s. c 29 § 208; 2016 c 158 § 4; 2000 c 94 § 4; 1991 c 105 § 2; 1989 c 120 § 3; 1987 c 212 § 301; 1979 ex.s. c 215 § 7; 1974 ex.s. c 145 § 7; 1973 2nd ex.s. c 24 § 5; 1973 1st ex.s. c 142 § 17.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Finding—Intent—2016 c 158: See note following RCW 71.05.455.

Additional notes found at www.leg.wa.gov

71.05.130 Duties of prosecuting attorney and attorney general. In any judicial proceeding for involuntary commitment or detention except under RCW 71.05.201, or in any proceeding challenging involuntary commitment or detention, the prosecuting attorney for the county in which the proceeding was initiated shall represent the individuals or agencies petitioning for commitment or detention and shall defend all challenges to such commitment or detention, except that the attorney general shall represent and provide legal services and advice to state hospitals or institutions with regard to all provisions of and proceedings under this chapter other than proceedings initiated by such hospitals and institutions seeking fourteen day detention. [2015 c 258 § 4; 1998 c 297 § 7; 1991 c 105 § 3; 1989 c 120 § 4; 1979 ex.s. c 215 § 8; 1973 1st ex.s. c 142 § 18.]

Short title—2015 c 258: See note following RCW 71.05.201.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.05.132 Court-ordered treatment—Required notifications. When any court orders a person to receive treatment under this chapter, the order shall include a statement that if the person is, or becomes, subject to supervision by the

department of corrections, the person must notify the treatment provider and the person's mental health treatment information and substance use disorder treatment information must be shared with the department of corrections for the duration of the offender's incarceration and supervision, under RCW 71.05.445. Upon a petition by a person who does not have a history of one or more violent acts, the court may, for good cause, find that public safety would not be enhanced by the sharing of this person's information. [2016 sp.s. c 29 § 209; 2004 c 166 § 12.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.05.135 Mental health commissioners—Appointment. In each county the superior court may appoint the following persons to assist the superior court in disposing of its business: PROVIDED, That such positions may not be created without prior consent of the county legislative authority:

(1) One or more attorneys to act as mental health commissioners; and

(2) Such investigators, stenographers, and clerks as the court shall find necessary to carry on the work of the mental health commissioners.

The appointments provided for in this section shall be made by a majority vote of the judges of the superior court of the county and may be in addition to all other appointments of commissioners and other judicial attaches otherwise authorized by law. Mental health commissioners and investigators shall serve at the pleasure of the judges appointing them and shall receive such compensation as the county legislative authority shall determine. The appointments may be full or part-time positions. A person appointed as a mental health commissioner may also be appointed to any other commissioner position authorized by law. [1993 c 15 § 2; 1991 c 363 § 146; 1989 c 174 § 1.]

Purpose—Captions not law—1991 c 363: See notes following RCW 2.32.180.

Additional notes found at www.leg.wa.gov

71.05.137 Mental health commissioners—Authority. The judges of the superior court of the county by majority vote may authorize mental health commissioners, appointed pursuant to RCW 71.05.135, to perform any or all of the following duties:

(1) Receive all applications, petitions, and proceedings filed in the superior court for the purpose of disposing of them pursuant to this chapter or RCW 10.77.094;

(2) Investigate the facts upon which to base warrants, subpoenas, orders to directions in actions, or proceedings filed pursuant to this chapter or RCW 10.77.094;

(3) For the purpose of this chapter, exercise all powers and perform all the duties of a court commissioner appointed pursuant to RCW 2.24.010;

(4) Hold hearings in proceedings under this chapter or RCW 10.77.094 and make written reports of all proceedings under this chapter or RCW 10.77.094 which shall become a part of the record of superior court;

(5) Provide such supervision in connection with the exercise of its jurisdiction as may be ordered by the presiding judge; and

(6) Cause the orders and findings to be entered in the same manner as orders and findings are entered in cases in the superior court. [2013 c 27 § 1; 1989 c 174 § 2.]

Additional notes found at www.leg.wa.gov

71.05.140 Records maintained. A record of all applications, petitions, and proceedings under this chapter shall be maintained by the county clerk in which the application, petition, or proceeding was initiated. [1973 1st ex.s. c 142 § 19.]

71.05.145 Offenders with behavioral health disorders who are believed to be dangerous—Less restrictive alternative. The legislature intends that, when evaluating a person who is identified under RCW 72.09.370(7), the professional person at the evaluation and treatment facility shall, when appropriate after consideration of the person's mental condition and relevant public safety concerns, file a petition for a ninety-day less restrictive alternative in lieu of a petition for a fourteen-day commitment. [1999 c 214 § 4.]

Intent—Effective date—1999 c 214: See notes following RCW 72.09.370.

71.05.148 Assisted outpatient treatment—Petitions, court orders for less restrictive alternative treatment—Procedure. (1) A person is in need of assisted outpatient treatment if the court finds by clear, cogent, and convincing evidence pursuant to a petition filed under this section that:

(a) The person has a behavioral health disorder;

(b) Based on a clinical determination and in view of the person's treatment history and current behavior, at least one of the following is true:

(i) The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating; or

(ii) The person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or a likelihood of serious harm to the person or to others;

(c) The person has a history of lack of compliance with treatment for his or her behavioral health disorder that has:

(i) At least twice within the 36 months prior to the filing of the petition been a significant factor in necessitating hospitalization of the person, or the person's receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, provided that the 36-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the 36-month period;

(ii) At least twice within the 36 months prior to the filing of the petition been a significant factor in necessitating emergency medical care or hospitalization for behavioral health-related medical conditions including overdose, infected abscesses, sepsis, endocarditis, or other maladies, or a significant factor in behavior which resulted in the person's incarceration in a state or local correctional facility; or

(iii) Resulted in one or more violent acts, threats, or attempts to cause serious physical harm to the person or another within the 48 months prior to the filing of the peti-

tion, provided that the 48-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred during the 48-month period;

(d) Participation in an assisted outpatient treatment program would be the least restrictive alternative necessary to ensure the person's recovery and stability; and

(e) The person will benefit from assisted outpatient treatment.

(2) The following individuals may directly file a petition for less restrictive alternative treatment on the basis that a person is in need of assisted outpatient treatment:

(a) The director of a hospital where the person is hospitalized or the director's designee;

(b) The director of a behavioral health service provider providing behavioral health care or residential services to the person or the director's designee;

(c) The person's treating mental health professional or substance use disorder professional or one who has evaluated the person;

(d) A designated crisis responder;

(e) A release planner from a corrections facility; or

(f) An emergency room physician.

(3) A court order for less restrictive alternative treatment on the basis that the person is in need of assisted outpatient treatment may be effective for up to 18 months. The petitioner must personally interview the person, unless the person refuses an interview, to determine whether the person will voluntarily receive appropriate treatment.

(4) The petitioner must allege specific facts based on personal observation, evaluation, or investigation, and must consider the reliability or credibility of any person providing information material to the petition.

(5) The petition must include:

(a) A statement of the circumstances under which the person's condition was made known and the basis for the opinion, from personal observation or investigation, that the person is in need of assisted outpatient treatment. The petitioner must state which specific facts come from personal observation and specify what other sources of information the petitioner has relied upon to form this belief;

(b) A declaration from a physician, physician assistant, advanced registered nurse practitioner, or the person's treating mental health professional or substance use disorder professional, who has examined the person no more than 10 days prior to the submission of the petition and who is willing to testify in support of the petition, or who alternatively has made appropriate attempts to examine the person within the same period but has not been successful in obtaining the person's cooperation, and who is willing to testify to the reasons they believe that the person meets the criteria for assisted outpatient treatment. If the declaration is provided by the person's treating mental health professional or substance use disorder professional, it must be cosigned by a supervising physician, physician assistant, or advanced registered nurse practitioner who certifies that they have reviewed the declaration;

(c) The declarations of additional witnesses, if any, supporting the petition for assisted outpatient treatment;

(d) The name of an agency, provider, or facility that agrees to provide less restrictive alternative treatment if the petition is granted by the court; and

(e) If the person is detained in a state hospital, inpatient treatment facility, jail, or correctional facility at the time the petition is filed, the anticipated release date of the person and any other details needed to facilitate successful reentry and transition into the community.

(6)(a) Upon receipt of a petition meeting all requirements of this section, the court shall fix a date for a hearing:

(i) No sooner than three days or later than seven days after the date of service or as stipulated by the parties or, upon a showing of good cause, no later than 30 days after the date of service; or

(ii) If the respondent is hospitalized at the time of filing of the petition, before discharge of the respondent and in sufficient time to arrange for a continuous transition from inpatient treatment to assisted outpatient treatment.

(b) A copy of the petition and notice of hearing shall be served, in the same manner as a summons, on the petitioner, the respondent, the qualified professional whose affidavit accompanied the petition, a current provider, if any, and a surrogate decision maker or agent under chapter 71.32 RCW, if any.

(c) If the respondent has a surrogate decision maker or agent under chapter 71.32 RCW who wishes to provide testimony at the hearing, the court shall afford the surrogate decision maker or agent an opportunity to testify.

(d) The respondent shall be represented by counsel at all stages of the proceedings.

(e) If the respondent fails to appear at the hearing after notice, the court may conduct the hearing in the respondent's absence; provided that the respondent's counsel is present.

(f) If the respondent has refused to be examined by the qualified professional whose affidavit accompanied the petition, the court may order a mental examination of the respondent. The examination of the respondent may be performed by the qualified professional whose affidavit accompanied the petition. If the examination is performed by another qualified professional, the examining qualified professional shall be authorized to consult with the qualified professional whose affidavit accompanied the petition.

(g) If the respondent has refused to be examined by a qualified professional and the court finds reasonable grounds to believe that the allegations of the petition are true, the court may issue a written order directing a peace officer who has completed crisis intervention training to detain and transport the respondent to a provider for examination by a qualified professional. A respondent detained pursuant to this subsection shall be detained no longer than necessary to complete the examination and in no event longer than 24 hours.

(7) If the petition involves a person whom the petitioner or behavioral health administrative services organization knows, or has reason to know, is an American Indian or Alaska Native who receives medical or behavioral health services from a tribe within this state, the behavioral health administrative services organization shall notify the tribe and Indian health care provider. Notification shall be made in person or by telephonic or electronic communication to the tribal contact listed in the authority's tribal crisis coordination plan as soon as possible.

(8) A petition for assisted outpatient treatment filed under this section shall be adjudicated under RCW 71.05.240.

(9) After January 1, 2023, a petition for assisted outpatient treatment must be filed on forms developed by the administrative office of the courts. [2022 c 210 § 3; 2019 c 446 § 21; 2018 c 291 § 3.]

Effective date—2018 c 291 §§ 1-4, 6, 7, 9, 11, 12, 13, and 15: See note following RCW 71.05.020.

71.05.150 Petition for initial detention of persons with behavioral health disorders—Evaluation and treatment period—Procedure—Tribal jurisdiction. ***(Effective until July 1, 2026.)*** (1) When a designated crisis responder receives information alleging that a person, as a result of a behavioral health disorder, presents a likelihood of serious harm or is gravely disabled, the designated crisis responder may, after investigation and evaluation of the specific facts alleged and of the reliability and credibility of any person providing information to initiate detention, if satisfied that the allegations are true and that the person will not voluntarily seek appropriate treatment, file a petition for initial detention under this section. Before filing the petition, the designated crisis responder must personally interview the person, unless the person refuses an interview, and determine whether the person will voluntarily receive appropriate evaluation and treatment at an evaluation and treatment facility, crisis stabilization unit, triage facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program. As part of the assessment, the designated crisis responder must attempt to ascertain if the person has executed a mental health advance directive under chapter 71.32 RCW. The interview performed by the designated crisis responder may be conducted by video provided that a licensed health care professional or professional person who can adequately and accurately assist with obtaining any necessary information is present with the person at the time of the interview.

(2)(a) A superior court judge may issue a warrant to detain a person with a behavioral health disorder to a designated evaluation and treatment facility, a secure withdrawal management and stabilization facility, or an approved substance use disorder treatment program, for a period of not more than one hundred twenty hours for evaluation and treatment upon request of a designated crisis responder, subject to (d) of this subsection, whenever it appears to the satisfaction of the judge that:

(i) There is probable cause to support the petition; and

(ii) The person has refused or failed to accept appropriate evaluation and treatment voluntarily.

(b) The petition for initial detention, signed under penalty of perjury, or sworn telephonic testimony may be considered by the court in determining whether there are sufficient grounds for issuing the order.

(c) The order shall designate retained counsel or, if counsel is appointed from a list provided by the court, the name, business address, and telephone number of the attorney appointed to represent the person.

(d) A court may not issue an order to detain a person to a secure withdrawal management and stabilization facility or approved substance use disorder treatment program unless there is an available secure withdrawal management and stabilization facility or approved substance use disorder treatment program that has adequate space for the person.

(e) If the court does not issue an order to detain a person pursuant to this subsection (2), the court shall issue an order to dismiss the initial petition.

(3) The designated crisis responder shall then serve or cause to be served on such person and his or her guardian, if any, a copy of the order together with a notice of rights, and a petition for initial detention. After service on such person the designated crisis responder shall file the return of service in court and provide copies of all papers in the court file to the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program, and the designated attorney. The designated crisis responder shall notify the court and the prosecuting attorney that a probable cause hearing will be held within one hundred twenty hours of the date and time of outpatient evaluation or admission to the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program. The person shall be permitted to be accompanied by one or more of his or her relatives, friends, an attorney, a personal physician, or other professional or religious advisor to the place of evaluation. An attorney accompanying the person to the place of evaluation shall be permitted to be present during the admission evaluation. Any other individual accompanying the person may be present during the admission evaluation. The facility may exclude the individual if his or her presence would present a safety risk, delay the proceedings, or otherwise interfere with the evaluation.

(4) The designated crisis responder may notify a peace officer to take such person or cause such person to be taken into custody and placed in an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program. At the time such person is taken into custody there shall commence to be served on such person, his or her guardian, and conservator, if any, a copy of the original order together with a notice of rights and a petition for initial detention.

(5) Tribal court orders for involuntary commitment shall be recognized and enforced in accordance with superior court civil rule 82.5.

(6) In any investigation and evaluation of an individual under this section or RCW 71.05.153 in which the designated crisis responder knows, or has reason to know, that the individual is an American Indian or Alaska Native who receives medical or behavioral health services from a tribe within this state, the designated crisis responder shall notify the tribe and Indian health care provider regarding whether or not a petition for initial detention or involuntary outpatient treatment will be filed. Notification shall be made in person or by telephonic or electronic communication to the tribal contact listed in the authority's tribal crisis coordination plan as soon as possible but no later than three hours subject to the requirements in RCW 70.02.230(2)(ee) and (3). A designated crisis responder may restrict the release of information as necessary to comply with 42 C.F.R. Part 2. [2022 c 210 § 5; 2021 c 264 § 1. Prior: 2020 c 302 § 13; (2020 c 302 § 12 expired January 1, 2021); 2020 c 256 § 302; 2020 c 5 § 2; 2019 c 446 § 4; 2018 c 291 § 4; 2016 sp.s. c 29 § 210; 2015 c 250 § 3; 2011 c 148 § 5; 2007 c 375 § 7; 1998 c 297 § 8; 1997 c 112 § 8; 1984 c 233 § 1; 1979 ex.s. c 215 § 9; 1975 1st ex.s. c 199 § 3; 1974 ex.s. c 145 § 8; 1973 1st ex.s. c 142 § 20.]

Expiration date—2022 c 210 §§ 5, 12, 17, and 23: "Sections 5, 12, 17, and 23 of this act expire July 1, 2026." [2022 c 210 § 32.]

Expiration date—2021 c 264 §§ 1, 3, 6, 8, 10, 14, 31, and 33: "Sections 1, 3, 6, 8, 10, 14, 31, and 33 of this act expire July 1, 2026." [2021 c 264 § 35.]

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: "Sections 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91 of this act expire January 1, 2021." [2020 c 302 § 106.]

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: "Sections 13, 16, 19 through 23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92 of this act take effect January 1, 2021." [2020 c 302 § 107.]

Expiration date—2020 c 302 §§ 13, 16, 26, 39, 45, 55, 78, 83, 86, 92, 94, and 97: "Sections 13, 16, 26, 39, 45, 55, 78, 83, 86, 92, 94, and 97 of this act expire July 1, 2026." [2020 c 302 § 108.]

Expiration date—2020 c 256 § 302: "Section 302 of this act expires July 1, 2026." [2020 c 256 § 501.]

Expiration date—2020 c 5 §§ 2 and 4: "Sections 2 and 4 of this act expire July 1, 2026." [2020 c 5 § 6.]

Expiration date—2019 c 446 §§ 4, 6, 8, 11, 14, 30, 32, 34, 37, 39, and 41: "Sections 4, 6, 8, 11, 14, 30, 32, 34, 37, 39, and 41 of this act expire July 1, 2026." [2019 c 446 § 55.]

Expiration date—2018 c 291 §§ 4, 7, and 9: "Sections 4, 7, and 9 of this act expire July 1, 2026." [2018 c 291 § 20.]

Effective date—2018 c 291 §§ 1-4, 6, 7, 9, 11, 12, 13, and 15: See note following RCW 71.05.020.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Purpose—Construction—Severability—2007 c 375: See notes following RCW 10.31.110.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.05.150 Petition for initial detention of persons with behavioral health disorders—Evaluation and treatment period—Procedure—Tribal jurisdiction. ***(Effective July 1, 2026.)*** (1) When a designated crisis responder receives information alleging that a person, as a result of a behavioral health disorder, presents a likelihood of serious harm or is gravely disabled, the designated crisis responder may, after investigation and evaluation of the specific facts alleged and of the reliability and credibility of any person providing information to initiate detention, if satisfied that the allegations are true and that the person will not voluntarily seek appropriate treatment, file a petition for initial detention under this section. Before filing the petition, the designated crisis responder must personally interview the person, unless the person refuses an interview, and determine whether the person will voluntarily receive appropriate evaluation and treatment at an evaluation and treatment facility, crisis stabilization unit, triage facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program. As part of the assessment, the designated crisis responder must attempt to ascertain if the person has executed a mental health advance directive under chapter 71.32 RCW. The interview performed by the designated crisis responder may be conducted by video provided that a licensed health care professional or professional person who can adequately and accurately assist with obtaining any necessary information is present with the person at the time of the interview.

(2)(a) A superior court judge may issue a warrant to detain a person with a behavioral health disorder to a designated evaluation and treatment facility, a secure withdrawal management and stabilization facility, or an approved substance use disorder treatment program, for a period of not more than one hundred twenty hours for evaluation and treatment upon request of a designated crisis responder whenever it appears to the satisfaction of the judge that:

(i) There is probable cause to support the petition; and

(ii) The person has refused or failed to accept appropriate evaluation and treatment voluntarily.

(b) The petition for initial detention, signed under penalty of perjury, or sworn telephonic testimony may be considered by the court in determining whether there are sufficient grounds for issuing the order.

(c) The order shall designate retained counsel or, if counsel is appointed from a list provided by the court, the name, business address, and telephone number of the attorney appointed to represent the person.

(d) If the court does not issue an order to detain a person pursuant to this subsection (2), the court shall issue an order to dismiss the initial petition.

(3) The designated crisis responder shall then serve or cause to be served on such person and his or her guardian, if any, a copy of the order together with a notice of rights, and a petition for initial detention. After service on such person the designated crisis responder shall file the return of service in court and provide copies of all papers in the court file to the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program, and the designated attorney. The designated crisis responder shall notify the court and the prosecuting attorney that a probable cause hearing will be held within one hundred twenty hours of the date and time of outpatient evaluation or admission to the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program. The person shall be permitted to be accompanied by one or more of his or her relatives, friends, an attorney, a personal physician, or other professional or religious advisor to the place of evaluation. An attorney accompanying the person to the place of evaluation shall be permitted to be present during the admission evaluation. Any other individual accompanying the person may be present during the admission evaluation. The facility may exclude the individual if his or her presence would present a safety risk, delay the proceedings, or otherwise interfere with the evaluation.

(4) The designated crisis responder may notify a peace officer to take such person or cause such person to be taken into custody and placed in an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program. At the time such person is taken into custody there shall commence to be served on such person, his or her guardian, and conservator, if any, a copy of the original order together with a notice of rights and a petition for initial detention.

(5) Tribal court orders for involuntary commitment shall be recognized and enforced in accordance with superior court civil rule 82.5.

(6) In any investigation and evaluation of an individual under this section or RCW 71.05.153 in which the designated

crisis responder knows, or has reason to know, that the individual is an American Indian or Alaska Native who receives medical or behavioral health services from a tribe within this state, the designated crisis responder shall notify the tribe and Indian health care provider regarding whether or not a petition for initial detention or involuntary outpatient treatment will be filed. Notification shall be made in person or by telephonic or electronic communication to the tribal contact listed in the authority's tribal crisis coordination plan as soon as possible but no later than three hours subject to the requirements in RCW 70.02.230(2)(ee) and (3). A designated crisis responder may restrict the release of information as necessary to comply with 42 C.F.R. Part 2. [2022 c 210 § 6; 2021 c 264 § 2. Prior: 2020 c 302 § 14; (2020 c 302 § 12 expired January 1, 2021); 2020 c 256 § 303; 2020 c 5 § 3; 2019 c 446 § 5; 2018 c 291 § 5; 2016 sp.s. c 29 § 211; 2016 sp.s. c 29 § 210; 2015 c 250 § 3; 2011 c 148 § 5; 2007 c 375 § 7; 1998 c 297 § 8; 1997 c 112 § 8; 1984 c 233 § 1; 1979 ex.s. c 215 § 9; 1975 1st ex.s. c 199 § 3; 1974 ex.s. c 145 § 8; 1973 1st ex.s. c 142 § 20.]

Effective date—2022 c 210 §§ 6, 13, 18, and 24: "Sections 6, 13, 18, and 24 of this act take effect July 1, 2026." [2022 c 210 § 33.]

Effective date—2021 c 264 §§ 2, 4, 7, 9, 11, 15, 32, and 34: "Sections 2, 4, 7, 9, 11, 15, 32, and 34 of this act take effect July 1, 2026." [2021 c 264 § 36.]

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: "Sections 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91 of this act expire January 1, 2021." [2020 c 302 § 106.]

Effective date—2020 c 302 §§ 14, 17, 27, 40, 46, 56, 79, 84, 87, 93, 95, and 98: "Sections 14, 17, 27, 40, 46, 56, 79, 84, 87, 93, 95, and 98 of this act take effect July 1, 2026." [2020 c 302 § 109.]

Effective date—2020 c 256 § 303: "Section 303 of this act takes effect July 1, 2026." [2020 c 256 § 502.]

Effective date—2020 c 5 §§ 3 and 5: "Sections 3 and 5 of this act take effect July 1, 2026." [2020 c 5 § 7.]

Effective date—2019 c 446 §§ 5, 7, 9, 12, 15, 31, 33, 35, 38, 40, and 42: "Sections 5, 7, 9, 12, 15, 31, 33, 35, 38, 40, and 42 of this act take effect July 1, 2026." [2019 c 446 § 56.]

Effective date—2018 c 291 §§ 5, 8, and 10: "Sections 5, 8, and 10 of this act take effect July 1, 2026." [2018 c 291 § 19.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Purpose—Construction—Severability—2007 c 375: See notes following RCW 10.31.110.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.05.153 Emergency detention of persons with behavioral health disorders—Procedure. ***(Effective until July 1, 2026.)*** (1) When a designated crisis responder receives information alleging that a person, as the result of a behavioral health disorder, presents an imminent likelihood of serious harm, or is in imminent danger because of being gravely disabled, after investigation and evaluation of the specific facts alleged and of the reliability and credibility of the person or persons providing the information if any, the designated crisis responder may take such person, or cause by oral or written order such person to be taken into emergency custody in an evaluation and treatment facility, secure withdrawal management and stabilization facility if available with adequate space for the person, or approved substance use disorder treatment program if available with adequate space for the person, for not more than one hundred twenty hours as described in RCW 71.05.180.

(2)(a) Subject to (b) of this subsection, a peace officer may take or cause such person to be taken into custody and immediately delivered to a triage facility, crisis stabilization unit, evaluation and treatment facility, secure withdrawal management and stabilization facility, approved substance use disorder treatment program, or the emergency department of a local hospital under the following circumstances:

(i) Pursuant to subsection (1) of this section; or

(ii) When he or she has reasonable cause to believe that such person is suffering from a behavioral health disorder and presents an imminent likelihood of serious harm or is in imminent danger because of being gravely disabled.

(b) A peace officer's delivery of a person, to a secure withdrawal management and stabilization facility or approved substance use disorder treatment program is subject to the availability of a secure withdrawal management and stabilization facility or approved substance use disorder treatment program with adequate space for the person.

(3) Persons delivered to a crisis stabilization unit, evaluation and treatment facility, emergency department of a local hospital, triage facility that has elected to operate as an involuntary facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program by peace officers pursuant to subsection (2) of this section may be held by the facility for a period of up to twelve hours, not counting time periods prior to medical clearance.

(4) Within three hours after arrival, not counting time periods prior to medical clearance, the person must be examined by a mental health professional or substance use disorder professional. Within twelve hours of notice of the need for evaluation, not counting time periods prior to medical clearance, the designated crisis responder must determine whether the individual meets detention criteria. In conjunction with this evaluation, the facility where the patient is located must inquire as to a person's veteran status or eligibility for veterans benefits and, if the person appears to be potentially eligible for these benefits, inquire whether the person would be amenable to treatment by the veterans health administration compared to other relevant treatment options. This information must be shared with the designated crisis responder. If the person has been identified as being potentially eligible for veterans health administration services and as being amenable for those services, and if appropriate in light of all reasonably available information about the person's circumstances, the designated crisis responder must first refer the person to the veterans health administration for mental health or substance use disorder treatment at a facility capable of meeting the needs of the person including, but not limited to, the involuntary treatment options available at the Seattle division of the VA Puget Sound health care system. If the person is accepted for treatment by the veterans health administration, and is willing to accept treatment by the veterans health administration as an alternative to other available treatment options, the designated crisis responder, the veterans health administration, and the facility where the patient is located will work to make arrangements to have the person transported to a veterans health administration facility. As part of the assessment, the designated crisis responder

must attempt to ascertain if the person has executed a mental health advance directive under chapter 71.32 RCW. The interview performed by the designated crisis responder may be conducted by video provided that a licensed health care professional or professional person who can adequately and accurately assist with obtaining any necessary information is present with the person at the time of the interview. If the individual is detained, the designated crisis responder shall file a petition for detention or a supplemental petition as appropriate and commence service on the designated attorney for the detained person. If the individual is released to the community, the behavioral health service provider shall inform the peace officer of the release within a reasonable period of time after the release if the peace officer has specifically requested notification and provided contact information to the provider.

(5) Dismissal of a commitment petition is not the appropriate remedy for a violation of the timeliness requirements of this section based on the intent of this chapter under RCW 71.05.010 except in the few cases where the facility staff or designated crisis responder has totally disregarded the requirements of this section. [2021 c 264 § 3; 2021 c 125 § 1. Prior: 2020 c 302 § 16; (2020 c 302 § 15 expired January 1, 2021); 2020 c 5 § 4; 2019 c 446 § 6; 2016 sp.s. c 29 § 212; 2015 c 269 § 6; prior: 2011 c 305 § 8; 2011 c 148 § 2; 2007 c 375 § 8.]

Reviser's note: This section was amended by 2021 c 125 § 1 and by 2021 c 264 § 3, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Expiration date—2021 c 264 §§ 1, 3, 6, 8, 10, 14, 31, and 33: See note following RCW 71.05.150.

Expiration date—2021 c 125 § 1: "Section 1 of this act expires July 1, 2026." [2021 c 125 § 3.]

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 13, 16, 26, 39, 45, 55, 78, 83, 86, 92, 94, and 97: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Expiration date—2020 c 5 §§ 2 and 4: See note following RCW 71.05.150.

Expiration date—2019 c 446 §§ 4, 6, 8, 11, 14, 30, 32, 34, 37, 39, and 41: See note following RCW 71.05.150.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2015 c 269 §§ 1-9 and 11-13: See note following RCW 71.05.010.

Findings—2011 c 305: See note following RCW 74.09.295.

Findings—Purpose—Construction—Severability—2007 c 375: See notes following RCW 10.31.110.

Additional notes found at www.leg.wa.gov

71.05.153 Emergency detention of persons with behavioral health disorders—Procedure. ***(Effective July 1, 2026.)*** (1) When a designated crisis responder receives information alleging that a person, as the result of a behavioral health disorder, presents an imminent likelihood of serious harm, or is in imminent danger because of being gravely disabled, after investigation and evaluation of the specific facts alleged and of the reliability and credibility of the person or persons providing the information if any, the designated crisis responder may take such person, or cause by oral or written order such person to be taken into emergency custody in an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program, for not more than one hundred twenty hours as described in RCW 71.05.180.

(2) A peace officer may take or cause such person to be taken into custody and immediately delivered to a triage facility, crisis stabilization unit, evaluation and treatment facility, secure withdrawal management and stabilization facility, approved substance use disorder treatment program, or the emergency department of a local hospital under the following circumstances:

(a) Pursuant to subsection (1) of this section; or

(b) When he or she has reasonable cause to believe that such person is suffering from a behavioral health disorder and presents an imminent likelihood of serious harm or is in imminent danger because of being gravely disabled.

(3) Persons delivered to a crisis stabilization unit, evaluation and treatment facility, emergency department of a local hospital, triage facility that has elected to operate as an involuntary facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program by peace officers pursuant to subsection (2) of this section may be held by the facility for a period of up to twelve hours, not counting time periods prior to medical clearance.

(4) Within three hours after arrival, not counting time periods prior to medical clearance, the person must be examined by a mental health professional or substance use disorder professional. Within twelve hours of notice of the need for evaluation, not counting time periods prior to medical clearance, the designated crisis responder must determine whether the individual meets detention criteria. In conjunction with this evaluation, the facility where the patient is located must inquire as to a person's veteran status or eligibility for veterans benefits and, if the person appears to be potentially eligible for these benefits, inquire whether the person would be amenable to treatment by the veterans health administration compared to other relevant treatment options. This information must be shared with the designated crisis responder. If the person has been identified as being potentially eligible for veterans health administration services and as being amenable for those services, and if appropriate in light of all reasonably available information about the person's circumstances, the designated crisis responder must first refer the person to the veterans health administration for mental health or substance use disorder treatment at a facility capable of meeting the needs of the person including, but not limited to, the involuntary treatment options available at the Seattle division of the VA Puget Sound health care system. If the person is accepted for treatment by the veterans health administration, and is willing to accept treatment by the veterans health administration as an alternative to other available treatment options, the designated crisis responder, the veterans health administration, and the facility where the patient is located will work to make arrangements to have the person transported to a veterans health administration facility. As part of the assessment, the designated crisis responder must attempt to ascertain if the person has executed a mental health advance directive under chapter 71.32 RCW. The

interview performed by the designated crisis responder may be conducted by video provided that a licensed health care professional or professional person who can adequately and accurately assist with obtaining any necessary information is present with the person at the time of the interview. If the individual is detained, the designated crisis responder shall file a petition for detention or a supplemental petition as appropriate and commence service on the designated attorney for the detained person. If the individual is released to the community, the behavioral health service provider shall inform the peace officer of the release within a reasonable period of time after the release if the peace officer has specifically requested notification and provided contact information to the provider.

(5) Dismissal of a commitment petition is not the appropriate remedy for a violation of the timeliness requirements of this section based on the intent of this chapter under RCW 71.05.010 except in the few cases where the facility staff or designated crisis responder has totally disregarded the requirements of this section. [2021 c 264 § 4; 2021 c 125 § 2. Prior: 2020 c 302 § 17; (2020 c 302 § 15 expired January 1, 2021); 2020 c 5 § 5; 2019 c 446 § 7; 2016 sp.s. c 29 § 213; 2016 sp.s. c 29 § 212; 2015 c 269 § 6; prior: 2011 c 305 § 8; 2011 c 148 § 2; 2007 c 375 § 8.]

Reviser's note: This section was amended by 2021 c 125 § 2 and by 2021 c 264 § 4, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2021 c 264 §§ 2, 4, 7, 9, 11, 15, 32, and 34: See note following RCW 71.05.150.

Effective date—2021 c 125 § 2: "Section 2 of this act takes effect July 1, 2026." [2021 c 125 § 4.]

Effective date—2020 c 302 §§ 14, 17, 27, 40, 46, 56, 79, 84, 87, 93, 95, and 98: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Effective date—2020 c 5 §§ 3 and 5: See note following RCW 71.05.150.

Effective date—2019 c 446 §§ 5, 7, 9, 12, 15, 31, 33, 35, 38, 40, and 42: See note following RCW 71.05.150.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2015 c 269 §§ 1-9 and 11-13: See note following RCW 71.05.010.

Findings—2011 c 305: See note following RCW 74.09.295.

Findings—Purpose—Construction—Severability—2007 c 375: See notes following RCW 10.31.110.

Additional notes found at www.leg.wa.gov

71.05.154 Detention of persons with behavioral health disorders—Evaluation—Consultation with emergency room physician. If a person subject to evaluation under RCW 71.05.150 or 71.05.153 is located in an emergency room at the time of evaluation, the designated crisis responder conducting the evaluation shall take serious consideration of observations and opinions by an examining emergency room physician, advanced registered nurse practitioner, or physician assistant in determining whether detention under this chapter is appropriate. The designated crisis responder must document his or her consultation with this professional, if the professional is available, or his or her review of the professional's written observations or opinions regarding whether detention of the person is appropriate. [2017 3rd sp.s. c 14 § 12; (2017 3rd sp.s. c 14 § 11 expired April 1, 2018); 2016 sp.s. c 29 § 214; 2013 c 334 § 1.]

Effective date—2017 3rd sp.s. c 14 §§ 9, 12, 14, 15, and 17-21: See note following RCW 71.05.590.

Expiration date—2017 3rd sp.s. c 14 §§ 8, 11, and 13: See note following RCW 71.05.590.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.05.156 Evaluation for imminent likelihood of serious harm or imminent danger—Individual with grave disability. A designated crisis responder who conducts an evaluation for imminent likelihood of serious harm or imminent danger because of being gravely disabled under RCW 71.05.153 must also evaluate the person under RCW 71.05.150 for likelihood of serious harm or grave disability that does not meet the imminent standard for emergency detention. [2022 c 210 § 7; 2018 c 291 § 12; 2016 sp.s. c 29 § 215; 2015 c 250 § 4; 2013 c 334 § 2.]

Effective date—2018 c 291 §§ 1-4, 6, 7, 9, 11, 12, 13, and 15: See note following RCW 71.05.020.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.05.157 Evaluation by designated crisis responder—When required—Required notifications. (1) When a designated crisis responder is notified by a jail that a defendant or offender who was subject to a discharge review under RCW 71.05.232 is to be released to the community, the designated crisis responder shall evaluate the person within seventy-two hours of release.

(2) When an offender is under court-ordered treatment in the community and the supervision of the department of corrections, and the treatment provider becomes aware that the person is in violation of the terms of the court order, the treatment provider shall notify the designated crisis responder and the department of corrections of the violation and request an evaluation for purposes of revocation of the less restrictive alternative.

(3) When a designated crisis responder becomes aware that an offender who is under court-ordered treatment in the community and the supervision of the department of corrections is in violation of a treatment order or a condition of supervision that relates to public safety, or the designated crisis responder detains a person under this chapter, the designated crisis responder shall notify the person's treatment provider and the department of corrections.

(4) When an offender who is confined in a state correctional facility or is under supervision of the department of corrections in the community is subject to a petition for involuntary treatment under this chapter, the petitioner shall notify the department of corrections and the department of corrections shall provide documentation of its risk assessment or other concerns to the petitioner and the court if the department of corrections classified the offender as a high risk or high-needs offender.

(5) Nothing in this section creates a duty on any treatment provider or designated crisis responder to provide offender supervision.

(6) No jail or state correctional facility may be considered a less restrictive alternative to an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program. [2019 c 446 § 20; 2016 sp.s. c 29 § 216; 2007 c 375 § 9; 2005 c 504 § 507; 2004 c 166 § 16.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Purpose—Construction—Severability—2007 c 375: See notes following RCW 10.31.110.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Additional notes found at www.leg.wa.gov

71.05.160 Petition for initial detention. (1) Any facility receiving a person pursuant to RCW 71.05.150 or 71.05.153 shall require the designated crisis responder to prepare a petition for initial detention stating the circumstances under which the person's condition was made known and stating that there is evidence, as a result of his or her personal observation or investigation, that the actions of the person for which application is made constitute a likelihood of serious harm, or that he or she is gravely disabled, and stating the specific facts known to him or her as a result of his or her personal observation or investigation, upon which he or she bases the belief that such person should be detained for the purposes and under the authority of this chapter.

(2)(a) If a person is involuntarily placed in an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program pursuant to RCW 71.05.150 or 71.05.153, on the next judicial day following the initial detention, the designated crisis responder shall file with the court and serve the designated attorney of the detained person the petition or supplemental petition for initial detention, proof of service of notice, and a copy of a notice of emergency detention.

(b) If the person is involuntarily detained at an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program in a different county from where the person was initially detained, the facility or program may file with the court and serve the designated attorney of the detained person the petition or supplemental petition for initial detention, proof of service of notice, and a copy of a notice of emergency detention at the request of the designated crisis responder. [2020 c 302 § 18; 2019 c 446 § 19; 2016 sp.s. c 29 § 217; 2007 c 375 § 13; 1998 c 297 § 9; 1997 c 112 § 10; 1974 ex.s. c 145 § 9; 1973 1st ex.s. c 142 § 21.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Purpose—Construction—Severability—2007 c 375: See notes following RCW 10.31.110.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.170 Acceptance of petition—Notice—Duty of state hospital. Whenever the designated crisis responder petitions for detention of a person whose actions constitute a likelihood of serious harm, or who is gravely disabled, the facility providing one hundred twenty hour evaluation and treatment must immediately accept on a provisional basis the petition and the person. The facility shall then evaluate the person's condition and admit, detain, transfer, or discharge such person in accordance with RCW 71.05.210. The facility shall notify in writing the court and the designated crisis responder of the date and time of the initial detention of each person involuntarily detained in order that a probable cause hearing shall be held no later than one hundred twenty hours after detention.

The duty of a state hospital to accept persons for evaluation and treatment under this section shall be limited by chapter 71.24 RCW. [2020 c 302 § 19; 2016 sp.s. c 29 § 218; 2000 c 94 § 5; 1998 c 297 § 10; 1997 c 112 § 11; 1989 c 205 § 10; 1974 ex.s. c 145 § 10; 1973 1st ex.s. c 142 § 22.]

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.180 Detention period for evaluation and treatment. If the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program admits the person, it may detain him or her for evaluation and treatment for a period not to exceed one hundred twenty hours from the time of acceptance as set forth in RCW 71.05.170. The computation of such one hundred twenty hour period shall exclude Saturdays, Sundays and holidays. [2020 c 302 § 20; 2019 c 446 § 18; 2016 sp.s. c 29 § 219; 1997 c 112 § 12; 1979 ex.s. c 215 § 11; 1974 ex.s. c 145 § 11; 1973 1st ex.s. c 142 § 23.]

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.05.182 Six-month suspension of right to possess firearms after detention for evaluation and treatment of person who presents likelihood of serious harm as a result of behavioral health disorder, substance use disorder, or both—Automatic restoration of right at expiration of six-month period. (1) A person who under RCW 71.05.150 or 71.05.153 has been detained at a facility for a period of not more than one hundred twenty hours for the purpose of evaluation and treatment on the grounds that the person presents a likelihood of serious harm, but who has not been subsequently committed for involuntary treatment under RCW 71.05.240, may not have in his or her possession or control any firearm for a period of six months after the date that the person is detained.

(2) Before the discharge of a person who has been initially detained under RCW 71.05.150 or 71.05.153 on the grounds that the person presents a likelihood of serious harm, but has not been subsequently committed for involuntary

treatment under RCW 71.05.240, the designated crisis responder shall inform the person orally and in writing that:

(a) He or she is prohibited from possessing or controlling any firearm for a period of six months;

(b) He or she must immediately surrender, for the six-month period, any concealed pistol license and any firearms that the person possesses or controls to the sheriff of the county or the chief of police of the municipality in which the person is domiciled;

(c) After the six-month suspension, the person's right to control or possess any firearm or concealed pistol license shall be automatically restored, absent further restrictions imposed by other law; and

(d) Upon discharge, the person may petition the superior court to have his or her right to possess a firearm restored before the six-month suspension period has elapsed by following the procedures provided in RCW 9.41.047(3).

(3) The designated crisis responder shall notify the sheriff of the county or the chief of police of the municipality in which the person is domiciled of the six-month suspension.

(4) A law enforcement agency holding any firearm that has been surrendered pursuant to this section shall, upon the request of the person from whom it was obtained, return the firearm at the expiration of the six-month suspension period, or prior to the expiration of the six-month period if the person's right to possess firearms has been restored by the court under RCW 9.41.047. The law enforcement agency, prior to returning the firearm, shall verify with the prosecuting attorney's office or designated crisis responders that the person has not been previously or subsequently committed for involuntary treatment under RCW 71.05.240. The law enforcement agency must comply with the provisions of RCW 9.41.345 when returning a firearm pursuant to this section.

(5) Any firearm surrendered pursuant to this section that remains unclaimed by the lawful owner shall be disposed of in accordance with the law enforcement agency's policies and procedures for the disposal of firearms in police custody. [2020 c 302 § 21; 2019 c 247 § 1.]

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

71.05.190 Persons not admitted—Transportation—Detention of arrested person pending return to custody. If the person is not approved for admission by a facility providing one hundred twenty hour evaluation and treatment, and the individual has not been arrested, the facility shall furnish transportation, if not otherwise available, for the person to his or her place of residence or other appropriate place. If the individual has been arrested, the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program shall detain the individual for not more than eight hours at the request of the peace officer. The facility shall make reasonable attempts to contact the requesting peace officer during this time to inform the peace officer that the person is not approved for admission in order to enable a peace officer to return to the facility and take the individual back into custody. [2020 c 302 § 22; 2019 c 446 § 17; 2016 sp.s. c 29 § 220; 2011 c 305 § 3; 1997 c 112 § 13; 1979 ex.s. c 215 § 12; 1974 ex.s. c 145 § 12; 1973 1st ex.s. c 142 § 24.]

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—2011 c 305: See note following RCW 74.09.295.

71.05.195 Not guilty by reason of insanity—Detention of persons who have fled from state of origin—Probable cause hearing. (1) A civil commitment may be initiated under the procedures described in RCW 71.05.150 or 71.05.153 for a person who has been found not guilty by reason of insanity in a state other than Washington and who has fled from detention, commitment, or conditional release in that state, on the basis of a request by the state in which the person was found not guilty by reason of insanity for the person to be detained and transferred back to the custody or care of the requesting state. A finding of likelihood of serious harm or grave disability is not required for a commitment under this section. The detention may occur at either an evaluation and treatment facility or a state hospital. The petition for one hundred twenty hour detention filed by the designated crisis responder must be accompanied by the following documents:

(a) A copy of an order for detention, commitment, or conditional release of the person in a state other than Washington on the basis of a judgment of not guilty by reason of insanity;

(b) A warrant issued by a magistrate in the state in which the person was found not guilty by reason of insanity indicating that the person has fled from detention, commitment, or conditional release in that state and authorizing the detention of the person within the state in which the person was found not guilty by reason of insanity;

(c) A statement from the executive authority of the state in which the person was found not guilty by reason of insanity requesting that the person be returned to the requesting state and agreeing to facilitate the transfer of the person to the requesting state.

(2) The person shall be entitled to a probable cause hearing within the time limits applicable to other detentions under this chapter and shall be afforded the rights described in this chapter including the right to counsel. At the probable cause hearing, the court shall determine the identity of the person and whether the other requirements of this section are met. If the court so finds, the court may order continued detention in a treatment facility for up to thirty days for the purpose of the transfer of the person to the custody or care of the requesting state. The court may order a less restrictive alternative to detention only under conditions which ensure the person's safe transfer to the custody or care of the requesting state within thirty days without undue risk to the safety of the person or others.

(3) For the purposes of this section, "not guilty by reason of insanity" shall be construed to include any provision of law which is generally equivalent to a finding of criminal insanity within the state of Washington; and "state" shall be construed to mean any state, district, or territory of the United States. [2020 c 302 § 23; 2016 sp.s. c 29 § 221; 2010 c 208 § 1.]

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.05.201 Petition for initial detention when designated crisis responder does not detain—Procedure—Court review. (1) If a designated crisis responder decides not to detain a person for evaluation and treatment under RCW 71.05.150 or 71.05.153 or forty-eight hours have elapsed since a designated crisis responder received a request for investigation and the designated crisis responder has not taken action to have the person detained, an immediate family member or guardian of the person, or a federally recognized Indian tribe if the person is a member of such tribe, may petition the superior court for the person's initial detention.

(2) A petition under this section must be filed within ten calendar days following the designated crisis responder investigation or the request for a designated crisis responder investigation. If more than ten days have elapsed, the immediate family member, guardian, or conservator may request a new designated crisis responder investigation.

(3)(a) The petition must be filed in the county in which the designated crisis responder investigation occurred or was requested to occur and must be submitted on forms developed by the administrative office of the courts for this purpose. The petition must be accompanied by a sworn declaration from the petitioner, and other witnesses if desired, describing why the person should be detained for evaluation and treatment. The description of why the person should be detained may contain, but is not limited to, the information identified in RCW 71.05.212.

(b) The petition must contain:

(i) A description of the relationship between the petitioner and the person; and

(ii) The date on which an investigation was requested from the designated crisis responder.

(4) The court shall, within one judicial day, review the petition to determine whether the petition raises sufficient evidence to support the allegation. If the court so finds, it shall provide a copy of the petition to the designated crisis responder agency with an order for the agency to provide the court, within one judicial day, with a written sworn statement describing the basis for the decision not to seek initial detention and a copy of all information material to the designated crisis responder's current decision.

(5) Following the filing of the petition and before the court reaches a decision, any person, including a mental health professional, may submit a sworn declaration to the court in support of or in opposition to initial detention.

(6) The court shall dismiss the petition at any time if it finds that a designated crisis responder has filed a petition for the person's initial detention under RCW 71.05.150 or 71.05.153 or that the person has voluntarily accepted appropriate treatment.

(7) The court must issue a final ruling on the petition within five judicial days after it is filed. After reviewing all of the information provided to the court, the court may enter an order for initial detention if the court finds that: (a) There is probable cause to support a petition for detention; and (b) the person has refused or failed to accept appropriate evaluation and treatment voluntarily. The court shall transmit its final decision to the petitioner.

(8) If the court enters an order for initial detention, it shall provide the order to the designated crisis responder agency and issue a warrant. The designated crisis responder agency serving the jurisdiction of the court must collaborate and coordinate with law enforcement regarding apprehensions and detentions under this subsection, including sharing of information relating to risk and which would assist in locating the person. A person may not be detained to jail pursuant to a warrant issued under this subsection. An order for detention under this section should contain the advisement of rights which the person would receive if the person were detained by a designated crisis responder. An order for initial detention under this section expires one hundred eighty days from issuance.

(9) Except as otherwise expressly stated in this chapter, all procedures must be followed as if the order had been entered under RCW 71.05.150. RCW 71.05.160 does not apply if detention was initiated under the process set forth in this section.

(10) For purposes of this section, "immediate family member" means a spouse, domestic partner, child, stepchild, parent, stepparent, grandparent, or sibling. [2022 c 210 § 8. Prior: 2020 c 302 § 24; 2020 c 256 § 304; 2018 c 291 § 11; 2017 3rd sp.s. c 14 § 2; prior: 2016 sp.s. c 29 § 222; 2016 c 107 § 1; 2015 c 258 § 2.]

Effective date—2018 c 291 §§ 1-4, 6, 7, 9, 11, 12, 13, and 15: See note following RCW 71.05.020.

Effective date—2017 3rd sp.s. c 14 §§ 2 and 4: "Sections 2 and 4 of this act take effect April 1, 2018." [2017 3rd sp.s. c 14 § 7.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Short title—2015 c 258: "This act may be known and cited as Joel's Law." [2015 c 258 § 1.]

71.05.203 Notice—Petition for detention by family member, guardian, or conservator. (1) The authority and each behavioral health administrative services organization or agency employing designated crisis responders shall publish information in an easily accessible format describing the process for an immediate family member, guardian, or conservator, or a federally recognized Indian tribe if the person is a member of such tribe, to petition for court review of a detention decision under RCW 71.05.201.

(2) A designated crisis responder or designated crisis responder agency that receives a request for investigation for possible detention under this chapter must inquire whether the request comes from an immediate family member, guardian, or conservator, or a federally recognized Indian tribe if the person is a member of such tribe, who would be eligible to petition under RCW 71.05.201. If the designated crisis responder decides not to detain the person for evaluation and treatment under RCW 71.05.150 or 71.05.153 or forty-eight hours have elapsed since the request for investigation was received and the designated crisis responder has not taken action to have the person detained, the designated crisis responder or designated crisis responder agency must inform the immediate family member, guardian, or conservator, or a

federally recognized Indian tribe if the person is a member of such tribe, who made the request for investigation about the process to petition for court review under RCW 71.05.201 and, to the extent feasible, provide the immediate family member, guardian, or conservator, or a federally recognized Indian tribe if the person is a member of such tribe, with written or electronic information about the petition process. Information provided to a federally recognized Indian tribe shall be sent to the tribal contact listed in the authority's tribal crisis coordination plan. If provision of written or electronic information is not feasible, the designated crisis responder or designated crisis responder agency must refer the immediate family member, guardian, or conservator, or a federally recognized Indian tribe if the person is a member of such tribe, to a website where published information on the petition process may be accessed. The designated crisis responder or designated crisis responder agency must document the manner and date on which the information required under this subsection was provided to the immediate family member, guardian, or conservator, or a federally recognized Indian tribe if the person is a member of such tribe.

(3) A designated crisis responder or designated crisis responder agency must, upon request, disclose the date of a designated crisis responder investigation under this chapter to an immediate family member, guardian, or conservator, or a federally recognized Indian tribe if the person is a member of such tribe, of a person to assist in the preparation of a petition under RCW 71.05.201. [2021 c 264 § 5; 2019 c 325 § 3006; 2018 c 201 § 3006; 2017 3rd sp.s. c 14 § 4; (2017 3rd sp.s. c 14 § 3 expired April 1, 2018); 2016 sp.s. c 29 § 223; 2015 c 258 § 3.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2017 3rd sp.s. c 14 §§ 2 and 4: See note following RCW 71.05.201.

Expiration date—2017 3rd sp.s. c 14 §§ 1 and 3: See note following RCW 71.05.201.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Short title—2015 c 258: See note following RCW 71.05.201.

71.05.210 Evaluation—Treatment and care—Release or other disposition. ***(Effective until July 1, 2026.)*** (1) Each person involuntarily detained and accepted or admitted at an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program:

(a) Shall, within twenty-four hours of his or her admission or acceptance at the facility, not counting time periods prior to medical clearance, be examined and evaluated by:

(i) One physician, physician assistant, or advanced registered nurse practitioner; and

(ii) One mental health professional. If the person is detained for substance use disorder evaluation and treatment, the person may be examined by a substance use disorder professional instead of a mental health professional; and

(b) Shall receive such treatment and care as his or her condition requires including treatment on an outpatient basis for the period that he or she is detained, except that, beginning twenty-four hours prior to a trial or hearing pursuant to RCW 71.05.215, 71.05.240, 71.05.310, 71.05.320, 71.05.590, or 71.05.217, the individual may refuse psychiatric medications, but may not refuse: (i) Any other medication previously prescribed by a person licensed under Title 18 RCW; or (ii) emergency lifesaving treatment, and the individual shall be informed at an appropriate time of his or her right of such refusal. The person shall be detained up to one hundred twenty hours, if, in the opinion of the professional person in charge of the facility, or his or her professional designee, the person presents a likelihood of serious harm, or is gravely disabled. A person who has been detained for one hundred twenty hours shall no later than the end of such period be released, unless referred for further care on a voluntary basis, or detained pursuant to court order for further treatment as provided in this chapter.

(2) If, at any time during the involuntary treatment hold and following the initial examination and evaluation, the mental health professional or substance use disorder professional and licensed physician, physician assistant, or psychiatric advanced registered nurse practitioner determine that the initial needs of the person, if detained to an evaluation and treatment facility, would be better served by placement in a secure withdrawal management and stabilization facility or approved substance use disorder treatment program, or, if detained to a secure withdrawal management and stabilization facility or approved substance use disorder treatment program, would be better served in an evaluation and treatment facility then the person shall be referred to the more appropriate placement for the remainder of the current commitment period without any need for further court review; however, a person may only be referred to a secure withdrawal management and stabilization facility or approved substance use disorder treatment program if there is an available secure withdrawal management and stabilization facility or approved substance use disorder treatment program with adequate space for the person.

(3) An evaluation and treatment center, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program admitting or accepting any person pursuant to this chapter whose physical condition reveals the need for hospitalization shall assure that such person is transferred to an appropriate hospital for evaluation or admission for treatment. Notice of such fact shall be given to the court, the designated attorney, and the designated crisis responder and the court shall order such continuance in proceedings under this chapter as may be necessary, but in no event may this continuance be more than fourteen days. [2021 c 264 § 6; 2020 c 302 § 26; (2020 c 302 § 25 expired January 1, 2021); 2019 c 446 § 8; 2017 3rd sp.s. c 14 § 15. Prior: 2016 sp.s. c 29 § 224; 2016 c 155 § 2; prior: 2015 c 269 § 7; 2015 c 250 § 20; 2009 c 217 § 1; 2000 c 94 § 6; 1998 c 297 § 12; 1997 c 112 § 15; 1994 sp.s. c 9 § 747; prior: 1991 c 364 § 11; 1991 c 105 § 4; 1989 c 120 § 6; 1987 c 439 § 2; 1975 1st ex.s. c 199 § 4; 1974 ex.s. c 145 § 14; 1973 1st ex.s. c 142 § 26.]

Expiration date—2021 c 264 §§ 1, 3, 6, 8, 10, 14, 31, and 33: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 13, 16, 26, 39, 45, 55, 78, 83, 86, 92, 94, and 97: See note following RCW 71.05.150.

Expiration date—2019 c 446 §§ 4, 6, 8, 11, 14, 30, 32, 34, 37, 39, and 41: See note following RCW 71.05.150.

Effective date—2017 3rd sp.s. c 14 §§ 9, 12, 14, 15, and 17-21: See note following RCW 71.05.590.

Expiration date—2017 3rd sp.s. c 14 §§ 9 and 15: See note following RCW 71.05.590.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2015 c 269 §§ 1-9 and 11-13: See note following RCW 71.05.010.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

Findings—1991 c 364: "The legislature finds that the use of alcohol and illicit drugs continues to be a primary crippler of our youth. This translates into incredible costs to individuals, families, and society in terms of traffic fatalities, suicides, criminal activity including homicides, sexual promiscuity, familial incorrigibility, and conduct disorders, and educational fallout. Among children of all socioeconomic groups lower expectations for the future, low motivation and self-esteem, alienation, and depression are associated with alcohol and drug abuse.

Studies reveal that deaths from alcohol and other drug-related injuries rise sharply through adolescence, peaking in the early twenties. But second peak occurs in later life, where it accounts for three times as many deaths from chronic diseases. A young victim's life expectancy is likely to be reduced by an average of twenty-six years.

Yet the cost of treating alcohol and drug addicts can be recouped in the first three years of abstinence in health care savings alone. Public money spent on treatment saves not only the life of the chemical abuser, it makes us safer as individuals, and in the long-run costs less.

The legislature further finds that many children who abuse alcohol and other drugs may not require involuntary treatment, but still are not adequately served. These children remain at risk for future chemical dependency, and may become mentally ill or a juvenile offender or need out-of-home placement. Children placed at risk because of chemical abuse may be better served by the creation of a comprehensive integrated system for children in crisis.

The legislature declares that an emphasis on the treatment of youth will pay the largest dividend in terms of preventable costs to individuals themselves, their families, and to society. The provision of augmented involuntary alcohol treatment services to youths, as well as involuntary treatment for youths addicted by other drugs, is in the interest of the public health and safety." [1991 c 364 § 7.]

Additional notes found at www.leg.wa.gov

71.05.210 Evaluation—Treatment and care—Release or other disposition. ***(Effective July 1, 2026.)*** (1) Each person involuntarily detained and accepted or admitted at an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program:

(a) Shall, within twenty-four hours of his or her admission or acceptance at the facility, not counting time periods prior to medical clearance, be examined and evaluated by:

(i) One physician, physician assistant, or advanced registered nurse practitioner; and

(ii) One mental health professional. If the person is detained for substance use disorder evaluation and treatment, the person may be examined by a substance use disorder professional instead of a mental health professional; and

(b) Shall receive such treatment and care as his or her condition requires including treatment on an outpatient basis for the period that he or she is detained, except that, beginning twenty-four hours prior to a trial or hearing pursuant to RCW 71.05.215, 71.05.240, 71.05.310, 71.05.320, 71.05.590, or 71.05.217, the individual may refuse psychiatric medications, but may not refuse: (i) Any other medication previously prescribed by a person licensed under Title 18 RCW; or (ii) emergency lifesaving treatment, and the individual shall be informed at an appropriate time of his or her right of such refusal. The person shall be detained up to one hundred twenty hours, if, in the opinion of the professional person in charge of the facility, or his or her professional designee, the person presents a likelihood of serious harm, or is gravely disabled. A person who has been detained for one hundred twenty hours shall no later than the end of such period be released, unless referred for further care on a voluntary basis, or detained pursuant to court order for further treatment as provided in this chapter.

(2) If, at any time during the involuntary treatment hold and following the initial examination and evaluation, the mental health professional or substance use disorder professional and licensed physician, physician assistant, or psychiatric advanced registered nurse practitioner determine that the initial needs of the person, if detained to an evaluation and treatment facility, would be better served by placement in a secure withdrawal management and stabilization facility or approved substance use disorder treatment program, or, if detained to a secure withdrawal management and stabilization facility or approved substance use disorder treatment program, would be better served in an evaluation and treatment facility then the person shall be referred to the more appropriate placement for the remainder of the current commitment period without any need for further court review.

(3) An evaluation and treatment center, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program admitting or accepting any person pursuant to this chapter whose physical condition reveals the need for hospitalization shall assure that such person is transferred to an appropriate hospital for evaluation or admission for treatment. Notice of such fact shall be given to the court, the designated attorney, and the designated crisis responder and the court shall order such continuance in proceedings under this chapter as may be necessary, but in no event may this continuance be more than fourteen days. [2021 c 264 § 7; 2020 c 302 § 27; (2020 c 302 § 25 expired January 1, 2021); 2019 c 446 § 9; 2017 3rd sp.s. c 14 § 16; 2016 sp.s. c 29 § 225; 2016 sp.s. c 29 § 224; 2016 c 155 § 2. Prior: 2015 c 269 § 7; 2015 c 250 § 20; 2009 c 217 § 1; 2000 c 94 § 6; 1998 c 297 § 12; 1997 c 112 § 15; 1994 sp.s. c 9 § 747; prior: 1991 c 364 § 11; 1991 c 105 § 4; 1989 c 120 § 6; 1987 c 439 § 2; 1975 1st ex.s. c 199 § 4; 1974 ex.s. c 145 § 14; 1973 1st ex.s. c 142 § 26.]

Effective date—2021 c 264 §§ 2, 4, 7, 9, 11, 15, 32, and 34: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Effective date—2020 c 302 §§ 14, 17, 27, 40, 46, 56, 79, 84, 87, 93, 95, and 98: See note following RCW 71.05.150.

Effective date—2019 c 446 §§ 5, 7, 9, 12, 15, 31, 33, 35, 38, 40, and 42: See note following RCW 71.05.150.

Effective date—2017 3rd sp.s. c 14 §§ 10 and 16: See note following RCW 71.05.590.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2015 c 269 §§ 1-9 and 11-13: See note following RCW 71.05.010.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

Findings—1991 c 364: "The legislature finds that the use of alcohol and illicit drugs continues to be a primary crippler of our youth. This translates into incredible costs to individuals, families, and society in terms of traffic fatalities, suicides, criminal activity including homicides, sexual promiscuity, familial incorrigibility, and conduct disorders, and educational fallout. Among children of all socioeconomic groups lower expectations for the future, low motivation and self-esteem, alienation, and depression are associated with alcohol and drug abuse.

Studies reveal that deaths from alcohol and other drug-related injuries rise sharply through adolescence, peaking in the early twenties. But second peak occurs in later life, where it accounts for three times as many deaths from chronic diseases. A young victim's life expectancy is likely to be reduced by an average of twenty-six years.

Yet the cost of treating alcohol and drug addicts can be recouped in the first three years of abstinence in health care savings alone. Public money spent on treatment saves not only the life of the chemical abuser, it makes us safer as individuals, and in the long-run costs less.

The legislature further finds that many children who abuse alcohol and other drugs may not require involuntary treatment, but still are not adequately served. These children remain at risk for future chemical dependency, and may become mentally ill or a juvenile offender or need out-of-home placement. Children placed at risk because of chemical abuse may be better served by the creation of a comprehensive integrated system for children in crisis.

The legislature declares that an emphasis on the treatment of youth will pay the largest dividend in terms of preventable costs to individuals themselves, their families, and to society. The provision of augmented involuntary alcohol treatment services to youths, as well as involuntary treatment for youths addicted by other drugs, is in the interest of the public health and safety." [1991 c 364 § 7.]

Additional notes found at www.leg.wa.gov

71.05.212 Evaluation—Consideration of information and records. ***(Contingent expiration date.)*** (1) Whenever a designated crisis responder or professional person is conducting an evaluation under this chapter, consideration shall include all reasonably available information from credible witnesses and records regarding:

(a) Prior recommendations for evaluation of the need for civil commitments when the recommendation is made pursuant to an evaluation conducted under chapter 10.77 RCW;

(b) Historical behavior, including history of one or more violent acts;

(c) Prior determinations of incompetency or insanity under chapter 10.77 RCW; and

(d) Prior commitments under this chapter.

(2) Credible witnesses may include family members, landlords, neighbors, or others with significant contact and history of involvement with the person. If the designated crisis responder relies upon information from a credible witness in reaching his or her decision to detain the individual, then he or she must provide contact information for any such witness to the prosecutor. The designated crisis responder or prosecutor shall provide notice of the date, time, and location of the probable cause hearing to such a witness.

(3) Symptoms and behavior of the respondent which standing alone would not justify civil commitment may support a finding of grave disability or likelihood of serious harm, or a finding that the person is in need of assisted outpatient treatment, when:

(a) Such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts;

(b) These symptoms or behavior represent a marked and concerning change in the baseline behavior of the respondent; and

(c) Without treatment, the continued deterioration of the respondent is probable.

(4) When conducting an evaluation for offenders identified under RCW 72.09.370, the designated crisis responder or professional person shall consider an offender's history of judicially required or administratively ordered antipsychotic medication while in confinement. [2022 c 210 § 9; 2020 c 256 § 305; 2018 c 291 § 13; 2016 sp.s. c 29 § 226; 2015 c 250 § 5; (2011 2nd sp.s. c 6 § 2 expired July 1, 2014); 2010 c 280 § 2; 1999 c 214 § 5; 1998 c 297 § 19.]

Effective date—2018 c 291 §§ 1-4, 6, 7, 9, 11, 12, 13, and 15: See note following RCW 71.05.020.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2013 c 335; 2011 2nd sp.s. c 6; 2010 c 280 §§ 2 and 3: "Sections 2 and 3 of this act take effect July 1, 2014." [2013 c 335 § 1; 2011 2nd sp.s. c 6 § 1; 2010 c 280 § 5.]

Expiration date—2013 c 335; 2011 2nd sp.s. c 6 § 2: "Section 2 of this act expires July 1, 2014." [2013 c 335 § 2; 2011 2nd sp.s. c 6 § 3.]

Intent—Effective date—1999 c 214: See notes following RCW 72.09.370.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.05.212 Evaluation—Consideration of information and records. ***(Contingent effective date.)*** (1) Whenever a designated crisis responder or professional person is conducting an evaluation under this chapter, consideration shall include all reasonably available information from credible witnesses and records regarding:

(a) Prior recommendations for evaluation of the need for civil commitments when the recommendation is made pursuant to an evaluation conducted under chapter 10.77 RCW;

(b) Historical behavior, including history of one or more violent acts;

(c) Prior determinations of incompetency or insanity under chapter 10.77 RCW; and

(d) Prior commitments under this chapter.

(2) Credible witnesses may include family members, landlords, neighbors, or others with significant contact and history of involvement with the person. If the designated crisis responder relies upon information from a credible witness in reaching his or her decision to detain the individual, then he or she must provide contact information for any such witness to the prosecutor. The designated crisis responder or prosecutor shall provide notice of the date, time, and location of the probable cause hearing to such a witness.

(3) Symptoms and behavior of the respondent which standing alone would not justify civil commitment may support a finding of grave disability or likelihood of serious harm, or a finding that the person is in need of assisted outpatient treatment, when:

(a) Such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration from safe behavior, or one or more violent acts;

(b) These symptoms or behavior represent a marked and concerning change in the baseline behavior of the respondent; and

(c) Without treatment, the continued deterioration of the respondent is probable.

(4) When conducting an evaluation for offenders identified under RCW 72.09.370, the designated crisis responder or professional person shall consider an offender's history of judicially required or administratively ordered antipsychotic medication while in confinement. [2022 c 210 § 10. Prior: 2020 c 302 § 28; 2020 c 256 § 305; 2018 c 291 § 13; 2016 sp.s. c 29 § 226; 2015 c 250 § 5; (2011 2nd sp.s. c 6 § 2 expired July 1, 2014); 2010 c 280 § 2; 1999 c 214 § 5; 1998 c 297 § 19.]

Contingent effective date—2022 c 210 §§ 2 and 10; 2021 c 264 §§ 22 and 23; 2021 c 263 §§ 13 and 14; 2020 c 302 §§ 4 and 28: See note following RCW 71.05.020.

Effective date—2018 c 291 §§ 1-4, 6, 7, 9, 11, 12, 13, and 15: See note following RCW 71.05.020.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2013 c 335; 2011 2nd sp.s. c 6; 2010 c 280 §§ 2 and 3: "Sections 2 and 3 of this act take effect July 1, 2014." [2013 c 335 § 1; 2011 2nd sp.s. c 6 § 1; 2010 c 280 § 5.]

Expiration date—2013 c 335; 2011 2nd sp.s. c 6 § 2: "Section 2 of this act expires July 1, 2014." [2013 c 335 § 2; 2011 2nd sp.s. c 6 § 3.]

Intent—Effective date—1999 c 214: See notes following RCW 72.09.370.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.05.214 Protocols—Development—Submission to governor and legislature. The authority shall develop statewide protocols to be utilized by professional persons and designated crisis responders in administration of this chapter and chapters 10.77 and 71.34 RCW. The protocols shall be updated at least every three years. The protocols shall provide uniform development and application of criteria in evaluation and commitment recommendations, of persons who have, or are alleged to have, behavioral health disorders and are subject to this chapter.

The initial protocols shall be developed not later than September 1, 1999. The authority shall develop and update the protocols in consultation with representatives of designated crisis responders, the department of social and health services, local government, law enforcement, county and city prosecutors, public defenders, and groups concerned with behavioral health disorders. The protocols shall be submitted to the governor and legislature upon adoption by the authority. [2020 c 302 § 29; 2018 c 201 § 3007; 2016 sp.s. c 29 § 227; 1998 c 297 § 26.]

Addendum to designated crisis responder statewide protocols—2019 c 446: "Within existing resources, the health care authority shall develop an addendum to the designated crisis responder statewide protocols adopted pursuant to RCW 71.05.214 in consultation with representatives of designated crisis responders, the department of social and health services, local government, law enforcement, county and city prosecutors, public defenders, and groups concerned with mental illness and substance use disorders. The addendum must update the current protocols to address the implementation of the integration of mental health and substance use disorder treatment systems, to include general processes for referrals and investigations of individuals with substance use disorders and the applicability of commitment criteria to individuals with substance use disorders. The authority shall adopt and submit the addendum to the governor and the legislature by December 1, 2019." [2019 c 446 § 1.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.215 Right to refuse antipsychotic medicine—Rules. (1) A person found to be gravely disabled or to present a likelihood of serious harm as a result of a behavioral health disorder has a right to refuse antipsychotic medication unless it is determined that the failure to medicate may result in a likelihood of serious harm or substantial deterioration or substantially prolong the length of involuntary commitment and there is no less intrusive course of treatment than medication in the best interest of that person.

(2) The authority shall adopt rules to carry out the purposes of this chapter. These rules shall include:

(a) An attempt to obtain the informed consent of the person prior to administration of antipsychotic medication.

(b) For short-term treatment up to thirty days, the right to refuse antipsychotic medications unless there is an additional concurring medical opinion approving medication by a psychiatrist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, or physician or physician assistant in consultation with a mental health professional with prescriptive authority.

(c) For continued treatment beyond thirty days through the hearing on any petition filed under RCW 71.05.217, the right to periodic review of the decision to medicate by the medical director or designee.

(d) Administration of antipsychotic medication in an emergency and review of this decision within twenty-four hours. An emergency exists if the person presents an imminent likelihood of serious harm, and medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to be successful; and in the opinion of the physician, physician assistant, or psychiatric advanced registered nurse practitioner, the person's condition constitutes an emergency requiring the treatment be instituted prior to obtaining a second medical opinion.

(e) Documentation in the medical record of the attempt by the physician, physician assistant, or psychiatric advanced registered nurse practitioner to obtain informed consent and the reasons why antipsychotic medication is being administered over the person's objection or lack of consent. [2020 c 302 § 30; 2018 c 201 § 3008. Prior: 2016 sp.s. c 29 § 228; 2016 c 155 § 3; 2008 c 156 § 2; 1997 c 112 § 16; 1991 c 105 § 1.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.05.217 Rights—Posting of list. (1) Insofar as danger to the individual or others is not created, each person involuntarily detained, treated in a less restrictive alternative course of treatment, or committed for treatment and evaluation pursuant to this chapter shall have, in addition to other rights not specifically withheld by law, the following rights, a list of which shall be prominently posted in all facilities, institutions, and hospitals providing such services:

(a) To wear his or her own clothes and to keep and use his or her own personal possessions, except when deprivation of same is essential to protect the safety of the resident or other persons;

(b) To keep and be allowed to spend a reasonable sum of his or her own money for canteen expenses and small purchases;

(c) To have access to individual storage space for his or her private use;

(d) To have visitors at reasonable times;

(e) To have reasonable access to a telephone, both to make and receive confidential calls;

(f) To have ready access to letter writing materials, including stamps, and to send and receive uncensored correspondence through the mails;

(g) To have the right to individualized care and adequate treatment;

(h) To discuss treatment plans and decisions with professional persons;

(i) To not be denied access to treatment by spiritual means through prayer in accordance with the tenets and practices of a church or religious denomination in addition to the treatment otherwise proposed;

(j) Not to consent to the administration of antipsychotic medications beyond the hearing conducted pursuant to RCW 71.05.320(4) or the performance of electroconvulsant therapy or surgery, except emergency lifesaving surgery, unless ordered by a court of competent jurisdiction pursuant to the following standards and procedures:

(i) The administration of antipsychotic medication or electroconvulsant therapy shall not be ordered unless the petitioning party proves by clear, cogent, and convincing evidence that there exists a compelling state interest that justifies overriding the patient's lack of consent to the administration of antipsychotic medications or electroconvulsant therapy, that the proposed treatment is necessary and effective, and that medically acceptable alternative forms of treatment are not available, have not been successful, or are not likely to be effective.

(ii) The court shall make specific findings of fact concerning: (A) The existence of one or more compelling state interests; (B) the necessity and effectiveness of the treatment; and (C) the person's desires regarding the proposed treatment. If the patient is unable to make a rational and informed decision about consenting to or refusing the proposed treatment, the court shall make a substituted judgment for the patient as if he or she were competent to make such a determination.

(iii) The person shall be present at any hearing on a request to administer antipsychotic medication or electroconvulsant therapy filed pursuant to this subsection. The person has the right: (A) To be represented by an attorney; (B) to present evidence; (C) to cross-examine witnesses; (D) to have the rules of evidence enforced; (E) to remain silent; (F) to view and copy all petitions and reports in the court file; and (G) to be given reasonable notice and an opportunity to prepare for the hearing. The court may appoint a psychiatrist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychologist within their scope of practice, physician assistant, or physician to examine and testify on behalf of such person. The court shall appoint a psychiatrist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychologist within their scope of practice, physician assistant, or physician designated by such person or the person's counsel to testify on behalf of the person in cases where an order for electroconvulsant therapy is sought.

(iv) An order for the administration of antipsychotic medications entered following a hearing conducted pursuant to this section shall be effective for the period of the current involuntary treatment order, and any interim period during which the person is awaiting trial or hearing on a new petition for involuntary treatment or involuntary medication.

(v) Any person detained pursuant to RCW 71.05.320(4), who subsequently refuses antipsychotic medication, shall be entitled to the procedures set forth in this subsection.

(vi) Antipsychotic medication may be administered to a nonconsenting person detained or committed pursuant to this chapter without a court order pursuant to RCW 71.05.215(2) or under the following circumstances:

(A) A person presents an imminent likelihood of serious harm;

(B) Medically acceptable alternatives to administration of antipsychotic medications are not available, have not been successful, or are not likely to be effective; and

(C) In the opinion of the physician, physician assistant, or psychiatric advanced registered nurse practitioner with responsibility for treatment of the person, or his or her designee, the person's condition constitutes an emergency requiring the treatment be instituted before a judicial hearing as authorized pursuant to this section can be held.

If antipsychotic medications are administered over a person's lack of consent pursuant to this subsection, a petition for an order authorizing the administration of antipsychotic medications shall be filed on the next judicial day. The hearing shall be held within two judicial days. If deemed necessary by the physician, physician assistant, or psychiatric advanced registered nurse practitioner with responsibility for the treatment of the person, administration of antipsychotic medications may continue until the hearing is held;

(k) To dispose of property and sign contracts unless such person has been adjudicated an incompetent in a court proceeding directed to that particular issue;

(l) Not to have psychosurgery performed on him or her under any circumstances.

(2) Every person involuntarily detained or committed under the provisions of this chapter is entitled to all the rights set forth in this chapter and retains all rights not denied him or her under this chapter except as limited by chapter 9.41 RCW.

(3) No person may be presumed incompetent as a consequence of receiving evaluation or treatment for a behavioral health disorder. Competency may not be determined or withdrawn except under the provisions of chapter 10.77 or *11.88 RCW.

(4) Subject to RCW 71.05.745 and related regulations, persons receiving evaluation or treatment under this chapter must be given a reasonable choice of an available physician, physician assistant, psychiatric advanced registered nurse practitioner, or other professional person qualified to provide such services.

(5) Whenever any person is detained under this chapter, the person must be advised that unless the person is released or voluntarily admits himself or herself for treatment within one hundred twenty hours of the initial detention, a judicial hearing must be held in a superior court within one hundred twenty hours to determine whether there is probable cause to detain the person for up to an additional fourteen days based on an allegation that because of a behavioral health disorder the person presents a likelihood of serious harm or is gravely disabled, and that at the probable cause hearing the person has the following rights:

(a) To communicate immediately with an attorney; to have an attorney appointed if the person is indigent; and to be told the name and address of the attorney that has been designated;

(b) To remain silent, and to know that any statement the person makes may be used against him or her;

(c) To present evidence on the person's behalf;

(d) To cross-examine witnesses who testify against him or her;

(e) To be proceeded against by the rules of evidence;

(f) To have the court appoint a reasonably available independent professional person to examine the person and testify in the hearing, at public expense unless the person is able to bear the cost;

(g) To view and copy all petitions and reports in the court file; and

(h) To refuse psychiatric medications, including antipsychotic medication beginning twenty-four hours prior to the probable cause hearing.

(6) The judicial hearing described in subsection (5) of this section must be held according to the provisions of subsection (5) of this section and rules promulgated by the supreme court.

(7)(a) Privileges between patients and physicians, physician assistants, psychologists, or psychiatric advanced registered nurse practitioners are deemed waived in proceedings under this chapter relating to the administration of antipsychotic medications. As to other proceedings under this chapter, the privileges are waived when a court of competent jurisdiction in its discretion determines that such waiver is necessary to protect either the detained person or the public.

(b) The waiver of a privilege under this section is limited to records or testimony relevant to evaluation of the detained person for purposes of a proceeding under this chapter. Upon motion by the detained person or on its own motion, the court shall examine a record or testimony sought by a petitioner to determine whether it is within the scope of the waiver.

(c) The record maker may not be required to testify in order to introduce medical or psychological records of the detained person so long as the requirements of RCW 5.45.020 are met except that portions of the record which contain opinions as to the detained person's mental state must be deleted from such records unless the person making such conclusions is available for cross-examination.

(8) Nothing contained in this chapter prohibits the patient from petitioning by writ of habeas corpus for release.

(9) Nothing in this section permits any person to knowingly violate a no-contact order or a condition of an active judgment and sentence or an active condition of supervision by the department of corrections.

(10) The rights set forth under this section apply equally to ninety-day or one hundred eighty-day hearings under RCW 71.05.310. [2020 c 302 § 32; (2020 c 302 § 31 expired January 1, 2021); 2016 c 155 § 4; 2008 c 156 § 3; 1997 c 112 § 31; 1991 c 105 § 5; 1989 c 120 § 8; 1974 ex.s. c 145 § 26; 1973 1st ex.s. c 142 § 42. Formerly RCW 71.05.370.]

***Reviser's note:** Chapter 11.88 RCW was repealed by 2020 c 312 § 904, effective January 1, 2022.

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Additional notes found at www.leg.wa.gov

71.05.220 Property of committed person. At the time a person is involuntarily admitted to an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program, the professional person in charge or his or her designee shall take reasonable precautions to inventory and safeguard the personal property of the person detained. A copy of the inventory, signed by the staff member making it, shall be given to the person detained and shall, in addition, be open to inspection to any responsible relative, subject to limitations, if any, specifically imposed by the detained person. For purposes of this section, "responsible relative" includes the guardian, conservator, attorney, spouse, parent, adult child, or adult brother or sister of the person. The facility shall not disclose the contents of the inventory to any other person without the consent of the patient or order of the court. [2019 c 446 § 10; 2016 sp.s. c 29 § 229; 1997 c 112 § 17; 1973 1st ex.s. c 142 § 27.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.05.230 Commitment beyond initial evaluation and treatment period—Petition for fourteen day involuntary treatment or ninety days of less restrictive alternative treatment—Procedure. A person detained for one hundred twenty hours of evaluation and treatment may be committed for not more than fourteen additional days of involuntary intensive treatment or ninety additional days of a less restrictive alternative treatment. A petition may only be filed if the following conditions are met:

(1) The professional staff of the facility providing evaluation services has analyzed the person's condition and finds that the condition is caused by a behavioral health disorder and results in: (a) A likelihood of serious harm; or (b) the per-

son being gravely disabled; and are prepared to testify those conditions are met; and

(2) The person has been advised of the need for voluntary treatment and the professional staff of the facility has evidence that he or she has not in good faith volunteered; and

(3) The facility providing intensive treatment is certified to provide such treatment by the department or under RCW 71.05.745; and

(4)(a)(i) The professional staff of the facility or the designated crisis responder has filed a petition with the court for a fourteen day involuntary detention or a ninety day less restrictive alternative. The petition must be signed by:

(A) One physician, physician assistant, or psychiatric advanced registered nurse practitioner; and

(B) One physician, physician assistant, psychiatric advanced registered nurse practitioner, or mental health professional.

(ii) If the petition is for substance use disorder treatment, the petition may be signed by a substance use disorder professional instead of a mental health professional and by an advanced registered nurse practitioner instead of a psychiatric advanced registered nurse practitioner. The persons signing the petition must have examined the person.

(b) If involuntary detention is sought the petition shall state facts that support the finding that such person, as a result of a behavioral health disorder, presents a likelihood of serious harm, or is gravely disabled and that there are no less restrictive alternatives to detention in the best interest of such person or others. The petition shall state specifically that less restrictive alternative treatment was considered and specify why treatment less restrictive than detention is not appropriate. If an involuntary less restrictive alternative is sought, the petition shall state facts that support the finding that such person, as a result of a behavioral health disorder, presents a likelihood of serious harm or is gravely disabled and shall set forth any recommendations for less restrictive alternative treatment services; and

(5) A copy of the petition has been served on the detained person, his or her attorney, and his or her guardian, if any, prior to the probable cause hearing; and

(6) The court at the time the petition was filed and before the probable cause hearing has appointed counsel to represent such person if no other counsel has appeared; and

(7) The petition reflects that the person was informed of the loss of firearm rights if involuntarily committed for mental health treatment; and

(8) At the conclusion of the initial commitment period, the professional staff of the agency or facility or the designated crisis responder may petition for an additional period of either 90 days of less restrictive alternative treatment or 90 days of involuntary intensive treatment as provided in RCW 71.05.290; and

(9) If the hospital or facility designated to provide less restrictive alternative treatment is other than the facility providing involuntary treatment, the outpatient facility so designated to provide less restrictive alternative treatment has agreed to assume such responsibility. [2022 c 210 § 11; 2020 c 302 § 34; (2020 c 302 § 33 expired January 1, 2021); 2018 c 291 § 6; 2017 3rd sp.s. c 14 § 17. Prior: 2016 sp.s. c 29 § 230; 2016 c 155 § 5; 2016 c 45 § 1; 2015 c 250 § 6; 2011 c 343 § 9; prior: 2009 c 293 § 3; 2009 c 217 § 2; 2006 c 333 § 302; 1998 c 297 § 13; 1997 c 112 § 18; 1987 c 439 § 3; 1975 1st ex.s. c 199 § 5; 1974 ex.s. c 145 § 15; 1973 1st ex.s. c 142 § 28.]

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Effective date—2018 c 291 §§ 1-4, 6, 7, 9, 11, 12, 13, and 15: See note following RCW 71.05.020.

Effective date—2017 3rd sp.s. c 14 §§ 9, 12, 14, 15, and 17-21: See note following RCW 71.05.590.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Intent—Effective date—2011 c 343: See notes following RCW 71.05.730.

Finding—Purpose—Intent—Severability—Part headings not law—Effective dates—2006 c 333: See notes following RCW 71.24.016.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.232 Discharge reviews—Consultations, notifications required. (1) When a state hospital admits a person for evaluation or treatment under this chapter who has a history of one or more violent acts and:

(a) Has been transferred from a correctional facility; or

(b) Is or has been under the authority of the department of corrections or the indeterminate sentence review board,

the state hospital shall consult with the appropriate corrections and *chemical dependency personnel and the appropriate forensic staff at the state hospital to conduct a discharge review to determine whether the person presents a likelihood of serious harm and whether the person is appropriate for release to a less restrictive alternative.

(2) When a state hospital returns a person who was reviewed under subsection (1) of this section to a correctional facility, the hospital shall notify the correctional facility that the person was subject to a discharge review pursuant to this section. [2004 c 166 § 18.]

***Reviser's note:** RCW 71.05.020 was amended by 2019 c 325 § 3001, deleting the definition of "chemical dependency," effective January 1, 2020.

Additional notes found at www.leg.wa.gov

71.05.235 Examination, evaluation of criminal defendant—Hearing. (1) If an individual is referred to a designated crisis responder under *RCW 10.77.088(2)(d)(i), the designated crisis responder shall examine the individual within forty-eight hours. If the designated crisis responder determines it is not appropriate to detain the individual or petition for a ninety-day less restrictive alternative under RCW 71.05.230(4), that decision shall be immediately presented to the superior court for hearing. The court shall hold a hearing to consider the decision of the designated crisis responder not later than the next judicial day. At the hearing the superior court shall review the determination of the designated crisis responder and determine whether an order should be entered requiring the person to be evaluated at an evaluation and treatment facility. No person referred to an evaluation and treatment facility may be held at the facility longer than one hundred twenty hours.

(2) If an individual is placed in an evaluation and treatment facility under *RCW 10.77.088(2)(d)(ii), a professional

person shall evaluate the individual for purposes of determining whether to file a ninety-day inpatient or outpatient petition under this chapter. Before expiration of the one hundred twenty hour evaluation period authorized under *RCW 10.77.088(2)(d)(ii), the professional person shall file a petition or, if the recommendation of the professional person is to release the individual, present his or her recommendation to the superior court of the county in which the criminal charge was dismissed. The superior court shall review the recommendation not later than forty-eight hours, excluding Saturdays, Sundays, and holidays, after the recommendation is presented. If the court rejects the recommendation to unconditionally release the individual, the court may order the individual detained at a designated evaluation and treatment facility for not more than a one hundred twenty hour evaluation and treatment period. If the evaluation and treatment facility files a ninety-day petition within the one hundred twenty hour period, the clerk shall set a hearing after the day of filing consistent with RCW 71.05.300. Upon the individual's first appearance in court after a petition has been filed, proceedings under RCW 71.05.310 and 71.05.320 shall commence. For an individual subject to this subsection, the professional person may directly file a petition for ninety-day inpatient or outpatient treatment and no petition for initial detention or fourteen-day detention is required before such a petition may be filed.

(3) If a designated crisis responder or the professional person and prosecuting attorney for the county in which the criminal charge was dismissed or attorney general, as appropriate, stipulate that the individual does not present a likelihood of serious harm or is not gravely disabled, the hearing under this section is not required and the individual, if in custody, shall be released. [2020 c 302 § 36; (2020 c 302 § 35 expired January 1, 2021); 2016 sp.s. c 29 § 231; 2015 1st sp.s. c 7 § 14; 2008 c 213 § 5; 2005 c 504 § 708; 2000 c 74 § 6; 1999 c 11 § 1; 1998 c 297 § 18.]

***Reviser's note:** RCW 10.77.088 was amended by 2022 c 288 § 5, changing subsection (2)(d)(i) and (ii) to subsection (5)(a) and (b).

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Finding—2015 1st sp.s. c 7: See note following RCW 10.77.075.

Effective dates—2015 1st sp.s. c 7: See note following RCW 10.77.075.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.05.236 Involuntary commitment hearing—Postponement—Continuance. (1) In any proceeding for involuntary commitment under this chapter, the court may continue or postpone such proceeding for a reasonable time on motion of the respondent for good cause, or on motion of the prosecuting attorney or the attorney general if:

(a) The respondent expressly consents to a continuance or delay and there is a showing of good cause; or

(b) Such continuance is required in the proper administration of justice and the respondent will not be substantially prejudiced in the presentation of the respondent's case.

(2) The court may continue a hearing on a petition filed under RCW 71.05.280(3) for good cause upon written request by the petitioner, respondent, or respondent's attorney.

(3) The court may on its own motion continue the case when required in due administration of justice and when the respondent will not be substantially prejudiced in the presentation of the respondent's case.

(4) The court shall state in any order of continuance or postponement the grounds for the continuance or postponement and whether detention will be extended. [2020 c 302 § 37.]

71.05.237 Judicial proceedings—Court to enter findings when recommendations of professional person not followed. In any judicial proceeding in which a professional person has made a recommendation regarding whether an individual should be committed for treatment under this chapter, and the court does not follow the recommendation, the court shall enter findings that state with particularity its reasoning, including a finding whether the state met its burden of proof in showing whether the person presents a likelihood of serious harm. [1998 c 297 § 25.]

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.240 Petition for up to 14 days of involuntary treatment or 90 days or 18 months of less restrictive alternative treatment—Probable cause hearing. ***(Effective until July 1, 2026.)*** (1) If a petition is filed for up to 14 days of involuntary treatment, 90 days of less restrictive alternative treatment, or 18 months of less restrictive alternative treatment under RCW 71.05.148, the court shall hold a probable cause hearing within 120 hours of the initial detention under RCW 71.05.180, or at a time scheduled under RCW 71.05.148.

(2) If the petition is for mental health treatment, the court or the prosecutor at the time of the probable cause hearing and before an order of commitment is entered shall inform the person both orally and in writing that the failure to make a good faith effort to seek voluntary treatment as provided in RCW 71.05.230 will result in the loss of his or her firearm rights if the person is subsequently detained for involuntary treatment under this section.

(3) If the person or his or her attorney alleges, prior to the commencement of the hearing, that the person has in good faith volunteered for treatment, the petitioner must show, by preponderance of the evidence, that the person has not in good faith volunteered for appropriate treatment. In order to qualify as a good faith volunteer, the person must abide by procedures and a treatment plan as prescribed by a treatment facility and professional staff.

(4)(a) Subject to (b) of this subsection, at the conclusion of the probable cause hearing, if the court finds by a preponderance of the evidence that a person detained for behavioral health treatment, as the result of a behavioral health disorder,

presents a likelihood of serious harm, or is gravely disabled, and, after considering less restrictive alternatives to involuntary detention and treatment, finds that no such alternatives are in the best interests of such person or others, the court shall order that such person be detained for involuntary treatment not to exceed 14 days in a facility licensed or certified to provide treatment by the department or under RCW 71.05.745.

(b) A court may only order commitment to a secure withdrawal management and stabilization facility or approved substance use disorder treatment program if there is an available facility with adequate space for the person.

(c) At the conclusion of the probable cause hearing, if the court finds by a preponderance of the evidence that a person detained for behavioral health treatment, as the result of a behavioral health disorder, presents a likelihood of serious harm or is gravely disabled, but that treatment in a less restrictive setting than detention is in the best interest of such person or others, the court shall order an appropriate less restrictive alternative course of treatment for up to ninety days.

(d) If the court finds by a preponderance of the evidence that a person subject to a petition under RCW 71.05.148, as the result of a behavioral health disorder, is in need of assisted outpatient treatment, the court shall order an appropriate less restrictive alternative course of treatment for up to 18 months.

(5) An order for less restrictive alternative treatment must name the behavioral health service provider responsible for identifying the services the person will receive in accordance with RCW 71.05.585, and must include a requirement that the person cooperate with the treatment recommendations of the behavioral health service provider.

(6) The court shall notify the person orally and in writing that if involuntary treatment is sought beyond the 14-day inpatient or 90-day less restrictive treatment period, the person has the right to a full hearing or jury trial under RCW 71.05.310. If the commitment is for mental health treatment, the court shall notify the person orally and in writing that the person is barred from the possession of firearms and that the prohibition remains in effect until a court restores his or her right to possess a firearm under RCW 9.41.047.

(7) If the court does not issue an order to detain or commit a person under this section, the court shall issue an order to dismiss the petition.

(8) Nothing in this section precludes the court from subsequently modifying the terms of an order for less restrictive alternative treatment under RCW 71.05.590(3). [2022 c 210 § 12; 2021 c 264 § 8; 2020 c 302 § 39; (2020 c 302 § 38 expired January 1, 2021); 2019 c 446 § 11. Prior: 2018 c 291 § 7; 2018 c 201 § 3009; prior: 2016 sp.s. c 29 § 232; 2016 c 45 § 2; 2015 c 250 § 7; 2009 c 293 § 4; 1997 c 112 § 19; 1992 c 168 § 3; 1987 c 439 § 5; 1979 ex.s. c 215 § 13; 1974 ex.s. c 145 § 16; 1973 1st ex.s. c 142 § 29.]

Expiration date—2022 c 210 §§ 5, 12, 17, and 23: See note following RCW 71.05.150.

Expiration date—2021 c 264 §§ 1, 3, 6, 8, 10, 14, 31, and 33: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 13, 16, 26, 39, 45, 55, 78, 83, 86, 92, 94, and 97: See note following RCW 71.05.150.

Expiration date—2019 c 446 §§ 4, 6, 8, 11, 14, 30, 32, 34, 37, 39, and 41: See note following RCW 71.05.150.

Effective date—2018 c 291 §§ 1-4, 6, 7, 9, 11, 12, 13, and 15: See note following RCW 71.05.020.

Expiration date—2018 c 291 §§ 4, 7, and 9: See note following RCW 71.05.150.

Expiration date—2018 c 201 §§ 3009, 3012, 3026, 5017, and 5020: "Sections 3009, 3012, 3026, 5017, and 5020 of this act expire July 1, 2026." [2018 c 201 § 11004.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.05.240 Petition for up to 14 days of involuntary treatment or 90 days or 18 months of less restrictive alternative treatment—Probable cause hearing. ***(Effective July 1, 2026.)*** (1) If a petition is filed for up to 14 days of involuntary treatment, 90 days of less restrictive alternative treatment, or 18 months of less restrictive alternative treatment under RCW 71.05.148, the court shall hold a probable cause hearing within 120 hours of the initial detention under RCW 71.05.180, or at a time scheduled under RCW 71.05.148.

(2) If the petition is for mental health treatment, the court or the prosecutor at the time of the probable cause hearing and before an order of commitment is entered shall inform the person both orally and in writing that the failure to make a good faith effort to seek voluntary treatment as provided in RCW 71.05.230 will result in the loss of his or her firearm rights if the person is subsequently detained for involuntary treatment under this section.

(3) If the person or his or her attorney alleges, prior to the commencement of the hearing, that the person has in good faith volunteered for treatment, the petitioner must show, by preponderance of the evidence, that the person has not in good faith volunteered for appropriate treatment. In order to qualify as a good faith volunteer, the person must abide by procedures and a treatment plan as prescribed by a treatment facility and professional staff.

(4)(a) At the conclusion of the probable cause hearing, if the court finds by a preponderance of the evidence that a person detained for behavioral health treatment, as the result of a behavioral health disorder, presents a likelihood of serious harm, or is gravely disabled, and, after considering less restrictive alternatives to involuntary detention and treatment, finds that no such alternatives are in the best interests of such person or others, the court shall order that such person be detained for involuntary treatment not to exceed fourteen days in a facility licensed or certified to provide treatment by the department or under RCW 71.05.745.

(b) At the conclusion of the probable cause hearing, if the court finds by a preponderance of the evidence that a person detained for behavioral health treatment, as the result of a behavioral health disorder, presents a likelihood of serious harm or is gravely disabled, but that treatment in a less

restrictive setting than detention is in the best interest of such person or others, the court shall order an appropriate less restrictive alternative course of treatment for up to ninety days.

(c) If the court finds by a preponderance of the evidence that a person subject to a petition under RCW 71.05.148, as the result of a behavioral health disorder, is in need of assisted outpatient treatment, the court shall order an appropriate less restrictive alternative course of treatment for up to 18 months.

(5) An order for less restrictive alternative treatment must name the behavioral health service provider responsible for identifying the services the person will receive in accordance with RCW 71.05.585, and must include a requirement that the person cooperate with the treatment recommendations of the behavioral health service provider.

(6) The court shall notify the person orally and in writing that if involuntary treatment is sought beyond the 14-day inpatient or 90-day less restrictive treatment period, such person has the right to a full hearing or jury trial under RCW 71.05.310. If the commitment is for mental health treatment, the court shall also notify the person orally and in writing that the person is barred from the possession of firearms and that the prohibition remains in effect until a court restores his or her right to possess a firearm under RCW 9.41.047.

(7) If the court does not issue an order to detain or commit a person under this section, the court shall issue an order to dismiss the petition.

(8) Nothing in this section precludes the court from subsequently modifying the terms of an order for less restrictive alternative treatment under RCW 71.05.590(3). [2022 c 210 § 13; 2021 c 264 § 9; 2020 c 302 § 40; (2020 c 302 § 38 expired January 1, 2021); 2019 c 446 § 12. Prior: 2018 c 291 § 8; 2018 c 201 § 3010; 2016 sp.s. c 29 § 233; 2016 sp.s. c 29 § 232; 2016 c 45 § 2; 2015 c 250 § 7; 2009 c 293 § 4; 1997 c 112 § 19; 1992 c 168 § 3; 1987 c 439 § 5; 1979 ex.s. c 215 § 13; 1974 ex.s. c 145 § 16; 1973 1st ex.s. c 142 § 29.]

Effective date—2022 c 210 §§ 6, 13, 18, and 24: See note following RCW 71.05.150.

Effective date—2021 c 264 §§ 2, 4, 7, 9, 11, 15, 32, and 34: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Effective date—2020 c 302 §§ 14, 17, 27, 40, 46, 56, 79, 84, 87, 93, 95, and 98: See note following RCW 71.05.150.

Effective date—2019 c 446 §§ 5, 7, 9, 12, 15, 31, 33, 35, 38, 40, and 42: See note following RCW 71.05.150.

Effective date—2018 c 291 §§ 5, 8, and 10: See note following RCW 71.05.150.

Effective date—2018 c 201 §§ 3010, 3013, 3027, 5018, and 5021: "Sections 3010, 3013, 3027, 5018, and 5021 of this act take effect July 1, 2026." [2018 c 201 § 11005.]

Findings—Intent—2018 c 201: See note following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.05.245 Determination of grave disability, likelihood of serious harm, or need of assisted outpatient treatment—Use of recent history evidence. (1) In making a determination of whether a person is gravely disabled, presents a likelihood of serious harm, or is in need of assisted outpatient treatment in a hearing conducted under RCW 71.05.240 or 71.05.320, the court must consider the symptoms and behavior of the respondent in light of all available evidence concerning the respondent's historical behavior.

(2) Symptoms or behavior which standing alone would not justify civil commitment may support a finding of grave disability or likelihood of serious harm, or a finding that the person is in need of assisted outpatient treatment, when: (a) Such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts; (b) these symptoms or behavior represent a marked and concerning change in the baseline behavior of the respondent; and (c) without treatment, the continued deterioration of the respondent is probable.

(3) In making a determination of whether there is a likelihood of serious harm in a hearing conducted under RCW 71.05.240 or 71.05.320, the court shall give great weight to any evidence before the court regarding whether the person has: (a) A recent history of one or more violent acts; or (b) a recent history of one or more commitments under this chapter or its equivalent provisions under the laws of another state which were based on a likelihood of serious harm. The existence of prior violent acts or commitments under this chapter or its equivalent shall not be the sole basis for determining whether a person presents a likelihood of serious harm.

For the purposes of this subsection "recent" refers to the period of time not exceeding three years prior to the current hearing. [2022 c 210 § 14; 2018 c 291 § 14; 2015 c 250 § 8; 2010 c 280 § 3; 1999 c 13 § 6; 1998 c 297 § 14.]

Effective date—2013 c 335; 2011 2nd sp.s. c 6; 2010 c 280 §§ 2 and 3: See note following RCW 71.05.212.

Purpose—Construction—1999 c 13: See note following RCW 10.77.010.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.260 Release from involuntary intensive treatment—Exception. (1) Involuntary intensive treatment ordered at the time of the probable cause hearing shall be for no more than fourteen days, and shall terminate sooner when, in the opinion of the professional person in charge of the facility or his or her professional designee, (a) the person no longer constitutes a likelihood of serious harm, or (b) no longer is gravely disabled, or (c) is prepared to accept voluntary treatment upon referral, or (d) is to remain in the facility providing intensive treatment on a voluntary basis.

(2) A person who has been detained for fourteen days of intensive treatment shall be released at the end of the fourteen days unless one of the following applies: (a) Such person agrees to receive further treatment on a voluntary basis; or (b) such person is a patient to whom RCW 71.05.280 is applicable. [1997 c 112 § 20; 1987 c 439 § 7; 1974 ex.s. c 145 § 18; 1973 1st ex.s. c 142 § 31.]

71.05.270 Temporary release. Nothing in this chapter shall prohibit the professional person in charge of a treatment facility, or his or her professional designee, from permitting a person detained for intensive treatment to leave the facility for prescribed periods during the term of the person's deten-

tion, under such conditions as may be appropriate. [1997 c 112 § 21; 1973 1st ex.s. c 142 § 32.]

71.05.280 Additional commitment—Grounds. At the expiration of the fourteen-day period of intensive treatment, a person may be committed for further treatment pursuant to RCW 71.05.320 if:

(1) Such person after having been taken into custody for evaluation and treatment has threatened, attempted, or inflicted: (a) Physical harm upon the person of another or himself or herself, or substantial damage upon the property of another, and (b) as a result of a behavioral health disorder presents a likelihood of serious harm; or

(2) Such person was taken into custody as a result of conduct in which he or she attempted or inflicted physical harm upon the person of another or himself or herself, or substantial damage upon the property of others, and continues to present, as a result of a behavioral health disorder, a likelihood of serious harm; or

(3) Such person has been determined to be incompetent and criminal charges have been dismissed pursuant to *RCW 10.77.086(4), and has committed acts constituting a felony, and as a result of a behavioral health disorder, presents a substantial likelihood of repeating similar acts.

(a) In any proceeding pursuant to this subsection it shall not be necessary to show intent, willfulness, or state of mind as an element of the crime;

(b) For any person subject to commitment under this subsection where the charge underlying the finding of incompetence is for a felony classified as violent under RCW 9.94A.030, the court shall determine whether the acts the person committed constitute a violent offense under RCW 9.94A.030; or

(4) Such person is gravely disabled. [2022 c 210 § 15; 2020 c 302 § 41; 2018 c 291 § 15; 2016 sp.s. c 29 § 234; 2015 c 250 § 9; 2013 c 289 § 4; 2008 c 213 § 6; 1998 c 297 § 15; 1997 c 112 § 22; 1986 c 67 § 3; 1979 ex.s. c 215 § 14; 1974 ex.s. c 145 § 19; 1973 1st ex.s. c 142 § 33.]

***Reviser's note:** RCW 10.77.086 was amended by 2022 c 288 § 4, changing subsection (4) to subsection (5).

Effective date—2018 c 291 §§ 1-4, 6, 7, 9, 11, 12, 13, and 15: See note following RCW 71.05.020.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—2013 c 289: See note following RCW 10.77.086.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.285 Additional confinement—Prior history evidence. In determining whether an inpatient or less restrictive alternative commitment under the process provided in RCW 71.05.280 and 71.05.320(4) is appropriate, great weight shall be given to evidence of a prior history or pattern of decompensation and discontinuation of treatment resulting in: (1) Repeated hospitalizations; or (2) repeated peace officer interventions resulting in juvenile offenses, criminal charges, diversion programs, or jail admissions. Such evidence may be used to provide a factual basis for concluding that the individual would not receive, if released, such care as is essential for his or her health or safety. [2018 c 201 § 3011; 2001 c 12 § 1; 1997 c 112 § 23.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.05.290 Petition for additional commitment—Affidavit. (1) At any time during a person's 14-day intensive treatment period, the professional person in charge of a treatment facility or his or her professional designee or the designated crisis responder may petition the superior court for an order requiring such person to undergo an additional period of treatment. Such petition must be based on one or more of the grounds set forth in RCW 71.05.280.

(2)(a)(i) The petition shall summarize the facts which support the need for further commitment and shall be supported by affidavits based on an examination of the patient and signed by:

(A) One physician, physician assistant, or psychiatric advanced registered nurse practitioner; and

(B) One physician, physician assistant, psychiatric advanced registered nurse practitioner, or mental health professional.

(ii) If the petition is for substance use disorder treatment, the petition may be signed by a substance use disorder professional instead of a mental health professional and by an advanced registered nurse practitioner instead of a psychiatric advanced registered nurse practitioner.

(b) The affidavits shall describe in detail the behavior of the detained person which supports the petition and shall explain what, if any, less restrictive treatments which are alternatives to detention are available to such person, and shall state the willingness of the affiant to testify to such facts in subsequent judicial proceedings under this chapter. If less restrictive alternative treatment is sought, the petition shall set forth any recommendations for less restrictive alternative treatment services.

(3) If a person has been determined to be incompetent pursuant to *RCW 10.77.086(4), then the professional person in charge of the treatment facility or his or her professional designee or the designated crisis responder may directly file a petition for 180-day treatment under RCW 71.05.280(3), or for 90-day treatment under RCW 71.05.280 (1), (2), or (4). No petition for initial detention or 14-day detention is required before such a petition may be filed. [2022 c 210 § 16; 2020 c 302 § 42; 2017 3rd sp.s. c 14 § 18. Prior: 2016 sp.s. c 29 § 235; 2016 c 155 § 6; 2016 c 45 § 3; 2015 c 250 § 10; 2009 c 217 § 3; 2008 c 213 § 7; 1998 c 297 § 16; 1997 c 112 § 24; 1986 c 67 § 4; 1975 1st ex.s. c 199 § 6; 1974 ex.s. c 145 § 20; 1973 1st ex.s. c 142 § 34.]

***Reviser's note:** RCW 10.77.086 was amended by 2022 c 288 § 4, changing subsection (4) to subsection (5).

Effective date—2017 3rd sp.s. c 14 §§ 9, 12, 14, 15, and 17-21: See note following RCW 71.05.590.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.300 Filing of petition—Appearance—Notice—Advice as to rights—Appointment of attorney, expert, or

professional person. (1) The petition for ninety day treatment shall be filed with the clerk of the superior court at least three days before expiration of the fourteen-day period of intensive treatment. The clerk shall set a trial setting date as provided in RCW 71.05.310 on the next judicial day after the date of filing the petition and notify the designated crisis responder. The designated crisis responder shall immediately notify the person detained, his or her attorney, if any, and his or her guardian or conservator, if any, the prosecuting attorney, and the behavioral health administrative services organization administrator, and provide a copy of the petition to such persons as soon as possible. The behavioral health administrative services organization administrator or designee may review the petition and may appear and testify at the full hearing on the petition.

(2) The attorney for the detained person shall advise him or her of his or her right to be represented by an attorney, his or her right to a jury trial, and, if the petition is for commitment for mental health treatment, his or her loss of firearm rights if involuntarily committed. If the detained person is not represented by an attorney, or is indigent or is unwilling to retain an attorney, the court shall immediately appoint an attorney to represent him or her. The court shall, if requested, appoint a reasonably available licensed physician, physician assistant, psychiatric advanced registered nurse practitioner, psychologist, psychiatrist, or other professional person, designated by the detained person to examine and testify on behalf of the detained person.

(3) The court may, if requested, also appoint a professional person as defined in RCW 71.05.020 to seek less restrictive alternative courses of treatment and to testify on behalf of the detained person. In the case of a person with a developmental disability who has been determined to be incompetent pursuant to *RCW 10.77.086(4), the appointed professional person under this section shall be a developmental disabilities professional. [2020 c 302 § 43; 2019 c 325 § 3007; 2017 3rd sp.s. c 14 § 19. Prior: 2016 sp.s. c 29 § 236; 2016 c 155 § 7; 2014 c 225 § 84; prior: 2009 c 293 § 5; 2009 c 217 § 4; 2008 c 213 § 8; 2006 c 333 § 303; 1998 c 297 § 17; 1997 c 112 § 25; 1989 c 420 § 14; 1987 c 439 § 8; 1975 1st ex.s. c 199 § 7; 1974 ex.s. c 145 § 21; 1973 1st ex.s. c 142 § 35.]

***Reviser's note:** RCW 10.77.086 was amended by 2022 c 288 § 4, changing subsection (4) to subsection (5).

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective date—2017 3rd sp.s. c 14 §§ 9, 12, 14, 15, and 17-21: See note following RCW 71.05.590.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2014 c 225: See note following RCW 71.24.016.

Finding—Purpose—Intent—Severability—Part headings not law—Effective dates—2006 c 333: See notes following RCW 71.24.016.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.310 Time for hearing—Due process—Jury trial—Continuation of treatment. The court shall set a hearing on the petition for ninety-day or one hundred eighty-day treatment within five judicial days of the trial setting hearing, or within ten judicial days for a petition filed under RCW 71.05.280(3). The court may continue the hearing in accordance with RCW 71.05.236. If the person named in the petition requests a jury trial, the trial must be set within ten judicial days of the next judicial day after the date of filing the petition. The burden of proof shall be by clear, cogent, and convincing evidence and shall be upon the petitioner. The person has the right to be present at such proceeding, which shall in all respects accord with the constitutional guarantees of due process of law and the rules of evidence under RCW 71.05.217.

During the proceeding, the person named in the petition shall continue to be treated until released by order of the superior court or discharged by the behavioral health service provider. If the hearing has not commenced within thirty days after the filing of the petition, not including extensions of time ordered under RCW 71.05.236, the detained person shall be released. [2020 c 302 § 44; 2012 c 256 § 8; 2005 c 504 § 709; 1987 c 439 § 9; 1975 1st ex.s. c 199 § 8; 1974 ex.s. c 145 § 22; 1973 1st ex.s. c 142 § 36.]

Purpose—Effective date—2012 c 256: See notes following RCW 10.77.068.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Additional notes found at www.leg.wa.gov

71.05.320 Remand for additional treatment—Less restrictive alternatives—Duration—Grounds—Hearing. ***(Effective until July 1, 2026.)*** (1)(a) Subject to (b) of this subsection, if the court or jury finds that grounds set forth in RCW 71.05.280 have been proven and that the best interests of the person or others will not be served by a less restrictive treatment which is an alternative to detention, the court shall remand him or her to the custody of the department of social and health services or to a facility certified for ninety day treatment by the department for a further period of intensive treatment not to exceed ninety days from the date of judgment.

(b) If the order for inpatient treatment is based on a substance use disorder, treatment must take place at an approved substance use disorder treatment program. The court may only enter an order for commitment based on a substance use disorder if there is an available approved substance use disorder treatment program with adequate space for the person.

(c) If the grounds set forth in RCW 71.05.280(3) are the basis of commitment, then the period of treatment may be up to but not exceed one hundred eighty days from the date of judgment to the custody of the department of social and health services or to a facility certified for 180-day treatment by the department or under RCW 71.05.745.

(2) If the court or jury finds that grounds set forth in RCW 71.05.280 have been proven, but finds that treatment less restrictive than detention will be in the best interest of the person or others, then the court shall remand him or her to the custody of the department of social and health services or to a facility certified for ninety day treatment by the department or to a less restrictive alternative for a further period of less restrictive treatment not to exceed 90 days from the date of judgment. If the grounds set forth in RCW 71.05.280(3) are the basis of commitment, then the period of treatment may be up to but not exceed 180 days from the date of judgment. If

the court has made an affirmative special finding under RCW 71.05.280(3)(b), the court shall appoint a multidisciplinary transition team as provided in subsection (6)(a)(i) of this section.

(3) An order for less restrictive alternative treatment entered under subsection (2) of this section must name the behavioral health service provider responsible for identifying the services the person will receive in accordance with RCW 71.05.585, and must include a requirement that the person cooperate with the services planned by the behavioral health service provider.

(4) The person shall be released from involuntary treatment at the expiration of the period of commitment imposed under subsection (1) or (2) of this section unless the superintendent or professional person in charge of the facility in which he or she is confined, or in the event of a less restrictive alternative, the designated crisis responder, files a new petition for involuntary treatment on the grounds that the committed person:

(a) During the current period of court ordered treatment: (i) Has threatened, attempted, or inflicted physical harm upon the person of another, or substantial damage upon the property of another, and (ii) as a result of a behavioral health disorder or developmental disability presents a likelihood of serious harm; or

(b) Was taken into custody as a result of conduct in which he or she attempted or inflicted serious physical harm upon the person of another, and continues to present, as a result of a behavioral health disorder or developmental disability, a likelihood of serious harm; or

(c)(i) Is in custody pursuant to RCW 71.05.280(3) and as a result of a behavioral health disorder or developmental disability continues to present a substantial likelihood of repeating acts similar to the charged criminal behavior, when considering the person's life history, progress in treatment, and the public safety.

(ii) In cases under this subsection where the court has made an affirmative special finding under RCW 71.05.280(3)(b), the commitment shall continue for up to an additional one hundred eighty-day period whenever the petition presents prima facie evidence that the person continues to suffer from a behavioral health disorder or developmental disability that results in a substantial likelihood of committing acts similar to the charged criminal behavior, unless the person presents proof through an admissible expert opinion that the person's condition has so changed such that the behavioral health disorder or developmental disability no longer presents a substantial likelihood of the person committing acts similar to the charged criminal behavior. The initial or additional commitment period may include transfer to a specialized program of intensive support and treatment, which may be initiated prior to or after discharge from the state hospital; or

(d) Continues to be gravely disabled.

If the conduct required to be proven in (b) and (c) of this subsection was found by a judge or jury in a prior trial under this chapter, it shall not be necessary to prove such conduct again.

If less restrictive alternative treatment is sought, the petition shall set forth any recommendations for less restrictive alternative treatment services.

(5) A new petition for involuntary treatment filed under subsection (4) of this section shall be filed and heard in the superior court of the county of the facility which is filing the new petition for involuntary treatment unless good cause is shown for a change of venue. The cost of the proceedings shall be borne by the state.

(6)(a) The hearing shall be held as provided in RCW 71.05.310, and if the court or jury finds that the grounds for additional confinement as set forth in this section are present, subject to subsection (1)(b) of this section, the court may order the committed person returned for an additional period of treatment not to exceed 180 days from the date of judgment, except as provided in subsection (7) of this section. An order for less restrictive alternative treatment must name the behavioral health service provider responsible for identifying the services the person will receive in accordance with RCW 71.05.585, and must include a requirement that the person cooperate with the services planned by the behavioral health service provider.

(i) In cases where the court has ordered less restrictive alternative treatment and has previously made an affirmative special finding under RCW 71.05.280(3)(b), the court shall appoint a multidisciplinary transition team to supervise and assist the person on the order for less restrictive treatment, which shall include a representative of the community behavioral health agency providing treatment under RCW 71.05.585, and a specially trained supervising community corrections officer. The court may omit the appointment of a community corrections officer if it makes a special finding that the appointment of a community corrections officer would not facilitate the success of the person, or the safety of the person and the community under (a)(ii) of this subsection.

(ii) The role of the transition team shall be to facilitate the success of the person on the less restrictive alternative order by monitoring the person's progress in treatment, compliance with court-ordered conditions, and to problem solve around extra support the person may need or circumstances which may arise that threaten the safety of the person or the community. The transition team may develop a monitoring plan which may be carried out by any member of the team. The transition team shall meet according to a schedule developed by the team, and shall communicate as needed if issues arise that require the immediate attention of the team.

(iii) The department of corrections shall collaborate with the department to develop specialized training for community corrections officers under this section. The lack of a trained community corrections officer must not be the cause of delay to entry of a less restrictive alternative order.

(b) At the end of the 180-day period of commitment, or one-year period of commitment if subsection (7) of this section applies, the committed person shall be released unless a petition for an additional 180-day period of continued treatment is filed and heard in the same manner as provided in this section. Successive 180-day commitments are permissible on the same grounds and pursuant to the same procedures as the original 180-day commitment.

(7) An order for less restrictive treatment entered under subsection (6) of this section may be for up to one year when the person's previous commitment term was for intensive inpatient treatment in a state hospital.

(8) No person committed under this section may be detained unless a valid order of commitment is in effect. No order of commitment under this section may exceed 180 days in length except as provided in subsection (7) of this section.

(9) Nothing in this section precludes the court from subsequently modifying the terms of an order for less restrictive alternative treatment under RCW 71.05.590(3). [2022 c 210 § 17. Prior: 2021 c 264 § 10; 2021 c 263 § 2; 2020 c 302 § 45; 2018 c 201 § 3012; prior: 2016 sp.s. c 29 § 237; 2016 c 45 § 4; 2015 c 250 § 11; 2013 c 289 § 5; 2009 c 323 § 2; 2008 c 213 § 9; 2006 c 333 § 304; 1999 c 13 § 7; 1997 c 112 § 26; 1989 c 420 § 15; 1986 c 67 § 5; 1979 ex.s. c 215 § 15; 1975 1st ex.s. c 199 § 9; 1974 ex.s. c 145 § 23; 1973 1st ex.s. c 142 § 37.]

Expiration date—2022 c 210 §§ 5, 12, 17, and 23: See note following RCW 71.05.150.

Expiration date—2021 c 264 §§ 1, 3, 6, 8, 10, 14, 31, and 33: See note following RCW 71.05.150.

Expiration date—2021 c 263 § 2: "Section 2 of this act expires July 1, 2026." [2021 c 263 § 22.]

Application—2021 c 263: See note following RCW 10.77.150.

Expiration date—2020 c 302 §§ 13, 16, 26, 39, 45, 55, 78, 83, 86, 92, 94, and 97: See note following RCW 71.05.150.

Expiration date—2018 c 201 §§ 3009, 3012, 3026, 5017, and 5020: See note following RCW 71.05.240.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—2013 c 289: See note following RCW 10.77.086.

Findings—Intent—2015 c 250; 2009 c 323: "(1) The legislature finds that many persons who are released from involuntary mental health treatment in an inpatient setting would benefit from an order for less restrictive treatment in order to provide the structure and support necessary to facilitate long-term stability and success in the community.

(2) The legislature intends to make it easier to renew orders for less restrictive treatment following a period of inpatient commitment in cases in which a person has been involuntarily committed more than once and is likely to benefit from a renewed order for less restrictive treatment.

(3) The legislature finds that public safety is enhanced when a designated mental health professional is able to file a petition to revoke an order for less restrictive treatment under RCW 71.05.590 before a person who is the subject of the petition becomes ill enough to present a likelihood of serious harm." [2015 c 250 § 21; 2009 c 323 § 1.]

Finding—Purpose—Intent—Severability—Part headings not law—Effective dates—2006 c 333: See notes following RCW 71.24.016.

Purpose—Construction—1999 c 13: See note following RCW 10.77.010.

71.05.320 Remand for additional treatment—Less restrictive alternatives—Duration—Grounds—Hearing. ***(Effective July 1, 2026.)*** (1) If the court or jury finds that grounds set forth in RCW 71.05.280 have been proven and that the best interests of the person or others will not be served by a less restrictive treatment which is an alternative to detention, the court shall remand him or her to the custody of the department of social and health services or to a facility certified for ninety day treatment by the department for a further period of intensive treatment not to exceed ninety days from the date of judgment.

If the order for inpatient treatment is based on a substance use disorder, treatment must take place at an approved substance use disorder treatment program. If the grounds set forth in RCW 71.05.280(3) are the basis of commitment, then the period of treatment may be up to but not exceed one hundred eighty days from the date of judgment to the custody of the department of social and health services or to a facility certified for 180-day treatment by the department or under RCW 71.05.745.

(2) If the court or jury finds that grounds set forth in RCW 71.05.280 have been proven, but finds that treatment less restrictive than detention will be in the best interest of the person or others, then the court shall remand him or her to the custody of the department of social and health services or to a facility certified for ninety day treatment by the department or to a less restrictive alternative for a further period of less restrictive treatment not to exceed 90 days from the date of judgment. If the grounds set forth in RCW 71.05.280(3) are the basis of commitment, then the period of treatment may be up to but not exceed 180 days from the date of judgment. If the court has made an affirmative special finding under RCW 71.05.280(3)(b), the court shall appoint a multidisciplinary transition team as provided in subsection (6)(a)(i) of this section.

(3) An order for less restrictive alternative treatment entered under subsection (2) of this section must name the behavioral health service provider responsible for identifying the services the person will receive in accordance with RCW 71.05.585, and must include a requirement that the person cooperate with the services planned by the behavioral health service provider.

(4) The person shall be released from involuntary treatment at the expiration of the period of commitment imposed under subsection (1) or (2) of this section unless the superintendent or professional person in charge of the facility in which he or she is confined, or in the event of a less restrictive alternative, the designated crisis responder, files a new petition for involuntary treatment on the grounds that the committed person:

(a) During the current period of court ordered treatment: (i) Has threatened, attempted, or inflicted physical harm upon the person of another, or substantial damage upon the property of another, and (ii) as a result of a behavioral health disorder or developmental disability presents a likelihood of serious harm; or

(b) Was taken into custody as a result of conduct in which he or she attempted or inflicted serious physical harm upon the person of another, and continues to present, as a result of a behavioral health disorder or developmental disability, a likelihood of serious harm; or

(c)(i) Is in custody pursuant to RCW 71.05.280(3) and as a result of a behavioral health disorder or developmental disability continues to present a substantial likelihood of repeating acts similar to the charged criminal behavior, when considering the person's life history, progress in treatment, and the public safety.

(ii) In cases under this subsection where the court has made an affirmative special finding under RCW 71.05.280(3)(b), the commitment shall continue for up to an additional one hundred eighty-day period whenever the petition presents prima facie evidence that the person continues to suffer from a behavioral health disorder or developmental disability that results in a substantial likelihood of committing acts similar to the charged criminal behavior, unless the

person presents proof through an admissible expert opinion that the person's condition has so changed such that the behavioral health disorder or developmental disability no longer presents a substantial likelihood of the person committing acts similar to the charged criminal behavior. The initial or additional commitment period may include transfer to a specialized program of intensive support and treatment, which may be initiated prior to or after discharge from the state hospital; or

(d) Continues to be gravely disabled.

If the conduct required to be proven in (b) and (c) of this subsection was found by a judge or jury in a prior trial under this chapter, it shall not be necessary to prove such conduct again.

If less restrictive alternative treatment is sought, the petition shall set forth any recommendations for less restrictive alternative treatment services.

(5) A new petition for involuntary treatment filed under subsection (4) of this section shall be filed and heard in the superior court of the county of the facility which is filing the new petition for involuntary treatment unless good cause is shown for a change of venue. The cost of the proceedings shall be borne by the state.

(6)(a) The hearing shall be held as provided in RCW 71.05.310, and if the court or jury finds that the grounds for additional confinement as set forth in this section are present, the court may order the committed person returned for an additional period of treatment not to exceed 180 days from the date of judgment, except as provided in subsection (7) of this section. An order for less restrictive alternative treatment must name the behavioral health service provider responsible for identifying the services the person will receive in accordance with RCW 71.05.585, and must include a requirement that the person cooperate with the services planned by the behavioral health service provider.

(i) In cases where the court has ordered less restrictive alternative treatment and has previously made an affirmative special finding under RCW 71.05.280(3)(b), the court shall appoint a multidisciplinary transition team to supervise and assist the person on the order for less restrictive treatment, which shall include a representative of the community behavioral health agency providing treatment under RCW 71.05.585, and a specially trained supervising community corrections officer. The court may omit the appointment of a community corrections officer if it makes a special finding that the appointment of a community corrections officer would not facilitate the success of the person, or the safety of the person and the community under (a)(ii) of this subsection.

(ii) The role of the transition team shall be to facilitate the success of the person on the less restrictive alternative order by monitoring the person's progress in treatment, compliance with court-ordered conditions, and to problem solve around extra support the person may need or circumstances which may arise that threaten the safety of the person or the community. The transition team may develop a monitoring plan which may be carried out by any member of the team. The transition team shall meet according to a schedule developed by the team, and shall communicate as needed if issues arise that require the immediate attention of the team.

(iii) The department of corrections shall collaborate with the department to develop specialized training for community corrections officers under this section. The lack of a trained community corrections officer must not be the cause of delay to entry of a less restrictive alternative order.

(b) At the end of the 180-day period of commitment, or one-year period of commitment if subsection (7) of this section applies, the committed person shall be released unless a petition for an additional 180-day period of continued treatment is filed and heard in the same manner as provided in this section. Successive 180-day commitments are permissible on the same grounds and pursuant to the same procedures as the original 180-day commitment.

(7) An order for less restrictive treatment entered under subsection (6) of this section may be for up to one year when the person's previous commitment term was for intensive inpatient treatment in a state hospital.

(8) No person committed under this section may be detained unless a valid order of commitment is in effect. No order of commitment under this section may exceed 180 days in length except as provided in subsection (7) of this section.

(9) Nothing in this section precludes the court from subsequently modifying the terms of an order for less restrictive alternative treatment under RCW 71.05.590(3). [2022 c 210 § 18. Prior: 2021 c 264 § 11; 2021 c 263 § 3; 2020 c 302 § 46; 2018 c 201 § 3013; 2016 sp.s. c 29 § 238; 2016 sp.s. c 29 § 237; 2016 c 45 § 4; 2015 c 250 § 11; 2013 c 289 § 5; 2009 c 323 § 2; 2008 c 213 § 9; 2006 c 333 § 304; 1999 c 13 § 7; 1997 c 112 § 26; 1989 c 420 § 15; 1986 c 67 § 5; 1979 ex.s. c 215 § 15; 1975 1st ex.s. c 199 § 9; 1974 ex.s. c 145 § 23; 1973 1st ex.s. c 142 § 37.]

Effective date—2022 c 210 §§ 6, 13, 18, and 24: See note following RCW 71.05.150.

Effective date—2021 c 264 §§ 2, 4, 7, 9, 11, 15, 32, and 34: See note following RCW 71.05.150.

Effective date—2021 c 263 § 3: "Section 3 of this act takes effect July 1, 2026." [2021 c 263 § 23.]

Application—2021 c 263: See note following RCW 10.77.150.

Effective date—2020 c 302 §§ 14, 17, 27, 40, 46, 56, 79, 84, 87, 93, 95, and 98: See note following RCW 71.05.150.

Effective date—2018 c 201 §§ 3010, 3013, 3027, 5018, and 5021: See note following RCW 71.05.240.

Findings—Intent—2018 c 201: See note following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—2013 c 289: See note following RCW 10.77.086.

Findings—Intent—2015 c 250; 2009 c 323: "(1) The legislature finds that many persons who are released from involuntary mental health treatment in an inpatient setting would benefit from an order for less restrictive treatment in order to provide the structure and support necessary to facilitate long-term stability and success in the community.

(2) The legislature intends to make it easier to renew orders for less restrictive treatment following a period of inpatient commitment in cases in which a person has been involuntarily committed more than once and is likely to benefit from a renewed order for less restrictive treatment.

(3) The legislature finds that public safety is enhanced when a designated mental health professional is able to file a petition to revoke an order for less restrictive treatment under RCW 71.05.590 before a person who is the subject of the petition becomes ill enough to present a likelihood of serious harm." [2015 c 250 § 21; 2009 c 323 § 1.]

Finding—Purpose—Intent—Severability—Part headings not law—Effective dates—2006 c 333: See notes following RCW 71.24.016.

Purpose—Construction—1999 c 13: See note following RCW 10.77.010.

71.05.325 Release—Authorized leave—Notice to prosecuting attorney. (1) Before a person committed under grounds set forth in RCW 71.05.280(3) is released because a new petition for involuntary treatment has not been filed under RCW 71.05.320(4), the superintendent, professional person, or designated crisis responder responsible for the decision whether to file a new petition shall in writing notify the prosecuting attorney of the county in which the criminal charges against the committed person were dismissed, of the decision not to file a new petition for involuntary treatment. Notice shall be provided at least forty-five days before the period of commitment expires.

(2)(a) Before a person committed under grounds set forth in RCW 71.05.280(3) is permitted temporarily to leave a treatment facility pursuant to RCW 71.05.270 for any period of time without constant accompaniment by facility staff, the superintendent, professional person in charge of a treatment facility, or his or her professional designee shall in writing notify the prosecuting attorney of any county of the person's destination and the prosecuting attorney of the county in which the criminal charges against the committed person were dismissed. The notice shall be provided at least forty-five days before the anticipated leave and shall describe the conditions under which the leave is to occur.

(b) The provisions of RCW 71.05.330(2) apply to proposed leaves, and either or both prosecuting attorneys receiving notice under this subsection may petition the court under RCW 71.05.330(2).

(3) Nothing in this section shall be construed to authorize detention of a person unless a valid order of commitment is in effect.

(4) The existence of the notice requirements in this section will not require any extension of the leave date in the event the leave plan changes after notification.

(5) The notice requirements contained in this section shall not apply to emergency medical transfers.

(6) The notice provisions of this section are in addition to those provided in RCW 71.05.425. [2018 c 201 § 3014; 2016 sp.s. c 29 § 239; 2000 c 94 § 7; 1994 c 129 § 8; 1990 c 3 § 111; 1989 c 401 § 1; 1986 c 67 § 2.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Intent—1994 c 129: See note following RCW 4.24.550.

71.05.330 Early release—Notice to court and prosecuting attorney—Petition for hearing. (1) Nothing in this chapter shall prohibit the superintendent or professional person in charge of the hospital or facility in which the person is being involuntarily treated from releasing him or her prior to the expiration of the commitment period when, in the opinion of the superintendent or professional person in charge, the person being involuntarily treated no longer presents a likelihood of serious harm.

Whenever the superintendent or professional person in charge of a hospital or facility providing involuntary treatment pursuant to this chapter releases a person prior to the expiration of the period of commitment, the superintendent or professional person in charge shall in writing notify the court which committed the person for treatment.

(2) Before a person committed under grounds set forth in RCW 71.05.280(3) or 71.05.320(4)(c) is released under this section, the superintendent or professional person in charge shall in writing notify the prosecuting attorney of the county in which the criminal charges against the committed person were dismissed, of the release date. Notice shall be provided at least thirty days before the release date. Within twenty days after receiving notice, the prosecuting attorney may petition the court in the county in which the person is being involuntarily treated for a hearing to determine whether the person is to be released. The prosecuting attorney shall provide a copy of the petition to the superintendent or professional person in charge of the hospital or facility providing involuntary treatment, the attorney, if any, and the guardian or conservator of the committed person. The court shall conduct a hearing on the petition within ten days of filing the petition. The committed person shall have the same rights with respect to notice, hearing, and counsel as for an involuntary treatment proceeding, except as set forth in this subsection and except that there shall be no right to jury trial. The issue to be determined at the hearing is whether or not the person may be released without substantial danger to other persons, or substantial likelihood of committing criminal acts jeopardizing public safety or security. If the court disapproves of the release, it may do so only on the basis of substantial evidence. Pursuant to the determination of the court upon the hearing, the committed person shall be released or shall be returned for involuntary treatment subject to release at the end of the period for which he or she was committed, or otherwise in accordance with the provisions of this chapter. [2018 c 201 § 3015; 1998 c 297 § 20; 1997 c 112 § 27; 1986 c 67 § 1; 1973 1st ex.s. c 142 § 38.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.335 Modification of order for inpatient treatment—Intervention by prosecuting attorney. In any proceeding under this chapter to modify a commitment order of a person committed to inpatient treatment under grounds set forth in RCW 71.05.280(3) or 71.05.320(4)(c) in which the requested relief includes treatment less restrictive than detention, the prosecuting attorney shall be entitled to intervene. The party initiating the motion to modify the commitment order shall serve the prosecuting attorney of the county in which the criminal charges against the committed person were dismissed with written notice and copies of the initiating papers. [2018 c 201 § 3016; 1986 c 67 § 7.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.05.340 Outpatient treatment or care—Conditional release. (1)(a) When, in the opinion of the superintendent or the professional person in charge of the hospital or facility providing involuntary treatment, the committed person can be appropriately served by outpatient treatment prior to or at the expiration of the period of commitment, then such outpatient care may be required as a term of conditional

release for a period which, when combined with the number of days the person has spent in inpatient treatment, shall not exceed 90 days if the underlying commitment was for a period of 14 or 90 days, or 180 days if the underlying commitment was for a period of 180 days. If the facility or agency designated to provide outpatient treatment is other than the facility providing involuntary treatment, the outpatient facility so designated must agree in writing to assume such responsibility. A copy of the terms of conditional release shall be given to the patient, the designated crisis responder in the county in which the patient is to receive outpatient treatment, and to the court of original commitment.

(b) Before a person committed under grounds set forth in RCW 71.05.280(3) or 71.05.320(4)(c) is conditionally released under (a) of this subsection, the superintendent or professional person in charge of the hospital or facility providing involuntary treatment shall in writing notify the prosecuting attorney of the county in which the criminal charges against the committed person were dismissed, of the decision to conditionally release the person. Notice and a copy of the terms of conditional release shall be provided at least thirty days before the person is released from inpatient care. Within twenty days after receiving notice, the prosecuting attorney may petition the court in the county that issued the commitment order to hold a hearing to determine whether the person may be conditionally released and the terms of the conditional release. The prosecuting attorney shall provide a copy of the petition to the superintendent or professional person in charge of the hospital or facility providing involuntary treatment, the attorney, if any, and guardian or conservator of the committed person, and the court of original commitment. If the county in which the committed person is to receive outpatient treatment is the same county in which the criminal charges against the committed person were dismissed, then the court shall, upon the motion of the prosecuting attorney, transfer the proceeding to the court in that county. The court shall conduct a hearing on the petition within ten days of the filing of the petition. The committed person shall have the same rights with respect to notice, hearing, and counsel as for an involuntary treatment proceeding, except as set forth in this subsection and except that there shall be no right to jury trial. The issue to be determined at the hearing is whether or not the person may be conditionally released without substantial danger to other persons, or substantial likelihood of committing criminal acts jeopardizing public safety or security. If the court disapproves of the conditional release, it may do so only on the basis of substantial evidence. Pursuant to the determination of the court upon the hearing, the conditional release of the person shall be approved by the court on the same or modified conditions or the person shall be returned for involuntary treatment on an inpatient basis subject to release at the end of the period for which he or she was committed, or otherwise in accordance with the provisions of this chapter.

(2) The facility or agency designated to provide outpatient care or the secretary of the department of social and health services may modify the conditions for continued release when such modification is in the best interest of the person. Notification of such changes shall be sent to all persons receiving a copy of the original conditions. Enforcement or revocation proceedings related to a conditional release may occur as provided under RCW 71.05.590. [2021 c 264 § 12; 2018 c 201 § 3017; 2016 sp.s. c 29 § 240; 2015 c 250 § 12; 2009 c 322 § 1; 2000 c 94 § 8; 1998 c 297 § 21; 1997 c 112 § 28; 1987 c 439 § 10; 1986 c 67 § 6; 1979 ex.s. c 215 § 16; 1974 ex.s. c 145 § 24; 1973 1st ex.s. c 142 § 39.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.350 Assistance to released persons. No indigent patient shall be conditionally released or discharged from involuntary treatment without suitable clothing, and the superintendent of a state hospital shall furnish the same, together with such sum of money as he or she deems necessary for the immediate welfare of the patient. Such sum of money shall be the same as the amount required by RCW 72.02.100 to be provided to persons in need being released from correctional institutions. As funds are available, the secretary of the department of social and health services may provide payment to indigent persons conditionally released pursuant to this chapter consistent with the optional provisions of RCW 72.02.100 and 72.02.110, and may adopt rules and regulations to do so. [2018 c 201 § 3018; 1997 c 112 § 29; 1973 1st ex.s. c 142 § 40.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.05.360 Rights of involuntarily detained persons.

Reviser's note: RCW 71.05.360 was amended by 2020 c 312 § 731 without reference to its repeal by 2020 c 302 § 104. It has been decodified for publication purposes under RCW 1.12.025.

71.05.365 Involuntary commitment—Individualized discharge plan. When a person has been involuntarily committed for treatment to a hospital for a period of 90 or 180 days, and the superintendent or professional person in charge of the hospital determines that the person no longer requires active psychiatric treatment at an inpatient level of care, the behavioral health administrative services organization, managed care organization, or agency providing oversight of long-term care or developmental disability services that is responsible for resource management services for the person must work with the hospital to develop an individualized discharge plan, including whether a petition should be filed for less restrictive alternative treatment on the basis that the person is in need of assisted outpatient treatment, and arrange for a transition to the community in accordance with the person's individualized discharge plan within 14 days of the determination. [2022 c 210 § 19; 2019 c 325 § 3008; 2016 sp.s. c 37 § 15; 2014 c 225 § 85; 2013 c 338 § 4.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective date—2016 sp.s. c 37 § 15: "Section 15 of this act takes effect July 1, 2018." [2016 sp.s. c 37 § 16.]

Effective date—2014 c 225 § 85: "Section 85 of this act takes effect July 1, 2018." [2014 c 225 § 113.]

Effective date—2013 c 338 § 4: "Section 4 of this act takes effect July 1, 2018." [2013 c 338 § 8.]

71.05.380 Rights of voluntarily committed persons. All persons voluntarily entering or remaining in any facility, institution, or hospital providing evaluation and treatment for behavioral health disorders shall have no less than all rights secured to involuntarily detained persons by RCW 71.05.217. [2020 c 302 § 47; 2016 sp.s. c 29 § 245; 1973 1st ex.s. c 142 § 43.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.05.425 Persons committed following dismissal of sex, violent, or felony harassment offense—Notification of conditional release, final release, leave, transfer, or escape—To whom given—Definitions. (1)(a) Except as provided in subsection (2) of this section, at the earliest possible date, and in no event later than thirty days before conditional release, final release, authorized leave under RCW 71.05.325(2), or transfer to a facility other than a state mental hospital, the superintendent shall send written notice of conditional release, release, authorized leave, or transfer of a person committed under RCW 71.05.280(3) or 71.05.320(4)(c) following dismissal of a sex, violent, or felony harassment offense pursuant to *RCW 10.77.086(4) to the following:

(i) The chief of police of the city, if any, in which the person will reside;

(ii) The sheriff of the county in which the person will reside; and

(iii) The prosecuting attorney of the county in which the criminal charges against the committed person were dismissed.

(b) The same notice as required by (a) of this subsection shall be sent to the following, if such notice has been requested in writing about a specific person committed under RCW 71.05.280(3) or 71.05.320(4)(c) following dismissal of a sex, violent, or felony harassment offense pursuant to *RCW 10.77.086(4):

(i) The victim of the sex, violent, or felony harassment offense that was dismissed pursuant to *RCW 10.77.086(4) preceding commitment under RCW 71.05.280(3) or 71.05.320(4)(c) or the victim's next of kin if the crime was a homicide;

(ii) Any witnesses who testified against the person in any court proceedings;

(iii) Any person specified in writing by the prosecuting attorney. Information regarding victims, next of kin, or witnesses requesting the notice, information regarding any other person specified in writing by the prosecuting attorney to receive the notice, and the notice are confidential and shall not be available to the person committed under this chapter; and

(iv) The chief of police of the city, if any, and the sheriff of the county, if any, which had jurisdiction of the person on the date of the applicable offense.

(c) The thirty-day notice requirements contained in this subsection shall not apply to emergency medical transfers.

(d) The existence of the notice requirements in this subsection will not require any extension of the release date in the event the release plan changes after notification.

(2) If a person committed under RCW 71.05.280(3) or 71.05.320(4)(c) following dismissal of a sex, violent, or felony harassment offense pursuant to *RCW 10.77.086(4) escapes, the superintendent shall immediately notify, by the most reasonable and expedient means available, the chief of police of the city and the sheriff of the county in which the person escaped and in which the person resided immediately before the person's arrest and the prosecuting attorney of the county in which the criminal charges against the committed person were dismissed. If previously requested, the superintendent shall also notify the witnesses and the victim of the sex, violent, or felony harassment offense that was dismissed pursuant to *RCW 10.77.086(4) preceding commitment under RCW 71.05.280(3) or 71.05.320(4) or the victim's next of kin if the crime was a homicide. In addition, the secretary shall also notify appropriate parties pursuant to RCW 70.02.230(2)(o). If the person is recaptured, the superintendent shall send notice to the persons designated in this subsection as soon as possible but in no event later than two working days after the department of social and health services learns of such recapture.

(3) If the victim, the victim's next of kin, or any witness is under the age of sixteen, the notice required by this section shall be sent to the parent or legal guardian of the child.

(4) The superintendent shall send the notices required by this chapter to the last address provided to the department of social and health services by the requesting party. The requesting party shall furnish the department of social and health services with a current address.

(5) For purposes of this section the following terms have the following meanings:

(a) "Violent offense" means a violent offense under RCW 9.94A.030;

(b) "Sex offense" means a sex offense under RCW 9.94A.030;

(c) "Next of kin" means a person's spouse, state registered domestic partner, parents, siblings, and children;

(d) "Felony harassment offense" means a crime of harassment as defined in RCW 9A.46.060 that is a felony. [2021 c 264 § 19; 2018 c 201 § 3019. Prior: 2013 c 289 § 6; 2013 c 200 § 30; 2011 c 305 § 5; 2009 c 521 § 158; 2008 c 213 § 10; 2005 c 504 § 710; 2000 c 94 § 10; 1999 c 13 § 8; 1994 c 129 § 9; 1992 c 186 § 9; 1990 c 3 § 109.]

***Reviser's note:** RCW 10.77.086 was amended by 2022 c 288 § 4, changing subsection (4) to subsection (5).

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Findings—2013 c 289: See note following RCW 10.77.086.

Effective date—2013 c 200: See note following RCW 70.02.010.

Findings—2011 c 305: See note following RCW 74.09.295.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Purpose—Construction—1999 c 13: See note following RCW 10.77.010.

Findings—Intent—1994 c 129: See note following RCW 4.24.550.

Additional notes found at www.leg.wa.gov

71.05.435 Discharge of person from treatment entity—Notice to designated crisis responder office. (1) Whenever a person who is the subject of an involuntary commitment order under this chapter is discharged from an evaluation and treatment facility, state hospital, secure with-

drawal management and stabilization facility, or approved substance use disorder treatment program providing involuntary treatment services, the entity discharging the person shall provide notice of the person's discharge to the designated crisis responder office responsible for the initial commitment, which may be a federally recognized Indian tribe or other Indian health care provider if the designated crisis responder is appointed by the authority, and the designated crisis responder office that serves the county in which the person is expected to reside. The entity discharging the person must also provide these offices with a copy of any less restrictive order or conditional release order entered in conjunction with the discharge of the person, unless the entity discharging the person has entered into a memorandum of understanding obligating another entity to provide these documents.

(2) The notice and documents referred to in subsection (1) of this section shall be provided as soon as possible and no later than one business day following the discharge of the person. Notice is not required under this section if the discharge is for the purpose of transferring the person for continued detention and treatment under this chapter at another treatment facility.

(3) The authority shall maintain and make available an updated list of contact information for designated crisis responder offices around the state. [2020 c 256 § 306; 2019 c 446 § 26; 2018 c 201 § 3020; 2016 sp.s. c 29 § 246; 2010 c 280 § 4.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.05.445 Court-ordered behavioral health treatment of persons subject to department of corrections supervision—Initial assessment inquiry—Required notifications—Rules. (1)(a) When a behavioral health service provider conducts its initial assessment for a person receiving court-ordered treatment, the service provider shall inquire and shall be told by the offender whether he or she is subject to supervision by the department of corrections.

(b) When a person receiving court-ordered treatment or treatment ordered by the department of corrections discloses to his or her behavioral health service provider that he or she is subject to supervision by the department of corrections, the behavioral health service provider shall notify the department of corrections that he or she is treating the offender and shall notify the offender that his or her community corrections officer will be notified of the treatment, provided that if the offender has received relief from disclosure pursuant to RCW 9.94A.562 or 71.05.132 and the offender has provided the behavioral health service provider with a copy of the order granting relief from disclosure pursuant to RCW 9.94A.562 or 71.05.132, the behavioral health service provider is not required to notify the department of corrections that the behavioral health service provider is treating the offender. The notification may be written or oral and shall not require the consent of the offender. If an oral notification is made, it must be confirmed by a written notification. For purposes of this section, a written notification includes notification by email or facsimile, so long as the notifying behavioral health service provider is clearly identified.

(2) The information to be released to the department of corrections shall include all relevant records and reports, as defined by rule, necessary for the department of corrections to carry out its duties.

(3) The authority and the department of corrections, in consultation with behavioral health administrative services organizations, managed care organizations, behavioral health service providers as defined in RCW 71.05.020, behavioral health consumers, and advocates for persons with behavioral health disorders, shall adopt rules to implement the provisions of this section related to the type and scope of information to be released. These rules shall:

(a) Enhance and facilitate the ability of the department of corrections to carry out its responsibility of planning and ensuring community protection with respect to persons subject to sentencing under chapter 9.94A or 9.95 RCW, including accessing and releasing or disclosing information of persons who received behavioral health services as a minor; and

(b) Establish requirements for the notification of persons under the supervision of the department of corrections regarding the provisions of this section.

(4) The information received by the department of corrections under this section shall remain confidential and subject to the limitations on disclosure outlined in this chapter, except as provided in RCW 72.09.585.

(5) No behavioral health service provider or individual employed by a behavioral health service provider shall be held responsible for information released to or used by the department of corrections under the provisions of this section or rules adopted under this section.

(6) Whenever federal law or federal regulations restrict the release of information and records related to behavioral health services for any patient who receives treatment for alcoholism or drug dependency, the release of the information may be restricted as necessary to comply with federal law and regulations.

(7) This section does not modify the terms and conditions of disclosure of information related to sexually transmitted diseases under chapter 70.24 RCW.

(8) The authority shall, subject to available resources, electronically, or by the most cost-effective means available, provide the department of corrections with the names, last dates of services, and addresses of specific behavioral health administrative services organizations, managed care organizations, and behavioral health service providers that delivered behavioral health services to a person subject to chapter 9.94A or 9.95 RCW pursuant to an agreement between the authority and the department of corrections. [2020 c 302 § 48; 2019 c 325 § 3009; 2018 c 201 § 3021. Prior: 2014 c 225 § 86; 2014 c 220 § 14; 2013 c 200 § 31; 2009 c 320 § 4; 2005 c 504 § 711; 2004 c 166 § 4; 2002 c 39 § 2; 2000 c 75 § 3.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

Effective date—2014 c 220: See note following RCW 70.02.290.

Effective date—2013 c 200: See note following RCW 70.02.010.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Intent—2000 c 75: "It is the intent of the legislature to enhance and facilitate the ability of the department of corrections to carry out its responsibility of planning and ensuring community protection with respect to persons subject to sentencing under chapter 9.94A RCW by authorizing access to, and release or disclosure of, necessary information related to mental health services. This includes accessing and releasing or disclosing information of persons who received mental health services as a minor. The legislature does not intend this act to readdress access to information and records regarding continuity of care.

The legislature recognizes that persons with mental illness have a right to the confidentiality of information related to mental health services, including the fact of their receiving such services, unless there is a state interest that supersedes this right. It is the intent of the legislature to balance that right of the individual with the state interest to enhance public safety." [2000 c 75 § 1.]

Additional notes found at www.leg.wa.gov

71.05.455 Law enforcement referrals to behavioral health agencies—Reports of threatened or attempted suicide—Model policy. When funded, the Washington association of sheriffs and police chiefs, in consultation with the criminal justice training commission, must develop and adopt a model policy for use by law enforcement agencies relating to a law enforcement officer's referral of a person to a behavioral health agency after receiving a report of threatened or attempted suicide. The model policy must complement the criminal justice training commission's crisis intervention training curriculum. [2020 c 302 § 49; 2016 c 158 § 2.]

Finding—Intent—2016 c 158: "The legislature finds that law enforcement officers may respond to situations in which an individual has threatened harm to himself or herself, but that individual does not meet the criteria to be taken into custody for an evaluation under the involuntary treatment act. In these situations, officers are encouraged to facilitate contact between the individual and a mental health professional in order to protect the individual and the community. While the legislature acknowledges that some law enforcement officers receive mental health training, law enforcement officers are not mental health professionals. It is the intent of the legislature that mental health incidents are addressed by mental health professionals." [2016 c 158 § 1.]

71.05.457 Law enforcement referrals to behavioral health agencies—Reports of threatened or attempted suicide—General authority law enforcement policy. By July 1, 2017, all general authority Washington law enforcement agencies must adopt a policy establishing criteria and procedures for a law enforcement officer to refer a person to a behavioral health agency after receiving a report of threatened or attempted suicide. [2020 c 302 § 50; 2016 c 158 § 3.]

Finding—Intent—2016 c 158: See note following RCW 71.05.455.

71.05.458 Law enforcement referral—Threatened or attempted suicide—Contact by designated crisis responder. As soon as possible, but no later than twenty-four hours from receiving a referral from a law enforcement officer or law enforcement agency, excluding Saturdays, Sundays, and holidays, a mental health professional contacted by the designated crisis responder agency must attempt to contact the referred person to determine whether additional mental health intervention is necessary, including, if needed, an assessment by a designated crisis responder for initial detention under RCW 71.05.150 or 71.05.153. Documentation of the mental health professional's attempt to contact and assess the person must be maintained by the designated crisis responder agency. [2019 c 325 § 3010; 2016 c 158 § 5.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Finding—Intent—2016 c 158: See note following RCW 71.05.455.

71.05.500 Liability of applicant. Any person making or filing an application alleging that a person should be involuntarily detained, certified, committed, treated, or evaluated pursuant to this chapter shall not be rendered civilly or criminally liable where the making and filing of such application was in good faith. [1973 1st ex.s. c 142 § 55.]

71.05.510 Damages for excessive detention. Any individual who knowingly, willfully or through gross negligence violates the provisions of this chapter by detaining a person for more than the allowable number of days shall be liable to the person detained in civil damages. It shall not be a prerequisite to an action under this section that the plaintiff shall have suffered or be threatened with special, as contrasted with general damages. [2018 c 201 § 3022; 1974 ex.s. c 145 § 30; 1973 1st ex.s. c 142 § 56.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.05.520 Protection of rights—Staff. The authority as the state's behavioral health authority, the department of social and health services in its operation of the state hospitals, and the department of health in exercising its function of licensing and certification of behavioral health providers and facilities shall have the responsibility to determine whether all rights of individuals recognized and guaranteed by the provisions of this chapter and the Constitutions of the state of Washington and the United States are in fact protected and effectively secured. To this end, each agency shall assign appropriate staff who shall from time to time as may be necessary have authority to examine records, inspect facilities, attend proceedings, and do whatever is necessary to monitor, evaluate, and assure adherence to such rights. Such persons shall also recommend such additional safeguards or procedures as may be appropriate to secure individual rights set forth in this chapter and as guaranteed by the state and federal Constitutions. [2018 c 201 § 3023; 1973 1st ex.s. c 142 § 57.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.05.530 Facilities part of comprehensive behavioral health program. Evaluation and treatment facilities and secure withdrawal management and stabilization facilities authorized pursuant to this chapter may be part of the comprehensive community behavioral health services program conducted in counties pursuant to chapter 71.24 RCW, and may receive funding pursuant to the provisions thereof. [2020 c 302 § 52; 2016 sp.s. c 29 § 247; 1998 c 297 § 23; 1973 1st ex.s. c 142 § 58.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.560 Adoption of rules. The department, the department of social and health services, and the authority shall adopt such rules as may be necessary to effectuate the intent and purposes of this chapter, which shall include but not be limited to evaluation of the quality of the program and facilities operating pursuant to this chapter, evaluation of the effectiveness and cost effectiveness of such programs and facilities, and procedures and standards for licensing or certification and other action relevant to evaluation and treatment facilities, secure detoxification facilities, and approved substance use disorder treatment programs. [2018 c 201 § 3025; 2016 sp.s. c 29 § 248; 1998 c 297 § 24; 1973 1st ex.s. c 142 § 61.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective dates—Severability—Intent—1998 c 297: See notes following RCW 71.05.010.

71.05.570 Rules of court. The supreme court of the state of Washington shall adopt such rules as it shall deem necessary with respect to the court procedures and proceedings provided for by this chapter. [1973 1st ex.s. c 142 § 62.]

71.05.575 Less restrictive alternative treatment—Consideration by court. (1) When making a decision under this chapter whether to require a less restrictive alternative treatment, the court shall consider whether it is appropriate to include or exclude time spent in confinement when determining whether the person has committed a recent overt act.

(2) When determining whether an offender is a danger to himself or herself or others under this chapter, a court shall give great weight to any evidence submitted to the court regarding an offender's recent history of judicially required or administratively ordered involuntary antipsychotic medication while in confinement. [1999 c 214 § 6.]

Intent—Effective date—1999 c 214: See notes following RCW 72.09.370.

71.05.585 Less restrictive alternative treatment. (1) Less restrictive alternative treatment, at a minimum, includes the following services:

(a) Assignment of a care coordinator;

(b) An intake evaluation with the provider of the less restrictive alternative treatment;

(c) A psychiatric evaluation, a substance use disorder evaluation, or both;

(d) A schedule of regular contacts with the provider of the treatment services for the duration of the order;

(e) A transition plan addressing access to continued services at the expiration of the order;

(f) An individual crisis plan;

(g) Consultation about the formation of a mental health advance directive under chapter 71.32 RCW; and

(h) Notification to the care coordinator assigned in (a) of this subsection if reasonable efforts to engage the client fail to produce substantial compliance with court-ordered treatment conditions.

(2) Less restrictive alternative treatment may additionally include requirements to participate in the following services:

(a) Medication management;

(b) Psychotherapy;

(c) Nursing;

(d) Substance use disorder counseling;

(e) Residential treatment;

(f) Partial hospitalization;

(g) Intensive outpatient treatment;

(h) Support for housing, benefits, education, and employment; and

(i) Periodic court review.

(3) If the person was provided with involuntary medication under RCW 71.05.215 or pursuant to a judicial order during the involuntary commitment period, the less restrictive alternative treatment order may authorize the less restrictive alternative treatment provider or its designee to administer involuntary antipsychotic medication to the person if the provider has attempted and failed to obtain the informed consent of the person and there is a concurring medical opinion approving the medication by a psychiatrist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, or physician or physician assistant in consultation with an independent mental health professional with prescribing authority.

(4) Less restrictive alternative treatment must be administered by a provider that is certified or licensed to provide or coordinate the full scope of services required under the less restrictive alternative order and that has agreed to assume this responsibility.

(5) The care coordinator assigned to a person ordered to less restrictive alternative treatment must submit an individualized plan for the person's treatment services to the court that entered the order. An initial plan must be submitted as soon as possible following the intake evaluation and a revised plan must be submitted upon any subsequent modification in which a type of service is removed from or added to the treatment plan.

(6) A care coordinator may disclose information and records related to mental health services pursuant to RCW 70.02.230(2)(k) for purposes of implementing less restrictive alternative treatment.

(7) For the purpose of this section, "care coordinator" means a clinical practitioner who coordinates the activities of less restrictive alternative treatment. The care coordinator coordinates activities with the designated crisis responders that are necessary for enforcement and continuation of less restrictive alternative orders and is responsible for coordinating service activities with other agencies and establishing and maintaining a therapeutic relationship with the individual on a continuing basis. [2022 c 210 § 20; 2021 c 264 § 13; 2020 c 302 § 53; 2018 c 291 § 2. Prior: 2016 sp.s. c 29 § 241; 2016 c 45 § 5; 2015 c 250 § 16.]

Effective date—2018 c 291 §§ 1-4, 6, 7, 9, 11, 12, 13, and 15: See note following RCW 71.05.020.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.05.590 Enforcement, modification, or revocation of less restrictive alternative or conditional release orders—Initiation of inpatient detention procedures. ***(Effective until July 1, 2026.)*** (1) Either an agency or facility designated to monitor or provide services under a less restrictive alternative order or conditional release, or a designated crisis responder, may take action to enforce, modify, or revoke a less restrictive alternative treatment order or conditional release order. The agency, facility, or designated crisis responder must determine that:

(a) The person is failing to adhere to the terms and conditions of the order;

(b) Substantial deterioration in the person's functioning has occurred;

(c) There is evidence of substantial decompensation with a reasonable probability that the decompensation can be reversed by further evaluation, intervention, or treatment; or

(d) The person poses a likelihood of serious harm.

(2) Actions taken under this section must include a flexible range of responses of varying levels of intensity appropriate to the circumstances and consistent with the interests of the individual and the public in personal autonomy, safety, recovery, and compliance. Available actions may include, but are not limited to, any of the following:

(a) To counsel or advise the person as to their rights and responsibilities under the court order, and to offer incentives to motivate compliance;

(b) To increase the intensity of outpatient services provided to the person by increasing the frequency of contacts with the provider, referring the person for an assessment for assertive community services, or by other means;

(c) To request a court hearing for review and modification of the court order. The request must be directed to the court with jurisdiction over the order and specify the circumstances that give rise to the request and what modification is being sought. The county prosecutor shall assist the entity requesting the hearing and issue an appropriate summons to the person. This subsection does not limit the inherent authority of a treatment provider to alter conditions of treatment for clinical reasons, and is intended to be used only when court intervention is necessary or advisable to secure the person's compliance and prevent decompensation or deterioration;

(d) To detain the person for up to 12 hours for evaluation at an agency, facility providing services under the court order, triage facility, crisis stabilization unit, emergency department, evaluation and treatment facility, secure withdrawal management and stabilization facility with available space, or an approved substance use disorder treatment program with available space. The purpose of the evaluation is to determine whether modification, revocation, or commitment proceedings are necessary and appropriate to stabilize the person and prevent decompensation, deterioration, or physical harm. Temporary detention for evaluation under this subsection is intended to occur only following a pattern of noncompliance or the failure of reasonable attempts at outreach and engagement, and may occur only when, based on clinical judgment, temporary detention is appropriate. The agency, facility, or designated crisis responder may request assistance from a peace officer for the purposes of temporary detention under this subsection (2)(d). This subsection does not limit the ability or obligation of the agency, facility, or designated crisis responder to pursue revocation procedures under subsection (5) of this section in appropriate circumstances; and

(e) To initiate revocation procedures under subsection (5) of this section.

(3) A court may supervise a person on an order for less restrictive alternative treatment or a conditional release. While the person is under the order, the court may:

(a) Require appearance in court for periodic reviews; and

(b) Modify the order after considering input from the agency or facility designated to provide or facilitate services. The court may not remand the person into inpatient treatment except as provided under subsection (5) of this section, but may take actions under subsection (2)(a) through (d) of this section.

(4) The facility or agency designated to provide outpatient treatment shall notify the secretary of the department of social and health services or designated crisis responder when a person fails to adhere to terms and conditions of court ordered treatment or experiences substantial deterioration in his or her condition and, as a result, presents an increased likelihood of serious harm.

(5)(a) A designated crisis responder or the secretary of the department of social and health services may, upon their own motion or upon request of the facility or agency designated to provide outpatient care, cause a person to be detained in an evaluation and treatment facility, available secure withdrawal management and stabilization facility with adequate space, or available approved substance use disorder treatment program with adequate space in or near the county in which he or she is receiving outpatient treatment for the purpose of a hearing for revocation of a less restrictive alternative treatment order or conditional release order under this chapter. The designated crisis responder or secretary of the department of social and health services shall file a petition for revocation within 24 hours and serve the person, their guardian, if any, and their attorney. A hearing for revocation of a less restrictive alternative treatment order or conditional release order may be scheduled without detention of the person.

(b) A person detained under this subsection (5) must be held until such time, not exceeding five days, as a hearing can be scheduled to determine whether or not the order for less restrictive alternative treatment or conditional release should be revoked, modified, or retained. If the person is not detained, the hearing must be scheduled within five days of service on the person. The designated crisis responder or the secretary of the department of social and health services may withdraw its petition for revocation at any time before the court hearing.

(c) A person detained under this subsection (5) has the same rights with respect to notice, hearing, and counsel as in any involuntary treatment proceeding, except as specifically set forth in this section. There is no right to jury trial. The venue for proceedings is the county where the petition is filed. Notice of the filing must be provided to the court that originally ordered commitment, if different from the court where the petition for revocation is filed, within two judicial days of the person's detention.

(d) The issues for the court to determine are whether: (i) The person adhered to the terms and conditions of the order; (ii) substantial deterioration in the person's functioning has

occurred; (iii) there is evidence of substantial decompensation with a reasonable probability that the decompensation can be reversed by further inpatient treatment; or (iv) there is a likelihood of serious harm; and, if any of the above conditions apply, whether it is appropriate for the court to reinstate or modify the person's less restrictive alternative treatment order or conditional release order or order the person's detention for inpatient treatment. The person may waive the court hearing and allow the court to enter a stipulated order upon the agreement of all parties. If the court orders detention for inpatient treatment, the treatment period must be for 14 days from the revocation hearing if the less restrictive alternative treatment order or conditional release order was based on a petition under RCW 71.05.148, 71.05.160, or 71.05.230. If the court orders detention for inpatient treatment and the less restrictive alternative treatment order or conditional release order was based on a petition under RCW 71.05.290 or 71.05.320, the number of days remaining on the order must be converted to days of inpatient treatment. A court may not detain a person for inpatient treatment to a secure withdrawal management and stabilization facility or approved substance use disorder treatment program under this subsection unless there is a facility or program available with adequate space for the person.

(6) In determining whether or not to take action under this section the designated crisis responder, agency, or facility must consider the factors specified under RCW 71.05.212 and the court must consider the factors specified under RCW 71.05.245 as they apply to the question of whether to enforce, modify, or revoke a court order for involuntary treatment. [2022 c 210 § 23; 2021 c 264 § 14; 2020 c 302 § 55; (2020 c 302 § 54 expired January 1, 2021); 2019 c 446 § 14. Prior: 2018 c 291 § 9; 2018 c 201 § 3026; 2017 3rd sp.s. c 14 § 9; (2017 3rd sp.s. c 14 § 8 expired April 1, 2018); 2016 sp.s. c 29 § 242; 2015 c 250 § 13.]

Expiration date—2022 c 210 §§ 5, 12, 17, and 23: See note following RCW 71.05.150.

Expiration date—2021 c 264 §§ 1, 3, 6, 8, 10, 14, 31, and 33: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 13, 16, 26, 39, 45, 55, 78, 83, 86, 92, 94, and 97: See note following RCW 71.05.150.

Expiration date—2019 c 446 §§ 4, 6, 8, 11, 14, 30, 32, 34, 37, 39, and 41: See note following RCW 71.05.150.

Effective date—2018 c 291 §§ 1-4, 6, 7, 9, 11, 12, 13, and 15: See note following RCW 71.05.020.

Expiration date—2018 c 291 §§ 4, 7, and 9: See note following RCW 71.05.150.

Expiration date—2018 c 201 §§ 3009, 3012, 3026, 5017, and 5020: See note following RCW 71.05.240.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2017 3rd sp.s. c 14 §§ 9, 12, 14, 15, and 17-21: "Sections 9, 12, 14, 15, and 17 through 21 of this act take effect April 1, 2018." [2017 3rd sp.s. c 14 § 24.]

Expiration date—2017 3rd sp.s. c 14 §§ 9 and 15: "Sections 9 and 15 of this act expire July 1, 2026." [2017 3rd sp.s. c 14 § 25.]

Expiration date—2017 3rd sp.s. c 14 §§ 8, 11, and 13: "Sections 8, 11, and 13 of this act expire April 1, 2018." [2017 3rd sp.s. c 14 § 23.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.05.590 Enforcement, modification, or revocation of less restrictive alternative or conditional release orders—Initiation of inpatient detention procedures. ***(Effective July 1, 2026.)*** (1) Either an agency or facility designated to monitor or provide services under a less restrictive alternative order or conditional release, or a designated crisis responder, may take action to enforce, modify, or revoke a less restrictive alternative treatment order or conditional release order. The agency, facility, or designated crisis responder must determine that:

(a) The person is failing to adhere to the terms and conditions of the order;

(b) Substantial deterioration in the person's functioning has occurred;

(c) There is evidence of substantial decompensation with a reasonable probability that the decompensation can be reversed by further evaluation, intervention, or treatment; or

(d) The person poses a likelihood of serious harm.

(2) Actions taken under this section must include a flexible range of responses of varying levels of intensity appropriate to the circumstances and consistent with the interests of the individual and the public in personal autonomy, safety, recovery, and compliance. Available actions may include, but are not limited to, any of the following:

(a) To counsel or advise the person as to their rights and responsibilities under the court order, and to offer incentives to motivate compliance;

(b) To increase the intensity of outpatient services provided to the person by increasing the frequency of contacts with the provider, referring the person for an assessment for assertive community services, or by other means;

(c) To request a court hearing for review and modification of the court order. The request must be directed to the court with jurisdiction over the order and specify the circumstances that give rise to the request and what modification is being sought. The county prosecutor shall assist [the] entity requesting the hearing and issue an appropriate summons to the person. This subsection does not limit the inherent authority of a treatment provider to alter conditions of treatment for clinical reasons, and is intended to be used only when court intervention is necessary or advisable to secure the person's compliance and prevent decompensation or deterioration;

(d) To detain the person for up to 12 hours for evaluation at an agency, facility providing services under the court order, triage facility, crisis stabilization unit, emergency department, evaluation and treatment facility, secure withdrawal management and stabilization facility, or an approved substance use disorder treatment program. The purpose of the evaluation is to determine whether modification, revocation, or commitment proceedings are necessary and appropriate to stabilize the person and prevent decompensation, deterioration, or physical harm. Temporary detention for evaluation under this subsection is intended to occur only following a pattern of noncompliance or the failure of reasonable attempts at outreach and engagement, and may occur only when, based on clinical judgment, temporary detention is appropriate. The agency, facility, or designated crisis

responder may request assistance from a peace officer for the purposes of temporary detention under this subsection (2)(d). This subsection does not limit the ability or obligation of the agency, facility, or designated crisis responder to pursue revocation procedures under subsection (5) of this section in appropriate circumstances; and

(e) To initiate revocation procedures under subsection (5) of this section.

(3) A court may supervise a person on an order for less restrictive alternative treatment or a conditional release. While the person is under the order, the court may:

(a) Require appearance in court for periodic reviews; and

(b) Modify the order after considering input from the agency or facility designated to provide or facilitate services. The court may not remand the person into inpatient treatment except as provided under subsection (5) of this section, but may take actions under subsection (2)(a) through (d) of this section.

(4) The facility or agency designated to provide outpatient treatment shall notify the secretary of the department of social and health services or designated crisis responder when a person fails to adhere to terms and conditions of court ordered treatment or experiences substantial deterioration in his or her condition and, as a result, presents an increased likelihood of serious harm.

(5)(a) A designated crisis responder or the secretary of the department of social and health services may, upon their own motion or upon request of the facility or agency designated to provide outpatient care, cause a person to be detained in an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program in or near the county in which he or she is receiving outpatient treatment for the purpose of a hearing for revocation of a less restrictive alternative treatment order or conditional release order under this chapter. The designated crisis responder or secretary of the department of social and health services shall file a petition for revocation within 24 hours and serve the person, their guardian, if any, and their attorney. A hearing for revocation of a less restrictive alternative treatment order or conditional release order may be scheduled without detention of the person.

(b) A person detained under this subsection (5) must be held until such time, not exceeding five days, as a hearing can be scheduled to determine whether or not the order for less restrictive alternative treatment or conditional release should be revoked, modified, or retained. If the person is not detained, the hearing must be scheduled within five days of service on the person. The designated crisis responder or the secretary of the department of social and health services may withdraw its petition for revocation at any time before the court hearing.

(c) A person detained under this subsection (5) has the same rights with respect to notice, hearing, and counsel as in any involuntary treatment proceeding, except as specifically set forth in this section. There is no right to jury trial. The venue for proceedings is the county where the petition is filed. Notice of the filing must be provided to the court that originally ordered commitment, if different from the court where the petition for revocation is filed, within two judicial days of the person's detention.

(d) The issues for the court to determine are whether: (i) The person adhered to the terms and conditions of the order; (ii) substantial deterioration in the person's functioning has occurred; (iii) there is evidence of substantial decompensation with a reasonable probability that the decompensation can be reversed by further inpatient treatment; or (iv) there is a likelihood of serious harm; and, if any of the above conditions apply, whether it is appropriate for the court to reinstate or modify the person's less restrictive alternative treatment order or conditional release order or order the person's detention for inpatient treatment. The person may waive the court hearing and allow the court to enter a stipulated order upon the agreement of all parties. If the court orders detention for inpatient treatment, the treatment period must be for 14 days from the revocation hearing if the less restrictive alternative treatment order or conditional release order was based on a petition under RCW 71.05.148, 71.05.160, or 71.05.230. If the court orders detention for inpatient treatment and the less restrictive alternative treatment order or conditional release order was based on a petition under RCW 71.05.290 or 71.05.320, the number of days remaining on the order must be converted to days of inpatient treatment.

(6) In determining whether or not to take action under this section the designated crisis responder, agency, or facility must consider the factors specified under RCW 71.05.212 and the court must consider the factors specified under RCW 71.05.245 as they apply to the question of whether to enforce, modify, or revoke a court order for involuntary treatment. [2022 c 210 § 24; 2021 c 264 § 15; 2020 c 302 § 56; (2020 c 302 § 54 expired January 1, 2021); 2019 c 446 § 15. Prior: 2018 c 291 § 10; 2018 c 201 § 3027; 2017 3rd sp.s. c 14 § 10; (2017 3rd sp.s. c 14 § 8 expired April 1, 2018); 2016 sp.s. c 29 § 243; 2016 sp.s. c 29 § 242; 2015 c 250 § 13.]

Effective date—2022 c 210 §§ 6, 13, 18, and 24: See note following RCW 71.05.150.

Effective date—2021 c 264 §§ 2, 4, 7, 9, 11, 15, 32, and 34: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Effective date—2020 c 302 §§ 14, 17, 27, 40, 46, 56, 79, 84, 87, 93, 95, and 98: See note following RCW 71.05.150.

Effective date—2019 c 446 §§ 5, 7, 9, 12, 15, 31, 33, 35, 38, 40, and 42: See note following RCW 71.05.150.

Effective date—2018 c 291 §§ 5, 8, and 10: See note following RCW 71.05.150.

Effective date—2018 c 201 §§ 3010, 3013, 3027, 5018, and 5021: See note following RCW 71.05.240.

Findings—Intent—2018 c 201: See note following RCW 41.05.018.

Effective date—2017 3rd sp.s. c 14 §§ 10 and 16: "Sections 10 and 16 of this act take effect July 1, 2026." [2017 3rd sp.s. c 14 § 26.]

Expiration date—2017 3rd sp.s. c 14 §§ 8, 11, and 13: "Sections 8, 11, and 13 of this act expire April 1, 2018." [2017 3rd sp.s. c 14 § 23.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.05.595 Less restrictive alternative treatment order—Termination. A court order for less restrictive alternative treatment for a person found to be in need of assisted outpatient treatment must be terminated prior to the expiration of the order when, in the opinion of the professional person in charge of the less restrictive alternative treatment pro-

vider, (1) the person is prepared to accept voluntary treatment, or (2) the outpatient treatment ordered is no longer necessary to prevent a relapse, decompensation, or deterioration that is likely to result in the person presenting a likelihood of serious harm or the person becoming gravely disabled within a reasonably short period of time. [2022 c 210 § 25; 2018 c 291 § 16; 2015 c 250 § 17.]

71.05.620 Court files and records closed—Exceptions—Rules. (1) The files and records of court proceedings under this chapter and chapter 71.34 RCW shall be closed but shall be accessible to:

(a) The department;

(b) The department of social and health services;

(c) The authority;

(d) The state hospitals as defined in RCW 72.23.010;

(e) Any person who is the subject of a petition;

(f) The attorney or guardian of the person;

(g) Resource management services for that person; and

(h) Service providers authorized to receive such information by resource management services.

(2) The authority shall adopt rules to implement this section. [2018 c 201 § 3028; 2016 sp.s. c 29 § 249; 2015 c 269 § 16; 2013 c 200 § 23; 2005 c 504 § 111; 1989 c 205 § 12.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2013 c 200: See note following RCW 70.02.010.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Additional notes found at www.leg.wa.gov

71.05.660 Treatment records—Privileged communications unaffected. Nothing in this chapter or chapter 70.02 or 71.34 RCW shall be construed to interfere with communications between physicians, physician assistants, psychiatric advanced registered nurse practitioners, or psychologists and patients and attorneys and clients. [2016 sp.s. c 29 § 420; 2016 c 155 § 9; 2013 c 200 § 21; 2009 c 217 § 9; 2005 c 504 § 114; 1989 c 205 § 16.]

Reviser's note: This section was amended by 2016 c 155 § 9 and by 2016 sp.s. c 29 § 420, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2013 c 200: See note following RCW 70.02.010.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Additional notes found at www.leg.wa.gov

71.05.680 Treatment records—Access under false pretenses, penalty. Any person who requests or obtains confidential information pursuant to RCW 71.05.620 under false pretenses shall be guilty of a gross misdemeanor. [2013 c 200 § 22; 2005 c 504 § 713; 1999 c 13 § 11. Prior: 1989 c 205 § 18.]

Effective date—2013 c 200: See note following RCW 70.02.010.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Purpose—Construction—1999 c 13: See note following RCW 10.77.010.

Additional notes found at www.leg.wa.gov

71.05.700 Home visit by designated crisis responder or crisis intervention worker—Accompaniment by second trained individual. No designated crisis responder or crisis intervention worker shall be required to respond to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's involuntary treatment act, unless a second trained individual, determined by the clinical team supervisor, on-call supervisor, or individual professional acting alone based on a risk assessment for potential violence, accompanies them. The second individual may be a law enforcement officer, a mental health professional, a mental health paraprofessional who has received training under RCW 71.05.715, or other first responder, such as fire or ambulance personnel. No retaliation may be taken against a worker who, following consultation with the clinical team, refuses to go on a home visit alone. [2016 sp.s. c 29 § 250; 2007 c 360 § 2.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—2007 c 360: "The legislature finds that designated mental health professionals go out into the community to evaluate people for potential detention under the state's involuntary treatment act. Also, designated mental health professionals and other mental health workers do crisis intervention work intended to stabilize a person in crisis and provide immediate treatment and intervention in communities throughout Washington state. In many cases, the presence of a second trained individual on outreach to a person's private home or other private location will enhance safety for consumers, families, and mental health professionals and will advance the legislature's interest in quality mental health care services." [2007 c 360 § 1.]

Additional notes found at www.leg.wa.gov

71.05.705 Provider of designated crisis responder or crisis outreach services—Policy for home visits. Each provider of designated crisis responder or crisis outreach services shall maintain a written policy that, at a minimum, describes the organization's plan for training, staff backup, information sharing, and communication for crisis outreach staff who respond to private homes or nonpublic settings. [2016 sp.s. c 29 § 251; 2007 c 360 § 3.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Short title—2007 c 360: See notes following RCW 71.05.700.

71.05.710 Home visit by mental health professional—Wireless telephone to be provided. Any mental health professional who engages in home visits to clients shall be provided by their employer with a wireless telephone or comparable device for the purpose of emergency communication. [2007 c 360 § 4.]

Findings—Short title—2007 c 360: See notes following RCW 71.05.700.

71.05.715 Crisis visit by mental health professional—Access to information. Any mental health professional who is dispatched on a crisis visit, as described in RCW 71.05.700, shall have prompt access to information about any history of dangerousness or potential dangerousness on the client they are being sent to evaluate that is documented in crisis plans or commitment records and is available without unduly delaying a crisis response. [2007 c 360 § 5.]

Findings—Short title—2007 c 360: See notes following RCW 71.05.700.

71.05.720 Training for community mental health employees. Annually, all community mental health employees who work directly with clients shall be provided with training on safety and violence prevention topics described in RCW 49.19.030. The curriculum for the training shall be developed collaboratively among the authority, the department, contracted behavioral health service providers, and employee organizations that represent community mental health workers. [2020 c 302 § 57; 2018 c 201 § 3029; 2007 c 360 § 6.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Findings—Short title—2007 c 360: See notes following RCW 71.05.700.

71.05.730 Judicial services—Civil commitment cases—Reimbursement. (1) A county may apply to its behavioral health administrative services organization on a quarterly basis for reimbursement of its direct costs in providing judicial services for civil commitment cases under this chapter and chapter 71.34 RCW. The behavioral health administrative services organization shall in turn be entitled to reimbursement from the behavioral health administrative services organization that serves the county of residence of the individual who is the subject of the civil commitment case.

(2) Reimbursement for judicial services shall be provided per civil commitment case at a rate to be determined based on an independent assessment of the county's actual direct costs. This assessment must be based on an average of the expenditures for judicial services within the county over the past three years. In the event that a baseline cannot be established because there is no significant history of similar cases within the county, the reimbursement rate shall be equal to eighty percent of the median reimbursement rate of counties included in the independent assessment.

(3) For the purposes of this section:

(a) "Civil commitment case" includes all judicial hearings related to a single episode of hospitalization or less restrictive alternative treatment, except that the filing of a petition for a one hundred eighty-day commitment under this chapter or a petition for a successive one hundred eighty-day commitment under chapter 71.34 RCW shall be considered to be a new case regardless of whether there has been a break in detention. "Civil commitment case" does not include the filing of a petition for a one hundred eighty-day commitment under this chapter on behalf of a patient at a state psychiatric hospital.

(b) "Judicial services" means a county's reasonable direct costs in providing prosecutor services, assigned counsel and defense services, court services, and court clerk services for civil commitment cases under this chapter and chapter 71.34 RCW.

(4) To the extent that resources have a shared purpose, the behavioral health administrative services organization may only reimburse counties to the extent such resources are necessary for and devoted to judicial services as described in this section.

(5) No filing fee may be charged or collected for any civil commitment case subject to reimbursement under this section. [2019 c 325 § 3011; 2015 c 250 § 15; (2015 c 250 § 14 expired April 1, 2016); 2014 c 225 § 87; 2011 c 343 § 2.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective date—2015 c 250 §§ 2, 15, and 19: See note following RCW 71.05.020.

Expiration date—2015 c 250 §§ 1, 14, and 18: See note following RCW 71.05.020.

Effective date—2014 c 225: See note following RCW 71.24.016.

Intent—2011 c 343: "The legislature recognizes that counties that host evaluation and treatment beds incur costs by providing judicial services associated with civil commitments under chapters 71.05 and 71.34 RCW. Because evaluation and treatment beds are not evenly distributed across the state, these commitments frequently occur in a different county from the county in which the person was originally detained. The intent of this act is to create a process for the state to reimburse counties through the regional support networks for the counties' reasonable direct costs incurred in providing these judicial services, and to prevent the burden of these costs from falling disproportionately on the counties or regional support networks in which the commitments are most likely to occur. The legislature recognizes that the costs of judicial services may vary across the state based on different factors and conditions." [2011 c 343 § 1.]

Additional notes found at www.leg.wa.gov

71.05.732 Reimbursement for judicial services—Assessment. (1) The joint legislative audit and review committee shall conduct an independent assessment of the direct costs of providing judicial services under this chapter and chapter 71.34 RCW as defined in RCW 71.05.730. The assessment shall include a review and analysis of the reasons for differences in costs among counties. The assessment shall be conducted for any county in which more than twenty civil commitment cases were conducted during the year prior to the study. The assessment must be completed by June 1, 2012.

(2) The administrative office of the courts, the authority, and the department of social and health services shall provide the joint legislative audit and review committee with assistance and data required to complete the assessment.

(3) The joint legislative audit and review committee shall present recommendations as to methods for updating the costs identified in the assessment to reflect changes over time. [2018 c 201 § 3030; 2011 c 343 § 3.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Intent—2011 c 343: See note following RCW 71.05.730.

71.05.740 Reporting of commitment data. (1) All behavioral health administrative services organizations in the state of Washington must forward historical behavioral health involuntary commitment information retained by the organization, including identifying information and dates of commitment to the authority. As soon as feasible, the behavioral health administrative services organizations must

arrange to report new commitment data to the authority within twenty-four hours. Commitment information under this section does not need to be resent if it is already in the possession of the authority. Behavioral health administrative services organizations and the authority shall be immune from liability related to the sharing of commitment information under this section.

(2) The clerk of the court must share commitment hearing outcomes in all hearings under this chapter with the local behavioral health administrative services organization that serves the region where the superior court is located, including in cases in which the designated crisis responder investigation occurred outside the region. The hearing outcome data must include the name of the facility to which a person has been committed. [2022 c 210 § 29; 2021 c 263 § 15; 2020 c 302 § 58; 2019 c 325 § 3012; 2018 c 201 § 3031; 2014 c 225 § 88; 2013 c 216 § 2.]

Application—2021 c 263: See note following RCW 10.77.150.

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

71.05.745 Single bed certification. (1) The authority may use a single bed certification process as outlined in rule to provide additional treatment capacity for a person suffering from a mental disorder for whom an evaluation and treatment bed is not available. The facility that is the proposed site of the single bed certification must be a facility that is willing and able to provide the person with timely and appropriate treatment either directly or by arrangement with other public or private agencies.

(2) A single bed certification must be specific to the patient receiving treatment.

(3) A designated crisis responder who submits an application for a single bed certification for treatment at a facility that is willing and able to provide timely and appropriate mental health treatment in good faith belief that the single bed certification is appropriate may presume that the single bed certification will be approved for the purpose of completing the detention process and responding to other emergency calls.

(4) The authority may adopt rules implementing this section and continue to enforce rules it has already adopted except where inconsistent with this section. [2018 c 201 § 3032; 2016 sp.s. c 29 § 252; 2015 c 269 § 2.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2015 c 269 §§ 1-9 and 11-13: See note following RCW 71.05.010.

71.05.750 Report—No bed available for person who meets detention criteria. (1) A designated crisis responder shall make a report to the authority when he or she determines a person meets detention criteria under RCW 71.05.150, 71.05.153, 71.34.700, or 71.34.710 and there are not any beds available at an evaluation and treatment facility, the person has not been provisionally accepted for admission by a facility, and the person cannot be served on a single bed certification or less restrictive alternative. Starting at the time when the designated crisis responder determines a person meets detention criteria and the investigation has been completed, the designated crisis responder has twenty-four hours to submit a completed report to the authority.

(2) The report required under subsection (1) of this section must contain at a minimum:

(a) The date and time that the investigation was completed;

(b) The identity of the responsible behavioral health administrative services organization and managed care organization, if applicable;

(c) The county in which the person met detention criteria;

(d) A list of facilities which refused to admit the person; and

(e) Identifying information for the person, including age or date of birth.

(3) The authority shall develop a standardized reporting form or modify the current form used for single bed certifications for the report required under subsection (2) of this section and may require additional reporting elements as it determines are necessary or supportive. The authority shall also determine the method for the transmission of the completed report from the designated crisis responder to the authority.

(4) The authority shall create quarterly reports displayed on its website that summarize the information reported under subsection (2) of this section. At a minimum, the reports must display data by county and by month. The reports must also include the number of single bed certifications granted by category. The categories must include all of the reasons that the authority recognizes for issuing a single bed certification, as identified in rule.

(5) The reports provided according to this section may not display "protected health information" as that term is used in the federal health insurance portability and accountability act of 1996, nor information contained in "mental health treatment records" as that term is used in chapter 70.02 RCW or elsewhere in state law, and must otherwise be compliant with state and federal privacy laws.

(6) For purposes of this section, the term "single bed certification" means a situation in which an adult on a one hundred twenty hour detention, fourteen-day commitment, ninety-day commitment, or one hundred eighty-day commitment is detained to a facility that is:

(a) Not licensed or certified as an inpatient evaluation and treatment facility; or

(b) A licensed or certified inpatient evaluation and treatment facility that is already at capacity. [2020 c 302 § 59; 2019 c 325 § 3013; 2018 c 201 § 3033; 2016 sp.s. c 29 § 253; 2015 c 269 § 3.]

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2015 c 269 §§ 1-9 and 11-13: See note following RCW 71.05.010.

71.05.755 Duties upon receipt of no bed available report—Corrective actions. (1) The authority shall promptly share reports it receives under RCW 71.05.750 with the responsible behavioral health administrative services organization or managed care organization, if applicable. The behavioral health administrative services organization or managed care organization, if applicable, receiving this notification must attempt to engage the person in appropriate services for which the person is eligible and report back within seven days to the authority.

(2) The authority shall track and analyze reports submitted under RCW 71.05.750. The authority must initiate corrective action when appropriate to ensure that each behavioral health administrative services organization or managed care organization, if applicable, has implemented an adequate plan to provide evaluation and treatment services. Corrective actions may include remedies under the authority's contract with such entity. An adequate plan may include development of less restrictive alternatives to involuntary commitment such as crisis triage, crisis diversion, voluntary treatment, or prevention programs reasonably calculated to reduce demand for evaluation and treatment under this chapter. [2019 c 325 § 3014; 2018 c 201 § 3034; 2015 c 269 § 4.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2015 c 269 §§ 1-9 and 11-13: See note following RCW 71.05.010.

71.05.760 Designated crisis responders—Training—Qualifications—Secure withdrawal management and stabilization facility capacity. (1)(a) The authority or its designee shall provide training to the designated crisis responders.

(b)(i) To qualify as a designated crisis responder, a person must have received substance use disorder training as determined by the authority and be a:

(A) Psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, or social worker;

(B) Person who is licensed by the department as a mental health counselor or mental health counselor associate, or marriage and family therapist or marriage and family therapist associate;

(C) Person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university and who have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the direction of a mental health professional;

(D) Person who meets the waiver criteria of RCW 71.24.260, which waiver was granted before 1986;

(E) Person who had an approved waiver to perform the duties of a mental health professional that was requested by the regional support network and granted by the department of social and health services before July 1, 2001; or

(F) Person who has been granted an exception of the minimum requirements of a mental health professional by the department consistent with rules adopted by the secretary.

(ii) Training must include training specific to the duties of a designated crisis responder, including diagnosis of substance abuse and dependence and assessment of risk associated with substance use.

(2)(a) The authority must ensure that at least one sixteen-bed secure withdrawal management and stabilization facility is operational by April 1, 2018, and that at least two sixteen-bed secure withdrawal management and stabilization facilities are operational by April 1, 2019.

(b) If, at any time during the implementation of secure withdrawal management and stabilization facility capacity, federal funding becomes unavailable for federal match for services provided in secure withdrawal management and stabilization facilities, then the authority must cease any expansion of secure withdrawal management and stabilization facilities until further direction is provided by the legislature. [2019 c 446 § 16; 2019 c 325 § 3015; 2018 c 201 § 3035; 2017 3rd sp.s. c 14 § 21; 2016 sp.s. c 29 § 201.]

Reviser's note: This section was amended by 2019 c 325 § 3015 and by 2019 c 446 § 16, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2017 3rd sp.s. c 14 §§ 9, 12, 14, 15, and 17-21: See note following RCW 71.05.590.

Effective dates—2016 sp.s. c 29: "(1) Sections 501, 503 through 532, and 701 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect *April 1, 2016.

(2) Sections 201 through 210, 212, 214 through 224, 226 through 232, 234 through 237, 239 through 242, 244 through 267, 269, 271, 273, 274, 276, 278, 279, 281, 401 through 429, and 502 of this act take effect April 1, 2018.

(3) Sections 211, 213, 225, 233, 238, 243, 268, 270, 272, 275, 277, and 280 of this act take effect July 1, 2026." [2016 sp.s. c 29 § 803.]

***Reviser's note:** 2016 sp.s. c 29 was signed by the governor on April 18, 2016.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.05.801 Persons with developmental disabilities—Service plans—Habilitation services. When appropriate and subject to available funds, the treatment and training of a person with a developmental disability who is committed to the custody of the department of social and health services or to a facility licensed or certified for ninety day treatment by the department for a further period of intensive treatment under RCW 71.05.320 must be provided in a program specifically reserved for the treatment and training of persons with developmental disabilities. A person so committed shall receive habilitation services pursuant to an individualized service plan specifically developed to treat the behavior which was the subject of the criminal proceedings. The treatment program shall be administered by developmental disabilities professionals and others trained specifically in the needs of persons with developmental disabilities. The department of social and health services may limit admissions to this specialized program in order to ensure that expenditures for services do not exceed amounts appropriated by the legislature and allocated by the department of social and health services for such services. The department of social and health services may establish admission priorities in the event

that the number of eligible persons exceeds the limits set by the department of social and health services. [2018 c 201 § 3036; 2009 c 323 § 3.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Findings—Intent—2009 c 323: See note following RCW 71.05.320.

71.05.810 Integration evaluation. ***(Expires August 1, 2023.)*** (1) The Washington state institute for public policy shall evaluate the effect of the integration of the involuntary treatment systems for substance use disorders and mental health and make preliminary reports to appropriate committees of the legislature by December 1, 2020, and June 30, 2021, and a final report by June 30, 2023.

(2) The evaluation must include an assessment of whether the integrated system:

(a) Has increased efficiency of evaluation and treatment of persons involuntarily detained for substance use disorders;

(b) Is cost-effective, including impacts on health care, housing, employment, and criminal justice costs;

(c) Results in better outcomes for persons involuntarily detained;

(d) Increases the effectiveness of the crisis response system statewide;

(e) Has an impact on commitments based upon mental disorders;

(f) Has been sufficiently resourced with enough involuntary treatment beds, less restrictive alternative treatment options, and state funds to provide timely and appropriate treatment for all individuals interacting with the integrated involuntary treatment system; and

(g) Has diverted from the mental health involuntary treatment system a significant number of individuals whose risk results from substance abuse, including an estimate of the net savings from serving these clients into the appropriate substance abuse treatment system.

(3) This section expires August 1, 2023. [2016 sp.s. c 29 § 202.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.05.820 Appearance by video technology. For purposes of this chapter, at any hearing the petitioner, the respondent, the witnesses, the interpreters, and the presiding judicial officer may be present and participate either in person or by video, as determined by the court. The term "video" as used in this section includes any functional equivalent. At any hearing conducted by video, the technology used must permit the judicial officer, counsel, all parties, and the witnesses to be able to see, hear, and speak, when authorized, during the hearing; to allow attorneys to use exhibits or other materials during the hearing; and to allow the respondent's counsel to be in the same location as the respondent unless otherwise requested by the respondent or the respondent's counsel. Witnesses in a proceeding may also appear in court through other means, including telephonically, pursuant to the requirements of superior court civil rule 43. Notwithstanding the foregoing, the court, upon its own motion or upon a motion for good cause by any party, may require all parties and witnesses to participate in the hearing in person rather than by video. In ruling on any such motion, the court may allow in-person or video testimony; and the court may consider, among other things, whether the respondent's alleged behavioral health disorder affects the respondent's ability to perceive or participate in the proceeding by video. [2020 c 302 § 101.]

71.05.940 Equal application of 1989 c 420—Evaluation for developmental disability. The provisions of chapter 420, Laws of 1989 shall apply equally to persons in the custody of the department of social and health services on May 13, 1989, who were found by a court to be not guilty by reason of insanity or incompetent to stand trial, or who have been found to have committed acts constituting a felony pursuant to RCW 71.05.280(3) and present a substantial likelihood of repeating similar acts, and the secretary of the department of social and health services shall cause such persons to be evaluated to ascertain if such persons have a developmental disability for placement in a program specifically reserved for the treatment and training of persons with developmental disabilities. [2018 c 201 § 3037; 1999 c 13 § 13; 1989 c 420 § 18.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Purpose—Construction—1999 c 13: See note following RCW 10.77.010.

71.05.950 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521. For the purposes of this chapter, the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family shall be interpreted as applying equally to state registered domestic partnerships or individuals in state registered domestic partnerships as well as to marital relationships and married persons, and references to dissolution of marriage shall apply equally to state registered domestic partnerships that have been terminated, dissolved, or invalidated, to the extent that such interpretation does not conflict with federal law. Where necessary to implement chapter 521, Laws of 2009, gender-specific terms such as husband and wife used in any statute, rule, or other law shall be construed to be gender neutral, and applicable to individuals in state registered domestic partnerships. [2009 c 521 § 157.]

Chapter 71.06 RCW
SEXUAL PSYCHOPATHS

Sections

Council for children and families: Chapter 43.121 RCW.

Nonresident sexual psychopaths and psychopathic delinquents: Chapter 72.25 RCW.

Telephone calls soliciting immoral acts: RCW 9.61.230 through 9.61.250.

71.06.005 Application of chapter. With respect to sexual psychopaths, this chapter applies only to crimes or offenses committed before July 1, 1984. [1984 c 209 § 27.]

Additional notes found at www.leg.wa.gov

71.06.010 Definitions. As used in this chapter, the following terms shall have the following meanings:

"Psychopathic personality" means the existence in any person of such hereditary, congenital, or acquired condition affecting the emotional or volitional rather than the intellectual field and manifested by anomalies of such character as to render satisfactory social adjustment of such person difficult or impossible.

"Sexual psychopath" means any person who is affected in a form of psychoneurosis or in a form of psychopathic personality, which form predisposes such person to the commission of sexual offenses in a degree constituting him or her a menace to the health or safety of others.

"Sex offense" means one or more of the following: Abduction, incest, rape, assault with intent to commit rape, indecent assault, contributing to the delinquency of a minor involving sexual misconduct, sodomy, indecent exposure, indecent liberties with children, carnal knowledge of children, soliciting or enticing or otherwise communicating with a child for immoral purposes, vagrancy involving immoral or sexual misconduct, or an attempt to commit any of the said offenses.

"Minor" means any person under eighteen years of age.

"Department" means department of social and health services.

"Court" means the superior court of the state of Washington.

"Superintendent" means the superintendent of a state institution designated for the custody, care, and treatment of sexual psychopaths or psychopathic delinquents. [2012 c 117 § 430; 1985 c 354 § 32; 1977 ex.s. c 80 § 42; 1971 ex.s. c 292 § 65; 1961 c 65 § 1; 1959 c 25 § 71.06.010. Prior: 1957 c 184 § 1; 1951 c 223 § 2; 1949 c 198 §§ 25 and 40; Rem. Supp. 1949 §§ 6953-25 and 6953-40.]

Purpose—Intent—Severability—1977 ex.s. c 80: See notes following RCW 4.16.190.

Additional notes found at www.leg.wa.gov

71.06.020 Sexual psychopaths—Petition. Where any person is charged in the superior court in this state with a sex offense and it appears that such person is a sexual psychopath, the prosecuting attorney may file a petition in the criminal proceeding, alleging that the defendant is a sexual psychopath and stating sufficient facts to support such allegation. Such petition must be filed and served on the defendant or his or her attorney at least ten days prior to hearing on the criminal charge. [2012 c 117 § 431; 1959 c 25 § 71.06.020. Prior: 1951 c 223 § 3; 1949 c 198 § 26; Rem. Supp. 1949 § 6953-26.]

71.06.030 Procedure on petition—Effect of acquittal on criminal charge. The court shall proceed to hear the criminal charge. If the defendant is convicted or has previously pleaded guilty to such charge, judgment shall be pronounced, but the execution of the sentence may be deferred or suspended, as in other criminal cases, and the court shall then proceed to hear and determine the allegation of sexual psychopathy. Acquittal on the criminal charge shall not operate to suspend the hearing on the allegation of sexual psychopathy: PROVIDED, That the provisions of RCW 71.06.140 authorizing transfer of a committed sexual psychopath to a correctional institution shall not apply to the committed sexual psychopath who has been acquitted on the criminal charge. [1967 c 104 § 1; 1959 c 25 § 71.06.030. Prior: 1951 c 223 § 4.]

71.06.040 Preliminary hearing—Evidence—Detention in hospital for observation. At a preliminary hearing upon the charge of sexual psychopathy, the court may require the testimony of two duly licensed physicians, physician assistants, or psychiatric advanced registered nurse practitioners who have examined the defendant. If the court finds that there are reasonable grounds to believe the defendant is a sexual psychopath, the court shall order said defendant confined at the nearest state hospital for observation as to the existence of sexual psychopathy. Such observation shall be for a period of not to exceed ninety days. The defendant shall be detained in the county jail or other county facilities pending execution of such observation order by the department. [2016 c 155 § 10; 2009 c 217 § 10; 1959 c 25 § 71.06.040. Prior: 1951 c 223 § 5.]

71.06.050 Preliminary hearing—Report of findings. Upon completion of said observation period, the superintendent of the state hospital shall return the defendant to the court, together with a written report of his or her findings as to whether or not the defendant is a sexual psychopath and the facts upon which his or her opinion is based. [2012 c 117 § 432; 1959 c 25 § 71.06.050. Prior: 1951 c 223 § 6.]

71.06.060 Preliminary hearing—Commitment, or other disposition of charge. After the superintendent's report has been filed, the court shall determine whether or not the defendant is a sexual psychopath. If said defendant is found to be a sexual psychopath, the court shall commit him or her to the secretary of social and health services for designation of the facility for detention, care, and treatment of the sexual psychopath. If the defendant is found not to be a sexual psychopath, the court shall order the sentence to be executed, or may discharge the defendant as the case may merit. [2012 c 117 § 433; 1979 c 141 § 129; 1967 c 104 § 2; 1959 c 25 § 71.06.060. Prior: 1951 c 223 § 7.]

71.06.070 Preliminary hearing—Jury trial. A jury may be demanded to determine the question of sexual psychopathy upon hearing after return of the superintendent's report. Such demand must be in writing and filed with the

court within ten days after filing of the petition alleging the defendant to be a sexual psychopath. [1959 c 25 § 71.06.070. Prior: 1951 c 223 § 14; 1949 c 198 § 38; Rem. Supp. 1949 § 6953-38.]

71.06.080 Preliminary hearing—Construction of chapter—Trial, evidence, law relating to criminally insane. Nothing in this chapter shall be construed as to affect the procedure for the ordinary conduct of criminal trials as otherwise set up by law. Nothing in this chapter shall be construed to prevent the defendant, his or her attorney, or the court of its own motion, from producing evidence and witnesses at the hearing on the probable existence of sexual psychopathy or at the hearing after the return of the superintendent's report. Nothing in this chapter shall be construed as affecting the laws relating to the criminally insane or the insane criminal, nor shall this chapter be construed as preventing the defendant from raising the defense of insanity as in other criminal cases. [2012 c 117 § 434; 1959 c 25 § 71.06.080. Prior: 1951 c 223 § 15.]

Criminally insane: Chapter 10.77 RCW.

71.06.091 Postcommitment proceedings, releases, and further dispositions. A sexual psychopath committed pursuant to RCW 71.06.060 shall be retained by the superintendent of the institution involved until in the superintendent's opinion he or she is safe to be at large, or until he or she has received the maximum benefit of treatment, or is not amenable to treatment, but the superintendent is unable to render an opinion that he or she is safe to be at large. Thereupon, the superintendent of the institution involved shall so inform whatever court committed the sexual psychopath. The court then may order such further examination and investigation of such person as seems necessary, and may at its discretion, summon such person before it for further hearing, together with any witnesses whose testimony may be pertinent, and together with any relevant documents and other evidence. On the basis of such reports, investigation, and possible hearing, the court shall determine whether the person before it shall be released unconditionally from custody as a sexual psychopath, released conditionally, returned to the custody of the institution as a sexual psychopath, or transferred to the department of corrections to serve the original sentence imposed upon him or her. The power of the court to grant conditional release for any such person before it shall be the same as its power to grant, amend, and revoke probation as provided by chapter 9.95 RCW. When the sexual psychopath has entered upon the conditional release, the indeterminate sentence review board shall supervise such person pursuant to the terms and conditions of the conditional release, as set by the court: PROVIDED, That the superintendent of the institution involved shall never release the sexual psychopath from custody without a court release as herein set forth. [2012 c 117 § 435; 1981 c 136 § 64; 1979 c 141 § 130; 1967 c 104 § 3.]

Additional notes found at www.leg.wa.gov

71.06.100 Postcommitment proceedings, releases, and further dispositions—Hospital record to be furnished court, indeterminate sentence review board. Where under RCW 71.06.091 the superintendent renders his or her opinion to the committing court, he or she shall provide the committing court, and, in the event of conditional release, the indeterminate sentence review board, with a copy of the hospital medical record concerning the sexual psychopath. [2012 c 117 § 436; 1967 c 104 § 4; 1959 c 25 § 71.06.100. Prior: 1951 c 223 § 10.]

71.06.120 Credit for time served in hospital. Time served by a sexual psychopath in a state hospital shall count as part of his or her sentence whether such sentence is pronounced before or after adjudication of his or her sexual psychopathy. [2012 c 117 § 437; 1959 c 25 § 71.06.120. Prior: 1951 c 223 § 13.]

71.06.130 Discharge pursuant to conditional release. Where a sexual psychopath has been conditionally released by the committing court, as provided by RCW 71.06.091 for a period of five years, the court shall review his or her record and when the court is satisfied that the sexual psychopath is safe to be at large, said sexual psychopath shall be discharged. [2012 c 117 § 438; 1967 c 104 § 5; 1959 c 25 § 71.06.130. Prior: 1951 c 223 § 12; 1949 c 198 § 28, part; Rem. Supp. 1949 § 6953-28, part.]

71.06.135 Sexual psychopaths—Release of information authorized. In addition to any other information required to be released under this chapter, the department is authorized, pursuant to RCW 4.24.550, to release relevant information that is necessary to protect the public, concerning a specific sexual psychopath committed under this chapter. [1990 c 3 § 120.]

71.06.140 State hospitals for care of sexual psychopaths—Transfers to correctional institutions—Examinations, reports. The department may designate one or more state hospitals for the care and treatment of sexual psychopaths: PROVIDED, That a committed sexual psychopath who has been determined by the superintendent of such mental hospital to be a custodial risk, or a hazard to other patients may be transferred by the secretary of social and health services, with the consent of the secretary of corrections, to one of the correctional institutions within the department of corrections which has psychiatric care facilities. A committed sexual psychopath who has been transferred to a correctional institution shall be observed and treated at the psychiatric facilities provided by the correctional institution. A complete psychiatric examination shall be given to each sexual psychopath so transferred at least twice annually. The examinations may be conducted at the correctional institution or at one of the mental hospitals. The examiners shall report in writing the results of said examinations, including recommendations as to future treatment and custody, to the superintendent of the mental hospital from which the sexual psychopath was transferred, and to the committing court, with copies of such reports and recommendations to the superintendent of the correctional institution. [1981 c 136 § 65; 1979 c 141 § 131; 1967 c 104 § 6; 1959 c 25 § 71.06.140. Prior: 1951 c 223 § 11; 1949 c 198 § 37; Rem. Supp. 1949 § 6953-37.]

Additional notes found at www.leg.wa.gov

71.06.260 Hospitalization costs—Sexual psychopaths—Financial responsibility. At any time any person is committed as a sexual psychopath the court shall, after reasonable notice of the time, place and purpose of the hearing has been given to persons subject to liability under this section, inquire into and determine the financial ability of said person, or his or her parents if he or she is a minor, or other relatives to pay the cost of care, meals and lodging during his or her period of hospitalization. Such cost shall be determined by the department of social and health services. Findings of fact shall be made relative to the ability to pay such cost and a judgment entered against the person or persons found to be financially responsible and directing the payment of said cost or such part thereof as the court may direct. The person committed, or his or her parents or relatives, may apply for modification of said judgment, or the order last entered by the court, if a proper showing of equitable grounds is made therefor. [2012 c 117 § 439; 1985 c 354 § 33; 1979 c 141 § 132; 1959 c 25 § 71.06.260. Prior: 1957 c 26 § 1; 1951 c 223 § 27.]

71.06.270 Availability of records. The records, files, and other written information prepared by the department of social and health services for individuals committed under this chapter shall be made available upon request to the department of corrections or the *board of prison terms and paroles for persons who are the subject of the records who are committed to the custody of the department of corrections or the board of prison terms and paroles. [1983 c 196 § 5.]

***Reviser's note:** The "board of prison terms and paroles" was redesignated the "indeterminate sentence review board" by 1986 c 224, effective July 1, 1986.

Chapter 71.09 RCW
SEXUALLY VIOLENT PREDATORS

Sections

71.09.010 Findings. The legislature finds that a small but extremely dangerous group of sexually violent predators exist who do not have a mental disease or defect that renders them appropriate for the existing involuntary treatment act, chapter 71.05 RCW, which is intended to be a short-term civil commitment system that is primarily designed to provide short-term treatment to individuals with serious mental disorders and then return them to the community. In contrast to persons appropriate for civil commitment under chapter 71.05 RCW, sexually violent predators generally have personality disorders and/or mental abnormalities which are unamenable to existing mental illness treatment modalities and those conditions render them likely to engage in sexually violent behavior. The legislature further finds that sex offenders' likelihood of engaging in repeat acts of predatory sexual violence is high. The existing involuntary commitment act, chapter 71.05 RCW, is inadequate to address the risk to reoffend because during confinement these offenders do not have access to potential victims and therefore they will not engage

in an overt act during confinement as required by the involuntary treatment act for continued confinement. The legislature further finds that the prognosis for curing sexually violent offenders is poor, the treatment needs of this population are very long term, and the treatment modalities for this population are very different than the traditional treatment modalities for people appropriate for commitment under the involuntary treatment act. [2001 c 286 § 3; 1990 c 3 § 1001.]

Additional notes found at www.leg.wa.gov

71.09.015 Finding—Intent—Clarification. The legislature finds that presentation of evidence related to conditions of a less restrictive alternative that are beyond the authority of the court to order, and that would not exist in the absence of a court order, reduces the public respect for the rule of law and for the authority of the courts. Consequently, the legislature finds that the decision in *In re the Detention of Casper Ross*, 102 Wn. App 108 (2000), is contrary to the legislature's intent. The legislature hereby clarifies that it intends, and has always intended, in any proceeding under this chapter that the court and jury be presented only with conditions that would exist or that the court would have the authority to order in the absence of a finding that the person is a sexually violent predator. [2001 c 286 § 1.]

Additional notes found at www.leg.wa.gov

71.09.020 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Department" means the department of social and health services.

(2) "Fair share principles" and "fair share principles of release" means that each county has adequate options for conditional release housing placements in a number generally equivalent to the number of residents from that county who are subject to total confinement pursuant to this chapter.

(3) "Health care facility" means any hospital, hospice care center, licensed or certified health care facility, health maintenance organization regulated under chapter 48.46 RCW, federally qualified health maintenance organization, federally approved renal dialysis center or facility, or federally approved blood bank.

(4) "Health care practitioner" means an individual or firm licensed or certified to engage actively in a regulated health profession.

(5) "Health care services" means those services provided by health professionals licensed pursuant to RCW 18.120.020(4).

(6) "Health profession" means those licensed or regulated professions set forth in RCW 18.120.020(4).

(7) "Less restrictive alternative" means court-ordered treatment in a setting less restrictive than total confinement which satisfies the conditions set forth in RCW 71.09.092. A less restrictive alternative may not include placement in the community protection program as pursuant to RCW 71A.12.230.

(8) "Likely to engage in predatory acts of sexual violence if not confined in a secure facility" means that the person more probably than not will engage in such acts if released unconditionally from detention on the sexually violent predator petition. Such likelihood must be evidenced by a recent overt act if the person is not totally confined at the time the petition is filed under RCW 71.09.030.

(9) "Mental abnormality" means a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts in a degree constituting such person a menace to the health and safety of others.

(10) "Personality disorder" means an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has onset in adolescence or early adulthood, is stable over time and leads to distress or impairment. Purported evidence of a personality disorder must be supported by testimony of a licensed forensic psychologist or psychiatrist.

(11) "Predatory" means acts directed towards: (a) Strangers; (b) individuals with whom a relationship has been established or promoted for the primary purpose of victimization; or (c) persons of casual acquaintance with whom no substantial personal relationship exists.

(12) "Prosecuting agency" means the prosecuting attorney of the county where the person was convicted or charged or the attorney general if requested by the prosecuting attorney, as provided in RCW 71.09.030.

(13) "Recent overt act" means any act, threat, or combination thereof that has either caused harm of a sexually violent nature or creates a reasonable apprehension of such harm in the mind of an objective person who knows of the history and mental condition of the person engaging in the act or behaviors.

(14) "Risk potential activity" or "risk potential facility" means an activity or facility that provides a higher incidence of risk to the public from persons conditionally released from the special commitment center. Risk potential activities and facilities include: Public and private schools, school bus stops, licensed day care and licensed preschool facilities, public parks, publicly dedicated trails, sports fields, playgrounds, recreational and community centers, churches, synagogues, temples, mosques, public libraries, public and private youth camps, and others identified by the department following the hearings on a potential site required in RCW 71.09.315. For purposes of this chapter, "school bus stops" does not include bus stops established primarily for public transit.

(15) "Secretary" means the secretary of social and health services or the secretary's designee.

(16) "Secure community transition facility" means a residential facility for persons civilly committed and conditionally released to a less restrictive alternative under this chapter. A secure community transition facility has supervision and security, and either provides or ensures the provision of sex offender treatment services. Secure community transition facilities include but are not limited to the facility established pursuant to RCW 71.09.250(1)(a)(i) and any community-based facilities established under this chapter and operated by the secretary or under contract with the secretary.

(17) "Secure facility" means a residential facility for persons civilly confined under the provisions of this chapter that includes security measures sufficient to protect the community. Such facilities include total confinement facilities, secure community transition facilities, and any residence used as a court-ordered placement under RCW 71.09.096.

(18) "Sexually violent offense" means an act committed on, before, or after July 1, 1990, that is: (a) An act defined in Title 9A RCW as rape in the first degree, rape in the second degree by forcible compulsion, rape of a child in the first or second degree, statutory rape in the first or second degree, indecent liberties by forcible compulsion, indecent liberties against a child under age fourteen, incest against a child under age fourteen, or child molestation in the first or second degree; (b) a felony offense in effect at any time prior to July 1, 1990, that is comparable to a sexually violent offense as defined in (a) of this subsection, or any federal or out-of-state conviction for a felony offense that under the laws of this state would be a sexually violent offense as defined in this subsection; (c) an act of murder in the first or second degree, assault in the first or second degree, assault of a child in the first or second degree, kidnapping in the first or second degree, burglary in the first degree, residential burglary, or unlawful imprisonment, which act, either at the time of sentencing for the offense or subsequently during civil commitment proceedings pursuant to this chapter, has been determined beyond a reasonable doubt to have been sexually motivated, as that term is defined in RCW 9.94A.030; or (d) an act as described in chapter 9A.28 RCW, that is an attempt, criminal solicitation, or criminal conspiracy to commit one of the felonies designated in (a), (b), or (c) of this subsection.

(19) "Sexually violent predator" means any person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence if not confined in a secure facility.

(20) "Total confinement facility" means a secure facility that provides supervision and sex offender treatment services in a total confinement setting. Total confinement facilities include the special commitment center and any similar facility designated as a total confinement facility by the secretary.

(21) "Treatment" means the sex offender specific treatment program at the special commitment center or a specific course of sex offender treatment pursuant to RCW 71.09.092 (1) and (2). [2021 c 236 § 2. Prior: 2015 c 278 § 2; 2009 c 409 § 1; 2006 c 303 § 10; prior: 2003 c 216 § 2; 2003 c 50 § 1; 2002 c 68 § 4; 2002 c 58 § 2; 2001 2nd sp.s. c 12 § 102; 2001 c 286 § 4; 1995 c 216 § 1; 1992 c 145 § 17; 1990 1st ex.s. c 12 § 2; 1990 c 3 § 1002.]

Findings—2021 c 236: "The legislature finds that in 2008, the sex offender policy board was established to provide a more coordinated and integrated response to sex offender management in Washington state. The legislature further finds that in March 2020, the board was convened to review policies and practices related to sexually violent predators. The legislature recognizes that the board released a report and a series of recommendations regarding improvement to the current practice in order to ensure a successful transition for individuals convicted of sex offenses from total confinement back into the community. The legislature resolves to increase community safety through successful transition by enacting the recommendations of the board and other related policies." [2021 c 236 § 1.]

Effective date—2015 c 278 §§ 1 and 2: See note following RCW 71.09.070.

Purpose—Severability—Effective date—2002 c 68: See notes following RCW 36.70A.200.

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

Additional notes found at www.leg.wa.gov

71.09.025 Notice to prosecuting attorney prior to release. (1)(a) When it appears that a person may meet the criteria of a sexually violent predator as defined in *RCW 71.09.020(16), the agency with jurisdiction shall refer the person in writing to the prosecuting attorney of the county in which an action under this chapter may be filed pursuant to RCW 71.09.030 and the attorney general, three months prior to:

(i) The anticipated release from total confinement of a person who has been convicted of a sexually violent offense;

(ii) The anticipated release from total confinement of a person found to have committed a sexually violent offense as a juvenile;

(iii) Release of a person who has been charged with a sexually violent offense and who has been determined to be incompetent to stand trial pursuant to **RCW 10.77.086(4); or

(iv) Release of a person who has been found not guilty by reason of insanity of a sexually violent offense pursuant to ***RCW 10.77.020(3).

(b) The agency shall provide the prosecuting agency with all relevant information including but not limited to the following information:

(i) A complete copy of the institutional records compiled by the department of corrections relating to the person, and any such out-of-state department of corrections' records, if available;

(ii) A complete copy, if applicable, of any file compiled by the indeterminate sentence review board relating to the person;

(iii) All records relating to the psychological or psychiatric evaluation and/or treatment of the person;

(iv) A current record of all prior arrests and convictions, and full police case reports relating to those arrests and convictions; and

(v) A current mental health evaluation or mental health records review.

(c) The prosecuting agency has the authority, consistent with ****RCW 72.09.345(3), to obtain all records relating to the person if the prosecuting agency deems such records are necessary to fulfill its duties under this chapter. The prosecuting agency may only disclose such records in the course of performing its duties pursuant to this chapter, unless otherwise authorized by law.

(d) The prosecuting agency has the authority to utilize the inquiry judge procedures of chapter 10.27 RCW prior to the filing of any action under this chapter to seek the issuance of compulsory process for the production of any records necessary for a determination of whether to seek the civil commitment of a person under this chapter. Any records obtained pursuant to this process may only be disclosed by the prosecuting agency in the course of performing its duties pursuant to this chapter, or unless otherwise authorized by law.

(2) The agency, its employees, and officials shall be immune from liability for any good-faith conduct under this section.

(3) As used in this section, "agency with jurisdiction" means that agency with the authority to direct the release of a person serving a sentence or term of confinement and includes the department of corrections, the indeterminate sentence review board, and the department of social and

health services. [2009 c 409 § 2; 2008 c 213 § 11; 2001 c 286 § 5; 1995 c 216 § 2; 1992 c 45 § 3.]

Reviser's note: *(1) RCW 71.09.020 was amended by 2009 c 409 § 1, changing subsection (16) to subsection (18). RCW 71.09.020 was subsequently amended by 2021 c 236 § 2, changing subsection (18) to subsection (19).

**(2) RCW 10.77.086 was amended by 2022 c 288 § 4, changing subsection (4) to subsection (5).

***(3) RCW 10.77.020 was amended by 1998 c 297 § 30, deleting subsection (3).

****(4) RCW 72.09.345 was amended by 2011 c 338 § 5, changing subsection (3) to subsection (4).

Additional notes found at www.leg.wa.gov

71.09.030 Sexually violent predator petition—Filing. (1) A petition may be filed alleging that a person is a sexually violent predator and stating sufficient facts to support such allegation when it appears that: (a) A person who at any time previously has been convicted of a sexually violent offense is about to be released from total confinement; (b) a person found to have committed a sexually violent offense as a juvenile is about to be released from total confinement; (c) a person who has been charged with a sexually violent offense and who has been determined to be incompetent to stand trial is about to be released, or has been released, pursuant to *RCW 10.77.086(4); (d) a person who has been found not guilty by reason of insanity of a sexually violent offense is about to be released, or has been released, pursuant to RCW **10.77.020(3), 10.77.110 (1) or (3), or 10.77.150; or (e) a person who at any time previously has been convicted of a sexually violent offense and has since been released from total confinement and has committed a recent overt act.

(2) The petition may be filed by:

(a) The prosecuting attorney of a county in which:

(i) The person has been charged or convicted with a sexually violent offense;

(ii) A recent overt act occurred involving a person covered under subsection (1)(e) of this section; or

(iii) The person committed a recent overt act, or was charged or convicted of a criminal offense that would qualify as a recent overt act, if the only sexually violent offense charge or conviction occurred in a jurisdiction other than Washington; or

(b) The attorney general, if requested by the county prosecuting attorney identified in (a) of this subsection. If the county prosecuting attorney requests that the attorney general file and prosecute a case under this chapter, then the county shall charge the attorney general only the fees, including filing and jury fees, that would be charged and paid by the county prosecuting attorney, if the county prosecuting attorney retained the case. [2009 c 409 § 3; 2008 c 213 § 12; 1995 c 216 § 3; 1992 c 45 § 4; 1990 1st ex.s. c 12 § 3; 1990 c 3 § 1003.]

Reviser's note: *(1) RCW 10.77.086 was amended by 2022 c 288 § 4, changing subsection (4) to subsection (5).

**(2) RCW 10.77.020 was amended by 1998 c 297 § 30, deleting subsection (3).

Additional notes found at www.leg.wa.gov

71.09.040 Sexually violent predator petition—Probable cause hearing—Judicial determination—Transfer to total confinement facility upon probable cause determination. (1) Upon the filing of a petition under RCW 71.09.030, the judge shall determine whether probable cause exists to believe that the person named in the petition is a sexually violent predator. If such determination is made the judge shall direct that the person be taken into custody and notify the office of public defense of the potential need for representation.

(2) Within seventy-two hours after a person is taken into custody pursuant to subsection (1) of this section, the court shall provide the person with notice of, and an opportunity to appear in person at, a hearing to contest probable cause as to whether the person is a sexually violent predator. In order to assist the person at the hearing, within twenty-four hours of service of the petition, the prosecuting agency shall provide to the person or his or her counsel a copy of all materials provided to the prosecuting agency by the referring agency pursuant to RCW 71.09.025, or obtained by the prosecuting agency pursuant to RCW 71.09.025(1) (c) and (d). At this hearing, the court shall (a) verify the person's identity, and (b) determine whether probable cause exists to believe that the person is a sexually violent predator. At the probable cause hearing, the state may rely upon the petition and certification for determination of probable cause filed pursuant to RCW 71.09.030. The state may supplement this with additional documentary evidence or live testimony. The person may be held in total confinement at the county jail until the trial court renders a decision after the conclusion of the seventy-two hour probable cause hearing. The county shall be entitled to reimbursement for the cost of housing and transporting the person pursuant to rules adopted by the secretary.

(3) At the probable cause hearing, the person shall have the following rights in addition to the rights previously specified: (a) To be represented by counsel, and if the person is indigent as defined in RCW 10.101.010, to have office of public defense contracted counsel appointed as provided in RCW 10.101.020; (b) to present evidence on his or her behalf; (c) to cross-examine witnesses who testify against him or her; (d) to view and copy all petitions and reports in the court file. The court must permit a witness called by either party to testify by telephone. Because this is a special proceeding, discovery pursuant to the civil rules shall not occur until after the hearing has been held and the court has issued its decision.

(4) If the probable cause determination is made, the judge shall direct that the person be transferred to the custody of the department of social and health services for placement in a total confinement facility operated by the department. In no event shall the person be released from confinement prior to trial. [2012 c 257 § 4; 2009 c 409 § 4; 2001 c 286 § 6; 1995 c 216 § 4; 1990 c 3 § 1004.]

Effective date—2012 c 257: See note following RCW 2.70.020.

Additional notes found at www.leg.wa.gov

71.09.045 Indigent defense services—Activities beyond the scope of representation by the office of public defense. The following activities, unless provided as part of investigation and preparation for any hearing or trial under this chapter, are beyond the scope of representation of an attorney under contract with the office of public defense pursuant to chapter 2.70 RCW for the purposes of providing indigent defense services in sexually violent predator civil commitment proceedings:

(1) Investigation or legal representation challenging the conditions of confinement at the special commitment center or any secure community transition facility;

(2) Investigation or legal representation for making requests under the public records act, chapter 42.56 RCW;

(3) Legal representation or advice regarding filing a grievance with the department as part of its grievance policy or procedure;

(4) Such other activities as may be excluded by policy or contract with the office of public defense. [2012 c 257 § 8.]

Effective date—2012 c 257: See note following RCW 2.70.020.

71.09.050 Trial—Rights of parties. (1) Within forty-five days after the completion of any hearing held pursuant to RCW 71.09.040, the court shall conduct a trial to determine whether the person is a sexually violent predator. The trial may be continued upon the request of either party and a showing of good cause, or by the court on its own motion in the due administration of justice, and when the respondent will not be substantially prejudiced. The prosecuting agency shall have a right to a current evaluation of the person by experts chosen by the state. The judge may require the person to complete any or all of the following procedures or tests if requested by the evaluator: (a) A clinical interview; (b) psychological testing; (c) plethysmograph testing; and (d) polygraph testing. The judge may order the person to complete any other procedures and tests relevant to the evaluation. The state is responsible for the costs of the evaluation. At all stages of the proceedings under this chapter, any person subject to this chapter shall be entitled to the assistance of counsel, and if the person is indigent as defined in RCW 10.101.010, the court, as provided in RCW 10.101.020, shall appoint office of public defense contracted counsel to assist him or her. The person shall be confined in a secure facility for the duration of the trial.

(2) Whenever any indigent person is subjected to an evaluation under this chapter, the office of public defense is responsible for the cost of one expert or professional person to conduct an evaluation on the person's behalf. When the person wishes to be evaluated by a qualified expert or professional person of his or her own choice, the expert or professional person must be permitted to have reasonable access to the person for the purpose of such evaluation, as well as to all relevant medical and psychological records and reports. In the case of a person who is indigent, the court shall, upon the person's request, assist the person in obtaining an expert or professional person to perform an evaluation or participate in the trial on the person's behalf. Nothing in this chapter precludes the person from paying for additional expert services at his or her own expense.

(3) The person, the prosecuting agency, or the judge shall have the right to demand that the trial be before a twelve-person jury. If no demand is made, the trial shall be before the court. [2012 c 257 § 5; 2010 1st sp.s. c 28 § 1; 2009 c 409 § 5; 1995 c 216 § 5; 1990 c 3 § 1005.]

Effective date—2012 c 257: See note following RCW 2.70.020.

Additional notes found at www.leg.wa.gov

71.09.055 Expert evaluations of indigent persons—Costs. (1) The office of public defense is responsible for the cost of one expert or professional person conducting an evaluation on an indigent person's behalf as provided in RCW 71.09.050, 71.09.070, or 71.09.090.

(2) Expert evaluations are capped at ten thousand dollars, to include all professional fees, travel, per diem, and other costs. Partial evaluations are capped at five thousand five hundred dollars and expert services apart from an evaluation, exclusive of testimony at trial or depositions, are capped at six thousand dollars.

(3) The office of public defense will pay for the costs related to the evaluation of an indigent person by an additional examiner or in excess of the stated fee caps only upon a finding by the superior court that such appointment or extraordinary fees are for good cause. [2012 c 257 § 9.]

Effective date—2012 c 257: See note following RCW 2.70.020.

71.09.060 Trial—Determination—Commitment procedures. (1) The court or jury shall determine whether, beyond a reasonable doubt, the person is a sexually violent predator. In determining whether or not the person would be likely to engage in predatory acts of sexual violence if not confined in a secure facility, the fact finder may consider only placement conditions and voluntary treatment options that would exist for the person if unconditionally released from detention on the sexually violent predator petition. The community protection program under RCW 71A.12.230 may not be considered as a placement condition or treatment option available to the person if unconditionally released from detention on a sexually violent predator petition. When the determination is made by a jury, the verdict must be unanimous.

If, on the date that the petition is filed, the person was living in the community after release from custody, the state must also prove beyond a reasonable doubt that the person had committed a recent overt act. If the state alleges that the prior sexually violent offense that forms the basis for the petition for commitment was an act that was sexually motivated as provided in *RCW 71.09.020(15)(c), the state must prove beyond a reasonable doubt that the alleged sexually violent act was sexually motivated as defined in RCW 9.94A.030.

If the court or jury determines that the person is a sexually violent predator, the person shall be committed to the custody of the department of social and health services for placement in a secure facility operated by the department of social and health services for control, care, and treatment until such time as: (a) The person's condition has so changed that the person no longer meets the definition of a sexually violent predator; or (b) conditional release to a less restrictive alternative as set forth in RCW 71.09.092 is in the best interest of the person and conditions can be imposed that would adequately protect the community.

If the court or unanimous jury decides that the state has not met its burden of proving that the person is a sexually violent predator, the court shall direct the person's release.

If the jury is unable to reach a unanimous verdict, the court shall declare a mistrial and set a retrial within forty-five days of the date of the mistrial unless the prosecuting agency earlier moves to dismiss the petition. The retrial may be continued upon the request of either party accompanied by a showing of good cause, or by the court on its own motion in the due administration of justice provided that the respondent will not be substantially prejudiced. In no event may the per-

son be released from confinement prior to retrial or dismissal of the case.

(2) If the person charged with a sexually violent offense has been found incompetent to stand trial, and is about to be or has been released pursuant to **RCW 10.77.086(4), and his or her commitment is sought pursuant to subsection (1) of this section, the court shall first hear evidence and determine whether the person did commit the act or acts charged if the court did not enter a finding prior to dismissal under **RCW 10.77.086(4) that the person committed the act or acts charged. The hearing on this issue must comply with all the procedures specified in this section. In addition, the rules of evidence applicable in criminal cases shall apply, and all constitutional rights available to defendants at criminal trials, other than the right not to be tried while incompetent, shall apply. After hearing evidence on this issue, the court shall make specific findings on whether the person did commit the act or acts charged, the extent to which the person's incompetence or developmental disability affected the outcome of the hearing, including its effect on the person's ability to consult with and assist counsel and to testify on his or her own behalf, the extent to which the evidence could be reconstructed without the assistance of the person, and the strength of the prosecution's case. If, after the conclusion of the hearing on this issue, the court finds, beyond a reasonable doubt, that the person did commit the act or acts charged, it shall enter a final order, appealable by the person, on that issue, and may proceed to consider whether the person should be committed pursuant to this section.

(3) Except as otherwise provided in this chapter, the state shall comply with RCW 10.77.220 while confining the person. During all court proceedings where the person is present, the person shall be detained in a secure facility. If the proceedings last more than one day, the person may be held in the county jail for the duration of the proceedings, except the person may be returned to the department's custody on weekends and court holidays if the court deems such a transfer feasible. The county shall be entitled to reimbursement for the cost of housing and transporting the person pursuant to rules adopted by the secretary. The department shall not place the person, even temporarily, in a facility on the grounds of any state mental facility or regional habilitation center because these institutions are insufficiently secure for this population.

(4) A court has jurisdiction to order a less restrictive alternative placement only after a hearing ordered pursuant to RCW 71.09.090 following initial commitment under this section and in accord with the provisions of this chapter. [2009 c 409 § 6; 2008 c 213 § 13; 2006 c 303 § 11; 2001 c 286 § 7; 1998 c 146 § 1; 1995 c 216 § 6; 1990 1st ex.s. c 12 § 4; 1990 c 3 § 1006.]

Reviser's note: *(1) RCW 71.09.020 was amended by 2009 c 409 § 1, changing subsection (15) to subsection (17). RCW 71.09.020 was subsequently amended by 2021 c 236 § 2, changing subsection (17) to subsection (18).

**(2) RCW 10.77.086 was amended by 2022 c 288 § 4, changing subsection (4) to subsection (5).

Additional notes found at www.leg.wa.gov

71.09.070 Annual examinations of persons committed under chapter—Suspension of section. (1) Each person committed under this chapter shall have a current examination of his or her mental condition made by the department at least once every year.

(2) The evaluator must prepare a report that includes consideration of whether:

(a) The committed person currently meets the definition of a sexually violent predator;

(b) Conditional release to a less restrictive alternative is in the best interest of the person; and

(c) Conditions can be imposed that would adequately protect the community.

(3) The department, on request of the committed person, shall allow a record of the annual review interview to be preserved by audio recording and made available to the committed person.

(4) The evaluator must indicate in the report whether the committed person participated in the interview and examination.

(5) The department shall file the report with the court that committed the person under this chapter. The report shall be in the form of a declaration or certification in compliance with the requirements of chapter 5.50 RCW and shall be prepared by a professionally qualified person as defined by rules adopted by the secretary. A copy of the report shall be served on the prosecuting agency involved in the initial commitment and upon the committed person and his or her counsel.

(6)(a) The committed person may retain, or if he or she is indigent and so requests, the court may appoint a qualified expert or a professional person to examine him or her, and such expert or professional person shall have access to all records concerning the person.

(b) Any report prepared by the expert or professional person and any expert testimony on the committed person's behalf is not admissible in a proceeding pursuant to RCW 71.09.090, unless the committed person participated in the most recent interview and evaluation completed by the department.

(7) If an unconditional release trial is ordered pursuant to RCW 71.09.090, this section is suspended until the completion of that trial. If the individual is found either by jury or the court to continue to meet the definition of a sexually violent predator, the department must conduct an examination pursuant to this section no later than one year after the date of the order finding that the individual continues to be a sexually violent predator. The examination must comply with the requirements of this section.

(8) During any period of confinement pursuant to a criminal conviction, or for any period of detention awaiting trial on criminal charges, this section is suspended. Upon the return of the person committed under this chapter to the custody of the department, the department shall initiate an examination of the person's mental condition. The examination must comply with the requirements of subsection (1) of this section. [2019 c 232 § 25; 2015 c 278 § 1; 2011 2nd sp.s. c 7 § 1; 2001 c 286 § 8; 1995 c 216 § 7; 1990 c 3 § 1007.]

Effective date—2015 c 278 §§ 1 and 2: "Sections 1 and 2 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect July 1, 2015." [2015 c 278 § 4.]

Additional notes found at www.leg.wa.gov

71.09.080 Rights of persons committed under this chapter—Use of personal computers regulated. (1) Any person subjected to restricted liberty as a sexually violent predator pursuant to this chapter shall not forfeit any legal right or suffer any legal disability as a consequence of any actions taken or orders made, other than as specifically provided in this chapter, or as otherwise authorized by law.

(2)(a) Any person committed or detained pursuant to this chapter shall be prohibited from possessing or accessing a personal computer if the resident's individualized treatment plan states that access to a computer is harmful to bringing about a positive response to a specific and certain phase or course of treatment.

(b) A person who is prohibited from possessing or accessing a personal computer under (a) of this subsection shall be permitted to access a limited functioning personal computer capable of word processing and limited data storage on the computer only that does not have: (i) Internet access capability; (ii) an optical drive, external drive, universal serial bus port, or similar drive capability; or (iii) the capability to display photographs, images, videos, or motion pictures, or similar display capability from any drive or port capability listed under (b)(ii) of this subsection.

(3) Any person committed pursuant to this chapter has the right to adequate care, individualized treatment, and the development of an ongoing, clinically appropriate discharge plan as part of the treatment process. The department of social and health services shall keep records detailing all medical, expert, and professional care and treatment received by a committed person, and shall keep copies of all reports of periodic examinations made pursuant to this chapter. All such records and reports shall be made available upon request only to: The committed person, his or her attorney, the prosecuting agency, the court, the protection and advocacy agency, or another expert or professional person who, upon proper showing, demonstrates a need for access to such records.

(4) The right to the development of a discharge plan under subsection (3) of this section does not guarantee that any particular person will be determined appropriate for discharge at any particular time. Nothing in this section precludes the department from expressing professional judgment regarding the suitability of discharge for the protection of a resident's safety or community safety. Individualized and ongoing discharge planning requires, at a minimum, and as part of a person's treatment plan, the following are addressed based on information known to the department and in accordance with policies developed by the department to implement this subsection:

(a) The resident's known physical health, functioning, and any need for health aid devices;

(b) The resident's known intellectual or cognitive level of functioning and need for specialized programming;

(c) The resident's known history of substance use and abuse;

(d) The resident's known history of risky or impulsive behaviors, criminogenic needs, and treatment interventions to address them;

(e) The resident's known ability to perform life skills and activities of daily living independently and the resident's known need for any disability accommodations;

(f) A summary of the known community services and supports the resident needs for a safe life in the community and the type of providers of such services and support; and

(g) A plan to mitigate the needs identified in this subsection that also addresses ways to develop or increase social supports, recreation opportunities, gainful employment, and if applicable, spiritual opportunities.

(5) At the time a person is taken into custody or transferred into a facility pursuant to a petition under this chapter, the professional person in charge of such facility or his or her designee shall take reasonable precautions to inventory and safeguard the personal property of the persons detained or transferred. A copy of the inventory, signed by the staff member making it, shall be given to the person detained and shall, in addition, be open to inspection to any responsible relative, subject to limitations, if any, specifically imposed by the detained person. For purposes of this subsection, "responsible relative" includes the guardian, conservator, attorney, spouse, parent, adult child, or adult brother or sister of the person. The facility shall not disclose the contents of the inventory to any other person without consent of the patient or order of the court.

(6) Nothing in this chapter prohibits a person presently committed from exercising a right presently available to him or her for the purpose of obtaining release from confinement, including the right to petition for a writ of habeas corpus.

(7) No indigent person may be conditionally released or unconditionally discharged under this chapter without suitable clothing, and the secretary shall furnish the person with such sum of money as is required by RCW 72.02.100 for persons without ample funds who are released from correctional institutions. As funds are available, the secretary may provide payment to the indigent persons conditionally released pursuant to this chapter consistent with the optional provisions of RCW 72.02.100 and 72.02.110, and may adopt rules to do so.

(8) If a civil commitment petition is dismissed, or a trier of fact determines that a person does not meet civil commitment criteria, the person shall be released within twenty-four hours of service of the release order on the superintendent of the special commitment center, or later by agreement of the person who is the subject of the petition. [2021 c 236 § 3; 2012 c 257 § 6; 2010 c 218 § 2; 2009 c 409 § 7; 1995 c 216 § 8; 1990 c 3 § 1008.]

Findings—2021 c 236: See note following RCW 71.09.020.

Effective date—2012 c 257: See note following RCW 2.70.020.

Findings—2010 c 218: "The legislature finds that there have been ongoing, egregious examples of certain residents of the special commitment center having illegal child pornography, other prohibited pornography, and other banned materials on their computers. The legislature also finds that activities at the special commitment center must be designed and implemented to meet the treatment goals of the special commitment center, and proper and appropriate computer usage is one such activity. The legislature also finds that by linking computer usage to treatment plans, residents are less likely to have prohibited materials on their computers and are more likely to successfully complete their treatment plans. Therefore, the legislature finds that residents' computer usage in compliance with conditions placed on computer usage is essential to achieving their therapeutic goals. If residents' usage of computers is not in compliance or is not related to meeting their treatment goals, computer usage will be limited in order to prevent or reduce residents' access to prohibited materials." [2010 c 218 § 1.]

Additional notes found at www.leg.wa.gov

71.09.085 Medical care—Contracts for services—Authorization to act on behalf of civilly committed residents. (1) Notwithstanding any other provisions of law, the secretary may enter into contracts with health care practitioners, health care facilities, and other entities or agents as may be necessary to provide basic medical care to residents. The contracts shall not cause the termination of classified employees of the department rendering the services at the time the contract is executed.

(2) In contracting for services, the secretary is authorized to provide for indemnification of health care practitioners who cannot obtain professional liability insurance through reasonable effort, from liability on any action, claim, or proceeding instituted against them arising out of the good faith performance or failure of performance of services on behalf of the department. The contracts may provide that for the purposes of chapter 4.92 RCW only, those health care practitioners with whom the department has contracted shall be considered state employees.

(3) To the extent that federal law allows and financial participation is available, the secretary or secretary's designee is authorized to act on behalf of a civilly committed resident for the purposes of applying for medicare and medicaid benefits, veterans health benefits, or other health care benefits or reimbursement available as a result of participation in a health care exchange as defined by the affordable care act. [2015 c 271 § 1; 2002 c 58 § 1.]

Additional notes found at www.leg.wa.gov

71.09.090 Petition for conditional release to less restrictive alternative or unconditional discharge—Procedures—Suspension of section. (1)(a) If the secretary determines that the person's condition has so changed that the person no longer meets the definition of a sexually violent predator, the secretary shall authorize the person to petition the court for unconditional discharge. The petition shall be filed with the court and served upon the prosecuting agency responsible for the initial commitment. The court, upon receipt of the petition for unconditional discharge, shall within 45 days order a hearing.

(b) If the secretary determines that the person's condition has so changed that conditional release to a less restrictive alternative is in the best interest of the person and conditions can be imposed that adequately protect the community, then the secretary shall authorize the person to petition the court for conditional release to a less restrictive alternative. Upon receipt of the petition, the court shall order the department to identify a less restrictive alternative placement that satisfies RCW 71.09.092 (1) through (4). Once identified, notice of the placement shall be filed with the court and served upon: The prosecuting agency responsible for the initial commitment; any person or persons identified in RCW 71.09.140(2)(a) who have opted to receive notifications under this chapter; and the person and his or her counsel. If the department cannot identify a placement available to the person that satisfies RCW 71.09.092 (1) through (4) within 90 days, the department shall provide a written certification to the court, the prosecuting agency responsible for the initial commitment, and the person and his or her counsel, detailing the efforts of the department to identify a qualifying placement. Upon the department's certification, the person may propose a placement that satisfies RCW 71.09.092 (1) through (3). After a less restrictive placement has been proposed by either the department or the person, the court shall within 45 days order a hearing.

(2)(a) Nothing contained in this chapter shall prohibit the person from otherwise petitioning the court for conditional release to a less restrictive alternative or unconditional discharge without the secretary's approval. The secretary shall provide the committed person with an annual written notice of the person's right to petition the court for conditional release to a less restrictive alternative or unconditional discharge over the secretary's objection. The notice shall contain a waiver of rights. The secretary shall file the notice and waiver form and the annual report with the court. If the person does not affirmatively waive the right to petition, the court shall set a show cause hearing to determine whether probable cause exists to warrant a hearing on whether the person's condition has so changed that: (i) He or she no longer meets the definition of a sexually violent predator; or (ii) conditional release to a proposed less restrictive alternative would be in the best interest of the person and conditions can be imposed that would adequately protect the community.

(b)(i) The committed person shall have a right to have an attorney represent him or her at the show cause hearing, which may be conducted solely on the basis of affidavits or declarations, but the person is not entitled to be present at the show cause hearing. At the show cause hearing, the prosecuting agency shall present prima facie evidence establishing: (A) That the committed person continues to meet the definition of a sexually violent predator; and (B) that a less restrictive alternative is not in the best interest of the person and conditions cannot be imposed that adequately protect the community.

(ii)(A) If the state produces prima facie evidence that the committed person continues to be a sexually violent predator, then the state's burden under (b)(i)(A) of this subsection is met and an unconditional release trial may not be ordered unless the committed person produces evidence satisfying: Subsection (4)(a) of this section; and subsection (4)(b) (i) or (ii) of this section.

(B) If the state produces prima facie evidence that a less restrictive alternative is not appropriate for the committed person, then the state's burden under (b)(i)(B) of this subsection is met, and a conditional release trial may not be ordered unless the committed person:

(I) Produces evidence satisfying: Subsection (4)(a) of this section; and subsection (4)(b) (i) or (ii) of this section; and

(II) Presents the court with a specific placement satisfying the requirements of RCW 71.09.092.

(iii) In making the showing required under (b)(i) of this subsection, the state may rely exclusively upon the annual report prepared pursuant to RCW 71.09.070. The committed person may present responsive affidavits or declarations to which the state may reply.

(c)(i) If the court at the show cause hearing determines that either: (A) The state has failed to present prima facie evidence that the committed person continues to meet the definition of a sexually violent predator; or (B) probable cause exists to believe that the person's condition has so changed that the person no longer meets the definition of a sexually

violent predator, then the court shall set a hearing on the issue of unconditional discharge.

(ii) If the court at the show cause hearing determines that the state has failed to present prima facie evidence that no proposed less restrictive alternative is in the best interest of the person and conditions cannot be imposed that would adequately protect the community, the court shall enter an order directing the department to propose a less restrictive alternative that satisfies RCW 71.09.092 (1) through (4). If the department cannot identify a placement available to the person that satisfies RCW 71.09.092 (1) through (4) within 90 days, the department shall provide a written certification to the court, the prosecuting agency responsible for the initial commitment, and the person and his or her counsel, detailing the efforts of the department to identify a qualifying placement. Upon the department's certification, the person may propose a placement that satisfies RCW 71.09.092 (1) through (3). After a less restrictive placement has been proposed by either the department or the person, the court shall set a hearing on the issue of conditional release.

(iii) If the court at the show cause hearing determines, based on the evidence submitted by the person, that probable cause exists to believe that release to a less restrictive alternative would be in the best interest of the person and conditions can be imposed that would adequately protect the community, the court shall set a hearing on the issue of conditional release if the person presents the court with a specific placement that satisfies the requirements of RCW 71.09.092.

(d) If the court has not previously considered the issue of release to a less restrictive alternative, either through a trial on the merits or through the procedures set forth in RCW 71.09.094(1), or if an immediately preceding less restrictive alternative was revoked due to the loss of adequate housing or treatment for reasons other than noncompliance with housing requirements, treatment, or other conditions of the less restrictive alternative, the court shall consider whether release to a less restrictive alternative would be in the best interests of the person and conditions can be imposed that would adequately protect the community, without considering whether the person's condition has changed.

(3)(a) At the hearing resulting from subsection (1) or (2) of this section, the committed person shall be entitled to be present and to the benefit of all constitutional protections that were afforded to the person at the initial commitment proceeding. The prosecuting agency shall represent the state and shall have a right to a jury trial and to have the committed person evaluated by experts chosen by the state. The prosecuting agency shall have a right to a current evaluation of the person by experts chosen by the state. The judge may require the person to complete any or all of the following procedures or tests if requested by the evaluator: (i) A clinical interview; (ii) psychological testing; (iii) plethysmograph testing; and (iv) polygraph testing. The judge may order the person to complete any other procedures and tests relevant to the evaluation. The state is responsible for the costs of the evaluation. The committed person shall also have the right to a jury trial and the right to have experts evaluate him or her on his or her behalf and the court shall appoint an expert if the person is indigent and requests an appointment.

(b) Whenever any indigent person is subjected to an evaluation under (a) of this subsection, the office of public defense is responsible for the cost of one expert or professional person conducting an evaluation on the person's behalf. When the person wishes to be evaluated by a qualified expert or professional person of his or her own choice, such expert or professional person must be permitted to have reasonable access to the person for the purpose of such evaluation, as well as to all relevant medical and psychological records and reports. In the case of a person who is indigent, the court shall, upon the person's request, assist the person in obtaining an expert or professional person to perform an evaluation or participate in the hearing on the person's behalf. Nothing in this chapter precludes the person from paying for additional expert services at his or her own expense.

(c) If the issue at the hearing is whether the person should be unconditionally discharged, the burden of proof shall be upon the state to prove beyond a reasonable doubt that the committed person's condition remains such that the person continues to meet the definition of a sexually violent predator. Evidence of the prior commitment trial and disposition is admissible. The recommitment proceeding shall otherwise proceed as set forth in RCW 71.09.050 and 71.09.060.

(d) If the issue at the hearing is whether the person should be conditionally released to a less restrictive alternative, the burden of proof at the hearing shall be upon the state to prove beyond a reasonable doubt that conditional release to any proposed less restrictive alternative either: (i) Is not in the best interest of the committed person; or (ii) does not include conditions that would adequately protect the community. Evidence of the prior commitment trial and disposition is admissible.

(4)(a) Probable cause exists to believe that a person's condition has "so changed," under subsection (2) of this section, only when evidence exists, since the person's last commitment trial, or less restrictive alternative revocation proceeding, of a substantial change in the person's physical or mental condition such that the person either no longer meets the definition of a sexually violent predator or that a conditional release to a less restrictive alternative is in the person's best interest and conditions can be imposed to adequately protect the community.

(b) A new trial proceeding under subsection (3) of this section may be ordered, or a trial proceeding may be held, only when there is current evidence from a licensed professional of one of the following and the evidence presents a change in condition since the person's last commitment trial proceeding:

(i) An identified physiological change to the person, such as paralysis, stroke, or dementia, that renders the committed person unable to commit a sexually violent act and this change is permanent; or

(ii) A change in the person's mental condition brought about through positive response to continuing participation in treatment which indicates that the person meets the standard for conditional release to a less restrictive alternative or that the person would be safe to be at large if unconditionally released from commitment.

(c) For purposes of this section, a change in a single demographic factor, without more, does not establish probable cause for a new trial proceeding under subsection (3) of this section. As used in this section, a single demographic

factor includes, but is not limited to, a change in the chronological age, marital status, or gender of the committed person.

(5) When the court enters an order for unconditional discharge of a person from an immediately preceding less restrictive placement, the court must direct the clerk to transmit a copy of the order to the department of corrections for discharge process and termination of cause.

(6) The jurisdiction of the court over a person civilly committed pursuant to this chapter continues until such time as the person is unconditionally discharged.

(7) During any period of confinement pursuant to a criminal conviction, or for any period of detention awaiting trial on criminal charges, this section is suspended. [2021 c 236 § 4; 2018 c 131 § 2; 2012 c 257 § 7; 2011 2nd sp.s. c 7 § 2; 2010 1st sp.s. c 28 § 2; 2009 c 409 § 8; 2005 c 344 § 2; 2001 c 286 § 9; 1995 c 216 § 9; 1992 c 45 § 7; 1990 c 3 § 1009.]

Findings—2021 c 236: See note following RCW 71.09.020.

Findings—Intent—2018 c 131: "(1) The legislature finds that the decision in *In re Det. of Marcum*, 189 Wn.2d 1 (2017) conflicts with the legislature's intent in RCW 71.09.090. The legislature's intent has always been that there are two independent issues at a postcommitment show cause hearing: Whether the individual continues to meet statutory criteria; and if so, whether conditional release to a less restrictive alternative placement is appropriate. Lack of proof of one issue should not affect the finding on the other issue. The supreme court's holding is not only a mistaken interpretation, but it will also lead to absurd results, where sexually violent predators could petition and receive a trial for unconditional release when they clearly do not qualify for it under chapter 71.09 RCW. The outcome places an unnecessary burden on the courts and risks releasing persons who are still sexually violent predators into the community.

(2) The legislature finds that the purpose of a show cause hearing under RCW 71.09.090 is to provide the court with an opportunity to determine whether probable cause exists to warrant a hearing on whether the person's condition has so changed as it relates either to the person's status as a sexually violent predator or to whether conditional release to a less restrictive alternative would be appropriate. If the court finds probable cause as to one or both of the issues, the court should set a hearing. However, as the dissent in *Marcum* correctly asserts, the statute also specifies that the court should not find probable cause if the state presents prima facie evidence to meet its burdens and the committed person does not meet his or her respective burdens. The legislature further finds that this safeguard was built into the statutory framework to prevent the outcome in *Marcum.*

(3) The intent of the statute is evident when evaluated in its entirety. The legislature intends that if the state produces prima facie evidence proving that a committed person is still a sexually violent predator, then the first prong of the state's burden is met, and an unconditional release trial may not be ordered unless the committed person produces evidence satisfying: RCW 71.09.090(4)(a); and RCW 71.09.090(4)(b) (i) or (ii). Further, the legislature intends that if the state produces prima facie evidence that a less restrictive alternative is not appropriate for the committed person, then the second prong of the state's burden is met, and a conditional release trial may not be ordered unless the committed person:

(a) Produces evidence satisfying: RCW 71.09.090(4)(a); and RCW 71.09.090(4)(b) (i) or (ii); and

(b) Presents the court with a proposed less restrictive alternative placement meeting the conditions under RCW 71.09.092.

(4) The legislature finds that the state's interest in avoiding costly and unnecessary trials is substantial. Therefore, the legislature intends to overturn the *Marcum* decision in favor of the original intent of the statute. The purpose of this act is curative and remedial, and it applies retroactively and prospectively to all petitions filed under chapter 71.09 RCW, regardless of when they were filed." [2018 c 131 § 1.]

Retroactive application—2018 c 131: "This act is curative and remedial, and it applies retroactively and prospectively to all petitions filed under this chapter." [2018 c 131 § 3.]

Effective date—2018 c 131: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [March 21, 2018]." [2018 c 131 § 5.]

Effective date—2012 c 257: See note following RCW 2.70.020.

Findings—Intent—2005 c 344: "The legislature finds that the decisions in *In re Young,* 120 Wn. App. 753, *review denied,* 152 Wn.2d 1007 (2004) and *In re Ward,* 125 Wn. App. 381 (2005) illustrate an unintended consequence of language in chapter 71.09 RCW.

The *Young* and *Ward* decisions are contrary to the legislature's intent set forth in RCW 71.09.010 that civil commitment pursuant to chapter 71.09 RCW address the "very long-term" needs of the sexually violent predator population for treatment and the equally long-term needs of the community for protection from these offenders. The legislature finds that the mental abnormalities and personality disorders that make a person subject to commitment under chapter 71.09 RCW are severe and chronic and do not remit due solely to advancing age or changes in other demographic factors.

The legislature finds, although severe medical conditions like stroke, paralysis, and some types of dementia can leave a person unable to commit further sexually violent acts, that a mere advance in age or a change in gender or some other demographic factor after the time of commitment does not merit a new trial proceeding under RCW 71.09.090. To the contrary, the legislature finds that a new trial ordered under the circumstances set forth in *Young* and *Ward* subverts the statutory focus on treatment and reduces community safety by removing all incentive for successful treatment participation in favor of passive aging and distracting committed persons from fully engaging in sex offender treatment.

The *Young* and *Ward* decisions are contrary to the legislature's intent that the risk posed by persons committed under chapter 71.09 RCW will generally require prolonged treatment in a secure facility followed by intensive community supervision in the cases where positive treatment gains are sufficient for community safety. The legislature has, under the guidance of the federal court, provided avenues through which committed persons who successfully progress in treatment will be supported by the state in a conditional release to a less restrictive alternative that is in the best interest of the committed person and provides adequate safeguards to the community and is the appropriate next step in the person's treatment.

The legislature also finds that, in some cases, a committed person may appropriately challenge whether he or she continues to meet the criteria for commitment. Because of this, the legislature enacted RCW 71.09.070 and 71.09.090, requiring a regular review of a committed person's status and permitting the person the opportunity to present evidence of a relevant change in condition from the time of the last commitment trial proceeding. These provisions are intended only to provide a method of revisiting the indefinite commitment due to a relevant change in the person's condition, not an alternate method of collaterally attacking a person's indefinite commitment for reasons unrelated to a change in condition. Where necessary, other existing statutes and court rules provide ample opportunity to resolve any concerns about prior commitment trials. Therefore, the legislature intends to clarify the "so changed" standard." [2005 c 344 § 1.]

Additional notes found at www.leg.wa.gov

71.09.092 Conditional release to less restrictive alternative—Findings. Before the court may enter an order directing conditional release to a less restrictive alternative, it must find the following: (1) The person will be treated by a treatment provider who is qualified to provide such treatment in the state of Washington under chapter 18.155 RCW; (2) the treatment provider has presented a specific course of treatment and has agreed to assume responsibility for such treatment and will report progress to the court on a regular basis, and will report violations immediately to the court, the prosecutor, the supervising community corrections officer, and the superintendent of the special commitment center; (3) housing exists in Washington that complies with distance restrictions, is sufficiently secure to protect the community, and the person or agency providing housing to the conditionally released person has agreed in writing to accept the person, to provide the level of security required by the court, and immediately to report to the court, the prosecutor, the supervising community corrections officer, and the superintendent of the special commitment center if the person leaves the housing to which he or she has been assigned without authorization; (4) if the department has proposed housing that is outside of the county of commitment, a documented effort

was made by the department to ensure that placement is consistent with fair share principles of release; (5) the person is willing to comply with the treatment provider and all requirements imposed by the treatment provider and by the court; and (6) the person will be under the supervision of the department of corrections and is willing to comply with supervision requirements imposed by the department of corrections. [2021 c 236 § 5; 2009 c 409 § 9; 1995 c 216 § 10.]

Findings—2021 c 236: See note following RCW 71.09.020.

Additional notes found at www.leg.wa.gov

71.09.094 Conditional release to less restrictive alternative—Verdict. (1) Upon the conclusion of the evidence in a hearing held pursuant to RCW 71.09.090 or through summary judgment proceedings prior to such a hearing, if the court finds that there is no legally sufficient evidentiary basis for a reasonable jury to find that the conditions set forth in RCW 71.09.092 have been met, the court shall grant a motion by the state for a judgment as a matter of law on the issue of conditional release to a less restrictive alternative.

(2) Whenever the issue of conditional release to a less restrictive alternative is submitted to the jury, the court shall instruct the jury to return a verdict in substantially the following form: Has the state proved beyond a reasonable doubt that either: (a) The proposed less restrictive alternative is not in the best interests of respondent; or (b) does not include conditions that would adequately protect the community? Answer: Yes or No. [2001 c 286 § 11; 1995 c 216 § 11.]

Additional notes found at www.leg.wa.gov

71.09.096 Conditional release to less restrictive alternative—Judgment—Conditions—Annual review. (1) If the court or jury determines that conditional release to a less restrictive alternative is in the best interest of the person and includes conditions that would adequately protect the community, and the court determines that the minimum conditions set forth in RCW 71.09.092 and in this section are met, the court shall enter judgment and direct a conditional release.

(2) The court shall impose any additional conditions necessary to ensure compliance with treatment and to protect the community. If the court finds that conditions do not exist that will both ensure the person's compliance with treatment and protect the community, then the person shall be remanded to the custody of the department of social and health services for control, care, and treatment in a secure facility as designated in RCW 71.09.060(1).

(3) If the service provider designated by the court to provide inpatient or outpatient treatment or to monitor or supervise any other terms and conditions of a person's placement in a less restrictive alternative is other than the department of social and health services or the department of corrections, then the service provider so designated must agree in writing to provide such treatment, monitoring, or supervision in accord with this section. Any person providing or agreeing to provide treatment, monitoring, or supervision services pursuant to this chapter may be compelled to testify and any privilege with regard to such person's testimony is deemed waived.

(4)(a) Prior to authorizing any release to a less restrictive alternative, the court shall impose such conditions upon the person as are necessary to ensure the safety of the community. In imposing conditions, the court must impose a restriction on the proximity of the person's residence to public or private schools providing instruction to kindergarten or any grades one through 12 in accordance with RCW 72.09.340. Courts shall require a minimum distance restriction of 500 feet on the proximity of the person's residence to child care facilities and public or private schools providing instruction to kindergarten or any grades one through 12. The court shall order the department of corrections to investigate the less restrictive alternative and, within 60 days of the order to investigate, recommend any additional conditions to the court. These conditions shall be individualized to address the person's specific risk factors and criminogenic needs and may include, but are not limited to[,] the following: Specification of residence or restrictions on residence including distance restrictions, specification of contact with a reasonable number of individuals upon the person's request who are verified by the department of corrections to be appropriate social contacts, prohibition of contact with potential or past victims, prohibition of alcohol and other drug use, participation in a specific course of inpatient or outpatient treatment that may include monitoring by the use of polygraph and plethysmograph, monitoring through the use of global positioning system technology, supervision by a department of corrections community corrections officer, a requirement that the person remain within the state unless the person receives prior authorization by the court, and any other conditions that the court determines are in the best interest of the person or others. A copy of the conditions of release shall be given to the person and to any designated service providers.

(b) To the greatest extent possible, the person, person's counsel, prosecuting agency responsible for the initial commitment, treatment provider, supervising community corrections officer, and appropriate clinical staff of the special commitment center shall meet and collaborate to craft individualized, narrowly tailored, and empirically based conditions to present to the court to help facilitate the person's successful transition to the community.

(5)(a) Prior to authorizing release to a less restrictive alternative proposed by the department, the court shall consider whether the person's less restrictive alternative placement is in accordance with fair share principles. To ensure equitable distribution of releases, and prevent the disproportionate grouping of persons subject to less restrictive orders in any one county, or in any one jurisdiction or community within a county, the legislature finds it is appropriate for releases to a less restrictive alternative to occur in a manner that adheres to fair share principles. The legislature recognizes that there may be reasons why the department may not recommend that a person be released to his or her county of commitment, including availability of individualized resources, the person's support needs, or when the court determines that the person's return to his or her county of commitment would be inappropriate considering any court-issued protection orders, victim safety concerns that cannot be addressed through use of global positioning system technology, the unavailability of appropriate treatment or facilities that would adequately protect the community, negative influences on the person, and the location of family or other persons or organizations offering support to the person. If the

court authorizes conditional release based on the department's proposal to a county other than the county of commitment, the court shall enter specific findings regarding its decision and identify whether the release remains in line with fair share principles.

(b)(i) When the department develops a less restrictive alternative placement under this section, it shall attempt to identify a placement satisfying the requirements of RCW 71.09.092 that is aligned with fair share principles. The department shall document its rationale for the recommended placement.

(ii) If the department does not support or recommend conditional release to a less restrictive alternative due to a clinical determination, the department shall document its objection and certify that the department is developing the less restrictive alternative pursuant to a court order and not because of a clinical determination.

(iii) When the department develops or proposes a less restrictive alternative placement under this chapter, it shall be considered a predisposition recommendation.

(iv) In developing, modifying, and enforcing less restrictive alternatives, the department shall be deemed to be performing a quasi-judicial function.

(c) If the committed person is not conditionally released to his or her county of commitment, the department shall provide the law and justice council of the county in which the person is conditionally released with notice and a written explanation, including whether the department remains in compliance with fair share principles regarding releases under this chapter.

(d) For purposes of this section, the person's county of commitment means the county of the court which ordered the person's commitment.

(e) This subsection (5) does not apply to releases to a secure community transition facility under RCW 71.09.250.

(6)(a) When ordered by the court, the department must provide less restrictive alternative treatment that includes, at a minimum:

(i) The services identified in the person's discharge plan as outlined in RCW 71.09.080(4);

(ii) The assignment of a community care coordinator;

(iii) Regular contacts with providers of court-ordered treatment services;

(iv) Community escorts, if needed;

(v) A transition plan that addresses the person's access to continued services upon unconditional discharge;

(vi) Financial support for necessary housing;

(vii) Life skills training and disability accommodations, if needed; and

(viii) Assistance in pursuing benefits, education, and employment.

(b) At the time the department of corrections is ordered to investigate a proposed less restrictive alternative placement, subject to the availability of amounts appropriated for this specific purpose, the department shall assign a social worker to assist the person with discharge planning, pursuing benefits, and coordination of care prior to release.

(i) The social worker shall assist the person with completing applications for benefits prior to the person's release from total confinement.

(ii) To promote continuity of care and the individual's success in the community, the department social worker shall be responsible for initiating a clinical transition of care between the last treating clinician at the special commitment center and the person's designated community treatment provider. This transition between one clinical setting to another shall occur no later than 15 days before an individual's release from the special commitment center.

(iii) If applicable, the social worker shall assist the person with locating any needed disability accommodations in the community and with obtaining resources to help address the person's identified life skills needs prior to release from total confinement.

(7) Any service provider designated to provide inpatient or outpatient treatment shall monthly, or as otherwise directed by the court, submit to the court, to the department of social and health services facility from which the person was released, to the prosecuting agency, and to the supervising community corrections officer, a report stating whether the person is complying with the terms and conditions of the conditional release to a less restrictive alternative.

(8) Each person released to a less restrictive alternative shall have his or her case reviewed by the court that released him or her no later than one year after such release and annually thereafter until the person is unconditionally discharged. Review may occur in a shorter time or more frequently, if the court, in its discretion on its own motion, or on motion of the person, the secretary, or the prosecuting agency so determines. The questions to be determined by the court are whether the person shall continue to be conditionally released to a less restrictive alternative, and if so, whether a modification to the person's less restrictive alternative order is appropriate to ensure the conditional release remains in the best interest of the person and adequate to protect the victim and the community. The court in making its determination shall be aided by the periodic reports filed pursuant to subsection (7) of this section and the opinions of the secretary and other experts or professional persons. [2021 c 236 § 6; 2015 c 278 § 3; 2009 c 409 § 10; 2001 c 286 § 12; 1995 c 216 § 12.]

Findings—2021 c 236: See note following RCW 71.09.020.

Additional notes found at www.leg.wa.gov

71.09.097 Conditional release to less restrictive alternative—Department developing placement—Considerations. (1) In accordance with RCW 71.09.090 and 71.09.096, the department shall have the primary responsibility for developing a less restrictive alternative placement. To ensure the department has sufficient less restrictive alternative placements to choose from that satisfy the requirements of RCW 71.09.092, subject to the availability of amounts appropriated for this specific purpose, the department shall use a request for proposal process to solicit and contract with housing and treatment providers from across the state and facilitate fair share principles among the counties. In order to increase the number of housing options for individuals qualifying for a less restrictive alternative, the department shall have oversight of the vendors and providers who contract with the state, including the authority to inspect and ensure compliance, negotiate the rates charged for services, ensure adequate living conditions of housing locations, and terminate contracts. The department shall maintain a statewide

accounting of the contracted community housing and treatment providers in each county and provide a biannual report to the legislature and governor by December 1st on the availability and adequacy of less restrictive alternative placements and the department's compliance with fair share principles.

(2) To facilitate its duties required under this section, the department shall use the following housing matrix and considerations as a guide to planning and developing less restrictive alternative placements. The following considerations may not be used as a reason to deny a less restrictive alternative placement.

(a) Considerations for evaluating a proposed vendor's application for less restrictive alternative housing services shall include applicable state and local zoning and building codes, general housing requirements, availability of public services, and other considerations identified in accordance with RCW 71.09.315. The department shall require the housing provider to provide proof that the facility is in compliance with all local zoning and building codes.

(i) General housing requirements include running water, electricity, bedroom and living space of adequate size, and no mold or infestations.

(ii) Availability of public services include availability of chaperones and whether the placement is within a reasonable distance to a grocery store, bank, public transportation options, and offices for public services and benefits.

(iii) Other considerations include whether the placement is consistent with fair share principles across the counties, whether the placement is within reasonable distance to other current or planned components of the less restrictive alternative, whether the placement is within reasonable distance to employment opportunities, and the reliability of global positioning system technology.

(b) Factors for evaluating less restrictive alternative options for a specific individual include sex offender treatment considerations, criminogenic needs and risk factors, protective factors, and the specific needs of the client.

(i) Sex offender treatment considerations include whether the housing is within a reasonable distance from the treatment provider, whether the treatment provider is a good therapeutic match with the client, and whether the treatment provider has relevant experience and background to treat the client if the client has special needs.

(ii) Criminogenic needs and risk factors include consideration of the person's specific needs and risk factors in evaluating less restrictive alternative options.

(iii) Protective factors include whether housing is within a reasonable distance of family, friends, potential hobbies, potential employment, and educational opportunities.

(iv) Consideration of the client's specific needs includes assessing the availability of personal care assistance and in-home care assistance, and whether housing is within a reasonable distance of mental health, medical treatment options, and substance use disorder treatment options. [2021 c 236 § 11.]

Findings—2021 c 236: See note following RCW 71.09.020.

71.09.098 Revoking or modifying terms of conditional release to less restrictive alternative—Hearing—Custody pending hearing on revocation or modification. (1) Any service provider submitting reports pursuant to *RCW 71.09.096(6), the supervising community corrections officer, the prosecuting agency, or the secretary's designee may petition the court for an immediate hearing for the purpose of revoking or modifying the terms of the person's conditional release to a less restrictive alternative if the petitioner believes the released person: (a) Violated or is in violation of the terms and conditions of the court's conditional release order; or (b) is in need of additional care, monitoring, supervision, or treatment.

(2) The community corrections officer or the secretary's designee may restrict the person's movement in the community until the petition is determined by the court. The person may be taken into custody if:

(a) The supervising community corrections officer, the secretary's designee, or a law enforcement officer reasonably believes the person has violated or is in violation of the court's conditional release order; or

(b) The supervising community corrections officer or the secretary's designee reasonably believes that the person is in need of additional care, monitoring, supervision, or treatment because the person presents a danger to himself or herself or others if his or her conditional release under the conditions imposed by the court's release order continues.

(3)(a) Persons taken into custody pursuant to subsection (2) of this section shall:

(i) Not be released until such time as a hearing is held to determine whether to revoke or modify the person's conditional release order and the court has issued its decision; and

(ii) Be held in the county jail, at a secure community transition facility, or at the total confinement facility, at the discretion of the secretary's designee.

(b) The court shall be notified before the close of the next judicial day that the person has been taken into custody and shall promptly schedule a hearing.

(4) Before any hearing to revoke or modify the person's conditional release order, both the prosecuting agency and the released person shall have the right to request an immediate mental examination of the released person. If the conditionally released person is indigent, the court shall, upon request, assist him or her in obtaining a qualified expert or professional person to conduct the examination.

(5) At any hearing to revoke or modify the conditional release order:

(a) The prosecuting agency shall represent the state, including determining whether to proceed with revocation or modification of the conditional release order;

(b) Hearsay evidence is admissible if the court finds that it is otherwise reliable; and

(c) The state shall bear the burden of proving by a preponderance of the evidence that the person has violated or is in violation of the court's conditional release order or that the person is in need of additional care, monitoring, supervision, or treatment.

(6)(a) If the court determines that the state has met its burden referenced in subsection (5)(c) of this section, and the issue before the court is revocation of the court's conditional release order, the court shall consider the evidence presented by the parties and the following factors relevant to whether continuing the person's conditional release is in the person's best interests or adequate to protect the community:

(i) The nature of the condition that was violated by the person or that the person was in violation of in the context of the person's criminal history and underlying mental conditions;

(ii) The degree to which the violation was intentional or grossly negligent;

(iii) The ability and willingness of the released person to strictly comply with the conditional release order;

(iv) The degree of progress made by the person in community-based treatment; and

(v) The risk to the public or particular persons if the conditional release continues under the conditional release order that was violated.

(b) Any factor alone, or in combination, shall support the court's determination to revoke the conditional release order.

(7) If the court determines the state has met its burden referenced in subsection (5)(c) of this section, and the issue before the court is modification of the court's conditional release order, the court shall modify the conditional release order by adding conditions if the court determines that the person is in need of additional care, monitoring, supervision, or treatment. The court has authority to modify its conditional release order by substituting a new treatment provider, requiring new housing for the person, or imposing such additional supervision conditions as the court deems appropriate.

(8) A person whose conditional release has been revoked shall be remanded to the custody of the secretary for control, care, and treatment in a total confinement facility as designated in RCW 71.09.060(1). The person is thereafter eligible for conditional release only in accord with the provisions of RCW 71.09.090 and related statutes. [2009 c 409 § 11; 2006 c 282 § 1; 2001 c 286 § 13; 1995 c 216 § 13.]

***Reviser's note:** RCW 71.09.096 was amended by 2015 c 278 § 3, changing subsection (6) to subsection (7). RCW 71.09.096 was subsequently amended by 2021 c 236 § 6, changing subsection (7) to subsection (8).

Additional notes found at www.leg.wa.gov

71.09.099 Conditional release to less restrictive alternative—Conditional release and transition facilities study. To facilitate the primary role of the department in identifying less restrictive alternative placements under RCW 71.09.090 and discharge planning under RCW 71.09.080, subject to the availability of amounts appropriated for this specific purpose, the department shall conduct a study to explore the development of conditional release and transition facilities, which may include community-based state-operated living alternatives similar to the state-operated living alternative program operated by the developmental disabilities administration. Any facilities or placements developed under this section may be identified through a request for proposal process or through direct state acquisition and development. Any contracts with facilities or placements entered into under this section shall include a provision requiring oversight by the department to ensure the programs are operating appropriately. [2021 c 236 § 10.]

Findings—2021 c 236: See note following RCW 71.09.020.

71.09.110 Department of social and health services—Duties—Reimbursement. The department of social and health services shall be responsible for the costs relating to the treatment of persons committed to their custody whether in a secure facility or under a less restrictive alternative as provided in this chapter. Reimbursement may be obtained by the department for the cost of care and treatment of persons committed to its custody whether in a secure facility or under a less restrictive alternative pursuant to RCW 43.20B.330 through 43.20B.370. [2012 c 257 § 10; 2010 1st sp.s. c 28 § 3; 1995 c 216 § 14; 1990 c 3 § 1011.]

Effective date—2012 c 257: See note following RCW 2.70.020.

71.09.111 Department of social and health services—Disclosures to the prosecuting agency. The department of social and health services shall provide to the prosecuting agency a copy of all reports made by the department to law enforcement in which a person detained or committed under this chapter is named or listed as a suspect, witness, or victim, as well as a copy of all reports received from law enforcement. [2009 c 409 § 12.]

Additional notes found at www.leg.wa.gov

71.09.112 Department of social and health services—Jurisdiction and revocation of conditional release after criminal conviction—Exception. A person subject to court order under the provisions of this chapter who is thereafter convicted of a criminal offense remains under the jurisdiction of the department and shall be returned to the custody of the department following: (1) Completion of the criminal sentence; or (2) release from confinement in a state, federal, or local correctional facility. Any conditional release order shall be immediately revoked upon conviction for a criminal offense.

This section does not apply to persons subject to a court order under the provisions of this chapter who are thereafter sentenced to life without the possibility of release. [2009 c 409 § 13; 2002 c 19 § 1.]

Additional notes found at www.leg.wa.gov

71.09.115 Record check required for employees of secure facility. (1) The safety and security needs of the secure facility operated by the department of social and health services pursuant to RCW 71.09.060(1) make it vital that employees working in the facility meet necessary character, suitability, and competency qualifications. The secretary shall require a record check through the Washington state patrol criminal identification system under chapter 10.97 RCW and through the federal bureau of investigation. The record check must include a fingerprint check using a complete Washington state criminal identification fingerprint card. The criminal history record checks shall be at the expense of the department. The secretary shall use the information only in making the initial employment or engagement decision, except as provided in subsection (2) of this section. Further dissemination or use of the record is prohibited.

(2) This section applies to all current employees hired prior to June 6, 1996, who have not previously submitted to a department of social and health services criminal history records check. The secretary shall use the information only in determining whether the current employee meets the necessary character, suitability, and competency requirements for employment or engagement. [1996 c 27 § 1.]

71.09.120 Release of information authorized. (1) In addition to any other information required to be released under this chapter, the department is authorized, pursuant to RCW 4.24.550, to release relevant information that is necessary to protect the public, concerning a specific sexually violent predator committed under this chapter.

(2) The department and the courts are authorized to release to the office of public defense records needed to implement the office's administration of public defense in these cases, including research, reports, and other functions as required by RCW 2.70.020 and 2.70.025. The office of public defense shall maintain the confidentiality of all confidential information included in the records.

(3) The inspection or copying of any nonexempt public record by persons residing in a civil commitment facility for sexually violent predators may be enjoined following procedures identified in RCW 42.56.565. The injunction may be requested by:

(a) An agency or its representative;

(b) A person named in the record or his or her representative;

(c) A person to whom the request specifically pertains or his or her representative. [2012 c 257 § 11; 1990 c 3 § 1012.]

Effective date—2012 c 257: See note following RCW 2.70.020.

71.09.130 Notice of escape or disappearance—Warrants—Liability. (1) In the event of an escape by a person committed under this chapter from a state institution or the disappearance of such a person while on conditional release, the superintendent or community corrections officer shall notify the following as appropriate: Local law enforcement officers, other governmental agencies, the person's relatives, and any other appropriate persons about information necessary for the public safety or to assist in the apprehension of the person.

(2) If a person committed under this chapter disappears while on conditional release, the department of corrections may enter a warrant for the person's arrest for up to 96 hours pending entry of a bench warrant by the court.

(3) The department of corrections, its officers, agents, and employees are not liable for the acts of individuals on conditional release unless the department of corrections, its officers, agents, and employees acted with gross negligence.

(4) The department, its officers, agents, and employees are not liable for the acts of individuals on conditional release unless the department, its officers, agents, and employees acted with gross negligence. [2021 c 236 § 7; 1995 c 216 § 16.]

Findings—2021 c 236: See note following RCW 71.09.020.

71.09.135 McNeil Island—Escape planning, response. The emergency response team for McNeil Island shall plan, coordinate, and respond in the event of an escape from the special commitment center or the secure community transition facility. [2003 c 216 § 6.]

Additional notes found at www.leg.wa.gov

71.09.140 Notice of conditional release or unconditional discharge—Notice of escape and recapture. (1)(a) At the earliest possible date, and in no event later than 30 days before conditional release, change of address for a person on conditional release, or unconditional discharge, except in the event of escape, the department of social and health services shall send written notice of conditional release, unconditional discharge, or escape, to the following:

(i) The chief of police of the city, if any, in which the person will reside or in which placement will be made under a less restrictive alternative;

(ii) The sheriff of the county in which the person will reside or in which placement will be made under a less restrictive alternative; and

(iii) The sheriff of the county where the person was last convicted of a sexually violent offense, if the department does not know where the person will reside.

The department shall notify the state patrol of the release of all sexually violent predators and that information shall be placed in the Washington crime information center for dissemination to all law enforcement.

(b) A return to total confinement or to a secure community transition facility pending revocation or modification proceedings is not considered a change of address for purposes of (a) of this subsection, and an additional community notification process is not required, unless conditional release is revoked under RCW 71.09.098 or the return lasts longer than 90 days.

(2) The same notice as required by subsection (1) of this section shall be sent to the following if such notice has been requested in writing about a specific person found to be a sexually violent predator under this chapter:

(a) The victim or victims of any sexually violent offenses for which the person was convicted in the past or the victim's next of kin if the crime was a homicide. "Next of kin" as used in this section means a person's spouse, parents, siblings, and children;

(b) Any witnesses who testified against the person in his or her commitment trial under RCW 71.09.060; and

(c) Any person specified in writing by the prosecuting agency.

Information regarding victims, next of kin, or witnesses requesting the notice, information regarding any other person specified in writing by the prosecuting agency to receive the notice, and the notice are confidential and shall not be available to the committed person.

(3) If a person committed as a sexually violent predator under this chapter escapes from a department of social and health services facility, the department shall immediately notify, by the most reasonable and expedient means available, the chief of police of the city and the sheriff of the county in which the committed person resided immediately before his or her commitment as a sexually violent predator, or immediately before his or her incarceration for his or her most recent offense. If previously requested, the department shall also notify the witnesses and the victims of the sexually violent offenses for which the person was convicted in the past or the victim's next of kin if the crime was a homicide. If the person is recaptured, the department shall send notice to the persons designated in this subsection as soon as possible but in no event later than two working days after the department learns of such recapture.

(4) If the victim or victims of any sexually violent offenses for which the person was convicted in the past or the victim's next of kin, or any witness is under the age of 16, the

notice required by this section shall be sent to the parents or legal guardian of the child.

(5) The department of social and health services shall send the notices required by this chapter to the last address provided to the department by the requesting party. The requesting party shall furnish the department with a current address.

(6) Nothing in this section shall impose any liability upon a chief of police of a city or sheriff of a county for failing to request in writing a notice as provided in subsection (1) of this section. [2021 c 236 § 8; 2012 c 257 § 12; 1995 c 216 § 17.]

Findings—2021 c 236: See note following RCW 71.09.020.

Effective date—2012 c 257: See note following RCW 2.70.020.

71.09.200 Escorted leave—Definitions. For purposes of RCW 71.09.210 through 71.09.230:

(1) "Escorted leave" means a leave of absence from a facility housing persons detained or committed pursuant to this chapter under the continuous supervision of an escort.

(2) "Escort" means a correctional officer or other person approved by the superintendent or the superintendent's designee to accompany a resident on a leave of absence and be in visual or auditory contact with the resident at all times.

(3) "Resident" means a person detained or committed pursuant to this chapter. [1995 c 216 § 18.]

71.09.210 Escorted leave—Conditions. The superintendent of any facility housing persons detained or committed pursuant to this chapter may, subject to the approval of the secretary, grant escorted leaves of absence to residents confined in such institutions to:

(1) Go to the bedside of the resident's wife, husband, child, mother or father, or other member of the resident's immediate family who is seriously ill;

(2) Attend the funeral of a member of the resident's immediate family listed in subsection (1) of this section; and

(3) Receive necessary medical or dental care which is not available in the institution. [1995 c 216 § 19.]

71.09.220 Escorted leave—Notice. A resident shall not be allowed to start a leave of absence under RCW 71.09.210 until the secretary, or the secretary's designee, has notified any county and city law enforcement agency having jurisdiction in the area of the resident's destination. [1995 c 216 § 20.]

71.09.230 Escorted leave—Rules. (1) The secretary is authorized to adopt rules providing for the conditions under which residents will be granted leaves of absence and providing for safeguards to prevent escapes while on leaves of absence. Leaves of absence granted to residents under RCW 71.09.210, however, shall not allow or permit any resident to go beyond the boundaries of this state.

(2) The secretary shall adopt rules requiring reimbursement of the state from the resident granted leave of absence, or the resident's family, for the actual costs incurred arising from any leave of absence granted under the authority of RCW 71.09.210 (1) and (2). No state funds shall be expended in connection with leaves of absence granted under RCW 71.09.210 (1) and (2) unless the resident and the resident's immediate family are indigent and without resources sufficient to reimburse the state for the expenses of such leaves of absence. [1995 c 216 § 21.]

71.09.250 Transition facility—Siting. (1)(a) The secretary is authorized to site, construct, occupy, and operate (i) a secure community transition facility on McNeil Island for persons authorized to petition for a less restrictive alternative under RCW 71.09.090(1) and who are conditionally released; and (ii) a special commitment center on McNeil Island with up to four hundred four beds as a total confinement facility under this chapter, subject to appropriated funding for those purposes. The secure community transition facility shall be authorized for the number of beds needed to ensure compliance with the orders of the superior courts under this chapter and the federal district court for the western district of Washington. The total number of beds in the secure community transition facility shall be limited to 24, consisting of up to 15 transitional beds and up to nine pretransitional beds. The residents occupying the transitional beds shall be the only residents eligible for transitional services occurring in Pierce county. In no event shall more than 15 residents of the secure community transition facility be participating in off-island transitional, educational, or employment activity at the same time in Pierce county. The department shall provide the Pierce county sheriff, or his or her designee, with a list of the 15 residents so designated, along with their photographs and physical descriptions, and the list shall be immediately updated whenever a residential change occurs. The Pierce county sheriff, or his or her designee, shall be provided an opportunity to confirm the residential status of each resident leaving McNeil Island.

(b) For purposes of this subsection, "transitional beds" means beds only for residents who are judged by a qualified expert to be suitable to leave the island for treatment, education, and employment.

(2)(a) The secretary is authorized to site, either within the secure community transition facility established pursuant to subsection (1)(a)(i) of this section, or within the special commitment center, up to nine pretransitional beds.

(b) Residents assigned to pretransitional beds shall not be permitted to leave McNeil Island for education, employment, treatment, or community activities in Pierce county.

(c) For purposes of this subsection, "pretransitional beds" means beds for residents whose progress toward a less secure residential environment and transition into more complete community involvement is projected to take substantially longer than a typical resident of the special commitment center.

(3) Notwithstanding RCW 36.70A.103 or any other law, this statute preempts and supersedes local plans, development regulations, permitting requirements, inspection requirements, and all other laws as necessary to enable the secretary to site, construct, occupy, and operate a secure community transition facility on McNeil Island and a total confinement facility on McNeil Island.

(4) To the greatest extent possible, until June 30, 2003, persons who were not civilly committed from the county in which the secure community transition facility established pursuant to subsection (1) of this section is located may not

be conditionally released to a setting in that same county less restrictive than that facility.

(5) As of June 26, 2001, the state shall immediately cease any efforts in effect on such date to site secure community transition facilities, other than the facility authorized by subsection (1) of this section, and shall instead site such facilities in accordance with the provisions of this section.

(6) The department must:

(a) Identify the minimum and maximum number of secure community transition facility beds in addition to the facility established under subsection (1) of this section that may be necessary for the period of May 2004 through May 2007 and provide notice of these numbers to all counties by August 31, 2001; and

(b) Develop and publish policy guidelines for the siting and operation of secure community transition facilities.

(7)(a) The total number of secure community transition facility beds that may be required to be sited in a county between June 26, 2001, and June 30, 2008, may be no greater than the total number of persons civilly committed from that county, or detained at the special commitment center under a pending civil commitment petition from that county where a finding of probable cause had been made on April 1, 2001. The total number of secure community transition facility beds required to be sited in each county between July 1, 2008, and June 30, 2015, may be no greater than the total number of persons civilly committed from that county or detained at the special commitment center under a pending civil commitment petition from that county where a finding of probable cause had been made as of July 1, 2008.

(b) Counties and cities that provide secure community transition facility beds above the maximum number that they could be required to site under this subsection are eligible for a bonus grant under the incentive provisions in RCW 71.09.255. The county where the special commitment center is located shall receive this bonus grant for the number of beds in the facility established in subsection (1) of this section in excess of the maximum number established by this subsection.

(c) No secure community transition facilities in addition to the one established in subsection (1) of this section may be required to be sited in the county where the special commitment center is located until after June 30, 2008, provided however, that the county and its cities may elect to site additional secure community transition facilities and shall be eligible under the incentive provisions of RCW 71.09.255 for any additional facilities meeting the requirements of that section.

(8) After the department demonstrates the need for additional bed capacity to the appropriate committees of the legislature, and receives approval and funding from the appropriate committees of the legislature to build additional bed capacity, the state is authorized to site and operate secure community transition facilities and other conditional release and transitional facilities in any county in the state in accordance with RCW 71.09.315. In identifying potential counties and sites within a county for the location of a secure community transition facility or other conditional release and transitional facilities, the department shall work with and assist local governments to provide for the equitable distribution of such facilities. In coordinating and deciding upon the siting of secure community transition facilities or other conditional release and transitional facilities within a county, great weight shall be given by the county and cities within the county to:

(a) The number and location of existing residential facility beds operated by the department of corrections or the mental health division of the department of social and health services in each jurisdiction in the county; and

(b) The number of registered sex offenders classified as level II or level III and the number of sex offenders registered as homeless residing in each jurisdiction in the county.

(9)(a) "Equitable distribution" means siting or locating secure community transition facilities and other conditional release and transitional facilities in a manner that will not cause a disproportionate grouping of similar facilities either in any one county, or in any one jurisdiction or community within a county, as relevant; and

(b) "Jurisdiction" means a city, town, or geographic area of a county in which distinct political or judicial authority may be exercised. [2021 c 236 § 9; 2003 c 216 § 3; 2001 2nd sp.s. c 12 § 201.]

Findings—2021 c 236: See note following RCW 71.09.020.

Intent—2001 2nd sp.s. c 12: "The legislature intends the following omnibus bill to address the management of sex offenders in the civil commitment and criminal justice systems for purposes of public health, safety, and welfare. Provisions address siting of and continued operation of facilities for persons civilly committed under chapter 71.09 RCW and sentencing of persons who have committed sex offenses. Other provisions address the need for sex offender treatment providers with specific credentials. Additional provisions address the continued operation or authorized expansion of criminal justice facilities at McNeil Island, because these facilities are impacted by the civil facilities on McNeil Island for persons committed under chapter 71.09 RCW." [2001 2nd sp.s. c 12 § 101.]

Additional notes found at www.leg.wa.gov

71.09.252 Transition facilities—Agreements for regional facilities. (1) To encourage economies of scale in the siting and operation of secure community transition facilities, the department may enter into an agreement with two or more counties to create a regional secure community transition facility. The agreement must clearly identify the number of beds from each county that will be contained in the regional secure community transition facility. The agreement must specify which county must contain the regional secure community transition facility and the facility must be sited accordingly. No county may withdraw from an agreement under this section unless it has provided an alternative acceptable secure community transition facility to house any displaced residents that meets the criteria established for such facilities in this chapter and the guidelines established by the department.

(2) A regional secure community transition facility must meet the criteria established for secure community transition facilities in this chapter and the guidelines established by the department.

(3) The department shall count the beds identified for each participating county in a regional secure community transition facility against the maximum number of beds that could be required for each county under RCW 71.09.250(7)(a).

(4) An agreement for a regional secure community transition facility does not alter the maximum number of beds for

purposes of the incentive grants under RCW 71.09.255 for the county containing the regional facility. [2002 c 68 § 18.]

Purpose—Severability—Effective date—2002 c 68: See notes following RCW 36.70A.200.

71.09.255 Transition facilities—Incentive grants and payments. (1) Upon receiving the notification required by RCW 71.09.250, counties must promptly notify the cities within the county of the maximum number of secure community transition facility beds that may be required and the projected number of beds to be needed in that county.

(2) The incentive grants and payments provided under this section are subject to the following provisions:

(a) Counties and the cities within the county must notify each other of siting plans to promote the establishment and equitable distribution of secure community transition facilities;

(b) Development regulations, ordinances, plans, laws, and criteria established for siting must be consistent with statutory requirements and rules applicable to siting and operating secure community transition facilities;

(c) The minimum size for any facility is three beds; and

(d) The department must approve any sites selected.

(3) Any county or city that makes a commitment to initiate the process to site one or more secure community transition facilities by one hundred twenty days after March 21, 2002, shall receive a planning grant as proposed and approved by the *department of community, trade, and economic development.

(4) Any county or city that has issued all necessary permits by May 1, 2003, for one or more secure community transition facilities that comply with the requirements of this section shall receive an incentive grant in the amount of fifty thousand dollars for each bed sited.

(5) To encourage the rapid permitting of sites, any county or city that has issued all necessary permits by January 1, 2003, for one or more secure community transition facilities that comply with the requirements of this section shall receive a bonus in the amount of twenty percent of the amount provided under subsection (4) of this section.

(6) Any county or city that establishes secure community transition facility beds in excess of the maximum number that could be required to be sited in that county shall receive a bonus payment of one hundred thousand dollars for each bed established in excess of the maximum requirement.

(7) No payment shall be made under subsection (4), (5), or (6) of this section until all necessary permits have been issued.

(8) The funds available to counties and cities under this section are contingent upon funds being appropriated by the legislature. [2002 c 68 § 8; 2001 2nd sp.s. c 12 § 204.]

***Reviser's note:** The "department of community, trade, and economic development" was renamed the "department of commerce" by 2009 c 565.

Purpose—Severability—Effective date—2002 c 68: See notes following RCW 36.70A.200.

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.260 Transition facilities not limited to residential neighborhoods. The provisions of chapter 12, Laws of 2001 2nd sp. sess. shall not be construed to limit siting of secure community transition facilities to residential neighborhoods. [2001 2nd sp.s. c 12 § 206.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.265 Transition facilities—Distribution of impact. (1) The department shall make reasonable efforts to distribute the impact of the employment, education, and social services needs of the residents of the secure community transition facility established pursuant to RCW 71.09.250(1) among the adjoining counties and not to concentrate the residents' use of resources in any one community.

(2) The department shall develop policies to ensure that, to the extent possible, placement of persons eligible in the future for conditional release to a setting less restrictive than the facility established pursuant to RCW 71.09.250(1) will be equitably distributed among the counties and within jurisdictions in the county. [2001 2nd sp.s. c 12 § 208.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.275 Transition facility—Transportation of residents. (1) If the department does not provide a separate vessel for transporting residents of the secure community transition facility established in RCW 71.09.250(1) between McNeil Island and the mainland, the department shall:

(a) Separate residents from minors and vulnerable adults, except vulnerable adults who have been found to be sexually violent predators.

(b) Not transport residents during times when children are normally coming to and from the mainland for school.

(2) The department shall designate a separate waiting area at the points of debarkation, and residents shall be required to remain in this area while awaiting transportation.

(3) The department shall provide law enforcement agencies in the counties and cities in which residents of the secure community transition facility established pursuant to RCW 71.09.250(1)(a)(i) regularly participate in employment, education, or social services, or through which these persons are regularly transported, with a copy of the court's order of conditional release with respect to these persons. [2003 c 216 § 4; 2001 2nd sp.s. c 12 § 211.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

Additional notes found at www.leg.wa.gov

71.09.280 Transition facility—Release to less restrictive placement. When considering whether a person civilly committed under this chapter and conditionally released to a secure community transition facility is appropriate for release to a placement that is less restrictive than that facility, the court shall comply with the procedures set forth in RCW 71.09.090 through 71.09.096. In addition, the court shall consider whether the person has progressed in treatment to the point that a significant change in the person's routine, including but not limited to a change of employment, education, residence, or sex offender treatment provider will not cause the person to regress to the point that the person presents a greater risk to the community than can reasonably be addressed in the proposed placement. [2001 2nd sp.s. c 12 § 212.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.285 Transition facility—Siting policy guidelines. (1) Except with respect to the secure community transition facility established pursuant to RCW 71.09.250, the secretary shall develop policy guidelines that balance the average response time of emergency services to the general area of a proposed secure community transition facility against the proximity of the proposed site to risk potential activities and facilities in existence at the time the site is listed for consideration.

(2) In no case shall the policy guidelines permit location of a facility adjacent to, immediately across a street or parking lot from, or within the line of sight of a risk potential activity or facility in existence at the time a site is listed for consideration. "Within the line of sight" means that it is possible to reasonably visually distinguish and recognize individuals.

(3) The policy guidelines shall require that great weight be given to sites that are the farthest removed from any risk potential activity.

(4) The policy guidelines shall specify how distance from the location is measured and any variations in the measurement based on the size of the property within which a proposed facility is to be located.

(5) The policy guidelines shall establish a method to analyze and compare the criteria for each site in terms of public safety and security, site characteristics, and program components. In making a decision regarding a site following the analysis and comparison, the secretary shall give priority to public safety and security considerations. The analysis and comparison of the criteria are to be documented and made available at the public hearings prescribed in RCW 71.09.315.

(6) Policy guidelines adopted by the secretary under this section shall be considered by counties and cities when providing for the siting of secure community transition facilities as required under RCW 36.70A.200. [2002 c 68 § 5; 2001 2nd sp.s. c 12 § 213.]

Purpose—Severability—Effective date—2002 c 68: See notes following RCW 36.70A.200.

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.290 Other transition facilities—Siting policy guidelines. The secretary shall establish policy guidelines for the siting of secure community transition facilities, other than the secure community transition facility established pursuant to RCW 71.09.250(1)(a)(i), which shall include at least the following minimum requirements:

(1) The following criteria must be considered prior to any real property being listed for consideration for the location of or use as a secure community transition facility:

(a) The proximity and response time criteria established under RCW 71.09.285;

(b) The site or building is available for lease for the anticipated use period or for purchase;

(c) Security monitoring services and appropriate backup systems are available and reliable;

(d) Appropriate mental health and sex offender treatment providers must be available within a reasonable commute; and

(e) Appropriate permitting for a secure community transition facility must be possible under the zoning code of the local jurisdiction.

(2) For sites which meet the criteria of subsection (1) of this section, the department shall analyze and compare the criteria in subsections (3) through (5) of this section using the method established in RCW 71.09.285.

(3) Public safety and security criteria shall include at least the following:

(a) Whether limited visibility between the facility and adjacent properties can be achieved prior to placement of any person;

(b) The distance from, and number of, risk potential activities and facilities, as measured using the policies adopted under RCW 71.09.285;

(c) The existence of or ability to establish barriers between the site and the risk potential facilities and activities;

(d) Suitability of the buildings to be used for the secure community transition facility with regard to existing or feasibly modified features; and

(e) The availability of electronic monitoring that allows a resident's location to be determined with specificity.

(4) Site characteristics criteria shall include at least the following:

(a) Reasonableness of rental, lease, or sale terms including length and renewability of a lease or rental agreement;

(b) Traffic and access patterns associated with the real property;

(c) Feasibility of complying with zoning requirements within the necessary time frame; and

(d) A contractor or contractors are available to install, monitor, and repair the necessary security and alarm systems.

(5) Program characteristics criteria shall include at least the following:

(a) Reasonable proximity to available medical, mental health, sex offender, and chemical dependency treatment providers and facilities;

(b) Suitability of the location for programming, staffing, and support considerations;

(c) Proximity to employment, educational, vocational, and other treatment plan components.

(6) For purposes of this section "available" or "availability" of qualified treatment providers includes provider qualifications and willingness to provide services, average commute time, and cost of services. [2003 c 216 § 5; 2001 2nd sp.s. c 12 § 214.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

Additional notes found at www.leg.wa.gov

71.09.295 Transition facilities—Security systems. (1) Security systems for all secure community transition facilities shall meet the following minimum qualifications:

(a) The security panel must be a commercial grade panel with tamper-proof switches and a key-lock to prevent unauthorized access.

(b) There must be an emergency electrical supply system which shall include a battery backup system and a generator.

(c) The system must include personal panic devices for all staff.

(d) The security system must be capable of being monitored and signaled either by telephone through either a land or cellular telephone system or by private radio network in the event of a total dial-tone failure or through equivalent technologies.

(e) The department shall issue photo-identification badges to all staff which must be worn at all times.

(2) Security systems for the secure community transition facility established pursuant to RCW 71.09.250(1) shall also include a fence and provide the maximum protection appropriate in a civil facility for persons in less than total confinement. [2001 2nd sp.s. c 12 § 215.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.300 Transition facilities—Staffing. Secure community transition facilities shall meet the following minimum staffing requirements:

(1) At any time the census of a facility is six or fewer residents, all staff shall be classified as residential rehabilitation counselor II or have a classification that indicates an equivalent or higher level of skill, experience, and training.

(2)(a) For the secure transition facility located on McNeil Island, the direct care staffing level shall be at least three qualified, trained staff as described in subsection (3) of this section, unless there are no residents housed at the facility, in which case the facility need not staff to this ratio.

(b) For the secure community transition facility located in Seattle, the direct care staffing level shall be at least two qualified, trained staff as described in subsection (3) of this section, unless there are no residents housed at the facility, in which case the facility need not staff to this ratio.

(3) Before being assigned to a facility, all staff must have received training in sex offender issues, self-defense, and crisis de-escalation skills in addition to departmental orientation and, as appropriate, management training. All staff with resident treatment or care duties must participate in ongoing in-service training.

(4) All staff must pass a departmental background check and the check is not subject to the limitations in chapter 9.96A RCW. A person who has been convicted of a felony, or any sex offense, may not be employed at the secure community transition facility or be approved as an escort for a resident of the facility. [2011 c 19 § 1; 2003 c 216 § 1; 2001 2nd sp.s. c 12 § 216.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

Additional notes found at www.leg.wa.gov

71.09.305 Transition facility residents—Monitoring, escorting. (1) Unless otherwise ordered by the court:

(a) Residents of a secure community transition facility shall wear electronic monitoring devices at all times. To the extent that electronic monitoring devices that employ global positioning system technology are available and funds for this purpose are appropriated by the legislature, the department shall use these devices.

(b) At least one staff member, or other court-authorized and department-approved person must escort each resident when the resident leaves the secure community transition facility for appointments, employment, or other approved activities. Escorting persons must supervise the resident closely and maintain close proximity to the resident. The escort must immediately notify the department of any serious violation, as defined in RCW 71.09.325, by the resident and must immediately notify law enforcement of any violation of law by the resident. The escort may not be a relative of the resident or a person with whom the resident has, or has had, a dating relationship as defined in RCW 7.105.010.

(2) Staff members of the special commitment center and any other total confinement facility and any secure community transition facility must be trained in self-defense and appropriate crisis responses including incident de-escalation. Prior to escorting a person outside of a facility, staff members must also have training in the offense pattern of the offender they are escorting.

(3) Any escort must carry a cellular telephone or a similar device at all times when escorting a resident of a secure community transition facility.

(4) The department shall require training in offender pattern, self-defense, and incident response for all court-authorized escorts who are not employed by the department or the department of corrections. [2021 c 215 § 156; 2002 c 68 § 6; 2001 2nd sp.s. c 12 § 217.]

Effective date—2022 c 268; 2021 c 215: See note following RCW 7.105.900.

Purpose—Severability—Effective date—2002 c 68: See notes following RCW 36.70A.200.

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.310 Transition facility residents—Mandatory escorts. Notwithstanding the provisions of RCW 71.09.305, residents of the secure community transition facility established pursuant to RCW 71.09.250(1) must be escorted at any time the resident leaves the facility. [2001 2nd sp.s. c 12 § 218.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.315 Transition facilities—Public notice, review, and comment. (1) Whenever the department operates, or the secretary enters into a contract to operate, a secure community transition facility except the secure community transition facility established pursuant to RCW 71.09.250(1), the secure community transition facility may be operated only after the public notification and opportunities for review and comment as required by this section.

(2) The secretary shall establish a process for early and continuous public participation in establishing or relocating secure community transition facilities. The process shall include, at a minimum, public meetings in the local communities affected, as well as opportunities for written and oral comments, in the following manner:

(a) If there are more than three sites initially selected as potential locations and the selection process by the secretary or a service provider reduces the number of possible sites for a secure community transition facility to no fewer than three, the secretary or the chief operating officer of the service provider shall notify the public of the possible siting and hold at

least two public hearings in each community where a secure community transition facility may be sited.

(b) When the secretary or service provider has determined the secure community transition facility's location, the secretary or the chief operating officer of the service provider shall hold at least one additional public hearing in the community where the secure community transition facility will be sited.

(c) When the secretary has entered negotiations with a service provider and only one site is under consideration, then at least two public hearings shall be held.

(d) To provide adequate notice of, and opportunity for interested persons to comment on, a proposed location, the secretary or the chief operating officer of the service provider shall provide at least fourteen days' advance notice of the meeting to all newspapers of general circulation in the community, all radio and television stations generally available to persons in the community, any school district in which the secure community transition facility would be sited or whose boundary is within two miles of a proposed secure community transition facility, any library district in which the secure community transition facility would be sited, local business or fraternal organizations that request notification from the secretary or agency, and any person or property owner within a one-half mile radius of the proposed secure community transition facility. Before initiating this process, the department of social and health services shall contact local government planning agencies in the communities containing the proposed secure community transition facility. The department of social and health services shall coordinate with local government agencies to ensure that opportunities are provided for effective citizen input and to reduce the duplication of notice and meetings.

(3) If local government land use regulations require that a special use or conditional use permit be submitted and approved before a secure community transition facility can be sited, and the process for obtaining such a permit includes public notice and hearing requirements similar to those required under this section, the requirements of this section shall not apply to the extent they would duplicate requirements under the local land use regulations.

(4) This section applies only to secure community transition facilities sited after June 26, 2001. [2001 2nd sp.s. c 12 § 219.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.320 Transition facilities—Operational advisory boards. (1) The secretary shall develop a process with local governments that allows each community in which a secure community transition facility is located to establish operational advisory boards of at least seven persons for the secure community transition facilities. The department may conduct community awareness activities to publicize this opportunity. The operational advisory boards developed under this section shall be implemented following the decision to locate a secure community transition facility in a particular community.

(2) The operational advisory boards may review and make recommendations regarding the security and operations of the secure community transition facility and conditions or modifications necessary with relation to any person who the secretary proposes to place in the secure community transition facility.

(3) The facility management must consider the recommendations of the community advisory boards. Where the facility management does not implement an operational advisory board recommendation, the management must provide a written response to the operational advisory board stating its reasons for its decision not to implement the recommendation.

(4) The operational advisory boards, their members, and any agency represented by a member shall not be liable in any cause of action as a result of its recommendations unless the advisory board acts with gross negligence or bad faith in making a recommendation. [2001 2nd sp.s. c 12 § 220.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.325 Transition facilities—Conditional release—Reports—Violations. (1) The secretary shall adopt a violation reporting policy for persons conditionally released to less restrictive alternative placements. The policy shall require written documentation by the department and service providers of all violations of conditions set by the department, the department of corrections, or the court and establish criteria for returning a violator to the special commitment center or a secure community transition facility with a higher degree of security. Any conditionally released person who commits a serious violation of conditions shall be returned to the special commitment center, unless arrested by a law enforcement officer, and the court shall be notified immediately and shall initiate proceedings under RCW 71.09.098 to revoke or modify the less restrictive alternative placement. Nothing in this section limits the authority of the department to return a person to the special commitment center based on a violation that is not a serious violation as defined in this section. For the purposes of this section, "serious violation" includes but is not limited to:

(a) The commission of any criminal offense;

(b) Any unlawful use or possession of a controlled substance; and

(c) Any violation of conditions targeted to address the person's documented pattern of offense that increases the risk to public safety.

(2) When a person is conditionally released to a less restrictive alternative under this chapter and is under the supervision of the department of corrections, notice of any violation of the person's conditions of release must also be made to the department of corrections.

(3) Whenever the secretary contracts with a service provider to operate a secure community transition facility, the contract shall include a requirement that the service provider must report to the department of social and health services any known violation of conditions committed by any resident of the secure community transition facility.

(4) The secretary shall document in writing all violations, penalties, actions by the department of social and health services to remove persons from a secure community transition facility, and contract terminations. The secretary shall compile this information and submit it to the appropriate committees of the legislature on an annual basis. The sec-

retary shall give great weight to a service provider's record of violations, penalties, actions by the department of social and health services or the department of corrections to remove persons from a secure community transition facility, and contract terminations in determining whether to execute, renew, or renegotiate a contract with a service provider. [2001 2nd sp.s. c 12 § 221.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.330 Transition facilities—Contracted operation—Enforcement remedies. Whenever the secretary contracts with a provider to operate a secure community transition facility, the secretary shall include in the contract provisions establishing intermediate contract enforcement remedies. [2001 2nd sp.s. c 12 § 222.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.335 Conditional release from total confinement—Community notification. A conditional release from a total confinement facility to a less restrictive alternative is a release that subjects the conditionally released person to the registration requirements specified in RCW 9A.44.130 and to community notification under RCW 4.24.550.

When a person is conditionally released to the secure community transition facility established pursuant to RCW 71.09.250(1), the sheriff must provide each household on McNeil Island with the community notification information provided for under RCW 4.24.550. [2001 2nd sp.s. c 12 § 223.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.340 Conditionally released persons—Employment, educational notification. An employer who hires a person who has been conditionally released to a less restrictive alternative must notify all other employees of the conditionally released person's status. Notification for conditionally released persons who enroll in an institution of higher education shall be made pursuant to the provisions of RCW 9A.44.130 related to sex offenders enrolled in institutions of higher education and RCW 4.24.550. This section applies only to conditionally released persons whose court-approved treatment plan includes permission or a requirement for the person to obtain education or employment and to employment positions or educational programs that meet the requirements of the court-approved treatment plan. [2001 2nd sp.s. c 12 § 224.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.341 Transition facilities—Authority of department—Effect of local regulations. The minimum requirements set out in RCW 71.09.285 through 71.09.340 are minimum requirements to be applied by the department. Nothing in this section is intended to prevent a city or county from adopting development regulations, as defined in RCW 36.70A.030, unless the proposed regulation imposes requirements more restrictive than those specifically addressed in RCW 71.09.285 through 71.09.340. Regulations that impose requirements more restrictive than those specifically addressed in these sections are void. Nothing in these sections prevents the department from adding requirements to enhance public safety. [2002 c 68 § 7.]

Purpose—Severability—Effective date—2002 c 68: See notes following RCW 36.70A.200.

71.09.342 Transition facilities—Siting—Local regulations preempted, when—Consideration of public safety measures. (1) After October 1, 2002, notwithstanding RCW 36.70A.103 or any other law, this section preempts and supersedes local plans, development regulations, permitting requirements, inspection requirements, and all other laws as necessary to enable the department to site, construct, renovate, occupy, and operate secure community transition facilities within the borders of the following:

(a) Any county that had five or more persons civilly committed from that county, or detained at the special commitment center under a pending civil commitment petition from that county where a finding of probable cause has been made, on April 1, 2001, if the department determines that the county has not met the requirements of RCW 36.70A.200 with respect to secure community transition facilities. This subsection does not apply to the county in which the secure community transition facility authorized under RCW 71.09.250(1) is located; and

(b) Any city located within a county listed in (a) of this subsection that the department determines has not met the requirements of RCW 36.70A.200 with respect to secure community transition facilities.

(2) The department's determination under subsection (1)(a) or (b) of this section is final and is not subject to appeal under chapter 34.05 or 36.70A RCW.

(3) When siting a facility in a county or city that has been preempted under this section, the department shall consider the policy guidelines established under RCW 71.09.285 and 71.09.290 and shall hold the hearings required in RCW 71.09.315.

(4) Nothing in this section prohibits the department from:

(a) Siting a secure community transition facility in a city or county that has complied with the requirements of RCW 36.70A.200 with respect to secure community transition facilities, including a city that is located within a county that has been preempted. If the department sites a secure community transition facility in such a city or county, the department shall use the process established by the city or county for siting such facilities; or

(b) Consulting with a city or county that has been preempted under this section regarding the siting of a secure community transition facility.

(5)(a) A preempted city or county may propose public safety measures specific to any finalist site to the department. The measures must be consistent with the location of the facility at that finalist site. The proposal must be made in writing by the date of:

(i) The second hearing under RCW 71.09.315(2)(a) when there are three finalist sites; or

(ii) The first hearing under RCW 71.09.315(2)(b) when there is only one site under consideration.

(b) The department shall respond to the city or county in writing within fifteen business days of receiving the proposed measures. The response shall address all proposed measures.

(c) If the city or county finds that the department's response is inadequate, the city or county may notify the department in writing within fifteen business days of the specific items which it finds inadequate. If the city or county does not notify the department of a finding that the response is inadequate within fifteen business days, the department's response shall be final.

(d) If the city or county notifies the department that it finds the response inadequate and the department does not revise its response to the satisfaction of the city or county within seven business days, the city or county may petition the governor to designate a person with law enforcement expertise to review the response under RCW 34.05.479.

(e) The governor's designee shall hear a petition filed under this subsection and shall make a determination within thirty days of hearing the petition. The governor's designee shall consider the department's response, and the effectiveness and cost of the proposed measures, in relation to the purposes of this chapter. The determination by the governor's designee shall be final and may not be the basis for any cause of action in civil court.

(f) The city or county shall bear the cost of the petition to the governor's designee. If the city or county prevails on all issues, the department shall reimburse the city or county costs incurred, as provided under chapter 34.05 RCW.

(g) Neither the department's consideration and response to public safety conditions proposed by a city or county nor the decision of the governor's designee shall affect the preemption under this section or the department's authority to site, construct, renovate, occupy, and operate the secure community transition facility at that finalist site or at any finalist site.

(6) Until June 30, 2009, the secretary shall site, construct, occupy, and operate a secure community transition facility sited under this section in an environmentally responsible manner that is consistent with the substantive objectives of chapter 43.21C RCW, and shall consult with the department of ecology as appropriate in carrying out the planning, construction, and operations of the facility. The secretary shall make a threshold determination of whether a secure community transition facility sited under this section would have a probable significant, adverse environmental impact. If the secretary determines that the secure community transition facility has such an impact, the secretary shall prepare an environmental impact statement that meets the requirements of RCW 43.21C.030 and 43.21C.031 and the rules promulgated by the department of ecology relating to such statements. Nothing in this subsection shall be the basis for any civil cause of action or administrative appeal.

(7) In no case may a secure community transition facility be sited adjacent to, immediately across a street or parking lot from, or within the line of sight of a risk potential activity or facility in existence at the time a site is listed for consideration unless the site that the department has chosen in a particular county or city was identified pursuant to a process for siting secure community transition facilities adopted by that county or city in compliance with RCW 36.70A.200. "Within the line of sight" means that it is possible to reasonably visually distinguish and recognize individuals.

(8) This section does not apply to the secure community transition facility established pursuant to RCW 71.09.250(1). [2003 c 50 § 2; 2002 c 68 § 9.]

Purpose—Severability—Effective date—2002 c 68: See notes following RCW 36.70A.200.

Additional notes found at www.leg.wa.gov

71.09.343 Transition facilities—Contract between state and local governments. (1) At the request of the local government of the city or county in which a secure community transition facility is initially sited after January 1, 2002, the department shall enter into a long-term contract memorializing the agreements between the state and the city or county for the operation of the facility. This contract shall be separate from any contract regarding mitigation due to the facility. The contract shall include a clause that states:

(a) The contract does not obligate the state to continue operating any aspect of the civil commitment program under this chapter;

(b) The operation of any secure community transition facility is contingent upon sufficient appropriation by the legislature. If sufficient funds are not appropriated, the department is not obligated to operate the secure community transition facility and may close it; and

(c) This contract does not obligate the city or county to operate a secure community transition facility.

(2) Any city or county may, at their option, contract with the department to operate a secure community transition facility. [2002 c 68 § 16.]

Purpose—Severability—Effective date—2002 c 68: See notes following RCW 36.70A.200.

71.09.344 Transition facilities—Mitigation agreements. (1) Subject to funds appropriated by the legislature, the department may enter into negotiation for a mitigation agreement with:

(a) The county and/or city in which a secure community transition facility sited after January 1, 2002, is located;

(b) Each community in which the persons from those facilities will reside or regularly spend time, pursuant to court orders, for regular work or education, or to receive social services, or through which the person or persons will regularly be transported to reach other communities; and

(c) Educational institutions in the communities identified in (a) and (b) of this subsection.

(2) Mitigation agreements are limited to the following:

(a) One-time training for local law enforcement and administrative staff, upon the establishment of a secure community transition facility.

(i) Training between local government staff and the department includes training in coordination, emergency procedures, program and facility information, legal requirements, and resident profiles.

(ii) Reimbursement for training under this subsection is limited to:

(A) The salaries or hourly wages and benefits of those persons who receive training directly from the department; and

(B) Costs associated with preparation for, and delivery of, training to the department or its contracted staff by local government staff or contractors;

(b) Information coordination:

(i) Information coordination includes database infrastructure establishment and programming for the dissemination of information among law enforcement and the department related to facility residents.

(ii) Reimbursement for information coordination is limited to start-up costs;

(c) One-time capital costs:

(i) One-time capital costs are off-site costs associated with the need for increased security in specific locations.

(ii) Reimbursement for one-time capital costs is limited to actual costs; and

(d) Incident response:

(i) Incident response costs are law enforcement and criminal justice costs associated with violations of conditions of release or crimes by residents of the secure community transition facility.

(ii) Reimbursement for incident response does not include private causes of action. [2002 c 68 § 17.]

Purpose—Severability—Effective date—2002 c 68: See notes following RCW 36.70A.200.

71.09.345 Alternative placement—Authority of court. Nothing in chapter 12, Laws of 2001 2nd sp. sess. shall operate to restrict a court's authority to make less restrictive alternative placements to a committed person's individual residence or to a setting less restrictive than a secure community transition facility. A court-ordered less restrictive alternative placement to a committed person's individual residence is not a less restrictive alternative placement to a secure community transition facility. [2001 2nd sp.s. c 12 § 226.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

71.09.350 Examination and treatment only by certified providers—Exceptions. (1) Examinations and treatment of sexually violent predators who are conditionally released to a less restrictive alternative under this chapter shall be conducted only by certified sex offender treatment providers or certified affiliate sex offender treatment providers under chapter 18.155 RCW unless the court or the department of social and health services finds that: (a) The treatment provider is employed by the department; or (b)(i) all certified sex offender treatment providers or certified affiliate sex offender treatment providers become unavailable to provide treatment within a reasonable geographic distance of the person's home, as determined in rules adopted by the department of social and health services; and (ii) the evaluation and treatment plan comply with the rules adopted by the department of social and health services.

A treatment provider approved by the department of social and health services under (b) of this subsection, who is not certified by the department of health, shall consult with a certified sex offender treatment provider during the person's period of treatment to ensure compliance with the rules adopted by the department of health. The frequency and content of the consultation shall be based on the recommendation of the certified sex offender treatment provider.

(2) A treatment provider, whether or not he or she is employed or approved by the department of social and health services under subsection (1) of this section or otherwise certified, may not perform or provide treatment of sexually violent predators under this section if the treatment provider has been:

(a) Convicted of a sex offense, as defined in RCW 9.94A.030;

(b) Convicted in any other jurisdiction of an offense that under the laws of this state would be classified as a sex offense as defined in RCW 9.94A.030; or

(c) Suspended or otherwise restricted from practicing any health care profession by competent authority in any state, federal, or foreign jurisdiction.

(3) Nothing in this section prohibits a qualified expert from examining or evaluating a sexually violent predator who has been conditionally released for purposes of presenting an opinion in court proceedings. [2009 c 409 § 14; 2004 c 38 § 14; 2001 2nd sp.s. c 12 § 404.]

Intent—Severability—Effective dates—2001 2nd sp.s. c 12: See notes following RCW 71.09.250.

Additional notes found at www.leg.wa.gov

71.09.360 Treatment of persons on conditional release by certified providers in underserved counties—Notification. To facilitate the equitable geographic distribution of conditional releases under this chapter, the department shall notify the secretary of health, or the secretary's designee, whenever a sex offender treatment provider in an underserved county has been contracted to provide treatment services to persons on conditional release under this chapter, in which case the secretary of health shall waive any fees for the initial issue, renewal, and reissuance of a credential for the provider under chapter 18.155 RCW. An underserved county is any county identified by the department as having an inadequate supply of qualified sex offender treatment providers to achieve equitable geographic distribution of conditional releases under this chapter. [2020 c 266 § 6.]

71.09.370 Residents in total confinement—State identification cards. (1) The department shall enter into a memorandum of understanding with the department of licensing to allow residents in total confinement at the special commitment center to obtain a state identification card through a written identification verification letter completed by the special commitment center and delivered to the department of licensing.

(2) The process shall occur upon the person's initial detention at the special commitment center. The process shall reoccur when the person's state identification card expires. [2021 c 236 § 12.]

Findings—2021 c 236: See note following RCW 71.09.020.

71.09.800 Rules. The secretary shall adopt rules under the administrative procedure act, chapter 34.05 RCW, for the oversight and operation of the program established pursuant to this chapter. Such rules shall include provisions for an annual inspection of the special commitment center; requirements for treatment plans and the retention of records; and

guidelines for attorneys to follow when bringing legal materials into secure facilities. Guidelines for attorneys shall not interfere with attorney-client privilege. [2013 c 43 § 2; 2000 c 44 § 1.]

Additional notes found at www.leg.wa.gov

71.09.810 Sex offender policy board—Quarterly meetings. ***(Expires June 30, 2023.)*** (1) In accordance with RCW 9.94A.8673, the sex offender policy board shall meet quarterly during the 2021-2023 biennium to continue its review of sexually violent predators and less restrictive alternative policies and best practices, collaborate with stakeholders and the department, provide outreach to providers and stakeholders, and monitor implementation of chapter 236, Laws of 2021. The board shall also explore and make recommendations whether to continue or remove the prohibition on a less restrictive alternative from including a placement in the community protection program pursuant to RCW 71A.12.230. The board shall provide semiannual updates to the appropriate committees of the legislature during the 2021-2023 biennium.

(2) This section expires June 30, 2023. [2021 c 236 § 14.]

Findings—2021 c 236: See note following RCW 71.09.020.

71.09.903 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521. For the purposes of this chapter, the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family shall be interpreted as applying equally to state registered domestic partnerships or individuals in state registered domestic partnerships as well as to marital relationships and married persons, and references to dissolution of marriage shall apply equally to state registered domestic partnerships that have been terminated, dissolved, or invalidated, to the extent that such interpretation does not conflict with federal law. Where necessary to implement chapter 521, Laws of 2009, gender-specific terms such as husband and wife used in any statute, rule, or other law shall be construed to be gender neutral, and applicable to individuals in state registered domestic partnerships. [2009 c 521 § 159.]

Chapter 71.12 RCW
PRIVATE ESTABLISHMENTS

Sections

Cost of services, disclosure: RCW 70.41.250.

Individuals with mental illness, commitment procedures, rights, etc.: Chapter 71.05 RCW.

Minors—Mental health services, commitment: Chapter 71.34 RCW.

State hospitals for individuals with mental illness: Chapter 72.23 RCW.

71.12.455 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Department" means the department of health.

(2) "Elopement" means any situation in which an admitted patient of a psychiatric hospital who is cognitively, physically, mentally, emotionally, and/or chemically impaired wanders, walks, runs away, escapes, or otherwise leaves a psychiatric hospital or the grounds of a psychiatric hospital prior to the patient's scheduled discharge unsupervised, unnoticed, and without the staff's knowledge.

(3) "Establishment" and "institution" mean:

(a) Every private or county or municipal hospital, including public hospital districts, sanitariums, homes, psychiatric hospitals, residential treatment facilities, or other places receiving or caring for any person with mental illness, mentally incompetent person, or chemically dependent person; and

(b) Beginning January 1, 2019, facilities providing pediatric transitional care services.

(4) "Immediate jeopardy" means a situation in which the psychiatric hospital's noncompliance with one or more statutory or regulatory requirements has placed the health and safety of patients in its care at risk for serious injury, serious harm, serious impairment, or death.

(5) "Pediatric transitional care services" means short-term, temporary, health and comfort services for drug exposed infants according to the requirements of this chapter and provided in an establishment licensed by the department of health.

(6) "Psychiatric hospital" means an establishment caring for any person with mental illness or substance use disorder excluding acute care hospitals licensed under chapter 70.41 RCW, state psychiatric hospitals established under chapter 72.23 RCW, and residential treatment facilities as defined in this section.

(7) "Residential treatment facility" means an establishment in which twenty-four hour on-site care is provided for the evaluation, stabilization, or treatment of residents for substance use, mental health, co-occurring disorders, or for drug exposed infants.

(8) "Secretary" means the secretary of the department of health.

(9) "Technical assistance" means the provision of information on the state laws and rules applicable to the regulation of psychiatric hospitals, the process to apply for a license, and methods and resources to avoid or address compliance problems. Technical assistance does not include assistance provided under chapter 43.05 RCW.

(10) "Trained caregiver" means a noncredentialed, unlicensed person trained by the establishment providing pediatric transitional care services to provide hands-on care to drug exposed infants. Caregivers may not provide medical care to infants and may only work under the supervision of an appropriate health care professional. [2020 c 115 § 6. Prior: 2017 c 263 § 2; 2001 c 254 § 1; 2000 c 93 § 21; 1977 ex.s. c 80 § 43; 1959 c 25 § 71.12.455; prior: 1949 c 198 § 53; Rem. Supp. 1949 § 6953-52a. Formerly RCW 71.12.010, part.]

Reviser's note: The definitions in this section have been alphabetized pursuant to RCW 1.08.015(2)(k).

Findings—Intent—Effective date—2020 c 115: See notes following RCW 71.12.700.

Findings—Intent—2017 c 263: "The legislature finds that more than twelve thousand infants born in Washington each year have been prenatally exposed to opiates, methamphetamines, and other drugs. Prenatal drug exposure frequently results in infants suffering from neonatal abstinence syndrome and its accompanying withdrawal symptoms after birth. Withdrawal symptoms may include sleep problems, excessive crying, tremors, seizures, poor feeding, fever, generalized convulsions, vomiting, diarrhea, and hyperactive reflexes. Consequently, the legislature finds that drug exposed infants have unique medical needs and benefit from specialized health care that addresses their withdrawal symptoms. Specialized care for infants experiencing neonatal abstinence syndrome is based on the individual needs of the infant and includes: Administration of intravenous fluids and drugs such as morphine; personalized, hands-on therapeutic care such as gentle rocking, reduction in noise and lights, and swaddling; and frequent high-calorie feedings.

The legislature further finds that drug exposed infants often require hospitalization which burdens hospitals and hospital staff who either have to increase staffing levels or require current staff to take on additional duties to administer the specialized care needed by drug exposed infants.

The legislature further finds that drug exposed infants benefit from early and consistent family involvement in their care, and families thrive when they are provided the opportunity, skills, and training to help them participate in their child's care.

The legislature further finds that infants with neonatal abstinence syndrome often can be treated in a nonhospital clinic setting where they receive appropriate medical and nonmedical care for their symptoms. The legislature, therefore, intends to encourage alternatives to continued hospitalization for drug exposed infants, including the continuation and development of pediatric transitional care services that provide short-term medical care as well as training and assistance to caregivers in order to support the transition from hospital to home for drug exposed infants." [2017 c 263 § 1.]

Purpose—Intent—Severability—1977 ex.s. c 80: See notes following RCW 4.16.190.

71.12.460 License to be obtained—Penalty. No person, association, county, municipality, public hospital district, or corporation, shall establish or keep, for compensation or hire, an establishment as defined in this chapter without first having obtained a license therefor from the department of health, complied with rules adopted under this chapter, and paid the license fee provided in this chapter. Any person who carries on, conducts, or attempts to carry on or conduct an establishment as defined in this chapter without first having obtained a license from the department of health, as in this chapter provided, is guilty of a misdemeanor and on conviction thereof shall be punished by imprisonment in a county jail not exceeding six months, or by a fine not exceeding one thousand dollars, or by both such fine and imprisonment. The managing and executive officers of any corporation violating the provisions of this chapter shall be liable under the provisions of this chapter in the same manner and to the same effect as a private individual violating the same. [2001 c 254 § 2; 2000 c 93 § 22; 1989 1st ex.s. c 9 § 226; 1979 c 141 § 133; 1959 c 25 § 71.12.460. Prior: 1949 c 198 § 54; Rem. Supp. 1949 § 6953-53.]

Additional notes found at www.leg.wa.gov

71.12.470 License application—Fees. Every application for a license shall be accompanied by a plan of the premises proposed to be occupied, describing the capacities of the buildings for the uses intended, the extent and location of grounds appurtenant thereto, and the number of patients proposed to be received therein, with such other information, and in such form, as the department of health requires. The application shall be accompanied by the proper license fee. The amount of the license fee shall be established by the department of health under RCW 43.70.110. [2000 c 93 § 23; 1987 c 75 § 19; 1982 c 201 § 14; 1959 c 25 § 71.12.470. Prior: 1949 c 198 § 56; Rem. Supp. 1949 § 6953-55.]

Additional notes found at www.leg.wa.gov

71.12.480 Examination before granting license—Inspection and technical assistance to psychiatric hospitals after granting license. (1) The department of health shall not grant any such license until it has made an examination of all phases of the operation of the establishment necessary to determine compliance with rules adopted under this chapter including the premises proposed to be licensed and is satisfied that the premises are substantially as described, and are otherwise fit and suitable for the purposes for which they are designed to be used, and that such license should be granted.

(2) During the first two years of licensure for a new psychiatric hospital or any existing psychiatric hospital that changes ownership after July 1, 2020, the department shall provide technical assistance, perform at least three unannounced inspections, and conduct additional inspections of the hospital as necessary to verify the hospital is complying with the requirements of this chapter. [2020 c 115 § 7; 2000 c 93 § 24; 1989 1st ex.s. c 9 § 227; 1979 c 141 § 134; 1959 c 25 § 71.12.480. Prior: 1949 c 198 § 57; Rem. Supp. 1949 § 6953-56.]

Findings—Intent—Effective date—2020 c 115: See notes following RCW 71.12.700.

Additional notes found at www.leg.wa.gov

71.12.485 Fire protection—Duties of chief of the Washington state patrol. Standards for fire protection and the enforcement thereof, with respect to all establishments to be licensed hereunder, shall be the responsibility of the chief of the Washington state patrol, through the director of fire protection, who shall adopt such recognized standards as may be applicable to such establishments for the protection of life against the cause and spread of fire and fire hazards. The department of health, upon receipt of an application for a license, or renewal of a license, shall submit to the chief of the Washington state patrol, through the director of fire pro-

tection, in writing, a request for an inspection, giving the applicant's name and the location of the premises to be licensed. Upon receipt of such a request, the chief of the Washington state patrol, through the director of fire protection, or his or her deputy shall make an inspection of the establishment to be licensed, and if it is found that the premises do not comply with the required safety standards and fire regulations as promulgated by the chief of the Washington state patrol, through the director of fire protection, he or she shall promptly make a written report to the establishment and the department of health as to the manner and time allowed in which the premises must qualify for a license and set forth the conditions to be remedied with respect to fire regulations. The department of health, applicant or licensee shall notify the chief of the Washington state patrol, through the director of fire protection, upon completion of any requirements made by him or her, and the director of fire protection or his or her deputy shall make a reinspection of such premises. Whenever the establishment to be licensed meets with the approval of the chief of the Washington state patrol, through the director of fire protection, he or she shall submit to the department of health a written report approving same with respect to fire protection before a full license can be issued. The chief of the Washington state patrol, through the director of fire protection, shall make or cause to be made inspections of such establishments at least annually. The department of health shall not license or continue the license of any establishment unless and until it shall be approved by the chief of the Washington state patrol, through the director of fire protection, as herein provided.

In cities which have in force a comprehensive building code, the provisions of which are determined by the chief of the Washington state patrol, through the director of fire protection, to be equal to the minimum standards of the chief of the Washington state patrol, through the director of fire protection, for such establishments, the chief of the fire department, provided the latter is a paid chief of a paid fire department, shall make the inspection with the chief of the Washington state patrol, through the director of fire protection, or his or her deputy, and they shall jointly approve the premises before a full license can be issued. [1995 c 369 § 61; 1989 1st ex.s. c 9 § 228; 1986 c 266 § 122; 1979 c 141 § 135; 1959 c 224 § 1.]

Additional notes found at www.leg.wa.gov

71.12.490 Expiration and renewal of license. All licenses issued under the provisions of this chapter shall expire on a date to be set by the department of health. No license issued pursuant to this chapter shall exceed thirty-six months in duration. Application for renewal of the license, accompanied by the necessary fee as established by the department of health under RCW 43.70.110, shall be filed with that department, not less than thirty days prior to its expiration and if application is not so filed, the license shall be automatically canceled. [1989 1st ex.s. c 9 § 229; 1987 c 75 § 20; 1982 c 201 § 15; 1971 ex.s. c 247 § 4; 1959 c 25 § 71.12.490. Prior: 1949 c 198 § 59; Rem. Supp. 1949 § 6953-58.]

Additional notes found at www.leg.wa.gov

71.12.500 Examination of premises as to compliance with the chapter, rules, and license—License changes. The department of health may at any time examine and ascertain how far a licensed establishment is conducted in compliance with this chapter, the rules adopted under this chapter, and the requirements of the license therefor. If the interests of the patients of the establishment so demand, the department may, for just and reasonable cause, suspend, modify, or revoke any such license. RCW 43.70.115 governs notice of a license denial, revocation, suspension, or modification and provides the right to an adjudicative proceeding. [2000 c 93 § 25. Prior: 1989 1st ex.s. c 9 § 230; 1989 c 175 § 137; 1979 c 141 § 136; 1959 c 25 § 71.12.500; prior: 1949 c 198 § 58; Rem. Supp. 1949 § 6953-57.]

Additional notes found at www.leg.wa.gov

71.12.510 Examination and visitation in general. The department of health may at any time cause any establishment as defined in this chapter to be visited and examined. [2000 c 93 § 26; 1959 c 25 § 71.12.510. Prior: 1949 c 198 § 60; Rem. Supp. 1949 § 6953-59.]

71.12.520 Scope of examination. Each such visit may include an inspection of every part of each establishment. The representatives of the department of health may make an examination of all records, methods of administration, the general and special dietary, the stores and methods of supply, and may cause an examination and diagnosis to be made of any person confined therein. The representatives of the department of health may examine to determine their fitness for their duties the officers, attendants, and other employees, and may talk with any of the patients apart from the officers and attendants. [2000 c 93 § 27; 1989 1st ex.s. c 9 § 231; 1979 c 141 § 137; 1959 c 25 § 71.12.520. Prior: 1949 c 198 § 61; Rem. Supp. 1949 § 6953-60.]

Additional notes found at www.leg.wa.gov

71.12.530 Conference with management—Improvement. The representatives of the department of health may, from time to time, at times and places designated by the department, meet the managers or responsible authorities of such establishments in conference, and consider in detail all questions of management and improvement of the establishments, and may send to them, from time to time, written recommendations in regard thereto. [1989 1st ex.s. c 9 § 232; 1979 c 141 § 138; 1959 c 25 § 71.12.530. Prior: 1949 c 198 § 62; Rem. Supp. 1949 § 6953-61.]

Additional notes found at www.leg.wa.gov

71.12.540 Recommendations to be kept on file—Records of inmates. The authorities of each establishment as defined in this chapter shall place on file in the office of the establishment the recommendations made by the department of health as a result of such visits, for the purpose of consultation by such authorities, and for reference by the department representatives upon their visits. Every such establishment shall keep records of every person admitted thereto as follows and shall furnish to the department, when required, the following data: Name, age, sex, marital status, date of admission, voluntary or other commitment, name of physician, physician assistant, or psychiatric advanced registered

nurse practitioner, diagnosis, and date of discharge. [2016 c 155 § 11; 2009 c 217 § 11; 1989 1st ex.s. c 9 § 233; 1979 c 141 § 139; 1959 c 25 § 71.12.540. Prior: 1949 c 198 § 63; Rem. Supp. 1949 § 6953-62.]

Additional notes found at www.leg.wa.gov

71.12.550 Local authorities may also prescribe standards. This chapter shall not prevent local authorities of any city, or city and county, within the reasonable exercise of the police power, from adopting rules and regulations, by ordinance or resolution, prescribing standards of sanitation, health and hygiene for establishments as defined in this chapter, which are not in conflict with the provisions of this chapter, and requiring a certificate by the local health officer, that the local health, sanitation and hygiene laws have been complied with before maintaining or conducting any such institution within such city or city and county. [1959 c 25 § 71.12.550. Prior: 1949 c 198 § 64; Rem. Supp. 1949 § 6953-63.]

71.12.560 Voluntary patients—Receipt authorized—Application—Report. The person in charge of any private institution, hospital, or sanitarium which is conducted for, or includes a department or ward conducted for, the care and treatment of persons who are mentally ill or deranged may receive therein as a voluntary patient any person suffering from mental illness or derangement who is a suitable person for care and treatment in the institution, hospital, or sanitarium, who voluntarily makes a written application to the person in charge for admission into the institution, hospital or sanitarium. At the expiration of fourteen continuous days of treatment of a patient voluntarily committed in a private institution, hospital, or sanitarium, if the period of voluntary commitment is to continue, the person in charge shall forward to the office of the department of social and health services a record of the voluntary patient showing the name, residence, date of birth, sex, place of birth, occupation, social security number, marital status, date of admission to the institution, hospital, or sanitarium, and such other information as may be required by rule of the department of social and health services. [1994 sp.s. c 7 § 441; 1974 ex.s. c 145 § 1; 1973 1st ex.s. c 142 § 1; 1959 c 25 § 71.12.560. Prior: 1949 c 198 § 65; Rem. Supp. 1949 § 6953-64.]

Finding—Intent—Severability—1994 sp.s. c 7: See notes following RCW 43.70.540.

Additional notes found at www.leg.wa.gov

71.12.570 Communications by patients—Rights. No person in an establishment as defined in this chapter shall be restrained from sending written communications of the fact of his or her detention in such establishment to a friend, relative, or other person. The physician in charge of such person and the person in charge of such establishment shall send each such communication to the person to whom it is addressed. All persons in an establishment shall have no less than all rights secured to involuntarily detained persons by RCW 71.05.217 and to voluntarily admitted or committed persons pursuant to RCW 71.05.050 and 71.05.380. [2020 c 302 § 114; 2012 c 117 § 440; 1973 1st ex.s. c 142 § 2; 1959 c 25 § 71.12.570. Prior: 1949 c 198 § 66; Rem. Supp. 1949 § 6953-65.]

71.12.590 Revocation of license for noncompliance—Exemption as to Christian Science establishments. Failure to comply with any of the provisions of RCW 71.12.550 through 71.12.570 or the requirements of RCW 71.34.375 shall constitute grounds for revocation of license: PROVIDED, HOWEVER, That nothing in this chapter or the rules and regulations adopted pursuant thereto shall be construed as authorizing the supervision, regulation, or control of the remedial care or treatment of residents or patients in any establishment, as defined in this chapter conducted in accordance with the practice and principles of the body known as Church of Christ, Scientist. [2011 c 302 § 4; 1983 c 3 § 180; 1959 c 25 § 71.12.590. Prior: 1949 c 198 § 68; Rem. Supp. 1949 § 6953-67.]

71.12.595 Suspension of license—Noncompliance with support order—Reissuance. The department of health shall immediately suspend the license or certificate of a person who has been certified pursuant to RCW 74.20A.320 by the department of social and health services as a person who is not in compliance with a support order or a *residential or visitation order. If the person has continued to meet all other requirements for reinstatement during the suspension, reissuance of the license or certificate shall be automatic upon the department of health's receipt of a release issued by the department of social and health services stating that the licensee is in compliance with the order. [1997 c 58 § 860.]

***Reviser's note:** 1997 c 58 § 886 requiring a court to order certification of noncompliance with residential provisions of a court-ordered parenting plan was vetoed. Provisions ordering the department of social and health services to certify a responsible parent based on a court order to certify for noncompliance with residential provisions of a parenting plan were vetoed. See RCW 74.20A.320.

Effective dates—Intent—1997 c 58: See notes following RCW 74.20A.320.

Additional notes found at www.leg.wa.gov

71.12.640 Prosecuting attorney shall prosecute violations. The prosecuting attorney of every county shall, upon application by the department of social and health services, the department of health, or its authorized representatives, institute and conduct the prosecution of any action brought for the violation within his or her county of any of the provisions of this chapter. [2012 c 117 § 441; 1989 1st ex.s. c 9 § 234; 1979 c 141 § 140; 1959 c 25 § 71.12.640. Prior: 1949 c 198 § 55; Rem. Supp. 1949 § 6953-54.]

Additional notes found at www.leg.wa.gov

71.12.670 Licensing, operation, inspection—Adoption of rules. The department of health shall adopt rules for the licensing, operation, and inspections of establishments and institutions and the enforcement thereof. [2000 c 93 § 28.]

71.12.680 Pediatric transitional care services—Requirements. (1) An establishment providing pediatric transitional care services to drug exposed infants must demonstrate that it is capable of providing services for children who:

(a) Are no more than one year of age;

(b) Have been exposed to drugs before birth;

(c) Require twenty-four hour continuous residential care and skilled nursing services as a result of prenatal substance exposure; and

(d) Are referred to the establishment by the department of social and health services, regional hospitals, and private parties.

(2) After January 1, 2019, no person may operate or maintain an establishment that provides pediatric transitional care services without a license under this chapter. [2017 c 263 § 3.]

Findings—Intent—2017 c 263: See note following RCW 71.12.455.

71.12.682 Pediatric transitional care services—Rules not considered new service category. For the purposes of this chapter, the rules for pediatric transitional care services are not considered as a new department of social and health services service category. [2017 c 263 § 4.]

Findings—Intent—2017 c 263: See note following RCW 71.12.455.

71.12.684 Pediatric transitional care services—Rules, requirements. The secretary must, in consultation with the department of social and health services, adopt rules on pediatric transitional care services. The rules must:

(1) Establish requirements for medical examinations and consultations which must be delivered by an appropriate health care professional;

(2) Require twenty-four hour medical supervision for children receiving pediatric transitional services in accordance with the staffing ratios established under subsection (3) of this section;

(3) Include staffing ratios that consider the number of registered nurses or licensed practical nurses employed by the establishment and the number of trained caregivers on duty at the establishment. These staffing ratios may not require more than:

(a) One registered nurse to be on duty at all times;

(b) One registered nurse or licensed practical nurse to eight infants; and

(c) One trained caregiver to four infants;

(4) Require establishments that provide pediatric transitional care services to prepare weekly plans specific to each infant in their care and in accordance with the health care professional's standing orders. The health care professional may modify an infant's weekly plan without reexamining the infant if he or she determines the modification is in the best interest of the child. This modification may be communicated to the registered nurse on duty at the establishment who must then implement the modification. Weekly plans are to include short-term goals for each infant and outcomes must be included in reports required by the department;

(5) Ensure that neonatal abstinence syndrome scoring is conducted by an appropriate health care professional;

(6) Establish drug exposed infant developmental screening tests for establishments that provide pediatric transitional care services to administer according to a schedule established by the secretary;

(7) Require the establishment to collaborate with the department of social and health services to develop an individualized safety plan for each child and to meet other contractual requirements of the department of social and health services to identify strategies to meet supervision needs, medical concerns, and family support needs;

(8) Establish the maximum amount of days an infant may be placed at an establishment;

(9) Develop timelines for initial and ongoing parent-infant visits to nurture and help develop attachment and bonding between the child and parent, if such visits are possible. Timelines must be developed upon placement of the infant in the establishment providing pediatric transitional care services;

(10) Determine how transportation for the infant will be provided, if needed;

(11) Establish on-site training requirements for caregivers, volunteers, parents, foster parents, and relatives;

(12) Establish background check requirements for caregivers, volunteers, employees, and any other person with unsupervised access to the infants under the care of the establishment; and

(13) Establish other requirements necessary to support the infant and the infant's family. [2017 c 263 § 5.]

Findings—Intent—2017 c 263: See note following RCW 71.12.455.

71.12.686 Pediatric transitional care services—Duties of the department of social and health services. After referral by the department of social and health services of an infant to an establishment approved to provide pediatric transitional care services, the department of social and health services:

(1) Retains primary responsibility for case management and must provide consultation to the establishment regarding all placements and permanency planning issues, including developing a parent-child visitation plan;

(2) Must work with the department and the establishment to identify and implement evidence-based practices that address current and best medical practices and parent participation; and

(3) Work with the establishment to ensure medicaid-eligible services are so billed. [2017 c 263 § 6.]

Findings—Intent—2017 c 263: See note following RCW 71.12.455.

71.12.688 Pediatric transitional care services—Facilities not subject to construction review. Facilities that provide pediatric transitional care services that are in existence on July 23, 2017, are not subject to construction review by the department for initial licensure. [2017 c 263 § 7.]

Findings—Intent—2017 c 263: See note following RCW 71.12.455.

71.12.700 Psychiatric hospitals—Technical assistance. (1) Any psychiatric hospital may request from the department or the department may offer to any psychiatric hospital technical assistance. The department may not provide technical assistance during an inspection or during the time between when an investigation of a psychiatric hospital has been initiated and when such investigation is resolved.

(2) The department may offer group training to psychiatric hospitals licensed under this chapter. [2020 c 115 § 2.]

Findings—Intent—2020 c 115: "The legislature finds that patients seeking behavioral health care in Washington would benefit from consistent regulatory oversight and transparency about patient outcomes. Current regulatory oversight of psychiatric hospitals licensed under chapter 71.12 RCW needs to be enhanced to protect the health, safety, and well-being of patients seeking behavioral health care in these facilities. Some hospitals have not

complied with state licensing requirements. Additional enforcement tools are needed to address noncompliance and protect patients from risk of harm.

The legislature also finds that licensing and enforcement requirements for all health care facility types regulated by the department of health are inconsistent and that patients are not well-served by this inconsistency. Review of the regulatory requirements for all health care facility types, including acute care hospitals, is needed to identify gaps and opportunities to consolidate and standardize requirements. Legislation will be necessary to implement uniform requirements that assure provision of safe, quality care and create consistency and predictability for facilities." [2020 c 115 § 1.]

Effective date—2020 c 115: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [March 25, 2020]." [2020 c 115 § 9.]

71.12.710 Psychiatric hospitals—Noncompliance—Penalties. (1) In any case in which the department finds that a licensed psychiatric hospital has failed or refused to comply with applicable state statutes or regulations, the department may take one or more of the actions identified in this section, except as otherwise limited in this section.

(a) When the department determines the psychiatric hospital has previously been subject to an enforcement action for the same or similar type of violation of the same statute or rule, or has been given any previous statement of deficiency that included the same or similar type of violation of the same or similar statute or rule, or when the psychiatric hospital failed to correct noncompliance with a statute or rule by a date established or agreed to by the department, the department may impose reasonable conditions on a license. Conditions may include correction within a specified amount of time, training, or hiring a department-approved consultant if the hospital cannot demonstrate to the department that it has access to sufficient internal expertise.

(b)(i) In accordance with the authority the department has under RCW 43.70.095, the department may assess a civil fine of up to ten thousand dollars per violation, not to exceed a total fine of one million dollars, on a hospital licensed under this chapter when the department determines the psychiatric hospital has previously been subject to an enforcement action for the same or similar type of violation of the same statute or rule, or has been given any previous statement of deficiency that included the same or similar type of violation of the same or similar statute or rule, or when the psychiatric hospital failed to correct noncompliance with a statute or rule by a date established or agreed to by the department.

(ii) Proceeds from these fines may only be used by the department to provide training or technical assistance to psychiatric hospitals and to offset costs associated with licensing psychiatric hospitals.

(iii) The department shall adopt in rules under this chapter specific fine amounts in relation to the severity of the noncompliance.

(iv) If a licensee is aggrieved by the department's action of assessing civil fines, the licensee has the right to appeal under RCW 43.70.095.

(c) In accordance with RCW 43.70.095, the department may impose civil fines of up to ten thousand dollars for each day a person operates a psychiatric hospital without a valid license. Proceeds from these fines may only be used by the department to provide training or technical assistance to psychiatric hospitals and to offset costs associated with licensing psychiatric hospitals.

(d) The department may suspend admissions of a specific category or categories of patients as related to the violation by imposing a limited stop placement. This may only be done if the department finds that noncompliance results in immediate jeopardy.

(i) Prior to imposing a limited stop placement, the department shall provide a psychiatric hospital written notification upon identifying deficient practices or conditions that constitute an immediate jeopardy, and the psychiatric hospital shall have twenty-four hours from notification to develop and implement a department-approved plan to correct the deficient practices or conditions that constitute an immediate jeopardy. If the deficient practice or conditions that constitute immediate jeopardy are not verified by the department as having been corrected within the same twenty-four hour period, the department may issue the limited stop placement.

(ii) When the department imposes a limited stop placement, the psychiatric hospital may not admit any new patients in the category or categories subject to the limited stop placement until the limited stop placement order is terminated.

(iii) The department shall conduct a follow-up inspection within five business days or within the time period requested by the psychiatric hospital if more than five business days is needed to verify the violation necessitating the limited stop placement has been corrected.

(iv) The limited stop placement shall be terminated when:

(A) The department verifies the violation necessitating the limited stop placement has been corrected or the department determines that the psychiatric hospital has taken intermediate action to address the immediate jeopardy; and

(B) The psychiatric hospital establishes the ability to maintain correction of the violation previously found deficient.

(e) The department may suspend new admissions to the psychiatric hospital by imposing a stop placement. This may only be done if the department finds that noncompliance results in immediate jeopardy and is not confined to a specific category or categories of patients or a specific area of the psychiatric hospital.

(i) Prior to imposing a stop placement, the department shall provide a psychiatric hospital written notification upon identifying deficient practices or conditions that constitute an immediate jeopardy, and the psychiatric hospital shall have twenty-four hours from notification to develop and implement a department-approved plan to correct the deficient practices or conditions that constitute an immediate jeopardy. If the deficient practice or conditions that constitute immediate jeopardy are not verified by the department as having been corrected within the same twenty-four hour period, the department may issue the stop placement.

(ii) When the department imposes a stop placement, the psychiatric hospital may not admit any new patients until the stop placement order is terminated.

(iii) The department shall conduct a follow-up inspection within five business days or within the time period requested by the psychiatric hospital if more than five business days is needed to verify the violation necessitating the stop placement has been corrected.

(iv) The stop placement order shall be terminated when:

(A) The department verifies the violation necessitating the stop placement has been corrected or the department determines that the psychiatric hospital has taken intermediate action to address the immediate jeopardy; and

(B) The psychiatric hospital establishes the ability to maintain correction of the violation previously found deficient.

(f) The department may suspend, revoke, or refuse to renew a license.

(2)(a) Except as otherwise provided, RCW 43.70.115 governs notice of the imposition of conditions on a license, a limited stop placement, stop placement, or the suspension, revocation, or refusal to renew a license and provides the right to an adjudicative proceeding. Adjudicative proceedings and hearings under this section are governed by the administrative procedure act, chapter 34.05 RCW. The application for an adjudicative proceeding must be in writing, state the basis for contesting the adverse action, including a copy of the department's notice, be served on and received by the department within twenty-eight days of the licensee's receipt of the adverse notice, and be served in a manner that shows proof of receipt.

(b) When the department determines a licensee's noncompliance results in immediate jeopardy, the department may make the imposition of conditions on a licensee, a limited stop placement, stop placement, or the suspension of a license effective immediately upon receipt of the notice by the licensee, pending any adjudicative proceeding.

(i) When the department makes the suspension of a license or imposition of conditions on a license effective immediately, a licensee is entitled to a show cause hearing before a presiding officer within fourteen days of making the request. The licensee must request the show cause hearing within twenty-eight days of receipt of the notice of immediate suspension or immediate imposition of conditions. At the show cause hearing the department has the burden of demonstrating that more probably than not there is an immediate jeopardy.

(ii) At the show cause hearing, the presiding officer may consider the notice and documents supporting the immediate suspension or immediate imposition of conditions and the licensee's response and must provide the parties with an opportunity to provide documentary evidence and written testimony, and to be represented by counsel. Prior to the show cause hearing, the department must provide the licensee with all documentation that supports the department's immediate suspension.

(iii) If the presiding officer determines there is no immediate jeopardy, the presiding officer may overturn the immediate suspension or immediate imposition of conditions.

(iv) If the presiding officer determines there is immediate jeopardy, the immediate suspension or immediate imposition of conditions shall remain in effect pending a full hearing.

(v) If the secretary sustains the immediate suspension or immediate imposition of conditions, the licensee may request an expedited full hearing on the merits of the department's action. A full hearing must be provided within ninety days of the licensee's request. [2020 c 115 § 3.]

Findings—Intent—Effective date—2020 c 115: See notes following RCW 71.12.700.

71.12.720 Psychiatric hospitals—Reporting. (1) Every psychiatric hospital licensed under this chapter shall report to the department every patient elopement and every death that meets the circumstances specified in subsection (2) of this section that occurs on the hospital grounds within three days of the elopement or death to the department's complaint intake system or another reporting mechanism specified by the department in rule.

(2) The patient or staff deaths that must be reported to the department under subsection (1) of this section include the following:

(a) Patient death associated with patient elopement;

(b) Patient suicide;

(c) Patient death associated with medication error;

(d) Patient death associated with a fall;

(e) Patient death associated with the use of physical restraints or bedrails; and

(f) Patient or staff member death resulting from a physical assault. [2020 c 115 § 8.]

Findings—Intent—Effective date—2020 c 115: See notes following RCW 71.12.700.

71.12.730 Psychiatric hospitals—Managed care organizations. With respect to a person enrolled in medical assistance under chapter 74.09 RCW, a psychiatric hospital shall make every effort to:

(1) Inform the medicaid managed care organization in which the person is enrolled of the person's discharge or change in care plan on the following timelines:

(a) For an anticipated discharge, no later than 24 hours prior to the known discharge date; or

(b) For all other discharges, including if the person leaves against medical advice, no later than the date of discharge or departure from the facility; and

(2) Engage with medicaid managed care organizations in discharge planning, which includes informing and connecting patients to care management resources at the appropriate managed care organization. [2022 c 215 § 4.]

Finding—Intent—2022 c 215: See note following RCW 70.320.020.

71.12.900 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521. For the purposes of this chapter, the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family shall be interpreted as applying equally to state registered domestic partnerships or individuals in state registered domestic partnerships as well as to marital relationships and married persons, and references to dissolution of marriage shall apply equally to state registered domestic partnerships that have been terminated, dissolved, or invalidated, to the extent that such interpretation does not conflict with federal law. Where necessary to implement chapter 521, Laws of 2009, gender-specific terms such as husband and wife used in any statute, rule, or other law shall be construed to be gender neutral, and applicable to individuals in state registered domestic partnerships. [2009 c 521 § 160.]

Chapter 71.20 RCW
LOCAL FUNDS FOR COMMUNITY SERVICES

Sections

71.20.100 Expenditures of county funds subject to county fiscal laws. Expenditures of county funds under this chapter shall be subject to the provisions of chapter 36.40 RCW and other statutes relating to expenditures by counties. [1967 ex.s. c 110 § 10.]

71.20.110 Tax levy directed—Allocation of funds for federal matching funds purposes. (1) In order to provide additional funds for the coordination and provision of community services for persons with developmental disabilities or mental health services, the county governing authority of each county in the state must budget and levy annually a tax in a sum equal to the amount which would be raised by a levy of two and one-half cents per thousand dollars of assessed value against the taxable property in the county, or as such amount is modified pursuant to subsection (2) or (3) of this section, to be used for such purposes. However, all or part of the funds collected from the tax levied for the purposes of this section may be transferred to the state of Washington, department of social and health services, for the purpose of obtaining federal matching funds to provide and coordinate community services for persons with developmental disabilities and mental health services. In the event a county elects to transfer such tax funds to the state for this purpose, the state must grant these moneys and the additional funds received as matching funds to service-providing community agencies or community boards in the county which has made such transfer, pursuant to the plan approved by the county, as provided by chapters 71.24 and 71.28 RCW and by chapter 71A.14 RCW, all as now or hereafter amended.

(2) The amount of a levy allocated to the purposes specified in this section may be reduced in the same proportion as the regular property tax levy of the county is reduced by chapter 84.55 RCW.

(3)(a) The amount of a levy allocated to the purposes specified in this section may be modified from the amount required by subsection (1) of this section as follows:

(i) If the certified levy is reduced from the preceding year's certified levy, the amount of the levy allocated to the purposes specified in this section may be reduced by no more than the same percentage as the certified levy is reduced from the preceding year's certified levy;

(ii) If the certified levy is increased from the preceding year's certified levy, the amount of the levy allocated to the purposes specified in this section must be increased from the amount of the levy so allocated in the previous year by at least the same percentage as the certified levy is increased from the preceding year's certified levy. However, the amount of the levy allocated to the purposes specified in this section does not have to be increased under this subsection (3)(a)(ii) for the portion of a certified levy increase resulting from a voter-approved increase under RCW 84.55.050 that is dedicated to a specific purpose; or

(iii) If the certified levy is unchanged from the preceding year's certified levy, the amount of the levy allocated to the purposes specified in this section must be equal to or greater than the amount of the levy so allocated in the preceding year.

(b) For purposes of this subsection, "certified levy" means the property tax levy for general county purposes certified to the county assessor as required by RCW 84.52.070, excluding any amounts certified under chapters 84.69 and 84.68 RCW.

(4) Subsections (2) and (3) of this section do not preclude a county from increasing the levy amount in subsection (1) of this section to an amount that is greater than the change in the regular county levy. [2013 c 123 § 1; 1988 c 176 § 910; 1983 c 3 § 183; 1980 c 155 § 5; 1974 ex.s. c 71 § 8; 1973 1st ex.s. c 195 § 85; 1971 ex.s. c 84 § 1; 1970 ex.s. c 47 § 8; 1967 ex.s. c 110 § 16.]

Additional notes found at www.leg.wa.gov

Chapter 71.24 RCW
COMMUNITY BEHAVIORAL HEALTH SERVICES ACT

(Formerly: Community mental health services act)

Sections

Comprehensive community health centers: Chapter 70.10 RCW.

Funding: RCW 43.79.201 and 79.02.410.

71.24.011 Short title. This chapter may be known and cited as the community behavioral health services act. [2019 c 325 § 1001; 2019 c 314 § 24; 1982 c 204 § 1.]

Effective date—2019 c 325: "Except as provided in sections 6005 and 6007 of this act, this act takes effect January 1, 2020." [2019 c 325 § 6008.]

Declaration—2019 c 314: See note following RCW 18.22.810.

71.24.015 Legislative intent—Community behavioral health system. It is the intent of the legislature to establish a community behavioral health system which shall help people experiencing mental illness or a substance use disorder to retain a respected and productive position in the community. This will be accomplished through programs that focus on resilience and recovery, and practices that are

evidence-based, research-based, consensus-based, or, where these do not exist, promising or emerging best practices, which provide for:

(1) Access to behavioral health services for adults with mental illness and children with mental illness, emotional disturbances, or substance use disorders, that recognize the special needs of underserved populations, including minorities, children, older adults, individuals with disabilities, and low-income persons. Access to mental health and substance use disorder services shall not be limited by a person's history of confinement in a state, federal, or local correctional facility. It is also the purpose of this chapter to promote the early identification of children with mental illness and to ensure that they receive the mental health care and treatment which is appropriate to their developmental level. This care should improve home, school, and community functioning, maintain children in a safe and nurturing home environment, and should enable treatment decisions to be made in response to clinical needs in accordance with sound professional judgment while also recognizing parents' rights to participate in treatment decisions for their children;

(2) The involvement of persons with mental illness or substance use disorder, their family members, and advocates in designing and implementing behavioral health services that reduce unnecessary hospitalization and incarceration and promote recovery and employment. To improve the quality of services available and promote the rehabilitation, recovery, and reintegration of persons with mental illness or substance use disorder, consumer and advocate participation in behavioral health services is an integral part of the community behavioral health system and shall be supported;

(3) Accountability of efficient and effective services through state-of-the-art outcome and performance measures and statewide standards for monitoring client and system outcomes, performance, and reporting of client and system outcome information. These processes shall be designed so as to maximize the use of available resources for direct care of people with a mental illness and to assure uniform data collection across the state;

(4) Minimum service delivery standards;

(5) Priorities for the use of available resources for the care of individuals with mental illness or substance use disorder consistent with the priorities defined in the statute;

(6) Coordination of services within the department of social and health services, the authority, the department, the department of children, youth, and families, and the office of the superintendent of public instruction, and among state mental hospitals, tribes, residential treatment facilities, county authorities, behavioral health administrative services organizations, managed care organizations, community behavioral health services, and other support services, which shall to the maximum extent feasible also include the families of individuals with mental illness or substance use disorder, and other service providers, including Indian health care providers; and

(7) Coordination of services aimed at reducing duplication in service delivery and promoting complementary services among all entities that provide behavioral health services to adults and children.

It is the policy of the state to encourage the provision of a full range of treatment and rehabilitation services in the state for mental disorders, or substance use disorders, including services operated by consumers and advocates. The legislature intends to encourage the development of regional behavioral health services with adequate local flexibility to assure eligible people in need of care access to the least-restrictive treatment alternative appropriate to their needs, and the availability of treatment components to assure continuity of care. The legislature hereby finds and declares that sound fiscal management requires vigilance to ensure that funds appropriated by the legislature for the provision of needed community behavioral health system services are ultimately expended solely for the purpose for which they were appropriated, and not for any other purpose.

It is further the intent of the legislature to integrate the provision of services to provide continuity of care through all phases of treatment. To this end, the legislature intends to promote active engagement with persons with mental illness and collaboration between families and service providers. [2019 c 325 § 1002; 2018 c 201 § 4001; 2014 c 225 § 6; 2005 c 503 § 1. Prior: 2001 c 334 § 6; 2001 c 323 § 1; 1999 c 214 § 7; 1991 c 306 § 1; 1989 c 205 § 1; 1986 c 274 § 1; 1982 c 204 § 2.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Intent—Effective date—1999 c 214: See notes following RCW 72.09.370.

Additional notes found at www.leg.wa.gov

71.24.016 Intent—Management of services—Work group on long-term involuntary inpatient care integration. (1) The legislature intends that eastern and western state hospitals shall operate as clinical centers for handling the most complicated long-term care needs of patients with a primary diagnosis of mental disorder. It is further the intent of the legislature that the community behavioral health service delivery system focus on maintaining individuals with mental illness in the community. The program shall be evaluated and managed through a limited number of outcome and performance measures, as provided in RCW 71.24.435, 70.320.020, and 71.36.025.

(2) The legislature intends to address the needs of people with mental disorders with a targeted, coordinated, and comprehensive set of evidence-based practices that are effective in serving individuals in their community and will reduce the need for placements in state mental hospitals. The legislature further intends to explicitly hold behavioral health administrative services organizations, within available resources, and managed care organizations accountable for serving people with mental disorders within the boundaries of their regional service area.

(3) The authority shall establish a work group to determine: (a) How to appropriately manage access to adult long-term inpatient involuntary care and the children's long-term inpatient program in the community and at eastern and western state hospitals, until such a time as the risk for long-term involuntary inpatient care may be fully integrated into managed care organization contracts, and provide advice to guide the integration process; and (b) how to expand bidirectional integration through increased support for co-occurring disorder services, including recommendations related to purchas-

ing and rates. The work group shall include representation from the department of social and health services, the department of health, behavioral health administrative services organizations, at least two managed care organizations, the Washington state association of counties, community behavioral health providers, including providers with experience providing co-occurring disorder services, and the Washington state hospital association. Managed care representation on the work group must include at least one member with financial expertise and at least one member with clinical expertise. The managed care organizations on the work group shall represent the entire managed care sector and shall collaborate with the nonrepresented managed care organizations. The work group shall provide recommendations to the office of financial management and appropriate committees of the legislature by December 15, 2019. [2019 c 325 § 1003; 2014 c 225 § 7; 2006 c 333 § 102; 2001 c 323 § 4.]

Effective date—2019 c 325 §§ 1003 and 5030: "Sections 1003 and 5030 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect immediately [May 9, 2019]." [2019 c 325 § 6007.]

Effective date—2014 c 225: "Sections 7, 10, 13 through 54, 56 through 84, and 86 through 104 of this act take effect April 1, 2016." [2014 c 225 § 112.]

Finding—Purpose—Intent—2006 c 333: "(1) The legislature finds that ambiguities have been identified regarding the appropriation and allocation of federal and state funds, and the responsibilities of the department of social and health services and the regional support networks with regard to the provision of inpatient mental health services under the community mental health services act, chapter 71.24 RCW, and the involuntary treatment act, chapter 71.05 RCW. The purpose of this 2006 act is to make retroactive, remedial, curative, and technical amendments in order to resolve such ambiguities.

(2) In enacting the community mental health services act, the legislature intended the relationship between the state and the regional support networks to be governed solely by the terms of the regional support network contracts and did not intend these relationships to create statutory causes of action not expressly provided for in the contracts. Therefore, the legislature's intent is that, except to the extent expressly provided in contracts entered after March 29, 2006, the department of social and health services and regional support networks shall resolve existing and future disagreements regarding the subject matter identified in sections 103 and 301 of this act through nonjudicial means." [2006 c 333 § 101.]

Additional notes found at www.leg.wa.gov

71.24.025 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "988 crisis hotline" means the universal telephone number within the United States designated for the purpose of the national suicide prevention and mental health crisis hotline system operating through the national suicide prevention lifeline.

(2) "Acutely mentally ill" means a condition which is limited to a short-term severe crisis episode of:

(a) A mental disorder as defined in RCW 71.05.020 or, in the case of a child, as defined in RCW 71.34.020;

(b) Being gravely disabled as defined in RCW 71.05.020 or, in the case of a child, a gravely disabled minor as defined in RCW 71.34.020; or

(c) Presenting a likelihood of serious harm as defined in RCW 71.05.020 or, in the case of a child, as defined in RCW 71.34.020.

(3) "Alcoholism" means a disease, characterized by a dependency on alcoholic beverages, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued, and impairment of health or disruption of social or economic functioning.

(4) "Approved substance use disorder treatment program" means a program for persons with a substance use disorder provided by a treatment program licensed or certified by the department as meeting standards adopted under this chapter.

(5) "Authority" means the Washington state health care authority.

(6) "Available resources" means funds appropriated for the purpose of providing community behavioral health programs, federal funds, except those provided according to Title XIX of the Social Security Act, and state funds appropriated under this chapter or chapter 71.05 RCW by the legislature during any biennium for the purpose of providing residential services, resource management services, community support services, and other behavioral health services. This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

(7) "Behavioral health administrative services organization" means an entity contracted with the authority to administer behavioral health services and programs under RCW 71.24.381, including crisis services and administration of chapter 71.05 RCW, the involuntary treatment act, for all individuals in a defined regional service area.

(8) "Behavioral health aide" means a counselor, health educator, and advocate who helps address individual and community-based behavioral health needs, including those related to alcohol, drug, and tobacco abuse as well as mental health problems such as grief, depression, suicide, and related issues and is certified by a community health aide program of the Indian health service or one or more tribes or tribal organizations consistent with the provisions of 25 U.S.C. Sec. 1616l and RCW 43.71B.010 (7) and (8).

(9) "Behavioral health provider" means a person licensed under chapter 18.57, 18.71, 18.71A, 18.83, 18.205, 18.225, or 18.79 RCW, as it applies to registered nurses and advanced registered nurse practitioners.

(10) "Behavioral health services" means mental health services as described in this chapter and chapter 71.36 RCW and substance use disorder treatment services as described in this chapter that, depending on the type of service, are provided by licensed or certified behavioral health agencies, behavioral health providers, or integrated into other health care providers.

(11) "Child" means a person under the age of eighteen years.

(12) "Chronically mentally ill adult" or "adult who is chronically mentally ill" means an adult who has a mental disorder and meets at least one of the following criteria:

(a) Has undergone two or more episodes of hospital care for a mental disorder within the preceding two years; or

(b) Has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding year; or

(c) Has been unable to engage in any substantial gainful activity by reason of any mental disorder which has lasted for

a continuous period of not less than twelve months. "Substantial gainful activity" shall be defined by the authority by rule consistent with Public Law 92-603, as amended.

(13) "Clubhouse" means a community-based program that provides rehabilitation services and is licensed or certified by the department.

(14) "Community behavioral health program" means all expenditures, services, activities, or programs, including reasonable administration and overhead, designed and conducted to prevent or treat substance use disorder, mental illness, or both in the community behavioral health system.

(15) "Community behavioral health service delivery system" means public, private, or tribal agencies that provide services specifically to persons with mental disorders, substance use disorders, or both, as defined under RCW 71.05.020 and receive funding from public sources.

(16) "Community support services" means services authorized, planned, and coordinated through resource management services including, at a minimum, assessment, diagnosis, emergency crisis intervention available twenty-four hours, seven days a week, prescreening determinations for persons who are mentally ill being considered for placement in nursing homes as required by federal law, screening for patients being considered for admission to residential services, diagnosis and treatment for children who are acutely mentally ill or severely emotionally or behaviorally disturbed discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment program, investigation, legal, and other nonresidential services under chapter 71.05 RCW, case management services, psychiatric treatment including medication supervision, counseling, psychotherapy, assuring transfer of relevant patient information between service providers, recovery services, and other services determined by behavioral health administrative services organizations.

(17) "Consensus-based" means a program or practice that has general support among treatment providers and experts, based on experience or professional literature, and may have anecdotal or case study support, or that is agreed but not possible to perform studies with random assignment and controlled groups.

(18) "County authority" means the board of county commissioners, county council, or county executive having authority to establish a behavioral health administrative services organization, or two or more of the county authorities specified in this subsection which have entered into an agreement to establish a behavioral health administrative services organization.

(19) "Crisis call center hub" means a state-designated center participating in the national suicide prevention lifeline network to respond to statewide or regional 988 calls that meets the requirements of RCW 71.24.890.

(20) "Crisis stabilization services" means services such as 23-hour crisis stabilization units based on the living room model, crisis stabilization units as provided in RCW 71.05.020, triage facilities as provided in RCW 71.05.020, short-term respite facilities, peer-run respite services, and same-day walk-in behavioral health services, including within the overall crisis system components that operate like hospital emergency departments that accept all walk-ins, and ambulance, fire, and police drop-offs.

(21) "Department" means the department of health.

(22) "Designated crisis responder" has the same meaning as in RCW 71.05.020.

(23) "Director" means the director of the authority.

(24) "Drug addiction" means a disease characterized by a dependency on psychoactive chemicals, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued, and impairment of health or disruption of social or economic functioning.

(25) "Early adopter" means a regional service area for which all of the county authorities have requested that the authority purchase medical and behavioral health services through a managed care health system as defined under *RCW 71.24.380(6).

(26) "Emerging best practice" or "promising practice" means a program or practice that, based on statistical analyses or a well established theory of change, shows potential for meeting the evidence-based or research-based criteria, which may include the use of a program that is evidence-based for outcomes other than those listed in subsection (27) of this section.

(27) "Evidence-based" means a program or practice that has been tested in heterogeneous or intended populations with multiple randomized, or statistically controlled evaluations, or both; or one large multiple site randomized, or statistically controlled evaluation, or both, where the weight of the evidence from a systemic review demonstrates sustained improvements in at least one outcome. "Evidence-based" also means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, is determined to be cost-beneficial.

(28) "Indian health care provider" means a health care program operated by the Indian health service or by a tribe, tribal organization, or urban Indian organization as those terms are defined in the Indian health care improvement act (25 U.S.C. Sec. 1603).

(29) "Intensive behavioral health treatment facility" means a community-based specialized residential treatment facility for individuals with behavioral health conditions, including individuals discharging from or being diverted from state and local hospitals, whose impairment or behaviors do not meet, or no longer meet, criteria for involuntary inpatient commitment under chapter 71.05 RCW, but whose care needs cannot be met in other community-based placement settings.

(30) "Licensed or certified behavioral health agency" means:

(a) An entity licensed or certified according to this chapter or chapter 71.05 RCW;

(b) An entity deemed to meet state minimum standards as a result of accreditation by a recognized behavioral health accrediting body recognized and having a current agreement with the department; or

(c) An entity with a tribal attestation that it meets state minimum standards for a licensed or certified behavioral health agency.

(31) "Licensed physician" means a person licensed to practice medicine or osteopathic medicine and surgery in the state of Washington.

(32) "Long-term inpatient care" means inpatient services for persons committed for, or voluntarily receiving intensive treatment for, periods of ninety days or greater under chapter 71.05 RCW. "Long-term inpatient care" as used in this chapter does not include: (a) Services for individuals committed under chapter 71.05 RCW who are receiving services pursuant to a conditional release or a court-ordered less restrictive alternative to detention; or (b) services for individuals voluntarily receiving less restrictive alternative treatment on the grounds of the state hospital.

(33) "Managed care organization" means an organization, having a certificate of authority or certificate of registration from the office of the insurance commissioner, that contracts with the authority under a comprehensive risk contract to provide prepaid health care services to enrollees under the authority's managed care programs under chapter 74.09 RCW.

(34) "Mental health peer-run respite center" means a peer-run program to serve individuals in need of voluntary, short-term, noncrisis services that focus on recovery and wellness.

(35) Mental health "treatment records" include registration and all other records concerning persons who are receiving or who at any time have received services for mental illness, which are maintained by the department of social and health services or the authority, by behavioral health administrative services organizations and their staffs, by managed care organizations and their staffs, or by treatment facilities. "Treatment records" do not include notes or records maintained for personal use by a person providing treatment services for the entities listed in this subsection, or a treatment facility if the notes or records are not available to others.

(36) "Mentally ill persons," "persons who are mentally ill," and "the mentally ill" mean persons and conditions defined in subsections (2), (12), (44), and (45) of this section.

(37) "Mobile rapid response crisis team" means a team that provides professional on-site community-based intervention such as outreach, de-escalation, stabilization, resource connection, and follow-up support for individuals who are experiencing a behavioral health crisis, that shall include certified peer counselors as a best practice to the extent practicable based on workforce availability, and that meets standards for response times established by the authority.

(38) "Recovery" means a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

(39) "Research-based" means a program or practice that has been tested with a single randomized, or statistically controlled evaluation, or both, demonstrating sustained desirable outcomes; or where the weight of the evidence from a systemic review supports sustained outcomes as described in subsection (27) of this section but does not meet the full criteria for evidence-based.

(40) "Residential services" means a complete range of residences and supports authorized by resource management services and which may involve a facility, a distinct part thereof, or services which support community living, for persons who are acutely mentally ill, adults who are chronically mentally ill, children who are severely emotionally disturbed, or adults who are seriously disturbed and determined by the behavioral health administrative services organization or managed care organization to be at risk of becoming acutely or chronically mentally ill. The services shall include at least evaluation and treatment services as defined in chapter 71.05 RCW, acute crisis respite care, long-term adaptive and rehabilitative care, and supervised and supported living services, and shall also include any residential services developed to service persons who are mentally ill in nursing homes, residential treatment facilities, assisted living facilities, and adult family homes, and may include outpatient services provided as an element in a package of services in a supported housing model. Residential services for children in out-of-home placements related to their mental disorder shall not include the costs of food and shelter, except for children's long-term residential facilities existing prior to January 1, 1991.

(41) "Resilience" means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.

(42) "Resource management services" mean the planning, coordination, and authorization of residential services and community support services administered pursuant to an individual service plan for: (a) Adults and children who are acutely mentally ill; (b) adults who are chronically mentally ill; (c) children who are severely emotionally disturbed; or (d) adults who are seriously disturbed and determined by a behavioral health administrative services organization or managed care organization to be at risk of becoming acutely or chronically mentally ill. Such planning, coordination, and authorization shall include mental health screening for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment program. Resource management services include seven day a week, twenty-four hour a day availability of information regarding enrollment of adults and children who are mentally ill in services and their individual service plan to designated crisis responders, evaluation and treatment facilities, and others as determined by the behavioral health administrative services organization or managed care organization, as applicable.

(43) "Secretary" means the secretary of the department of health.

(44) "Seriously disturbed person" means a person who:

(a) Is gravely disabled or presents a likelihood of serious harm to himself or herself or others, or to the property of others, as a result of a mental disorder as defined in chapter 71.05 RCW;

(b) Has been on conditional release status, or under a less restrictive alternative order, at some time during the preceding two years from an evaluation and treatment facility or a state mental health hospital;

(c) Has a mental disorder which causes major impairment in several areas of daily living;

(d) Exhibits suicidal preoccupation or attempts; or

(e) Is a child diagnosed by a mental health professional, as defined in chapter 71.34 RCW, as experiencing a mental disorder which is clearly interfering with the child's functioning in family or school or with peers or is clearly interfering with the child's personality development and learning.

(45) "Severely emotionally disturbed child" or "child who is severely emotionally disturbed" means a child who has been determined by the behavioral health administrative services organization or managed care organization, if appli-

cable, to be experiencing a mental disorder as defined in chapter 71.34 RCW, including those mental disorders that result in a behavioral or conduct disorder, that is clearly interfering with the child's functioning in family or school or with peers and who meets at least one of the following criteria:

(a) Has undergone inpatient treatment or placement outside of the home related to a mental disorder within the last two years;

(b) Has undergone involuntary treatment under chapter 71.34 RCW within the last two years;

(c) Is currently served by at least one of the following child-serving systems: Juvenile justice, child-protection/welfare, special education, or developmental disabilities;

(d) Is at risk of escalating maladjustment due to:

(i) Chronic family dysfunction involving a caretaker who is mentally ill or inadequate;

(ii) Changes in custodial adult;

(iii) Going to, residing in, or returning from any placement outside of the home, for example, psychiatric hospital, short-term inpatient, residential treatment, group or foster home, or a correctional facility;

(iv) Subject to repeated physical abuse or neglect;

(v) Drug or alcohol abuse; or

(vi) Homelessness.

(46) "State minimum standards" means minimum requirements established by rules adopted and necessary to implement this chapter by:

(a) The authority for:

(i) Delivery of mental health and substance use disorder services; and

(ii) Community support services and resource management services;

(b) The department of health for:

(i) Licensed or certified behavioral health agencies for the purpose of providing mental health or substance use disorder programs and services, or both;

(ii) Licensed behavioral health providers for the provision of mental health or substance use disorder services, or both; and

(iii) Residential services.

(47) "Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using the substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances.

(48) "Tribe," for the purposes of this section, means a federally recognized Indian tribe. [2021 c 302 § 402; (2021 c 302 § 401 expired July 1, 2022). Prior: 2020 c 256 § 201; 2020 c 80 § 52; prior: 2019 c 325 § 1004; 2019 c 324 § 2; 2018 c 201 § 4002; prior: 2016 sp.s. c 29 § 502; 2016 sp.s. c 29 § 501; 2016 c 155 § 12; prior: 2014 c 225 § 10; 2013 c 338 § 5; 2012 c 10 § 59; 2008 c 261 § 2; 2007 c 414 § 1; 2006 c 333 § 104; prior: 2005 c 504 § 105; 2005 c 503 § 2; 2001 c 323 § 8; 1999 c 10 § 2; 1997 c 112 § 38; 1995 c 96 § 4; prior: 1994 sp.s. c 9 § 748; 1994 c 204 § 1; 1991 c 306 § 2; 1989 c 205 § 2; 1986 c 274 § 2; 1982 c 204 § 3.]

Reviser's note: *(1) RCW 71.24.380 was amended by 2021 c 202 § 16, changing subsection (6) to subsection (7), effective October 1, 2022.

(2) The definitions in this section have been alphabetized pursuant to RCW 1.08.015(2)(k).

Effective date—2021 c 302 § 402: "Section 402 of this act takes effect July 1, 2022." [2021 c 302 § 407.]

Expiration date—2021 c 302 § 401: "Section 401 of this act expires July 1, 2022." [2021 c 302 § 406.]

Findings—Intent—2021 c 302: See note following RCW 71.24.890.

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—2019 c 324: See note following RCW 71.24.648.

Mental health drop-in center services pilot program—2019 c 324: See note following RCW 71.24.649.

Report—2019 c 324: See note following RCW 70.38.111.

Recommendations—Residential intensive behavioral health and developmental disability services—2019 c 324: See note following RCW 74.39A.030.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2014 c 225: See note following RCW 71.24.016.

Application—2012 c 10: See note following RCW 18.20.010.

Intent—Findings—2008 c 261: "In the event that an existing regional support network will no longer be contracting to provide services, it is the intent of the legislature to provide flexibility to the department to facilitate a stable transition which avoids disruption of services to consumers and families, maximizes efficiency and public safety, and maintains the integrity of the public mental health system. By granting this authority and flexibility, the legislature finds that the department will be able to maximize purchasing power within allocated resources and attract high quality organizations with optimal infrastructure to perform regional support network functions through competitive procurement processes. The legislature intends for the department of social and health services to partner with political subdivisions and other entities to provide quality, coordinated, and integrated services to address the needs of individuals with behavioral health needs." [2008 c 261 § 1.]

Finding—Purpose—Intent—Severability—Part headings not law—Effective dates—2006 c 333: See notes following RCW 71.24.016.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Purpose—Intent—1999 c 10: "The purpose of this act is to eliminate dates and provisions in chapter 71.24 RCW which are no longer needed. The legislature does not intend this act to make, and no provision of this act shall be construed as, a substantive change in the service delivery system or funding of the community mental health services law." [1999 c 10 § 1.]

Additional notes found at www.leg.wa.gov

71.24.030 Grants, purchasing of services, for community behavioral health programs. The director is authorized to make grants and/or purchase services from counties, combinations of counties, or other entities, to establish and operate community behavioral health programs. [2019 c 325 § 1005; 2018 c 201 § 4003; 2005 c 503 § 3; 2001 c 323 § 9; 1999 c 10 § 3; 1982 c 204 § 6; 1973 1st ex.s. c 155 § 5; 1972 ex.s. c 122 § 30; 1971 ex.s. c 304 § 7; 1967 ex.s. c 111 § 3.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Purpose—Intent—1999 c 10: See note following RCW 71.24.025.

Additional notes found at www.leg.wa.gov

71.24.035 Director's powers and duties as state behavioral health authority. (1) The authority is designated

as the state behavioral health authority which includes recognition as the single state authority for substance use disorders and state mental health authority.

(2) The director shall provide for public, client, tribal, and licensed or certified behavioral health agency participation in developing the state behavioral health program, developing related contracts, and any waiver request to the federal government under medicaid.

(3) The director shall provide for participation in developing the state behavioral health program for children and other underserved populations, by including representatives on any committee established to provide oversight to the state behavioral health program.

(4) The authority shall be designated as the behavioral health administrative services organization for a regional service area if a behavioral health administrative services organization fails to meet the authority's contracting requirements or refuses to exercise the responsibilities under its contract or state law, until such time as a new behavioral health administrative services organization is designated.

(5) The director shall:

(a) Assure that any behavioral health administrative services organization, managed care organization, or community behavioral health program provides medically necessary services to medicaid recipients consistent with the state's medicaid state plan or federal waiver authorities, and nonmedicaid services consistent with priorities established by the authority;

(b) Develop contracts in a manner to ensure an adequate network of inpatient services, evaluation and treatment services, and facilities under chapter 71.05 RCW to ensure access to treatment, resource management services, and community support services;

(c) Make contracts necessary or incidental to the performance of its duties and the execution of its powers, including managed care contracts for behavioral health services, contracts entered into under RCW 74.09.522, and contracts with public and private agencies, organizations, and individuals to pay them for behavioral health services;

(d) Define administrative costs and ensure that the behavioral health administrative services organization does not exceed an administrative cost of ten percent of available funds;

(e) Establish, to the extent possible, a standardized auditing procedure which is designed to assure compliance with contractual agreements authorized by this chapter and minimizes paperwork requirements. The audit procedure shall focus on the outcomes of service as provided in RCW 71.24.435, 70.320.020, and 71.36.025;

(f) Develop and maintain an information system to be used by the state and behavioral health administrative services organizations and managed care organizations that includes a tracking method which allows the authority to identify behavioral health clients' participation in any behavioral health service or public program on an immediate basis. The information system shall not include individual patient's case history files. Confidentiality of client information and records shall be maintained as provided in this chapter and chapter 70.02 RCW;

(g) Monitor and audit behavioral health administrative services organizations as needed to assure compliance with contractual agreements authorized by this chapter;

(h) Monitor and audit access to behavioral health services for individuals eligible for medicaid who are not enrolled in a managed care organization;

(i) Adopt such rules as are necessary to implement the authority's responsibilities under this chapter;

(j) Administer or supervise the administration of the provisions relating to persons with substance use disorders and intoxicated persons of any state plan submitted for federal funding pursuant to federal health, welfare, or treatment legislation;

(k) Require the behavioral health administrative services organizations and the managed care organizations to develop agreements with tribal, city, and county jails and the department of corrections to accept referrals for enrollment on behalf of a confined person, prior to the person's release;

(l) Require behavioral health administrative services organizations and managed care organizations, as applicable, to provide services as identified in RCW 71.05.585 and 10.77.175 to individuals committed for involuntary treatment under less restrictive alternative court orders when:

(i) The individual is enrolled in the medicaid program; or

(ii) The individual is not enrolled in medicaid and does not have other insurance which can pay for the services; and

(m) Coordinate with the centers for medicare and medicaid services to provide that behavioral health aide services are eligible for federal funding of up to one hundred percent.

(6) The director shall use available resources only for behavioral health administrative services organizations and managed care organizations, except:

(a) To the extent authorized, and in accordance with any priorities or conditions specified, in the biennial appropriations act; or

(b) To incentivize improved performance with respect to the client outcomes established in RCW 71.24.435, 70.320.020, and 71.36.025, integration of behavioral health and medical services at the clinical level, and improved care coordination for individuals with complex care needs.

(7) Each behavioral health administrative services organization, managed care organization, and licensed or certified behavioral health agency shall file with the secretary of the department of health or the director, on request, such data, statistics, schedules, and information as the secretary of the department of health or the director reasonably requires. A behavioral health administrative services organization, managed care organization, or licensed or certified behavioral health agency which, without good cause, fails to furnish any data, statistics, schedules, or information as requested, or files fraudulent reports thereof, may be subject to the contractual remedies in RCW 74.09.871 or may have its service provider certification or license revoked or suspended.

(8) The superior court may restrain any behavioral health administrative services organization, managed care organization, or service provider from operating without a contract, certification, or a license or any other violation of this section. The court may also review, pursuant to procedures contained in chapter 34.05 RCW, any denial, suspension, limitation, restriction, or revocation of certification or license, and

grant other relief required to enforce the provisions of this chapter.

(9) Upon petition by the secretary of the department of health or the director, and after hearing held upon reasonable notice to the facility, the superior court may issue a warrant to an officer or employee of the secretary of the department of health or the director authorizing him or her to enter at reasonable times, and examine the records, books, and accounts of any behavioral health administrative services organization, managed care organization, or service provider refusing to consent to inspection or examination by the authority.

(10) Notwithstanding the existence or pursuit of any other remedy, the secretary of the department of health or the director may file an action for an injunction or other process against any person or governmental unit to restrain or prevent the establishment, conduct, or operation of a behavioral health administrative services organization, managed care organization, or service provider without a contract, certification, or a license under this chapter.

(11) The authority shall distribute appropriated state and federal funds in accordance with any priorities, terms, or conditions specified in the appropriations act.

(12) The authority, in cooperation with the state congressional delegation, shall actively seek waivers of federal requirements and such modifications of federal regulations as are necessary to allow federal medicaid reimbursement for services provided by freestanding evaluation and treatment facilities licensed under chapter 71.12 RCW or certified under chapter 71.05 RCW. The authority shall periodically share the results of its efforts with the appropriate committees of the senate and the house of representatives.

(13) The authority may:

(a) Plan, establish, and maintain substance use disorder prevention and substance use disorder treatment programs as necessary or desirable;

(b) Coordinate its activities and cooperate with behavioral programs in this and other states, and make contracts and other joint or cooperative arrangements with state, tribal, local, or private agencies in this and other states for behavioral health services and for the common advancement of substance use disorder programs;

(c) Solicit and accept for use any gift of money or property made by will or otherwise, and any grant of money, services, or property from the federal government, the state, or any political subdivision thereof or any private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for any grant;

(d) Keep records and engage in research and the gathering of relevant statistics; and

(e) Acquire, hold, or dispose of real property or any interest therein, and construct, lease, or otherwise provide substance use disorder treatment programs. [2021 c 263 § 16; 2021 c 263 § 8; 2020 c 256 § 202; 2019 c 325 § 1006; 2018 c 201 § 4004; 2016 sp.s. c 29 § 503; 2015 c 269 § 8; 2014 c 225 § 11; 2013 c 200 § 24; 2011 c 148 § 4. Prior: 2008 c 267 § 5; 2008 c 261 § 3; prior: 2007 c 414 § 2; 2007 c 410 § 8; 2007 c 375 § 12; 2006 c 333 § 201; prior: 2005 c 504 § 715; 2005 c 503 § 7; prior: 2001 c 334 § 7; 2001 c 323 § 10; 1999 c 10 § 4; 1998 c 245 § 137; prior: 1991 c 306 § 3; 1991 c 262 § 1; 1991 c 29 § 1; 1990 1st ex.s. c 8 § 1; 1989 c 205 § 3; 1987 c 105 § 1; 1986 c 274 § 3; 1982 c 204 § 4.]

Reviser's note: This section was amended by 2021 c 263 § 8 and by 2021 c 263 § 16, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Application—2021 c 263: See note following RCW 10.77.150.

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2015 c 269 §§ 1-9 and 11-13: See note following RCW 71.05.010.

Effective date—2013 c 200: See note following RCW 70.02.010.

Intent—Findings—2008 c 261: See note following RCW 71.24.025.

Findings—Purpose—Construction—Severability—2007 c 375: See notes following RCW 10.31.110.

Finding—Purpose—Intent—Severability—Part headings not law—Effective dates—2006 c 333: See notes following RCW 71.24.016.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Purpose—Intent—1999 c 10: See note following RCW 71.24.025.

Additional notes found at www.leg.wa.gov

71.24.037 Licensed or certified behavioral health agencies and providers—Minimum standards—Investigations and enforcement actions—Inspections. (1) The secretary shall license or certify any agency or facility that: (a) Submits payment of the fee established under RCW 43.70.110 and 43.70.250; (b) submits a complete application that demonstrates the ability to comply with requirements for operating and maintaining an agency or facility in statute or rule; and (c) successfully completes the prelicensure inspection requirement.

(2) The secretary shall establish by rule minimum standards for licensed or certified behavioral health agencies that must, at a minimum, establish: (a) Qualifications for staff providing services directly to persons with mental disorders, substance use disorders, or both; (b) the intended result of each service; and (c) the rights and responsibilities of persons receiving behavioral health services pursuant to this chapter and chapter 71.05 RCW. The secretary shall provide for deeming of licensed or certified behavioral health agencies as meeting state minimum standards as a result of accreditation by a recognized behavioral health accrediting body recognized and having a current agreement with the department.

(3) The department shall review reports or other information alleging a failure to comply with this chapter or the standards and rules adopted under this chapter and may initiate investigations and enforcement actions based on those reports.

(4) The department shall conduct inspections of agencies and facilities, including reviews of records and documents required to be maintained under this chapter or rules adopted under this chapter.

(5) The department may suspend, revoke, limit, restrict, or modify an approval, or refuse to grant approval, for failure to meet the provisions of this chapter, or the standards adopted under this chapter. RCW 43.70.115 governs notice of a license or certification denial, revocation, suspension, or

modification and provides the right to an adjudicative proceeding.

(6) No licensed or certified behavioral health service provider may advertise or represent itself as a licensed or certified behavioral health service provider if approval has not been granted or has been denied, suspended, revoked, or canceled.

(7) Licensure or certification as a behavioral health service provider is effective for one calendar year from the date of issuance of the license or certification. The license or certification must specify the types of services provided by the behavioral health service provider that meet the standards adopted under this chapter. Renewal of a license or certification must be made in accordance with this section for initial approval and in accordance with the standards set forth in rules adopted by the secretary.

(8) Licensure or certification as a licensed or certified behavioral health service provider must specify the types of services provided that meet the standards adopted under this chapter. Renewal of a license or certification must be made in accordance with this section for initial approval and in accordance with the standards set forth in rules adopted by the secretary.

(9) The department shall develop a process by which a provider may obtain dual licensure as an evaluation and treatment facility and secure withdrawal management and stabilization facility.

(10) Licensed or certified behavioral health service providers may not provide types of services for which the licensed or certified behavioral health service provider has not been certified. Licensed or certified behavioral health service providers may provide services for which approval has been sought and is pending, if approval for the services has not been previously revoked or denied.

(11) The department periodically shall inspect licensed or certified behavioral health service providers at reasonable times and in a reasonable manner.

(12) Upon petition of the department and after a hearing held upon reasonable notice to the facility, the superior court may issue a warrant to an officer or employee of the department authorizing him or her to enter and inspect at reasonable times, and examine the books and accounts of, any licensed or certified behavioral health service provider refusing to consent to inspection or examination by the department or which the department has reasonable cause to believe is operating in violation of this chapter.

(13) The department shall maintain and periodically publish a current list of licensed or certified behavioral health service providers.

(14) Each licensed or certified behavioral health service provider shall file with the department or the authority upon request, data, statistics, schedules, and information the department or the authority reasonably requires. A licensed or certified behavioral health service provider that without good cause fails to furnish any data, statistics, schedules, or information as requested, or files fraudulent returns thereof, may have its license or certification revoked or suspended.

(15) The authority shall use the data provided in subsection (14) of this section to evaluate each program that admits children to inpatient substance use disorder treatment upon application of their parents. The evaluation must be done at least once every twelve months. In addition, the authority shall randomly select and review the information on individual children who are admitted on application of the child's parent for the purpose of determining whether the child was appropriately placed into substance use disorder treatment based on an objective evaluation of the child's condition and the outcome of the child's treatment.

(16) Any settlement agreement entered into between the department and licensed or certified behavioral health service providers to resolve administrative complaints, license or certification violations, license or certification suspensions, or license or certification revocations may not reduce the number of violations reported by the department unless the department concludes, based on evidence gathered by inspectors, that the licensed or certified behavioral health service provider did not commit one or more of the violations.

(17) In cases in which a behavioral health service provider that is in violation of licensing or certification standards attempts to transfer or sell the behavioral health service provider to a family member, the transfer or sale may only be made for the purpose of remedying license or certification violations and achieving full compliance with the terms of the license or certification. Transfers or sales to family members are prohibited in cases in which the purpose of the transfer or sale is to avoid liability or reset the number of license or certification violations found before the transfer or sale. If the department finds that the owner intends to transfer or sell, or has completed the transfer or sale of, ownership of the behavioral health service provider to a family member solely for the purpose of resetting the number of violations found before the transfer or sale, the department may not renew the behavioral health service provider's license or certification or issue a new license or certification to the behavioral health service provider. [2019 c 446 § 23; 2019 c 325 § 1007; 2018 c 201 § 4005; 2017 c 330 § 2; 2016 sp.s. c 29 § 505; 2001 c 323 § 11; 1999 c 10 § 5.]

Reviser's note: This section was amended by 2019 c 325 § 1007 and by 2019 c 446 § 23, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Finding—2017 c 330: "The state finds that the department should not reduce the number of license violations found by field inspectors for the purpose of allowing licensed behavioral health service providers to avoid liability in a manner that permits the violating service provider to continue to provide care at the risk of public safety. The state also recognizes the need to prohibit fraudulent transfers of licenses between licensed behavioral health service providers found in violation of the terms of their license agreement and their family members." [2017 c 330 § 1.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Purpose—Intent—1999 c 10: See note following RCW 71.24.025.

71.24.045 Behavioral health administrative services organization powers and duties. ***(Effective until October 1, 2022.)*** (1) The behavioral health administrative services organization contracted with the authority pursuant to RCW 71.24.381 shall:

(a) Administer crisis services for the assigned regional service area. Such services must include:

(i) A behavioral health crisis hotline for its assigned regional service area;

(ii) Crisis response services twenty-four hours a day, seven days a week, three hundred sixty-five days a year;

(iii) Services related to involuntary commitments under chapters 71.05 and 71.34 RCW;

(iv) Tracking of less restrictive alternative orders issued within the region by superior courts, and providing notification to a managed care organization in the region when one of its enrollees receives a less restrictive alternative order so that the managed care organization may ensure that the person is connected to services and that the requirements of RCW 71.05.585 are complied with. If the person receives a less restrictive alternative order and is returning to another region, the behavioral health administrative services organization shall notify the behavioral health administrative services organization in the home region of the less restrictive alternative order so that the home behavioral health administrative services organization may notify the person's managed care organization or provide services if the person is not enrolled in medicaid and does not have other insurance which can pay for those services;

(v) Additional noncrisis behavioral health services, within available resources, to individuals who meet certain criteria set by the authority in its contracts with the behavioral health administrative services organization. These services may include services provided through federal grant funds, provisos, and general fund state appropriations;

(vi) Care coordination, diversion services, and discharge planning for nonmedicaid individuals transitioning from state hospitals or inpatient settings to reduce rehospitalization and utilization of crisis services, as required by the authority in contract; and

(vii) Regional coordination, cross-system and cross-jurisdiction coordination with tribal governments, and capacity building efforts, such as supporting the behavioral health advisory board, the behavioral health ombuds, and efforts to support access to services or to improve the behavioral health system;

(b) Administer and provide for the availability of an adequate network of evaluation and treatment services to ensure access to treatment, investigation, transportation, court-related, and other services provided as required under chapter 71.05 RCW;

(c) Coordinate services for individuals under RCW 71.05.365;

(d) Administer and provide for the availability of resource management services, residential services, and community support services as required under its contract with the authority;

(e) Contract with a sufficient number, as determined by the authority, of licensed or certified providers for crisis services and other behavioral health services required by the authority;

(f) Maintain adequate reserves or secure a bond as required by its contract with the authority;

(g) Establish and maintain quality assurance processes;

(h) Meet established limitations on administrative costs for agencies that contract with the behavioral health administrative services organization; and

(i) Maintain patient tracking information as required by the authority.

(2) The behavioral health administrative services organization must collaborate with the authority and its contracted managed care organizations to develop and implement strategies to coordinate care with tribes and community behavioral health providers for individuals with a history of frequent crisis system utilization.

(3) The behavioral health administrative services organization shall:

(a) Assure that the special needs of minorities, older adults, individuals with disabilities, children, and low-income persons are met;

(b) Collaborate with local government entities to ensure that policies do not result in an adverse shift of persons with mental illness into state and local correctional facilities; and

(c) Work with the authority to expedite the enrollment or reenrollment of eligible persons leaving state or local correctional facilities and institutions for mental diseases.

(4) The behavioral health administrative services organization shall employ an assisted outpatient treatment program coordinator to oversee system coordination and legal compliance for assisted outpatient treatment under RCW 71.05.148 and 71.34.815. [2022 c 210 § 26; 2021 c 263 § 17; 2019 c 325 § 1008. Prior: 2018 c 201 § 4006; 2018 c 175 § 7; 2016 sp.s. c 29 § 421; 2014 c 225 § 13; 2014 c 225 § 12; 2006 c 333 § 105; 2005 c 503 § 8; 2001 c 323 § 12; 1992 c 230 § 5; prior: 1991 c 363 § 147; 1991 c 306 § 5; 1991 c 29 § 2; 1989 c 205 § 4; 1986 c 274 § 5; 1982 c 204 § 5.]

Expiration date—2022 c 210 § 26: "Section 26 of this act expires October 1, 2022." [2022 c 210 § 34.]

Application—2021 c 263: See note following RCW 10.77.150.

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Findings—Intent—2018 c 175: See note following RCW 74.09.495.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2014 c 225: See note following RCW 71.24.016.

Finding—Purpose—Intent—Severability—Part headings not law—Effective dates—2006 c 333: See notes following RCW 71.24.016.

Intent—1992 c 230: See note following RCW 72.23.025.

Purpose—Captions not law—1991 c 363: See notes following RCW 2.32.180.

Additional notes found at www.leg.wa.gov

71.24.045 Behavioral health administrative services organization powers and duties. ***(Effective October 1, 2022.)*** (1) The behavioral health administrative services organization contracted with the authority pursuant to RCW 71.24.381 shall:

(a) Administer crisis services for the assigned regional service area. Such services must include:

(i) A behavioral health crisis hotline for its assigned regional service area;

(ii) Crisis response services twenty-four hours a day, seven days a week, three hundred sixty-five days a year;

(iii) Services related to involuntary commitments under chapters 71.05 and 71.34 RCW;

(iv) Tracking of less restrictive alternative orders issued within the region by superior courts, and providing notification to a managed care organization in the region when one of its enrollees receives a less restrictive alternative order so that the managed care organization may ensure that the person is connected to services and that the requirements of RCW 71.05.585 are complied with. If the person receives a less restrictive alternative order and is returning to another region, the behavioral health administrative services organization shall notify the behavioral health administrative services organization in the home region of the less restrictive alternative order so that the home behavioral health administrative services organization may notify the person's managed care organization or provide services if the person is not enrolled in medicaid and does not have other insurance which can pay for those services;

(v) Additional noncrisis behavioral health services, within available resources, to individuals who meet certain criteria set by the authority in its contracts with the behavioral health administrative services organization. These services may include services provided through federal grant funds, provisos, and general fund state appropriations;

(vi) Care coordination, diversion services, and discharge planning for nonmedicaid individuals transitioning from state hospitals or inpatient settings to reduce rehospitalization and utilization of crisis services, as required by the authority in contract; and

(vii) Regional coordination, cross-system and cross-jurisdiction coordination with tribal governments, and capacity building efforts, such as supporting the behavioral health advisory board and efforts to support access to services or to improve the behavioral health system;

(b) Administer and provide for the availability of an adequate network of evaluation and treatment services to ensure access to treatment, investigation, transportation, court-related, and other services provided as required under chapter 71.05 RCW;

(c) Coordinate services for individuals under RCW 71.05.365;

(d) Administer and provide for the availability of resource management services, residential services, and community support services as required under its contract with the authority;

(e) Contract with a sufficient number, as determined by the authority, of licensed or certified providers for crisis services and other behavioral health services required by the authority;

(f) Maintain adequate reserves or secure a bond as required by its contract with the authority;

(g) Establish and maintain quality assurance processes;

(h) Meet established limitations on administrative costs for agencies that contract with the behavioral health administrative services organization; and

(i) Maintain patient tracking information as required by the authority.

(2) The behavioral health administrative services organization must collaborate with the authority and its contracted managed care organizations to develop and implement strategies to coordinate care with tribes and community behavioral health providers for individuals with a history of frequent crisis system utilization.

(3) The behavioral health administrative services organization shall:

(a) Assure that the special needs of minorities, older adults, individuals with disabilities, children, and low-income persons are met;

(b) Collaborate with local government entities to ensure that policies do not result in an adverse shift of persons with mental illness into state and local correctional facilities; and

(c) Work with the authority to expedite the enrollment or reenrollment of eligible persons leaving state or local correctional facilities and institutions for mental diseases.

(4) The behavioral health administrative services organization shall employ an assisted outpatient treatment program coordinator to oversee system coordination and legal compliance for assisted outpatient treatment under RCW 71.05.148 and 71.34.815. [2022 c 210 § 27. Prior: 2021 c 263 § 17; 2021 c 202 § 15; 2019 c 325 § 1008; prior: 2018 c 201 § 4006; 2018 c 175 § 7; 2016 sp.s. c 29 § 421; 2014 c 225 § 13; 2014 c 225 § 12; 2006 c 333 § 105; 2005 c 503 § 8; 2001 c 323 § 12; 1992 c 230 § 5; prior: 1991 c 363 § 147; 1991 c 306 § 5; 1991 c 29 § 2; 1989 c 205 § 4; 1986 c 274 § 5; 1982 c 204 § 5.]

Effective date—2022 c 210 § 27: "Section 27 of this act takes effect October 1, 2022." [2022 c 210 § 35.]

Application—2021 c 263: See note following RCW 10.77.150.

Effective date—2021 c 202 §§ 15-17: "Sections 15 through 17 of this act take effect October 1, 2022." [2021 c 202 § 19.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Findings—Intent—2018 c 175: See note following RCW 74.09.495.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2014 c 225: See note following RCW 71.24.016.

Finding—Purpose—Intent—Severability—Part headings not law—Effective dates—2006 c 333: See notes following RCW 71.24.016.

Intent—1992 c 230: See note following RCW 72.23.025.

Purpose—Captions not law—1991 c 363: See notes following RCW 2.32.180.

Additional notes found at www.leg.wa.gov

71.24.061 Children's mental health provider networks—Children's mental health evidence-based practice institute—Partnership access line pilot programs—Report to legislature. (1) The authority shall provide flexibility to encourage licensed or certified community behavioral health agencies to subcontract with an adequate, culturally competent, and qualified children's mental health provider network.

(2) To the extent that funds are specifically appropriated for this purpose or that nonstate funds are available, a children's mental health evidence-based practice institute shall be established at the University of Washington department of psychiatry and behavioral sciences. The institute shall closely collaborate with entities currently engaged in evaluating and promoting the use of evidence-based, research-based, promising, or consensus-based practices in children's mental health treatment, including but not limited to the University of Washington department of psychiatry and behavioral sciences, Seattle children's hospital, the University of Washing-

ton school of nursing, the University of Washington school of social work, and the Washington state institute for public policy. To ensure that funds appropriated are used to the greatest extent possible for their intended purpose, the University of Washington's indirect costs of administration shall not exceed ten percent of appropriated funding. The institute shall:

(a) Improve the implementation of evidence-based and research-based practices by providing sustained and effective training and consultation to licensed children's mental health providers and child-serving agencies who are implementing evidence-based or researched-based practices for treatment of children's emotional or behavioral disorders, or who are interested in adapting these practices to better serve ethnically or culturally diverse children. Efforts under this subsection should include a focus on appropriate oversight of implementation of evidence-based practices to ensure fidelity to these practices and thereby achieve positive outcomes;

(b) Continue the successful implementation of the "partnerships for success" model by consulting with communities so they may select, implement, and continually evaluate the success of evidence-based practices that are relevant to the needs of children, youth, and families in their community;

(c) Partner with youth, family members, family advocacy, and culturally competent provider organizations to develop a series of information sessions, literature, and online resources for families to become informed and engaged in evidence-based and research-based practices;

(d) Participate in the identification of outcome-based performance measures under RCW 71.36.025(2) and partner in a statewide effort to implement statewide outcomes monitoring and quality improvement processes; and

(e) Serve as a statewide resource to the authority and other entities on child and adolescent evidence-based, research-based, promising, or consensus-based practices for children's mental health treatment, maintaining a working knowledge through ongoing review of academic and professional literature, and knowledge of other evidence-based practice implementation efforts in Washington and other states.

(3)(a) To the extent that funds are specifically appropriated for this purpose, the authority in collaboration with the University of Washington department of psychiatry and behavioral sciences and Seattle children's hospital shall implement the following access lines:

(i) The partnership access line to support primary care providers in the assessment and provision of appropriate diagnosis and treatment of children with mental and behavioral health disorders and track outcomes of this program;

(ii) The partnership access line for moms to support obstetricians, pediatricians, primary care providers, mental health professionals, and other health care professionals providing care to pregnant women and new mothers through same-day telephone consultations in the assessment and provision of appropriate diagnosis and treatment of depression in pregnant women and new mothers; and

(iii) The mental health referral service for children and teens to facilitate referrals to children's mental health services and other resources for parents and guardians with concerns related to the mental health of the parent or guardian's child. Facilitation activities include assessing the level of services needed by the child; within an average of seven days from call intake processing with a parent or guardian, identifying mental health professionals who are in-network with the child's health care coverage who are accepting new patients and taking appointments; coordinating contact between the parent or guardian and the mental health professional; and providing postreferral reviews to determine if the child has outstanding needs. In conducting its referral activities, the program shall collaborate with existing databases and resources to identify in-network mental health professionals.

(b) The program activities described in (a) of this subsection shall be designed to promote more accurate diagnoses and treatment through timely case consultation between primary care providers and child psychiatric specialists, and focused educational learning collaboratives with primary care providers.

(4) The authority, in collaboration with the University of Washington department of psychiatry and behavioral sciences and Seattle children's hospital, shall report on the following:

(a) The number of individuals who have accessed the resources described in subsection (3) of this section;

(b) The number of providers, by type, who have accessed the resources described in subsection (3) of this section;

(c) Demographic information, as available, for the individuals described in (a) of this subsection. Demographic information may not include any personally identifiable information and must be limited to the individual's age, gender, and city and county of residence;

(d) A description of resources provided;

(e) Average time frames from receipt of call to referral for services or resources provided; and

(f) Systemic barriers to services, as determined and defined by the health care authority, the University of Washington department of psychiatry and behavioral sciences, and Seattle children's hospital.

(5) Beginning December 30, 2019, and annually thereafter, the authority must submit, in compliance with RCW 43.01.036, a report to the governor and appropriate committees of the legislature with findings and recommendations for improving services and service delivery from subsection (4) of this section.

(6) The authority shall enforce requirements in managed care contracts to ensure care coordination and network adequacy issues are addressed in order to remove barriers to access to mental health services identified in the report described in subsection (4) of this section. [2021 c 126 § 1; 2020 c 291 § 1; 2019 c 325 § 1009. Prior: 2018 c 288 § 2; 2018 c 201 § 4007; 2014 c 225 § 35; 2007 c 359 § 7.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

Additional notes found at www.leg.wa.gov

71.24.062 Psychiatry consultation line—Implementation. (1) To the extent that funds are specifically appropriated for this purpose or nonstate funds are available, the authority in collaboration with the University of Washington department of psychiatry and behavioral sciences shall implement a psychiatric consultation call center to provide

emergency department providers, primary care providers, and county and municipal correctional facility providers with on-demand access to psychiatric and substance use disorder clinical consultation for adult patients.

(2) When clinically appropriate and technically feasible, the clinical consultation may occur via telemedicine.

(3) Beginning in fiscal year 2021, to the extent that adequate funds are appropriated, the service shall be available seven days a week, twenty-four hours a day. [2020 c 291 § 2.]

71.24.063 Partnership access lines—Psychiatric consultation lines—Data collection. (1) The University of Washington department of psychiatry and behavioral health sciences shall collect the following information for the partnership access line described in RCW 71.24.061(3)(a)(i), partnership access line for moms described in *RCW 71.24.061(3)(a)(ii)(A), and the psychiatric consultation line described in RCW 71.24.062, in coordination with any hospital that it collaborates with to administer the programs:

(a) The number of individuals served;

(b) Demographic information regarding the individuals served, as available, including the individual's age, gender, and city and county of residence. Demographic information may not include any personally identifiable information;

(c) Demographic information regarding the providers placing the calls, including type of practice, and city and county of practice;

(d) Insurance information, including health plan and carrier, as available;

(e) A description of the resources provided; and

(f) Provider satisfaction.

(2) The University of Washington department of psychiatry and behavioral health sciences shall collect the following information for the program called the partnership access line for kids referral and assistance service described in *RCW 71.24.061(3)(a)(ii)(B), in coordination with any hospital that it collaborates with to administer the program:

(a) The number of individuals served;

(b) Demographic information regarding the individuals served, as available, including the individual's age, gender, and city and county of residence. Demographic information may not include any personally identifiable information;

(c) Demographic information regarding the parents or guardians placing the calls, including family location;

(d) Insurance information, including health plan and carrier, as available;

(e) A description of the resources provided;

(f) Average time frames from receipt of the call to referral for services or resources provided;

(g) The most frequently requested issues that parents and guardians are asking for assistance with;

(h) The most frequently requested issues that families are asking for referral assistance with;

(i) The number of individuals that receive an appointment based on referral assistance; and

(j) Parent or guardian satisfaction. [2020 c 291 § 3.]

***Reviser's note:** RCW 71.24.061 was amended by 2021 c 126 § 1, changing subsection (3)(a)(ii)(A) and (B) to subsection (3)(a)(ii) and (iii), respectively. Also, the "partnership access line for kids referral and assistance service" was changed to "mental health referral service for children and teens."

71.24.064 Partnership access lines—Psychiatric consultation lines—Funding—Performance measures. (1) Beginning July 1, 2021, the partnership access lines described in RCW 71.24.061(3)(a), and the psychiatric consultation line described in RCW 71.24.062, shall be funded as follows:

(a) The authority, in consultation with the University of Washington department of psychiatry and behavioral sciences and Seattle children's hospital shall determine the annual costs of operating each program, as well as the authority's costs for administering the programs.

(b) For each program, the authority shall calculate the proportion of clients that are covered by programs administered pursuant to chapter 74.09 RCW. The state must cover the cost for programs administered pursuant to chapter 74.09 RCW through state and federal funds, as appropriated.

(c)(i) The authority shall collect a proportional share of program costs from each of the following entities that are not for covered lives under contract with the authority as medicaid managed care organizations:

(A) Health carriers, as defined in RCW 48.43.005;

(B) Self-funded multiple employer welfare arrangements, as defined in RCW 48.125.010;

(C) Employers or other entities that provide health care in this state, including self-funding entities or employee welfare benefit plans.

(ii) For entities listed in (c)(i) of this subsection, a proportional share of the entity's annual program costs for each program must be calculated by determining the annual cost of operating the program not covered under (b) of this subsection and multiplying it by a fraction that in which the numerator is the entity's total number of resident insured persons among the population served by the program and the denominator is the total number of residents in the state who are served by the program and not covered by programs administered pursuant to chapter 74.09 RCW. The total number of resident insured persons among the population served by the program shall be determined according to the covered lives per calendar year determined by covered person months.

(iii) The entities listed in (c)(i) of this subsection shall provide information needed to calculate the proportional share of program costs under this section to the authority.

(d) The authority's administrative costs for these programs may not be included in the assessments.

(2) The authority may contract with a third-party administrator to calculate and administer the assessments of the entities identified in subsection (1)(c)(i) of this section.

(3) The authority shall develop separate performance measures for the partnership access lines described in RCW 71.24.061(3)(a), and the psychiatric consultation line described in RCW 71.24.062.

(4) The University of Washington department of psychiatry and behavioral sciences, in coordination with any hospital that it collaborates with to administer the programs, shall provide quarterly reports to the authority on the demographic data collected by each program, as described in RCW 71.24.063 (1) and (2), any performance measures specified by the authority, and systemic barriers to services, as deter-

mined and defined by the authority, the University of Washington, and Seattle children's hospital. [2020 c 291 § 4.]

71.24.066 Partnership access line pilot programs—Determination to be made permanent—Long-term funding. Using data from the reports required in RCW 71.24.061(5), the legislature shall decide whether to make the partnership access line for moms and the partnership access line for kids referral and assistance [service] programs, as described in *RCW 71.24.061(3)(a)(ii), permanent programs. If the legislature decides to make the programs permanent, the programs shall be funded in the same manner as in RCW 71.24.062 beginning July 1, 2021. [2020 c 291 § 5.]

***Reviser's note:** RCW 71.24.061 was amended by 2021 c 126 § 1, changing subsection (3)(a)(ii)(A) and (B) to subsection (3)(a)(ii) and (iii), respectively. Also, the "partnership access line for kids referral and assistance service" was changed to "mental health referral service for children and teens."

71.24.067 Partnership access lines—Psychiatric consultation lines—Review. (1) The joint legislative audit and review committee shall conduct a review, in consultation with the authority, the University of Washington department of psychiatry and behavioral science[s,] and Seattle children's hospital, of the programs as described in RCW 71.24.061(3)(a) and 71.24.062, covering the period from January 1, 2019, through December 30, 2021. The review shall evaluate the programs' success at addressing patients' issues related to access to mental health and substance use disorder services.

(2) The joint legislative audit and review committee shall submit the review, including its findings and recommendations, to the legislature by December 1, 2022. [2020 c 291 § 6.]

71.24.068 Telebehavioral health access account. The telebehavioral health access account is created in the state treasury. All receipts from collections under RCW 71.24.064 must be deposited into the account. Moneys in the account may be spent only after appropriation. Expenditures from the account may be used only for supporting telebehavioral health programs identified in RCW 71.24.061(3)(a) and 71.24.062. [2020 c 291 § 7.]

71.24.100 County-run behavioral health administrative services organizations—Joint operating agreements—Requirements. (1) A county authority or a group of county authorities may enter into a joint operating agreement to submit a request to contract with the authority to operate a behavioral health administrative services organization whose boundaries are consistent with the regional service areas established under RCW 74.09.870.

(2) All counties within the regional service area must mutually agree to enter into a contract with the authority to become a behavioral health administrative services organization and appoint a single fiscal agent for the regional service area. Similarly, in order to terminate such contract, all counties that are contracted with the authority as a behavioral health administrative services organization must mutually agree to terminate the contract with the authority.

(3) Once the authority receives a request from a county or a group of counties within a regional service area to be the designated behavioral health administrative services organization, the authority must promptly collaborate with the county or group of counties within that regional service area to determine the most feasible implementation date and coordinate readiness reviews.

(4) No behavioral health administrative services organization may contract with itself as a behavioral health agency, or contract with a behavioral health agency that has administrative linkages to the behavioral health administrative services organization in any manner that would give the agency a competitive advantage in obtaining or competing for contracts, except that a county or group of counties may provide designated crisis responder services, initial crisis services, criminal diversion services, hospital reentry services, and criminal reentry services. The county-administered service must have a clear separation of powers and duties separate from a county-run behavioral health administrative services organization and suitable accounting procedures must be followed to ensure the funding is traceable and accounted for separately from other funds.

(5) Nothing in this section limits the authority's ability to take remedial actions up to and including termination of a contract in order to enforce contract terms or to remedy nonperformance of contractual duties. [2019 c 325 § 1010; 2018 c 201 § 4008; 2014 c 225 § 14; 2012 c 117 § 442; 2005 c 503 § 9; 1982 c 204 § 7; 1967 ex.s. c 111 § 10.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

Additional notes found at www.leg.wa.gov

71.24.115 Recovery navigator programs—Reports. (1) Each behavioral health administrative services organization shall establish a recovery navigator program. The program shall provide community-based outreach, intake, assessment, and connection to services and, as appropriate, long-term intensive case management and recovery coaching services, to youth and adults with substance use disorder, including for persons with co-occurring substance use disorders and mental health conditions, who are referred to the program from diverse sources and shall facilitate and coordinate connections to a broad range of community resources for youth and adults with substance use disorder, including treatment and recovery support services.

(2) The authority shall establish uniform program standards for behavioral health administrative services organizations to follow in the design of their recovery navigator programs. The uniform program standards must be modeled upon the components of the law enforcement assisted diversion program and address project management, field engagement, biopsychosocial assessment, intensive case management and care coordination, stabilization housing when available and appropriate, and, as necessary, legal system coordination. The authority must adopt the uniform program standards from the components of the law enforcement assisted diversion program to accommodate an expanded population of persons with substance use disorders, including persons with co-occurring substance use disorders and mental health conditions, and allow for referrals from a broad range of sources. In addition to accepting referrals from law

enforcement, the uniform program standards must provide guidance for accepting referrals on behalf of persons with substance use disorders, including persons with co-occurring substance use disorders and mental health conditions, from various sources including, but not limited to, self-referral, family members of the individual, emergency department personnel, persons engaged with serving homeless persons, including those living unsheltered or in encampments, fire department personnel, emergency medical service personnel, community-based organizations, members of the business community, harm reduction program personnel, faith-based organization staff, and other sources within the criminal legal system, as outlined within the sequential intercept model. In developing response time requirements within the statewide program standards, the authority shall require, subject to the availability of amounts appropriated for this specific purpose, that responses to referrals from law enforcement occur immediately for in-custody referrals and shall strive for rapid response times to other appropriate settings such as emergency departments.

(3) Subject to the availability of amounts appropriated for this specific purpose, the authority shall provide funding to each behavioral health administrative services organization for the development of its recovery navigator program. Before receiving funding for implementation and ongoing administration, each behavioral health administrative services organization must submit a program plan that demonstrates the ability to fully comply with statewide program standards. The authority shall establish a schedule for the regular review of behavioral health administrative services organizations' programs. The authority shall arrange for technical assistance to be provided by the LEAD national support bureau to all behavioral health administrative services organizations.

(4) Each behavioral health administrative services organization must have a substance use disorder regional administrator for its recovery navigator program. The regional administrator shall be responsible for assuring compliance with program standards, including staffing standards. Each recovery navigator program must maintain a sufficient number of appropriately trained personnel for providing intake and referral services, conducting comprehensive biopsychosocial assessments, providing intensive case management services, and making warm handoffs to treatment and recovery support services along the continuum of care. Program staff must include people with lived experience with substance use disorder to the extent possible. The substance use disorder regional administrator must assure that staff who are conducting intake and referral services and field assessments are paid a livable and competitive wage and have appropriate initial training and receive continuing education.

(5) Each recovery navigator program must submit quarterly reports to the authority with information identified by the authority and the substance use recovery services advisory committee. The reports must be provided to the substance use recovery services advisory committee for discussion at meetings following the submission of the reports. [2021 c 311 § 2.]

Effective date—2021 c 311 §§ 1-11 and 13-21: "Sections 1 through 11 and 13 through 21 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect immediately [May 13, 2021]." [2021 c 311 § 26.]

71.24.125 Grant program—Treatment services—Regional access standards. (1) Subject to the availability of amounts appropriated for this specific purpose, the authority shall establish a grant program to:

(a) Provide treatment services for low-income individuals with substance use disorder who are not eligible for medical assistance programs under chapter 74.09 RCW, with priority for the use of the funds for very low-income individuals; and

(b) Provide treatment services that are not eligible for federal matching funds to individuals who are enrolled in medical assistance programs under chapter 74.09 RCW.

(2) In establishing the grant program, the authority shall consult with the substance use recovery services advisory committee established in RCW 71.24.546, behavioral health administrative services organizations, managed care organizations, and regional behavioral health providers to adopt regional standards that are consistent with the substance use recovery services plan developed under RCW 71.24.546 to provide sufficient access for youth and adults to meet each region's needs for:

(a) Opioid use disorder treatment programs;

(b) Low-barrier buprenorphine clinics;

(c) Outpatient substance use disorder treatment;

(d) Withdrawal management services, including both subacute and medically managed withdrawal management;

(e) Secure withdrawal management and stabilization services;

(f) Inpatient substance use disorder treatment services;

(g) Inpatient co-occurring disorder treatment services; and

(h) Behavioral health crisis walk-in and drop-off services.

(3) Funds in the grant program must be used to reimburse providers for the provision of services to individuals identified in subsection (1) of this section. The authority may use the funds to support evidence-based practices and promising practices that are not reimbursed by medical assistance or private insurance, including contingency management. In addition, funds may be used to provide assistance to organizations to establish or expand services as reasonably necessary and feasible to increase the availability of services to achieve the regional access standards developed under subsection (2) of this section, including such items as training and recruitment of personnel, reasonable modifications to existing facilities to accommodate additional clients, start-up funding, and similar forms of assistance. Funds may not be used to support the ongoing operational costs of a provider or organization, except in relation to payments for specific service encounters with an individual identified in subsection (1) of this section or for noninsurance reimbursable services.

(4) The authority must establish regional access standards under subsection (2) of this section, subject to the availability of amounts appropriated for this specific purpose, by January 1, 2023, and begin distributing grant funds by March 1, 2023. [2021 c 311 § 3.]

Effective date—2021 c 311 §§ 1-11 and 13-21: See note following RCW 71.24.115.

71.24.135 Expanded recovery support services program—Regional expanded recovery plans. (1) Subject to the availability of amounts appropriated for this specific purpose, the authority shall establish the expanded recovery support services program to increase access to recovery services for individuals in recovery from substance use disorder.

(2) In establishing the program, the authority shall consult with the substance use recovery services advisory committee established in RCW 71.24.546, behavioral health administrative services organizations, regional behavioral health providers, and regional community organizations that support individuals in recovery from substance use disorders, including individuals with co-occurring substance use disorders and mental health conditions, to adopt regional expanded recovery plans that are consistent with the substance use recovery services plan developed under RCW 71.24.546 to provide sufficient access for youth and adults to meet each region's needs for:

(a) Recovery housing;

(b) Employment pathways, support, training, and job placement, including evidence-based supported employment program services;

(c) Education pathways, including recovery high schools and collegiate recovery programs;

(d) Recovery coaching and substance use disorder peer support;

(e) Social connectedness initiatives, including the recovery café model;

(f) Family support services, including family reconciliation services;

(g) Technology-based recovery support services;

(h) Transportation assistance; and

(i) Legal support services.

(3) Funds in the expanded recovery support services program must be used to reimburse providers for the provision of services to individuals in recovery from substance use disorders, including individuals with co-occurring substance use disorders and mental health conditions. In addition, the funds may be used to provide assistance to organizations to establish or expand recovery support services as reasonably necessary and feasible to increase the availability of services to achieve the regional expanded recovery plans developed under subsection (2) of this section, including such items as training and recruitment of personnel, reasonable modifications to existing facilities to accommodate additional clients, and similar forms of assistance.

(4) The authority must establish regional expanded recovery plans under subsection (2) of this section, subject to the availability of amounts appropriated for this specific purpose, by January 1, 2023, and begin distributing grant funds by March 1, 2023. [2021 c 311 § 4.]

Effective date—2021 c 311 §§ 1-11 and 13-21: See note following RCW 71.24.115.

71.24.145 Homeless outreach stabilization transition program—Psychiatric outreach—Contingency management resources—Substance misuse prevention effort—Grants. (1) Subject to the availability of amounts appropriated for this specific purpose, the authority shall establish a homeless outreach stabilization transition program to expand access to modified assertive community treatment services provided by multidisciplinary behavioral health outreach teams to serve people who are living with serious substance use disorders or co-occurring substance use disorders and mental health conditions, are experiencing homelessness, and whose severity of behavioral health symptom acuity level creates a barrier to accessing and receiving conventional behavioral health services and outreach models.

(a) In establishing the program, the authority shall consult with behavioral health outreach organizations who have experience delivering this service model in order to establish program guidelines regarding multidisciplinary team staff types, service intensity and quality fidelity standards, and criteria to ensure programs are reaching the appropriate priority population.

(b) Funds for the homeless outreach stabilization transition program must be used to reimburse organizations for the provision of multidisciplinary outreach services to individuals who are living with substance use disorders or co-occurring substance use and mental health disorders and are experiencing homelessness or transitioning from homelessness to housing. The funds may be used to provide assistance to organizations to establish or expand services as reasonably necessary to create a homeless outreach stabilization transition program, including items such as training and recruitment of personnel, outreach and engagement resources, client engagement and health supplies, medications for people who do not have access to insurance, and similar forms of assistance.

(c) The authority must establish one or more homeless outreach stabilization transition programs by January 1, 2024, and begin distributing grant funds by March 1, 2024.

(2) Subject to the availability of amounts appropriated for this specific purpose, the authority shall establish a project for psychiatric outreach to the homeless program to expand access to behavioral health medical services for people who are experiencing homelessness and living in permanent supportive housing.

(a) In establishing the program, the authority shall consult with behavioral health medical providers, homeless service providers, and permanent supportive housing providers that support people living with substance use disorders, co-occurring substance use and mental health conditions, and people who are currently or have formerly experienced homelessness.

(b) Funds for the project for psychiatric outreach to the homeless program must be used to reimburse organizations for the provision of medical services to individuals who are living with or in recovery from substance use disorders, co-occurring substance use and mental health disorders, or other behavioral and physical health conditions. Organizations must provide medical services to people who are experiencing homelessness or are living in permanent supportive housing and would be at risk of homelessness without access to appropriate services. The funds may be used to provide assistance to organizations to establish or expand behavioral health medical services as reasonably necessary to create a project for psychiatric outreach to the homeless program, including items such as training and recruitment of personnel, outreach and engagement resources, medical equipment and health supplies, medications for people who do not have access to insurance, and similar forms of assistance.

(c) The authority must establish one or more projects for psychiatric outreach to the homeless programs by January 1, 2024, and begin distributing grant funds by March 1, 2024.

(3) Subject to the availability of amounts appropriated for this specific purpose, the authority shall increase contingency management resources for opioid treatment networks that are serving people living with co-occurring stimulant use and opioid use disorder.

(4) Subject to the availability of amounts appropriated for this specific purpose, the authority shall develop a plan for implementing a comprehensive statewide substance misuse prevention effort. The plan must be completed by January 1, 2024.

(5) Subject to the availability of amounts appropriated for this specific purpose, the authority shall administer a competitive grant process to broaden existing local community coalition efforts to prevent substance misuse by increasing relevant protective factors while decreasing risk factors. Coalitions are to be open to all stakeholders interested in substance misuse prevention, including, but not limited to, representatives from people in recovery, law enforcement, education, behavioral health, parent organizations, treatment organizations, organizations serving youth, prevention professionals, and business. [2021 c 311 § 5.]

Effective date—2021 c 311 §§ 1-11 and 13-21: See note following RCW 71.24.115.

71.24.155 Grants to behavioral health administrative services, managed care organizations, and Indian health care providers—Accounting. Grants shall be made by the authority to behavioral health administrative services organizations, managed care organizations for community behavioral health programs, and Indian health care providers who have community behavioral health programs totaling not less than ninety-five percent of available resources. The authority may use up to forty percent of the remaining five percent to provide community demonstration projects, including early intervention or primary prevention programs for children, and the remainder shall be for emergency needs and technical assistance under this chapter. [2020 c 256 § 203; 2019 c 325 § 1011; 2018 c 201 § 4009; 2014 c 225 § 36; 2001 c 323 § 14; 1987 c 505 § 65; 1986 c 274 § 9; 1982 c 204 § 9.]

Effective date—2020 c 256 § 203: "Section 203 of this act takes effect July 1, 2021." [2020 c 256 § 503.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

Additional notes found at www.leg.wa.gov

71.24.160 Proof as to uses made of state funds—Use of maintenance of effort funds. The behavioral health administrative services organizations shall make satisfactory showing to the director that state funds shall in no case be used to replace local funds from any source being used to finance mental health services prior to January 1, 1990. Maintenance of effort funds devoted to judicial services related to involuntary commitment reimbursed under RCW 71.05.730 must be expended for other purposes that further treatment for mental health and substance use disorders. [2019 c 325 § 1012; 2018 c 201 § 4010; 2014 c 225 § 37; 2011 c 343 § 6; 2001 c 323 § 15; 1989 c 205 § 7; 1982 c 204 § 10; 1967 ex.s. c 111 § 16.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

Intent—Effective date—2011 c 343: See notes following RCW 71.05.730.

71.24.200 Expenditures of county funds subject to county fiscal laws. Expenditures of county funds under this chapter shall be subject to the provisions of chapter 36.40 RCW and other statutes relating to expenditures by counties. [1967 ex.s. c 111 § 20.]

71.24.215 Sliding-scale fee schedules for clients receiving behavioral health services. Clients receiving behavioral health services funded by available resources shall be charged a fee under sliding-scale fee schedules, based on ability to pay, approved by the authority. Fees shall not exceed the actual cost of care. [2019 c 325 § 1013; 2018 c 201 § 4011; 1982 c 204 § 11.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.24.220 State grants may be withheld for noncompliance with chapter or related rules. The director may withhold state grants in whole or in part for any community behavioral health program in the event of a failure to comply with this chapter or the related rules adopted by the authority. [2019 c 325 § 1014; 2018 c 201 § 4012; 1999 c 10 § 8; 1982 c 204 § 12; 1967 ex.s. c 111 § 22.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Purpose—Intent—1999 c 10: See note following RCW 71.24.025.

71.24.240 Eligibility for funding—Community behavioral health program plans to be approved by director prior to submittal to federal agency. In order to establish eligibility for funding under this chapter, any behavioral health administrative services organization seeking to obtain federal funds for the support of any aspect of a community behavioral health program as defined in this chapter shall submit program plans to the director for prior review and approval before such plans are submitted to any federal agency. [2019 c 325 § 1015; 2018 c 201 § 4013; 2014 c 225 § 49; 2005 c 503 § 10; 1982 c 204 § 13; 1967 ex.s. c 111 § 24.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

Additional notes found at www.leg.wa.gov

71.24.250 Behavioral health administrative services organizations—Receipt of gifts and grants. The behavioral health administrative services organization may accept and expend gifts and grants received from private, county,

state, and federal sources. [2019 c 325 § 1016; 2014 c 225 § 38; 2001 c 323 § 16; 1982 c 204 § 14; 1967 ex.s. c 111 § 25.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective date—2014 c 225: See note following RCW 71.24.016.

71.24.260 Waiver of postgraduate educational requirements—Mental health professionals. The department shall waive postgraduate educational requirements applicable to mental health professionals under this chapter for those persons who have a bachelor's degree and on June 11, 1986:

(1) Are employed by an agency subject to licensure under this chapter, the community behavioral health services act, in a capacity involving the treatment of mental illness; and

(2) Have at least ten years of full-time experience in the treatment of mental illness. [2019 c 325 § 1017; 1986 c 274 § 10.]

Effective date—2019 c 325: See note following RCW 71.24.011.

71.24.300 Behavioral health administrative services organizations—Advisory boards—Inclusion of tribes—Roles and responsibilities. (1) Each behavioral health administrative services organization shall appoint a behavioral health advisory board which shall review and provide comments on plans and policies developed under this chapter, provide local oversight regarding the activities of the behavioral health administrative services organization, and work with the behavioral health administrative services organization to resolve significant concerns regarding service delivery and outcomes. The authority shall establish statewide procedures for the operation of regional advisory committees including mechanisms for advisory board feedback to the authority regarding behavioral health administrative services organization performance. The composition of the board shall be broadly representative of the demographic character of the region and shall include, but not be limited to, representatives of consumers of substance use disorder and mental health services and their families, law enforcement, and, where the county is not the behavioral health administrative services organization, county elected officials. Composition and length of terms of board members may differ between behavioral health administrative services organizations but shall be included in each behavioral health administrative services organization's contract and approved by the director.

(2) The authority must allow for the inclusion of tribes in any interlocal leadership structure or committees formed under RCW 71.24.880, when requested by a tribe.

(3) If an interlocal leadership structure is not formed under RCW 71.24.880, the roles and responsibilities of the behavioral health administrative services organizations, managed care organizations, counties, and each tribe shall be determined by the authority through negotiation with the tribes. [2019 c 325 § 1018; 2018 c 201 § 4014; 2016 sp.s. c 29 § 522; 2015 c 269 § 10; 2014 c 225 § 39; 2008 c 261 § 4; 2006 c 333 § 106; 2005 c 503 § 11; 2001 c 323 § 17. Prior: 1999 c 214 § 8; 1999 c 10 § 9; 1994 c 204 § 2; 1992 c 230 § 6; prior: 1991 c 295 § 3; 1991 c 262 § 2; 1991 c 29 § 3; 1989 c 205 § 5.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2015 c 269 §§ 10 and 14: "Sections 10 and 14 of this act take effect April 1, 2016." [2015 c 269 § 19.]

Effective date—2014 c 225: See note following RCW 71.24.016.

Intent—Findings—2008 c 261: See note following RCW 71.24.025.

Finding—Purpose—Intent—Severability—Part headings not law—Effective dates—2006 c 333: See notes following RCW 71.24.016.

Intent—Effective date—1999 c 214: See notes following RCW 72.09.370.

Purpose—Intent—1999 c 10: See note following RCW 71.24.025.

Intent—1992 c 230: See note following RCW 72.23.025.

Additional notes found at www.leg.wa.gov

71.24.335 Reimbursement for behavioral health services provided through telemedicine or store and forward technology—Coverage requirements—Audio-only telemedicine. (1) Upon initiation or renewal of a contract with the authority, behavioral health administrative services organizations and managed care organizations shall reimburse a provider for a behavioral health service provided to a covered person through telemedicine or store and forward technology if:

(a) The behavioral health administrative services organization or managed care organization in which the covered person is enrolled provides coverage of the behavioral health service when provided in person by the provider;

(b) The behavioral health service is medically necessary; and

(c) Beginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider.

(2)(a) If the service is provided through store and forward technology there must be an associated visit between the covered person and the referring provider. Nothing in this section prohibits the use of telemedicine for the associated office visit.

(b) For purposes of this section, reimbursement of store and forward technology is available only for those services specified in the negotiated agreement between the behavioral health administrative services organization, or managed care organization, and the provider.

(3) An originating site for a telemedicine behavioral health service subject to subsection (1) of this section means an originating site as defined in rule by the department or the health care authority.

(4) Any originating site, other than a home, under subsection (3) of this section may charge a facility fee for infrastructure and preparation of the patient. Reimbursement must be subject to a negotiated agreement between the originating site and the behavioral health administrative services organization, or managed care organization, as applicable. A distant site, a hospital that is an originating site for audio-only telemedicine, or any other site not identified in subsection (3) of this section may not charge a facility fee.

(5) Behavioral health administrative services organizations and managed care organizations may not distinguish

between originating sites that are rural and urban in providing the coverage required in subsection (1) of this section.

(6) Behavioral health administrative services organizations and managed care organizations may subject coverage of a telemedicine or store and forward technology behavioral health service under subsection (1) of this section to all terms and conditions of the behavioral health administrative services organization or managed care organization in which the covered person is enrolled, including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable behavioral health care service provided in person.

(7) This section does not require a behavioral health administrative services organization or a managed care organization to reimburse:

(a) An originating site for professional fees;

(b) A provider for a behavioral health service that is not a covered benefit; or

(c) An originating site or provider when the site or provider is not a contracted provider.

(8)(a) If a provider intends to bill a patient, a behavioral health administrative services organization, or a managed care organization for an audio-only telemedicine service, the provider must obtain patient consent for the billing in advance of the service being delivered.

(b) If the health care authority has cause to believe that a provider has engaged in a pattern of unresolved violations of this subsection (8), the health care authority may submit information to the appropriate disciplining authority, as defined in RCW 18.130.020, for action. Prior to submitting information to the appropriate disciplining authority, the health care authority may provide the provider with an opportunity to cure the alleged violations or explain why the actions in question did not violate this subsection (8).

(c) If the provider has engaged in a pattern of unresolved violations of this subsection (8), the appropriate disciplining authority may levy a fine or cost recovery upon the provider in an amount not to exceed the applicable statutory amount per violation and take other action as permitted under the authority of the disciplining authority. Upon completion of its review of any potential violation submitted by the health care authority or initiated directly by an enrollee, the disciplining authority shall notify the health care authority of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation.

(9) For purposes of this section:

(a)(i) "Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.

(ii) For purposes of this section only, "audio-only telemedicine" does not include:

(A) The use of facsimile or email; or

(B) The delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results;

(b) "Disciplining authority" has the same meaning as in RCW 18.130.020;

(c) "Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine;

(d) "Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and:

(i) The covered person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(ii) The covered person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine;

(e) "Hospital" means a facility licensed under chapter 70.41, 71.12, or 72.23 RCW;

(f) "Originating site" means the physical location of a patient receiving behavioral health services through telemedicine;

(g) "Provider" has the same meaning as in RCW 48.43.005;

(h) "Store and forward technology" means use of an asynchronous transmission of a covered person's medical or behavioral health information from an originating site to the provider at a distant site which results in medical or behavioral health diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email; and

(i) "Telemedicine" means the delivery of health care or behavioral health services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" includes audio-only telemedicine, but does not include facsimile or email.

(10) The authority must adopt rules as necessary to implement the provisions of this section. [2022 c 213 § 3. Prior: 2021 c 157 § 4; 2021 c 100 § 1; 2019 c 325 § 1019; 2017 c 202 § 7.]

Conflict with federal requirements—2022 c 213: See note following RCW 41.05.700.

Conflict with federal requirements—2021 c 157: See note following RCW 74.09.327.

Effective date—2019 c 325: See note following RCW 71.24.011.

Contingent effective date—2017 c 202 § 7: "Section 7 of this act takes effect January 1, 2018, but only if neither Substitute House Bill No. 1388 (including any later amendments or substitutes) nor Substitute Senate Bill No. 5259 (including any later amendments or substitutes) is signed into law by the governor by July 23, 2017." [2017 c 202 § 10.] Neither Substitute

House Bill No. 1388 nor Substitute Senate Bill No. 5259 was signed into law by July 23, 2017.

Findings—Intent—2017 c 202: See note following RCW 74.09.495.

71.24.350 Behavioral health ombuds office. ***(Effective until October 1, 2022.)*** The authority shall require each behavioral health administrative services organization to provide for a separately funded behavioral health ombuds office that is independent of the behavioral health administrative services organization and managed care organizations for the assigned regional service area. The ombuds office shall maximize the use of consumer advocates. [2019 c 325 § 1020; 2018 c 201 § 4019; 2016 sp.s. c 29 § 523; 2014 c 225 § 41; 2013 c 23 § 189; 2005 c 504 § 803.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2014 c 225: See note following RCW 71.24.016.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Additional notes found at www.leg.wa.gov

71.24.370 Behavioral health services contracts—Limitation on state liability. (1) Except for monetary damage claims which have been reduced to final judgment by a superior court, this section applies to all claims against the state, state agencies, state officials, or state employees that exist on or arise after March 29, 2006.

(2) Except as expressly provided in contracts entered into by the authority, the entities identified in subsection (3) of this section shall have no claim for declaratory relief, injunctive relief, judicial review under chapter 34.05 RCW, or civil liability against the state, state agencies, state officials, or state employees for actions or inactions performed pursuant to the administration of this chapter with regard to the following: (a) The allocation or payment of federal or state funds; (b) the use or allocation of state hospital beds; or (c) financial responsibility for the provision of inpatient mental health care.

(3) This section applies to counties, behavioral health administrative services organizations, managed care organizations, and entities which contract to provide behavioral health services and their subcontractors, agents, or employees. [2019 c 325 § 1021; 2018 c 201 § 4021; 2014 c 225 § 42; 2006 c 333 § 103.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

Finding—Purpose—Intent—Severability—Part headings not law—Effective dates—2006 c 333: See notes following RCW 71.24.016.

71.24.380 Purchase of behavioral health services—Managed care contracting—Requirements. ***(Effective until October 1, 2022.)*** (1) The director shall purchase behavioral health services primarily through managed care contracting, but may continue to purchase behavioral health services directly from providers serving medicaid clients who are not enrolled in a managed care organization.

(2) The director shall require that contracted managed care organizations have a sufficient network of providers to provide adequate access to behavioral health services for residents of the regional service area that meet eligibility criteria for services, and for maintenance of quality assurance processes. Contracts with managed care organizations must comply with all federal medicaid and state law requirements related to managed health care contracting, including RCW 74.09.522.

(3) A managed care organization must contract with the authority's selected behavioral health administrative services organization for the assigned regional service area for the administration of crisis services. The contract shall require the managed care organization to reimburse the behavioral health administrative services organization for behavioral health crisis services delivered to individuals enrolled in the managed care organization.

(4) A managed care organization must collaborate with the authority and its contracted behavioral health administrative services organization to develop and implement strategies to coordinate care with tribes and community behavioral health providers for individuals with a history of frequent crisis system utilization.

(5) A managed care organization must work closely with designated crisis responders, behavioral health administrative services organizations, and behavioral health providers to maximize appropriate placement of persons into community services, ensuring the client receives the least restrictive level of care appropriate for their condition. Additionally, the managed care organization shall work with the authority to expedite the enrollment or reenrollment of eligible persons leaving state or local correctional facilities and institutions for mental diseases.

(6) As an incentive to county authorities to become early adopters of fully integrated purchasing of medical and behavioral health services, the standards adopted by the authority shall provide for an incentive payment to counties which elect to move to full integration by January 1, 2016. Subject to federal approval, the incentive payment shall be targeted at ten percent of savings realized by the state within the regional service area in which the fully integrated purchasing takes place. Savings shall be calculated in alignment with the outcome and performance measures established in RCW 71.24.435, 70.320.020, and 71.36.025, and incentive payments for early adopter counties shall be made available for up to a six-year period, or until full integration of medical and behavioral health services is accomplished statewide, whichever comes sooner, according to rules to be developed by the authority. [2019 c 325 § 1022; 2018 c 201 § 4022; 2014 c 225 § 5.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.24.380 Purchase of behavioral health services—Managed care contracting—Requirements. ***(Effective October 1, 2022.)*** (1) The director shall purchase behavioral health services primarily through managed care contracting, but may continue to purchase behavioral health services

directly from providers serving medicaid clients who are not enrolled in a managed care organization.

(2) The director shall require that contracted managed care organizations have a sufficient network of providers to provide adequate access to behavioral health services for residents of the regional service area that meet eligibility criteria for services, and for maintenance of quality assurance processes. Contracts with managed care organizations must comply with all federal medicaid and state law requirements related to managed health care contracting, including RCW 74.09.522.

(3) A managed care organization must contract with the authority's selected behavioral health administrative services organization for the assigned regional service area for the administration of crisis services. The contract shall require the managed care organization to reimburse the behavioral health administrative services organization for behavioral health crisis services delivered to individuals enrolled in the managed care organization.

(4) A managed care organization must contract with the contracting advocacy organization selected by the state office of behavioral health consumer advocacy established in RCW 71.40.030 for the provision of behavioral health consumer advocacy services delivered to individuals enrolled in the managed care organization. The contract shall require the managed care organization to reimburse the office of behavioral health consumer advocacy for behavioral health consumer advocacy services delivered to individuals enrolled in the managed care organization.

(5) A managed care organization must collaborate with the authority and its contracted behavioral health administrative services organization to develop and implement strategies to coordinate care with tribes and community behavioral health providers for individuals with a history of frequent crisis system utilization.

(6) A managed care organization must work closely with designated crisis responders, behavioral health administrative services organizations, and behavioral health providers to maximize appropriate placement of persons into community services, ensuring the client receives the least restrictive level of care appropriate for their condition. Additionally, the managed care organization shall work with the authority to expedite the enrollment or reenrollment of eligible persons leaving state or local correctional facilities and institutions for mental diseases.

(7) As an incentive to county authorities to become early adopters of fully integrated purchasing of medical and behavioral health services, the standards adopted by the authority shall provide for an incentive payment to counties which elect to move to full integration by January 1, 2016. Subject to federal approval, the incentive payment shall be targeted at ten percent of savings realized by the state within the regional service area in which the fully integrated purchasing takes place. Savings shall be calculated in alignment with the outcome and performance measures established in RCW 71.24.435, 70.320.020, and 71.36.025, and incentive payments for early adopter counties shall be made available for up to a six-year period, or until full integration of medical and behavioral health services is accomplished statewide, whichever comes sooner, according to rules to be developed by the authority. [2021 c 202 § 16; 2019 c 325 § 1022; 2018 c 201 § 4022; 2014 c 225 § 5.]

Effective date—2021 c 202 §§ 15-17: See note following RCW 71.24.045.

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.24.381 Contracting for crisis services and medically necessary physical and behavioral health services. (1) The authority shall contract with one or more behavioral health administrative services organizations to carry out the duties and responsibilities set forth in this chapter and chapter 71.05 RCW to provide crisis services to assigned regional service areas.

(2) For clients eligible for medical assistance under chapter 74.09 RCW, the authority shall contract with one or more managed care organizations as set forth in RCW 71.24.380 and 74.09.871 to provide medically necessary physical and behavioral health services. [2019 c 325 § 1046.]

Effective date—2019 c 325: See note following RCW 71.24.011.

71.24.383 Managed care organization contracting—Requirements. By January 1, 2023, the authority shall require that any contract with a managed care organization include a requirement to provide housing-related care coordination services for enrollees who need such services upon being discharged from inpatient behavioral health settings as allowed by the centers for medicare and medicaid services. [2022 c 215 § 3.]

Finding—Intent—2022 c 215: See note following RCW 70.320.020.

71.24.385 Behavioral health administrative services and managed care organizations—Mental health and substance use disorder treatment programs—Development and design requirements. (1) Within funds appropriated by the legislature for this purpose, behavioral health administrative services organizations and managed care organizations, as applicable, shall develop the means to serve the needs of people:

(a) With mental disorders residing within the boundaries of their regional service area. Elements of the program may include:

(i) Crisis diversion services;

(ii) Evaluation and treatment and community hospital beds;

(iii) Residential treatment;

(iv) Programs for intensive community treatment;

(v) Outpatient services, including family support;

(vi) Peer support services;

(vii) Community support services;

(viii) Resource management services;

(ix) Partial hospitalization and intensive outpatient programs for persons under 21 years of age; and

(x) Supported housing and supported employment services.

(b) With substance use disorders and their families, people incapacitated by alcohol or other psychoactive chemicals, and intoxicated people.

(i) Elements of the program shall include, but not necessarily be limited to, a continuum of substance use disorder treatment services that includes:

(A) Withdrawal management;

(B) Residential treatment; and

(C) Outpatient treatment.

(ii) The program may include peer support, supported housing, supported employment, crisis diversion, recovery support services, or technology-based recovery supports.

(iii) The authority may contract for the use of an approved substance use disorder treatment program or other individual or organization if the director considers this to be an effective and economical course to follow.

(2)(a) The managed care organization and the behavioral health administrative services organization shall have the flexibility, within the funds appropriated by the legislature for this purpose and the terms of their contract, to design the mix of services that will be most effective within their service area of meeting the needs of people with behavioral health disorders and avoiding placement of such individuals at the state mental hospital. Managed care organizations and behavioral health administrative services organizations are encouraged to maximize the use of evidence-based practices and alternative resources with the goal of substantially reducing and potentially eliminating the use of institutions for mental diseases.

(b) Managed care organizations and behavioral health administrative services organizations may allow reimbursement to providers for services delivered through a partial hospitalization or intensive outpatient program. Such payment and services are distinct from the state's delivery of wraparound with intensive services under the *T.R. v. Strange and Birch* settlement agreement.

(3)(a) Treatment provided under this chapter must be purchased primarily through managed care contracts.

(b) Consistent with RCW 71.24.580, services and funding provided through the criminal justice treatment account are intended to be exempted from managed care contracting. [2022 c 94 § 1. Prior: 2019 c 325 § 1023; 2019 c 264 § 6; prior: 2018 c 201 § 4023; 2018 c 175 § 6; 2016 sp.s. c 29 § 510; 2014 c 225 § 9.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—2019 c 264: See note following RCW 41.05.760.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Findings—Intent—2018 c 175: See note following RCW 74.09.495.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.24.400 Streamlining delivery system—Finding. The legislature finds that the current complex set of federal, state, and local rules and regulations, audited and administered at multiple levels, which affect the community mental health service delivery system, focus primarily on the process of providing mental health services and do not sufficiently address consumer and system outcomes. The legislature finds that the authority and the community mental health service delivery system must make ongoing efforts to achieve the purposes set forth in RCW 71.24.015 related to reduced administrative layering, duplication, elimination of process measures not specifically required by the federal government for the receipt of federal funds, and reduced administrative costs. [2018 c 201 § 4024; 2001 c 323 § 18; 1999 c 10 § 10; 1995 c 96 § 1; 1994 c 259 § 1.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Purpose—Intent—1999 c 10: See note following RCW 71.24.025.

Additional notes found at www.leg.wa.gov

71.24.405 Streamlining delivery system. The authority shall work comprehensively and collaboratively with behavioral health administrative services organizations and with local behavioral health service providers to create innovative and streamlined community behavioral health service delivery systems and to capture the diversity of the community behavioral health service delivery system. The authority shall periodically:

(1) Identify, review, and catalog all rules, regulations, duplicative administrative and monitoring functions, and other requirements that lead to inefficiencies in the community behavioral health service delivery system and, if possible, eliminate the requirements;

(2) Review regulations, contracts, and reporting requirements to ensure achievement of outcomes for behavioral health adult and children clients under RCW 71.24.435;

(3) Involve behavioral health consumers and their representatives; and

(4) Provide for an independent evaluation component to measure the success of the authority in fully implementing the provisions of RCW 71.24.400 and this section. [2019 c 325 § 1024; 2018 c 201 § 4025; 2014 c 225 § 53; 2001 c 323 § 19; 1999 c 10 § 11; 1995 c 96 § 2; 1994 c 259 § 2.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

Purpose—Intent—1999 c 10: See note following RCW 71.24.025.

Additional notes found at www.leg.wa.gov

71.24.415 Streamlining delivery system—Authority duties to achieve outcomes. To carry out the purposes specified in RCW 71.24.400, the authority is encouraged to utilize its authority to eliminate any unnecessary rules, regulations, standards, or contracts, to immediately eliminate duplication of audits or any other unnecessarily duplicated functions, and to seek any waivers of federal or state rules or regulations necessary to achieve the purpose of streamlining the community mental health service delivery system and infusing it with incentives that reward efficiency, positive outcomes for clients, and quality services. [2018 c 201 § 4026; 1999 c 10 § 12; 1995 c 96 § 3; 1994 c 259 § 4.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Purpose—Intent—1999 c 10: See note following RCW 71.24.025.

Additional notes found at www.leg.wa.gov

71.24.420 Expenditure of funds for operation of service delivery system—Appropriation levels—Outcome and performance measures—Report. The authority shall operate the community behavioral health service delivery

system authorized under this chapter within the following constraints:

(1) The full amount of federal funds for community behavioral health system services, plus qualifying state expenditures as appropriated in the biennial operating budget, shall be appropriated to the authority each year in the biennial appropriations act to carry out the provisions of the community behavioral health service delivery system authorized in this chapter.

(2) The authority may expend funds defined in subsection (1) of this section in any manner that will effectively accomplish the outcome measures established in RCW 71.24.435 and 71.36.025 and performance measures linked to those outcomes.

(3) The authority shall implement strategies that accomplish the outcome measures established in RCW 71.24.435, 70.320.020, and 71.36.025 and performance measures linked to those outcomes.

(4) The authority shall monitor expenditures against the appropriation levels provided for in subsection (1) of this section and report to the governor's office and the appropriate committees of the legislature once every two years, on or about December 1st, on each even-numbered year. [2019 c 325 § 1025; 2018 c 201 § 4027; 2014 c 225 § 17; 2001 c 323 § 2.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

71.24.430 Coordination of services for behavioral health clients—Collaborative service delivery. (1) The authority shall ensure the coordination of allied services for behavioral health clients. The authority shall implement strategies for resolving organizational, regulatory, and funding issues at all levels of the system, including the state, the behavioral health administrative services organizations, managed care organizations, and local service providers.

(2) The authority shall propose, in operating budget requests, transfers of funding among programs to support collaborative service delivery to persons who require services from multiple department of social and health services and authority programs. The authority shall provide status reports as requested by the legislature. [2019 c 325 § 1026; 2018 c 201 § 4028; 2014 c 225 § 54; 2001 c 323 § 3.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

71.24.435 Behavioral health system—Improvement strategy. (1) The systems responsible for financing, administration, and delivery of publicly funded mental health and substance use disorder services to adults must be designed and administered to achieve improved outcomes for adult clients served by those systems through increased use and development of evidence-based, research-based, and promising practices, as defined in RCW 71.24.025. For purposes of this section, client outcomes include: Improved health status; increased participation in employment and education; reduced involvement with the criminal justice system; enhanced safety and access to treatment for forensic patients; reduction in avoidable utilization of and costs associated with hospital, emergency room, and crisis services; increased housing stability; improved quality of life, including measures of recovery and resilience; and decreased population level disparities in access to treatment and treatment outcomes.

(2) The authority must implement a strategy for the improvement of the behavioral health system. [2019 c 325 § 5010; 2014 c 225 § 64; 2013 c 338 § 2. Formerly RCW 43.20A.895.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective date—2014 c 225: See note following RCW 71.24.016.

Effective date—2014 c 225 § 1: "Section 1 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [April 4, 2014]." [2014 c 225 § 111.]

71.24.450 Offenders with mental illnesses—Findings and intent. (1) Many offenders with acute and chronic mental illness are delayed in their release from Washington correctional facilities due to their inability to access reasonable treatment and living accommodations prior to the maximum expiration of their sentences. Often the offender reaches the end of his or her sentence and is released without any follow-up care, funds, or housing. These delays are costly to the state, often lead to psychiatric relapse, and result in unnecessary risk to the public.

Many of these offenders lack the skills or emotional stability to maintain employment or even complete applications to receive entitlement funding. Housing and appropriate treatment are difficult to obtain.

This lack of resources, funding, treatment, and housing creates additional stress for the offender with mental illness, impairing self-control and judgment. When the mental illness is instrumental in the offender's patterns of crime, such stresses may lead to a worsening of his or her illness, reoffending, and a threat to public safety.

(2) It is the intent of the legislature to create a program to provide for postrelease mental health care and housing for a select group of offenders with mental illness entering community living, in order to reduce incarceration costs, increase public safety, and enhance the offender's quality of life. [2019 c 325 § 1027; 1997 c 342 § 1.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Additional notes found at www.leg.wa.gov

71.24.455 Offenders with mental illnesses—Contracts for specialized access and services. (1) The director shall select and contract with a behavioral health administrative services organization, managed care organization, behavioral health agency, or private provider to provide specialized access and services to offenders with mental illness upon release from total confinement within the department of corrections who have been identified by the department of corrections and selected by the behavioral health administrative services organization, managed care organization, behavioral health agency, or private provider as high-priority clients for services and who meet service program entrance criteria. The program shall enroll no more than twenty-five offenders at any one time, or a number of offenders that can

be accommodated within the appropriated funding level, and shall seek to fill any vacancies that occur.

(2) Criteria shall include a determination by department of corrections staff that:

(a) The offender suffers from a major mental illness and needs continued mental health treatment;

(b) The offender's previous crime or crimes have been determined by either the court or department of corrections staff to have been substantially influenced by the offender's mental illness;

(c) It is believed the offender will be less likely to commit further criminal acts if provided ongoing mental health care;

(d) The offender is unable or unlikely to obtain housing and/or treatment from other sources for any reason; and

(e) The offender has at least one year remaining before his or her sentence expires but is within six months of release to community housing and is currently housed within a work release facility or any department of corrections' division of prisons facility.

(3) The behavioral health administrative services organization, managed care organization, behavioral health agency, or private provider shall provide specialized access and services to the selected offenders. The services shall be aimed at lowering the risk of recidivism. An oversight committee composed of a representative of the authority, a representative of the selected managed care organization, behavioral health administrative services organization, or private provider, and a representative of the department of corrections shall develop policies to guide the pilot program, provide dispute resolution including making determinations as to when entrance criteria or required services may be waived in individual cases, advise the department of corrections and the managed care organization, behavioral health administrative services organization, or private provider on the selection of eligible offenders, and set minimum requirements for service contracts. The selected managed care organization, behavioral health administrative services organization, or private provider shall implement the policies and service contracts. The following services shall be provided:

(a) Intensive case management to include a full range of intensive community support and treatment in client-to-staff ratios of not more than ten offenders per case manager including: (i) A minimum of weekly group and weekly individual counseling; (ii) home visits by the program manager at least two times per month; and (iii) counseling focusing on maintaining and promoting ongoing stability, relapse prevention, and recovery.

(b) The case manager shall attempt to locate and procure housing appropriate to the living and clinical needs of the offender and as needed to maintain the psychiatric stability of the offender. The entire range of emergency, transitional, and permanent housing and involuntary hospitalization must be considered as available housing options. A housing subsidy may be provided to offenders to defray housing costs up to a maximum of six thousand six hundred dollars per offender per year and be administered by the case manager. Additional funding sources may be used to offset these costs when available.

(c) The case manager shall collaborate with the assigned prison, work release, or community corrections staff during release planning, prior to discharge, and in ongoing supervision of the offender while under the authority of the department of corrections.

(d) Medications including the full range of psychotropic medications including atypical antipsychotic medications may be required as a condition of the program. Medication prescription, medication monitoring, and counseling to support offender understanding, acceptance, and compliance with prescribed medication regimens must be included.

(e) A systematic effort to engage offenders to continuously involve themselves in current and long-term treatment and appropriate habilitative activities shall be made.

(f) Classes appropriate to the clinical and living needs of the offender and appropriate to his or her level of understanding.

(g) The case manager shall assist the offender in the application and qualification for entitlement funding, including medicaid, state assistance, and other available government and private assistance at any point that the offender is qualified and resources are available.

(h) The offender shall be provided access to daily activities such as drop-in centers, prevocational and vocational training and jobs, and volunteer activities.

(4) Once an offender has been selected into the pilot program, the offender shall remain in the program until the end of his or her sentence or unless the offender is released from the pilot program earlier by the department of corrections.

(5) Specialized training in the management and supervision of high-crime risk offenders with mental illness shall be provided to all participating mental health providers by the authority and the department of corrections prior to their participation in the program and as requested thereafter. [2019 c 325 § 1028; 2018 c 201 § 4029; 2014 c 225 § 43; 1997 c 342 § 2.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

Additional notes found at www.leg.wa.gov

71.24.460 Offenders with mental illnesses—Report to legislature. The authority, in collaboration with the department of corrections and the oversight committee created in RCW 71.24.455, shall track outcomes and submit to the legislature annual reports regarding services and outcomes. The reports shall include the following: (1) A statistical analysis regarding the reoffense and reinstitutionalization rate by the enrollees in the program set forth in RCW 71.24.455; (2) a quantitative description of the services provided in the program set forth in RCW 71.24.455; and (3) recommendations for any needed modifications in the services and funding levels to increase the effectiveness of the program set forth in RCW 71.24.455. [2019 c 325 § 1029; 2018 c 201 § 4030; 1999 c 10 § 13; 1997 c 342 § 4.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Purpose—Intent—1999 c 10: See note following RCW 71.24.025.

Additional notes found at www.leg.wa.gov

71.24.470 Reentry community services program—Contract for case management—Use of appropriated funds. (1) The director shall contract, to the extent that funds are appropriated for this purpose, for case management services and such other services as the director deems necessary to assist persons identified under RCW 72.09.370 for participation in the reentry community services program. The contracts may be with any qualified and appropriate entities. The director shall ensure the authority has coverage in all counties of the state for the purposes of providing reentry community services program services.

(2) The case manager has the authority to assist these persons in obtaining the services, as set forth in the plan created under RCW 72.09.370(2), for up to five years. The services may include coordination of mental health services, assistance with unfunded medical expenses, assistance obtaining substance use disorder treatment, housing, employment services, educational or vocational training, independent living skills, parenting education, anger management services, peer services, and such other services as the case manager deems necessary.

(3) The legislature intends that funds appropriated for the purposes of RCW 72.09.370, 71.05.145, and 71.05.212, and this section are to supplement and not to supplant general funding. Funds appropriated to implement RCW 72.09.370, 71.05.145, and 71.05.212, and this section are not to be considered available resources as defined in RCW 71.24.025 and are not subject to the priorities, terms, or conditions in the appropriations act established pursuant to RCW 71.24.035.

(4) The reentry community services program was formerly known as the community integration assistance program. [2021 c 243 § 7; 2019 c 325 § 1030; 2018 c 201 § 4031; 2014 c 225 § 44; 2009 c 319 § 1; 1999 c 214 § 9.]

Findings—2021 c 243: See note following RCW 74.09.670.

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

Intent—Effective date—1999 c 214: See notes following RCW 72.09.370.

71.24.480 Reentry community services program—Limitation on liability due to treatment—Reporting requirements. (1) A licensed or certified behavioral health agency acting in the course of the agency's duties under this chapter and its individual employees are not liable for civil damages resulting from the injury or death of another caused by a participant in the reentry community services program who is a client of the agency, unless the act or omission of the agency or employee constitutes:

(a) Gross negligence;

(b) Willful or wanton misconduct; or

(c) A breach of the duty to warn of and protect from a client's threatened violent behavior if the client has communicated a serious threat of physical violence against a reasonably ascertainable victim or victims.

(2) In addition to any other requirements to report violations, the licensed or certified behavioral health agency shall report a reentry community services program participant's expressions of intent to harm or other predatory behavior, regardless of whether there is an ascertainable victim, in progress reports and other established processes that enable courts and supervising entities to assess and address the progress and appropriateness of treatment.

(3) A licensed or certified behavioral health agency's mere act of treating a participant in the reentry community services program is not negligence. Nothing in this subsection alters the licensed or certified behavioral health agency's normal duty of care with regard to the client.

(4) The limited liability provided by this section applies only to the conduct of licensed or certified behavioral health agencies and their employees and does not apply to conduct of the state.

(5) For purposes of this section, "participant in the reentry community services program" means a person who has been identified under RCW 72.09.370 as a person who: (a) Is reasonably believed to present a danger to himself or herself or others if released to the community without supportive services; and (b) has a mental disorder. [2021 c 243 § 8; 2019 c 325 § 1031; 2018 c 201 § 4032; 2014 c 225 § 45; 2009 c 319 § 2; 2002 c 173 § 1.]

Findings—2021 c 243: See note following RCW 74.09.670.

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

71.24.490 Evaluation and treatment services—Capacity needs—Behavioral health administrative services and managed care organizations. The authority must collaborate with behavioral health administrative services organizations, managed care organizations, and the Washington state institute for public policy to estimate the capacity needs for evaluation and treatment services within each regional service area. Estimated capacity needs shall include consideration of the average occupancy rates needed to provide an adequate network of evaluation and treatment services to ensure access to treatment. Behavioral health administrative services organizations and managed care organizations must develop and maintain an adequate plan to provide for evaluation and treatment needs. [2019 c 325 § 1032; 2018 c 201 § 4033; 2015 c 269 § 11.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2015 c 269 §§ 1-9 and 11-13: See note following RCW 71.05.010.

71.24.500 Written guidance and trainings—Managed care—Incarcerated and involuntarily hospitalized persons. The authority shall periodically publish written guidance and provide trainings to behavioral health administrative services organizations, managed care organizations, and behavioral health providers related to how these organizations may provide outreach, assistance, transition planning, and rehabilitation case management reimbursable under federal law to persons who are incarcerated, involuntarily hospitalized, or in the process of transitioning out of one of these services. The guidance and trainings may also highlight preventive activities not reimbursable under federal law which may be cost-effective in a managed care environment. The purpose of this written guidance and trainings is to champion

best clinical practices including, where appropriate, use of care coordination and long-acting injectable psychotropic medication, and to assist the health community to leverage federal funds and standardize payment and reporting procedures. [2019 c 325 § 1033; 2018 c 201 § 4034; 2016 c 154 § 3.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Intent—2016 c 154: See note following RCW 74.09.670.

71.24.510 Integrated comprehensive screening and assessment process—Implementation. (1) All persons providing treatment under this chapter shall also implement the integrated comprehensive screening and assessment process for substance use and mental disorders adopted pursuant to RCW 71.24.630 and shall document the numbers of clients with co-occurring mental and substance use disorders based on a quadrant system of low and high needs.

(2) Treatment providers contracted to provide treatment under this chapter who fail to implement the integrated comprehensive screening and assessment process for substance use and mental disorders are subject to contractual penalties established under RCW 71.24.630. [2016 sp.s. c 29 § 512; 2005 c 504 § 302. Formerly RCW 70.96A.035.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Additional notes found at www.leg.wa.gov

71.24.520 Substance use disorder program authority. The authority, in the operation of the substance use disorder program, may:

(1) Plan, establish, and maintain prevention and treatment programs as necessary or desirable;

(2) Make contracts necessary or incidental to the performance of its duties and the execution of its powers, including managed care contracts for behavioral health services, contracts entered into under RCW 74.09.522, and contracts with public and private agencies, organizations, and individuals to pay them for services rendered or furnished to persons with substance use disorders, persons incapacitated by alcohol or other psychoactive chemicals, or intoxicated persons;

(3) Enter into agreements for monitoring of verification of qualifications of counselors employed by approved treatment programs;

(4) Adopt rules under chapter 34.05 RCW to carry out the provisions and purposes of this chapter and contract, cooperate, and coordinate with other public or private agencies or individuals for those purposes;

(5) Solicit and accept for use any gift of money or property made by will or otherwise, and any grant of money, services, or property from the federal government, the state, or any political subdivision thereof or any private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for any grant;

(6) Administer or supervise the administration of the provisions relating to persons with substance use disorders and intoxicated persons of any state plan submitted for federal funding pursuant to federal health, welfare, or treatment legislation;

(7) Coordinate its activities and cooperate with substance use disorder programs in this and other states, and make contracts and other joint or cooperative arrangements with state, local, or private agencies in this and other states for the treatment of persons with substance use disorders and their families, persons incapacitated by alcohol or other psychoactive chemicals, and intoxicated persons and for the common advancement of substance use disorder programs;

(8) Keep records and engage in research and the gathering of relevant statistics;

(9) Do other acts and things necessary or convenient to execute the authority expressly granted to it;

(10) Acquire, hold, or dispose of real property or any interest therein, and construct, lease, or otherwise provide treatment programs. [2019 c 325 § 1034; 2018 c 201 § 4036; 2014 c 225 § 22; 1989 c 270 § 5; 1988 c 193 § 2; 1972 ex.s. c 122 § 4. Formerly RCW 70.96A.040.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

71.24.525 Agreements authorized under the interlocal cooperation act. Pursuant to the interlocal cooperation act, chapter 39.34 RCW, the authority may enter into agreements to accomplish the purposes of this chapter. [2018 c 201 § 4037; 1989 c 270 § 7. Formerly RCW 70.96A.043.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.24.530 Local funding and donative funding requirements—Facilities, plans, programs. Except as provided in this chapter, the director shall not approve any substance use disorder facility, plan, or program for financial assistance under RCW 71.24.520 unless at least ten percent of the amount spent for the facility, plan, or program is provided from local public or private sources. When deemed necessary to maintain public standards of care in the substance use disorder facility, plan, or program, the director may require the substance use disorder facility, plan, or program to provide up to fifty percent of the total spent for the program through fees, gifts, contributions, or volunteer services. The director shall determine the value of the gifts, contributions, and volunteer services. [2018 c 201 § 4038; 2016 sp.s. c 29 § 515; 1989 c 270 § 11. Formerly RCW 70.96A.047.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.24.535 Duties of authority. The authority shall:

(1) Develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and other drug addiction, treatment of persons with substance use disorders and their families, persons incapacitated by alcohol or other psychoactive chemicals, and intoxicated

persons in cooperation with public and private agencies, organizations, and individuals and provide technical assistance and consultation services for these purposes;

(2) Assure that any contract with a managed care organization for behavioral health services or programs for the treatment of persons with substance use disorders and their families provides medically necessary services to medicaid recipients. This must include a continuum of mental health and substance use disorder services consistent with the state's medicaid plan or federal waiver authorities, and nonmedicaid services consistent with priorities established by the authority;

(3) Coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and drug addiction, and treatment of persons with substance use disorders and their families, persons incapacitated by alcohol or other psychoactive chemicals, and intoxicated persons;

(4) Cooperate with public and private agencies in establishing and conducting programs to provide treatment for persons with substance use disorders and their families, persons incapacitated by alcohol or other psychoactive chemicals, and intoxicated persons who are clients of the correctional system;

(5) Cooperate with the superintendent of public instruction, state board of education, schools, police departments, courts, and other public and private agencies, organizations and individuals in establishing programs for the prevention of substance use disorders, treatment of persons with substance use disorders and their families, persons incapacitated by alcohol or other psychoactive chemicals, and intoxicated persons, and preparing curriculum materials thereon for use at all levels of school education;

(6) Prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol and other psychoactive chemicals and the consequences of their use;

(7) Develop and implement, as an integral part of substance use disorder treatment programs, an educational program for use in the treatment of persons with substance use disorders, persons incapacitated by alcohol or other psychoactive chemicals, and intoxicated persons, which program shall include the dissemination of information concerning the nature and effects of alcohol and other psychoactive chemicals, the consequences of their use, the principles of recovery, and HIV and AIDS;

(8) Organize and foster training programs for persons engaged in treatment of persons with substance use disorders, persons incapacitated by alcohol or other psychoactive chemicals, and intoxicated persons;

(9) Sponsor and encourage research into the causes and nature of substance use disorders, treatment of persons with substance use disorders, persons incapacitated by alcohol or other psychoactive chemicals, and intoxicated persons, and serve as a clearinghouse for information relating to substance use disorders;

(10) Specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(11) Advise the governor in the preparation of a comprehensive plan for treatment of persons with substance use disorders, persons incapacitated by alcohol or other psychoactive chemicals, and intoxicated persons for inclusion in the state's comprehensive health plan;

(12) Review all state health, welfare, and treatment plans to be submitted for federal funding under federal legislation, and advise the governor on provisions to be included relating to substance use disorders;

(13) Assist in the development of, and cooperate with, programs for substance use disorder education and treatment for employees of state and local governments and businesses and industries in the state;

(14) Use the support and assistance of interested persons in the community to encourage persons with substance use disorders voluntarily to undergo treatment;

(15) Cooperate with public and private agencies in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated;

(16) Encourage general hospitals and other appropriate health facilities to admit without discrimination persons with substance use disorders, persons incapacitated by alcohol or other psychoactive chemicals, and intoxicated persons and to provide them with adequate and appropriate treatment;

(17) Encourage all health and disability insurance programs to include substance use disorders as a covered illness; and

(18) Organize and sponsor a statewide program to help court personnel, including judges, better understand substance use disorders and the uses of substance use disorder treatment programs and medications. [2019 c 325 § 1035; 2018 c 201 § 4039; 2016 sp.s. c 29 § 504; 2014 c 225 § 23; 2001 c 13 § 2; 1989 c 270 § 6; 1979 ex.s. c 176 § 7; 1972 ex.s. c 122 § 5. Formerly RCW 70.96A.050.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2014 c 225: See note following RCW 71.24.016.

Additional notes found at www.leg.wa.gov

71.24.540 Drug courts. The authority shall contract with behavioral health administrative services organizations, managed care organizations, or counties, as applicable, for the provision of substance use disorder treatment services ordered by a county-operated drug court. [2019 c 325 § 1036; 2018 c 201 § 4040; 2016 sp.s. c 29 § 516; 1999 c 197 § 10. Formerly RCW 70.96A.055.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.24.545 Comprehensive program for treatment—Regional facilities. (1) The authority shall establish by appropriate means a comprehensive and coordinated program for the treatment of persons with substance use disorders and their families, persons incapacitated by alcohol or other psychoactive chemicals, and intoxicated persons.

(2)(a) The program shall include, but not necessarily be limited to, a continuum of substance use disorder treatment services that includes:

(i) Withdrawal management;

(ii) Residential treatment; and

(iii) Outpatient treatment.

(b) The program may include peer support, supported housing, supported employment, crisis diversion, or recovery support services.

(3) All appropriate public and private resources shall be coordinated with and used in the program when possible.

(4) The authority may contract for the use of an approved treatment program or other individual or organization if the director considers this to be an effective and economical course to follow.

(5) Treatment provided under this chapter must be purchased primarily through managed care contracts. Consistent with RCW 71.24.580, services and funding provided through the criminal justice treatment account are intended to be exempted from managed care contracting. [2019 c 325 § 1037; 2018 c 201 § 4041; 2014 c 225 § 25; 1989 c 270 § 18; 1972 ex.s. c 122 § 8. Formerly RCW 70.96A.080.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

71.24.546 Substance use recovery services plan—Substance use recovery services advisory committee—Rules—Report. ***(Expires December 31, 2026.)*** (1) The authority, in collaboration with the substance use recovery services advisory committee established in subsection (2) of this section, shall establish a substance use recovery services plan. The purpose of the plan is to implement measures to assist persons with substance use disorder in accessing outreach, treatment, and recovery support services that are low barrier, person centered, informed by people with lived experience, and culturally and linguistically appropriate. The plan must articulate the manner in which continual, rapid, and widespread access to a comprehensive continuum of care will be provided to all persons with substance use disorder.

(2)(a) The authority shall establish the substance use recovery services advisory committee to collaborate with the authority in the development and implementation of the substance use recovery services plan under this section. The authority must appoint members to the advisory committee who have relevant background related to the needs of persons with substance use disorder. The advisory committee shall be reflective of the community of individuals living with substance use disorder, including persons who are black, indigenous, and persons of color, persons with co-occurring substance use disorders and mental health conditions, as well as persons who represent the unique needs of rural communities. The advisory committee shall be convened and chaired by the director of the authority, or the director's designee. In addition to the member from the authority, the advisory committee shall include:

(i) One member and one alternate from each of the two largest caucuses of the house of representatives, as appointed by the speaker of the house of representatives;

(ii) One member and one alternate from each of the two largest caucuses of the senate, as appointed by the president of the senate;

(iii) One representative of the governor's office;

(iv) At least one adult in recovery from substance use disorder who has experienced criminal legal consequences as a result of substance use;

(v) At least one youth in recovery from substance use disorder who has experienced criminal legal consequences as a result of substance use;

(vi) One expert from the addictions, drug, and alcohol institute at the University of Washington;

(vii) One outreach services provider;

(viii) One substance use disorder treatment provider;

(ix) One peer recovery services provider;

(x) One recovery housing provider;

(xi) One expert in serving persons with co-occurring substance use disorders and mental health conditions;

(xii) One expert in antiracism and equity in health care delivery systems;

(xiii) One employee who provides substance use disorder treatment or services as a member of a labor union representing workers in the behavioral health field;

(xiv) One representative of the association of Washington health plans;

(xv) One expert in diversion from the criminal legal system to community-based care for persons with substance use disorder;

(xvi) One representative of public defenders;

(xvii) One representative of prosecutors;

(xviii) One representative of sheriffs and police chiefs;

(xix) One representative of a federally recognized tribe; and

(xx) One representative of local governments.

(b) The advisory committee may create subcommittees with expanded participation.

(c) In its collaboration with the advisory committee to develop the substance use recovery services plan, the authority must give due consideration to the recommendations of the advisory committee. If the authority determines that any of the advisory committee's recommendations are not feasible to adopt and implement, the authority must notify the advisory committee and offer an explanation.

(d) The advisory committee must convene as necessary for the development of the substance use recovery services plan and to provide consultation and advice related to the development and adoption of rules to implement the plan. The advisory committee must convene to monitor implementation of the plan and advise the authority.

(3) The plan must consider:

(a) The points of intersection that persons with substance use disorder have with the health care, behavioral health, criminal, civil legal, and child welfare systems as well as the various locations in which persons with untreated substance use disorder congregate, including homeless encampments, motels, and casinos;

(b) New community-based care access points, including crisis stabilization services and the safe station model in partnership with fire departments;

(c) Current regional capacity for substance use disorder assessments, including capacity for persons with co-occurring substance use disorders and mental health conditions, each of the American society of addiction medicine levels of care, and recovery support services;

(d) Barriers to accessing the existing behavioral health system and recovery support services for persons with untreated substance use disorder, especially indigent youth and adult populations, persons with co-occurring substance use disorders and mental health conditions, and populations chronically exposed to criminal legal system responses, and possible innovations that could improve the quality and accessibility of care for those populations;

(e) Evidence-based, research-based, and promising treatment and recovery services appropriate for target populations, including persons with co-occurring substance use disorders and mental health conditions;

(f) Options for leveraging existing integrated managed care, medicaid waiver, American Indian or Alaska Native fee-for-service behavioral health benefits, and private insurance service capacity for substance use disorders, including but not limited to coordination with managed care organizations, behavioral health administrative services organizations, the Washington health benefit exchange, accountable communities of health, and the office of the insurance commissioner;

(g) Framework and design assistance for jurisdictions to assist in compliance with the requirements of RCW 10.31.110 for diversion of individuals with complex or co-occurring behavioral health conditions to community-based care whenever possible and appropriate, and identifying resource gaps that impede jurisdictions in fully realizing the potential impact of this approach;

(h) The design of recovery navigator programs in RCW 71.24.115, including reporting requirements by behavioral health administrative services organizations to monitor the effectiveness of the programs and recommendations for program improvement;

(i) The proposal of a funding framework in which, over time, resources are shifted from punishment sectors to community-based care interventions such that community-based care becomes the primary strategy for addressing and resolving public order issues related to behavioral health conditions;

(j) Strategic grant making to community organizations to promote public understanding and eradicate stigma and prejudice against persons with substance use disorder by promoting hope, empathy, and recovery;

(k) Recommendations for diversion to community-based care for individuals with substance use disorders, including persons with co-occurring substance use disorders and mental health conditions, across all points of the sequential intercept model;

(l) Recommendations regarding the appropriate criminal legal system response, if any, to possession of controlled substances;

(m) Recommendations regarding the collection and reporting of data that identifies the number of persons law enforcement officers and prosecutors engage related to drug possession and disparities across geographic areas, race, ethnicity, gender, age, sexual orientation, and income. The recommendations shall include, but not be limited to, the number and rate of persons who are diverted from charges to recovery navigator services or other services, who receive services and what type of services, who are charged with simple possession, and who are taken into custody; and

(n) The design of a mechanism for referring persons with substance use disorder or problematic behaviors resulting from substance use into the supportive services described in RCW 71.24.115.

(4) The plan and related rules adopted by the authority must give due consideration to persons with co-occurring substance use disorders and mental health conditions and the needs of youth. The plan must include the substance use outreach, treatment, and recovery services outlined in RCW 71.24.115 through 71.24.135 which must be available in or accessible by all jurisdictions. These services must be equitably distributed across urban and rural settings. If feasible and appropriate, service initiation shall be made available on demand through 24-hour, seven days a week peer recovery coach response, behavioral health walk-in centers, or other innovative rapid response models. These services must, at a minimum, incorporate the following principles: Establish low barriers to entry and reentry; improve the health and safety of the individual; reduce the harm of substance use and related activity for the public; include integrated and coordinated services; incorporate structural competency and anti-racism; use noncoercive methods of engaging and retaining people in treatment and recovery services, including contingency management; consider the unique needs of rural communities; and have a focus on services that increase social determinants of health.

(5) In developing the plan, the authority shall:

(a) Align the components of the plan with previous and ongoing studies, plans, and reports, including the Washington state opioid overdose and response plan, published by the authority, the roadmap to recovery planning grant strategy being developed by the authority, and plans associated with federal block grants; and

(b) Coordinate its work with the efforts of the blue ribbon commission on the intersection of the criminal justice and behavioral health crisis systems and the crisis response improvement strategy committee established in chapter 302, Laws of 2021.

(6) The authority must submit a preliminary report by December 1, 2021, regarding progress toward the substance use recovery services plan. The authority must submit the final substance use recovery services plan to the governor and the legislature by December 1, 2022. After submitting the plan, the authority shall adopt rules and enter into contracts with providers to implement the plan by December 1, 2023. In addition to seeking public comment under chapter 34.05 RCW, the authority must adopt rules in accordance with the recommendations of the substance use recovery services advisory committee as provided in subsection (2) of this section.

(7) In consultation with the substance use recovery services advisory committee, the authority must submit a report on the implementation of the substance use recovery services

plan to the appropriate committees of the legislature and governor by December 1st of each year, beginning in 2023. This report shall include progress on the substance use disorder continuum of care, including availability of outreach, treatment, and recovery support services statewide.

(8) For the purposes of this section, "recovery support services" means a collection of resources that sustain long-term recovery from substance use disorder, including for persons with co-occurring substance use disorders and mental health conditions, recovery housing, permanent supportive housing, employment and education pathways, peer supports and recovery coaching, family education, technological recovery supports, transportation and child care assistance, and social connectedness.

(9) This section expires December 31, 2026. [2021 c 311 § 1.]

Effective date—2021 c 311 §§ 1-11 and 13-21: See note following RCW 71.24.115.

71.24.550 City, town, or county without facility—Contribution of liquor taxes prerequisite to use of another's facility. A city, town, or county that does not have its own facility or program for the treatment and rehabilitation of persons with substance use disorders may share in the use of a facility or program maintained by another city or county so long as it contributes no less than two percent of its share of liquor taxes and profits to the support of the facility or program. [2014 c 225 § 26; 1989 c 270 § 12. Formerly RCW 70.96A.085.]

Effective date—2014 c 225: See note following RCW 71.24.016.

71.24.555 Liquor taxes and profits—City and county eligibility conditioned. To be eligible to receive its share of liquor taxes and profits, each city and county shall devote no less than two percent of its share of liquor taxes and profits to the support of a substance use disorder program licensed or certified by the department of health. [2019 c 325 § 1038; 2018 c 201 § 4042; 2016 sp.s. c 29 § 517; 1989 c 270 § 13. Formerly RCW 70.96A.087.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.24.560 Opioid treatment programs—Pregnant individuals—Information and education. (1) All approved opioid treatment programs that provide services to individuals who are pregnant are required to disseminate up-to-date and accurate health education information to all their pregnant individuals concerning the effects opioid use and opioid use disorder medication may have on their baby, including the development of dependence and subsequent withdrawal. All pregnant individuals must also be advised of the risks to both themselves and their babies associated with discontinuing an opioid treatment program. The information must be provided to these individuals both verbally and in writing. The health education information provided to the pregnant individuals must include referral options for a baby who has been exposed to opioids in utero.

(2) The department shall adopt rules that require all opioid treatment programs to educate all pregnant individuals in their program on the benefits and risks of medication-assisted treatment to a developing fetus before they are prescribed these medications, as part of their treatment. The department shall also adopt rules requiring all opioid treatment programs to educate individuals who become pregnant about the risks to both the expecting parent and the fetus of not treating opioid use disorder. The department shall meet the requirements under this subsection within the appropriations provided for opioid treatment programs. The department, working with treatment providers and medical experts, shall develop and disseminate the educational materials to all certified opioid treatment programs.

(3) For pregnant individuals who participate in medicaid, the authority, through its managed care organizations, must ensure that pregnant individuals receive outreach related to opioid use disorder when identified as a person at risk. [2019 c 314 § 26; 2017 c 297 § 11; 2016 sp.s. c 29 § 506; 2005 c 70 § 2; 1995 c 312 § 46; 1990 c 151 § 5. Prior: 1989 c 270 § 19; 1989 c 175 § 131; 1972 ex.s. c 122 § 9. Formerly RCW 70.96A.090.]

Declaration—2019 c 314: See note following RCW 18.22.810.

Findings—Intent—2017 c 297: See note following RCW 18.22.800.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Intent—2019 c 314; 2005 c 70: "The legislature finds that drug use among pregnant individuals is a significant and growing concern statewide. Evidence-informed group prenatal care reduces preterm birth for infants, and increases maternal social cohesion and support during pregnancy and postpartum, which is good for maternal mental health.

It is the intent of the legislature to notify all pregnant individuals who are receiving medication for the treatment of opioid use disorder of the risks and benefits such medication could have on their baby during pregnancy through birth and to inform them of the potential need for the newborn baby to be treated in a hospital setting or in a specialized supportive environment designed specifically to address and manage neonatal opioid or other drug withdrawal syndromes." [2019 c 314 § 2; 2005 c 70 § 1.]

Additional notes found at www.leg.wa.gov

71.24.565 Acceptance for approved treatment—Rules. The director shall adopt and may amend and repeal rules for acceptance of persons into the approved treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of persons with substance use disorders, persons incapacitated by alcohol or other psychoactive chemicals, and intoxicated persons. In establishing the rules, the director shall be guided by the following standards:

(1) If possible a patient shall be treated on a voluntary rather than an involuntary basis.

(2) A patient shall be initially assigned or transferred to outpatient treatment, unless he or she is found to require residential treatment.

(3) A person shall not be denied treatment solely because he or she has withdrawn from treatment against medical advice on a prior occasion or because he or she has relapsed after earlier treatment.

(4) An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

(5) Provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facil-

ity or a form of treatment will have available and use other appropriate treatment. [2019 c 325 § 1039; 2018 c 201 § 4043; 2014 c 225 § 27; 1989 c 270 § 23; 1972 ex.s. c 122 § 10. Formerly RCW 70.96A.100.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

71.24.570 Emergency service patrol—Establishment—Rules. (1) The state and counties, cities, and other municipalities may establish or contract for emergency service patrols which are to be under the administration of the appropriate jurisdiction. A patrol consists of persons trained to give assistance in the streets and in other public places to persons who are intoxicated. Members of an emergency service patrol shall be capable of providing first aid in emergency situations and may transport intoxicated persons to their homes and to and from substance use disorder treatment programs.

(2) The secretary shall adopt rules pursuant to chapter 34.05 RCW for the establishment, training, and conduct of emergency service patrols. [2016 sp.s. c 29 § 518; 1989 c 270 § 30; 1972 ex.s. c 122 § 17. Formerly RCW 70.96A.170.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.24.575 Criminal laws limitations. (1) No county, municipality, or other political subdivision may adopt or enforce a local law, ordinance, resolution, or rule having the force of law that includes drinking, being an individual with a substance use disorder, or being found in an intoxicated condition as one of the elements of the offense giving rise to a criminal or civil penalty or sanction.

(2) No county, municipality, or other political subdivision may interpret or apply any law of general application to circumvent the provision of subsection (1) of this section.

(3) Nothing in this chapter affects any law, ordinance, resolution, or rule against drunken driving, driving under the influence of alcohol or other psychoactive chemicals, or other similar offense involving the operation of a vehicle, aircraft, boat, machinery, or other equipment, or regarding the sale, purchase, dispensing, possessing, or use of alcoholic beverages or other psychoactive chemicals at stated times and places or by a particular class of persons; nor shall evidence of intoxication affect, other than as a defense, the application of any law, ordinance, resolution, or rule to conduct otherwise establishing the elements of an offense. [2014 c 225 § 30; 1989 c 270 § 32; 1972 ex.s. c 122 § 19. Formerly RCW 70.96A.190.]

Effective date—2014 c 225: See note following RCW 71.24.016.

71.24.580 Criminal justice treatment account. (1) The criminal justice treatment account is created in the state treasury. Moneys in the account may be expended solely for: (a) Substance use disorder treatment and treatment support services for offenders with a substance use disorder that, if not treated, would result in addiction, against whom charges are filed by a prosecuting attorney in Washington state; (b) the provision of substance use disorder treatment services and treatment support services for nonviolent offenders within a drug court program and, during the 2021-23 fiscal biennium, for 180 days following graduation from the drug court program; and (c) the administrative and overhead costs associated with the operation of a drug court. Amounts provided in this subsection must be used for treatment and recovery support services for criminally involved offenders and authorization of these services shall not be subject to determinations of medical necessity. During the 2019-2021 and 2021-2023 fiscal biennia, funding from the criminal justice treatment account may be used to provide treatment and support services through the conclusion of an individual's treatment plan to individuals participating in a drug court program as of February 24, 2021, if that individual wishes to continue treatment following dismissal of charges they were facing under RCW 69.50.4013(1). Such participation is voluntary and contingent upon substantial compliance with drug court program requirements. The legislature may appropriate from the account for municipal drug courts and increased treatment options. During the 2019-2021 fiscal biennium, the legislature may direct the state treasurer to make transfers of moneys in the criminal justice treatment account to the home security fund account created in RCW 43.185C.060. Moneys in the account may be spent only after appropriation.

(2) For purposes of this section:

(a) "Treatment" means services that are critical to a participant's successful completion of his or her substance use disorder treatment program, including but not limited to the recovery support and other programmatic elements outlined in RCW 2.30.030 authorizing therapeutic courts; and

(b) "Treatment support" includes transportation to or from inpatient or outpatient treatment services when no viable alternative exists, and child care services that are necessary to ensure a participant's ability to attend outpatient treatment sessions.

(3) Revenues to the criminal justice treatment account consist of: (a) Funds transferred to the account pursuant to this section; and (b) any other revenues appropriated to or deposited in the account.

(4)(a) For the fiscal year beginning July 1, 2005, and each subsequent fiscal year, the state treasurer shall transfer eight million two hundred fifty thousand dollars from the general fund to the criminal justice treatment account, divided into four equal quarterly payments. For the fiscal year beginning July 1, 2006, and each subsequent fiscal year, the amount transferred shall be increased on an annual basis by the implicit price deflator as published by the federal bureau of labor statistics.

(b) In each odd-numbered year, the legislature shall appropriate the amount transferred to the criminal justice treatment account in (a) of this subsection to the department for the purposes of subsection (5) of this section.

(5) Moneys appropriated to the authority from the criminal justice treatment account shall be distributed as specified in this subsection. The authority may retain up to three percent of the amount appropriated under subsection (4)(b) of this section for its administrative costs.

(a) Seventy percent of amounts appropriated to the authority from the account shall be distributed to counties pursuant to the distribution formula adopted under this section. The authority, in consultation with the department of

corrections, the Washington state association of counties, the Washington state association of drug court professionals, the superior court judges' association, the Washington association of prosecuting attorneys, representatives of the criminal defense bar, representatives of substance use disorder treatment providers, and any other person deemed by the authority to be necessary, shall establish a fair and reasonable methodology for distribution to counties of moneys in the criminal justice treatment account. County or regional plans submitted for the expenditure of formula funds must be approved by the panel established in (b) of this subsection.

(b) Thirty percent of the amounts appropriated to the authority from the account shall be distributed as grants for purposes of treating offenders against whom charges are filed by a county prosecuting attorney. The authority shall appoint a panel of representatives from the Washington association of prosecuting attorneys, the Washington association of sheriffs and police chiefs, the superior court judges' association, the Washington state association of counties, the Washington defender's association or the Washington association of criminal defense lawyers, the department of corrections, the Washington state association of drug court professionals, and substance use disorder treatment providers. The panel shall review county or regional plans for funding under (a) of this subsection and grants approved under this subsection. The panel shall attempt to ensure that treatment as funded by the grants is available to offenders statewide.

(6) The county alcohol and drug coordinator, county prosecutor, county sheriff, county superior court, a substance abuse treatment provider appointed by the county legislative authority, a member of the criminal defense bar appointed by the county legislative authority, and, in counties with a drug court, a representative of the drug court shall jointly submit a plan, approved by the county legislative authority or authorities, to the panel established in subsection (5)(b) of this section, for disposition of all the funds provided from the criminal justice treatment account within that county. The submitted plan should incorporate current evidence-based practices in substance use disorder treatment. The funds shall be used solely to provide approved alcohol and substance use disorder treatment pursuant to RCW 71.24.560 and treatment support services. No more than ten percent of the total moneys received under subsections (4) and (5) of this section by a county or group of counties participating in a regional agreement shall be spent for treatment support services.

(7) Counties are encouraged to consider regional agreements and submit regional plans for the efficient delivery of treatment under this section.

(8) Moneys allocated under this section shall be used to supplement, not supplant, other federal, state, and local funds used for substance abuse treatment.

(9) If a region or county uses criminal justice treatment account funds to support a therapeutic court, the therapeutic court must allow the use of all medications approved by the federal food and drug administration for the treatment of opioid use disorder as deemed medically appropriate for a participant by a medical professional. If appropriate medication-assisted treatment resources are not available or accessible within the jurisdiction, the health care authority's designee for assistance must assist the court with acquiring the resource.

(10) Counties must meet the criteria established in RCW 2.30.030(3).

(11) The authority shall annually review and monitor the expenditures made by any county or group of counties that receives appropriated funds distributed under this section. Counties shall repay any funds that are not spent in accordance with the requirements of its contract with the authority. [2022 c 297 § 964; 2022 c 157 § 18; 2021 c 334 § 989; 2020 c 357 § 917. Prior: 2019 c 415 § 980; 2019 c 325 § 1040; 2019 c 314 § 27; prior: 2018 c 205 § 2; 2018 c 201 § 4044; 2017 3rd sp.s. c 1 § 981; 2016 sp.s. c 29 § 511; prior: 2015 3rd sp.s. c 4 § 968; 2015 c 291 § 10; 2013 2nd sp.s. c 4 § 990; 2011 2nd sp.s. c 9 § 910; 2011 1st sp.s. c 40 § 34; prior: 2009 c 479 § 50; 2009 c 445 § 1; 2008 c 329 § 918; 2003 c 379 § 11; 2002 c 290 § 4. Formerly RCW 70.96A.350.]

Reviser's note: This section was amended by 2022 c 157 § 18 and by 2022 c 297 § 964, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2022 c 297: See note following RCW 43.79.565.

Conflict with federal requirements—Effective date—2021 c 334: See notes following RCW 43.79.555.

Effective date—2020 c 357: See note following RCW 43.79.545.

Effective date—2019 c 415: See note following RCW 28B.20.476.

Effective date—2019 c 325: See note following RCW 71.24.011.

Declaration—2019 c 314: See note following RCW 18.22.810.

Finding—Intent—2018 c 205: "Drug courts remove a defendant's or respondent's case from the criminal and civil court traditional trial track and allow those defendants or respondents the opportunity to obtain treatment services to address particular issues that may have contributed to the conduct that led to their arrest or other issues before the court. Such courts, by focusing on specific individuals' needs, provide treatment for the issues presented and ensure rapid and appropriate accountability for program violations, which decreases recidivism, improves the safety of the community, and improves the life of the program participant and the lives of the participant's family members by decreasing the severity and frequency of the specific behavior addressed by the therapeutic court. Therefore, the legislature finds compelling the research conducted by the Washington state institute for public policy and the research and data analysis division of the department of social and health services showing that providing recovery support services to clients in drug courts creates a benefit to the state of approximately seven dollars and sixty cents in reduced public expenditures and reduced costs of victimization for each dollar spent. Therefore, it is the intent of the legislature to allow the use of a portion of the criminal justice treatment account to provide such services to foster increased success in drug courts." [2018 c 205 § 1.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2017 3rd sp.s. c 1: See note following RCW 43.41.455.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective dates—2015 3rd sp.s. c 4: See note following RCW 28B.15.069.

Conflict with federal requirements—2015 c 291: See note following RCW 2.30.010.

Effective dates—2013 2nd sp.s. c 4: See note following RCW 2.68.020.

Intent—2002 c 290: See note following RCW 9.94A.517.

Additional notes found at www.leg.wa.gov

71.24.585 Opioid and substance use disorder treatment—State response. (1)(a) The state of Washington declares that substance use disorders are medical conditions.

Substance use disorders should be treated in a manner similar to other medical conditions by using interventions that are supported by evidence, including medications approved by the federal food and drug administration for the treatment of opioid use disorder. It is also recognized that many individuals have multiple substance use disorders, as well as histories of trauma, developmental disabilities, or mental health conditions. As such, all individuals experiencing opioid use disorder should be offered evidence-supported treatments to include federal food and drug administration approved medications for the treatment of opioid use disorders and behavioral counseling and social supports to address them. For behavioral health agencies, an effective plan of treatment for most persons with opioid use disorder integrates access to medications and psychosocial counseling and should be consistent with the American society of addiction medicine patient placement criteria. Providers must inform patients with opioid use disorder or substance use disorder of options to access federal food and drug administration approved medications for the treatment of opioid use disorder or substance use disorder. Because some such medications are controlled substances in chapter 69.50 RCW, the state of Washington maintains the legal obligation and right to regulate the uses of these medications in the treatment of opioid use disorder.

(b) The authority must work with other state agencies and stakeholders to develop value-based payment strategies to better support the ongoing care of persons with opioid and other substance use disorders.

(c) The department of corrections shall develop policies to prioritize services based on available grant funding and funds appropriated specifically for opioid use disorder treatment.

(2) The authority must promote the use of medication therapies and other evidence-based strategies to address the opioid epidemic in Washington state. Additionally, by January 1, 2020, the authority must prioritize state resources for the provision of treatment and recovery support services to inpatient and outpatient treatment settings that allow patients to start or maintain their use of medications for opioid use disorder while engaging in services.

(3) The state declares that the main goals of treatment for persons with opioid use disorder are the cessation of unprescribed opioid use, reduced morbidity, and restoration of the ability to lead a productive and fulfilling life.

(4) To achieve the goals in subsection (3) of this section, to promote public health and safety, and to promote the efficient and economic use of funding for the medicaid program under Title XIX of the social security act, the authority may seek, receive, and expend alternative sources of funding to support all aspects of the state's response to the opioid crisis.

(5) The authority must partner with the department of social and health services, the department of corrections, the department of health, the department of children, youth, and families, and any other agencies or entities the authority deems appropriate to develop a statewide approach to leveraging medicaid funding to treat opioid use disorder and provide emergency overdose treatment. Such alternative sources of funding may include:

(a) Seeking a section 1115 demonstration waiver from the federal centers for medicare and medicaid services to fund opioid treatment medications for persons eligible for medicaid at or during the time of incarceration and juvenile detention facilities; and

(b) Soliciting and receiving private funds, grants, and donations from any willing person or entity.

(6)(a) The authority shall work with the department of health to promote coordination between medication-assisted treatment prescribers, federally accredited opioid treatment programs, substance use disorder treatment facilities, and state-certified substance use disorder treatment agencies to:

(i) Increase patient choice in receiving medication and counseling;

(ii) Strengthen relationships between opioid use disorder providers;

(iii) Acknowledge and address the challenges presented for individuals needing treatment for multiple substance use disorders simultaneously; and

(iv) Study and review effective methods to identify and reach out to individuals with opioid use disorder who are at high risk of overdose and not involved in traditional systems of care, such as homeless individuals using syringe service programs, and connect such individuals to appropriate treatment.

(b) The authority must work with stakeholders to develop a set of recommendations to the governor and the legislature that:

(i) Propose, in addition to those required by federal law, a standard set of services needed to support the complex treatment needs of persons with opioid use disorder treated in opioid treatment programs;

(ii) Outline the components of and strategies needed to develop opioid treatment program centers of excellence that provide fully integrated care for persons with opioid use disorder;

(iii) Estimate the costs needed to support these models and recommendations for funding strategies that must be included in the report;

(iv) Outline strategies to increase the number of waivered health care providers approved for prescribing buprenorphine by the substance abuse and mental health services administration; and

(v) Outline strategies to lower the cost of federal food and drug administration approved products for the treatment of opioid use disorder.

(7) State agencies shall review and promote positive outcomes associated with the accountable communities of health funded opioid projects and local law enforcement and human services opioid collaborations as set forth in the Washington state interagency opioid working plan.

(8) The authority must partner with the department and other state agencies to replicate effective approaches for linking individuals who have had a nonfatal overdose with treatment opportunities, with a goal to connect certified peer counselors with individuals who have had a nonfatal overdose.

(9) State agencies must work together to increase outreach and education about opioid overdoses to non-English-speaking communities by developing a plan to conduct outreach and education to non-English-speaking communities. The department must submit a report on the outreach and education plan with recommendations for implementation to

the appropriate legislative committees by July 1, 2020. [2019 c 314 § 28; 2017 c 297 § 12; 2016 sp.s. c 29 § 519; 2001 c 242 § 1; 1995 c 321 § 1; 1989 c 270 § 20. Formerly RCW 70.96A.400.]

Declaration—2019 c 314: See note following RCW 18.22.810.

Findings—Intent—2017 c 297: See note following RCW 18.22.800.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.24.587 Opioid use disorder treatment—Possession or use of lawfully prescribed medication—Declaration by state. The state declares that a person lawfully possessing or using lawfully prescribed medication for the treatment of opioid use disorder must be treated the same in judicial and administrative proceedings as a person lawfully possessing or using other lawfully prescribed medications. [2017 c 297 § 13.]

Findings—Intent—2017 c 297: See note following RCW 18.22.800.

71.24.589 Substance use disorders—Law enforcement assisted diversion—Pilot project. (1) Subject to funds appropriated by the legislature, the authority shall implement a pilot project for law enforcement assisted diversion which shall adhere to law enforcement assisted diversion core principles recognized by the law enforcement assisted diversion national support bureau, the efficacy of which have been demonstrated in peer-reviewed research studies.

(2) Under the pilot project, the authority must partner with the law enforcement assisted diversion national support bureau to award a contract, subject to appropriation, for two or more geographic areas in the state of Washington for law enforcement assisted diversion. Cities, counties, and tribes may compete for participation in a pilot project.

(3) The pilot projects must provide for comprehensive technical assistance from law enforcement assisted diversion implementation experts to develop and implement a law enforcement assisted diversion program in the pilot project's geographic areas in a way that ensures fidelity to the research-based law enforcement assisted diversion model.

(4) The key elements of a law enforcement assisted diversion pilot project must include:

(a) Long-term case management for individuals with substance use disorders;

(b) Facilitation and coordination with community resources focusing on overdose prevention;

(c) Facilitation and coordination with community resources focused on the prevention of infectious disease transmission;

(d) Facilitation and coordination with community resources providing physical and behavioral health services;

(e) Facilitation and coordination with community resources providing medications for the treatment of substance use disorders;

(f) Facilitation and coordination with community resources focusing on housing, employment, and public assistance;

(g) Twenty-four hours per day and seven days per week response to law enforcement for arrest diversions; and

(h) Prosecutorial support for diversion services. [2019 c 314 § 29.]

Declaration—2019 c 314: See note following RCW 18.22.810.

71.24.590 Opioid treatment—Program licensing or certification by department, department duties—Use of medications by program—Definition. (1) When making a decision on an application for licensing or certification of a program, the department shall:

(a) Consult with the county legislative authorities in the area in which an applicant proposes to locate a program and the city legislative authority in any city in which an applicant proposes to locate a program;

(b) License or certify only programs that will be sited in accordance with the appropriate county or city land use ordinances. Counties and cities may require conditional use permits with reasonable conditions for the siting of programs. Pursuant to RCW 36.70A.200, no local comprehensive plan or development regulation may preclude the siting of essential public facilities;

(c) Not discriminate in its licensing or certification decision on the basis of the corporate structure of the applicant;

(d) Consider the size of the population in need of treatment in the area in which the program would be located and license or certify only applicants whose programs meet the necessary treatment needs of that population;

(e) Consider the availability of other certified opioid treatment programs near the area in which the applicant proposes to locate the program;

(f) Consider the transportation systems that would provide service to the program and whether the systems will provide reasonable opportunities to access the program for persons in need of treatment;

(g) Consider whether the applicant has, or has demonstrated in the past, the capability to provide the appropriate services to assist the persons who utilize the program in meeting goals established by the legislature in RCW 71.24.585. The department shall prioritize licensing or certification to applicants who have demonstrated such capability and are able to measure their success in meeting such outcomes;

(h) Hold one public hearing in the community in which the facility is proposed to be located. The hearing shall be held at a time and location that are most likely to permit the largest number of interested persons to attend and present testimony. The department shall notify all appropriate media outlets of the time, date, and location of the hearing at least three weeks in advance of the hearing.

(2) A county may impose a maximum capacity for a program of notless than three hundred fifty participants if necessary to addressspecific local conditions cited by the county.

(3) A program applying for licensing or certification from the department and a program applying for a contract from a state agency that has been denied the licensing or certification or contract shall be provided with a written notice specifying the rationale and reasons for the denial.

(4) Opioid treatment programs may order, possess, dispense, and administer medications approved by the United States food and drug administration for the treatment of opioid use disorder, alcohol use disorder, tobacco use disorder, and reversal of opioid overdose. For an opioid treatment program to order, possess, and dispense any other legend drug, including controlled substances, the opioid treatment pro-

gram must obtain additional licensure as required by the department, except for patient-owned medications.

(5) Opioid treatment programs may accept, possess, and administer patient-owned medications.

(6) Registered nurses and licensed practical nurses may dispense up to a thirty-one day supply of medications approved by the United States food and drug administration for the treatment of opioid use disorder to patients of the opioid treatment program, under an order or prescription and in compliance with 42 C.F.R. Sec. 8.12.

(7) For the purpose of this chapter, "opioid treatment program" means a program that:

(a) Engages in the treatment of opioid use disorder with medications approved by the United States food and drug administration for the treatment of opioid use disorder and reversal of opioid overdose; and

(b) Provides a comprehensive range of medical and rehabilitative services. [2019 c 314 § 30; 2018 c 201 § 4045; 2017 c 297 § 14; 2001 c 242 § 2; 1995 c 321 § 2; 1989 c 270 § 21. Formerly RCW 70.96A.410.]

Declaration—2019 c 314: See note following RCW 18.22.810.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Contingent effective date—2017 c 297 §§ 14 and 16: "Sections 14 and 16 of this act take effect only if neither Substitute House Bill No. 1388 (including any later amendments or substitutes) nor Substitute Senate Bill No. 5259 (including any later amendments or substitutes) is signed into law by the governor by July 23, 2017." [2017 c 297 § 18.] Neither Substitute House Bill No. 1388 nor Substitute Senate Bill No. 5259 was signed into law by July 23, 2017.

Findings—Intent—2017 c 297: See note following RCW 18.22.800.

71.24.593 Opioid use disorder treatment—Care of individuals and their newborns—Authority recommendations required. (1) Recognizing that treatment strategies and modalities for the treatment of individuals with opioid use disorder and their newborns continue to evolve, and that improved health outcomes are seen when birth parents and their infants are allowed to room together, the authority must provide recommendations to the office of financial management by October 1, 2019, to better support the care of individuals who have recently delivered and their newborns.

(2) These recommendations must support:

(a) Successful transition from the early postpartum and newborn period for the birth parent and infant to the next level of care;

(b) Reducing the risk of parental infant separation; and

(c) Increasing the chance of uninterrupted recovery of the parent and foster the development of positive parenting practices.

(3) The authority's recommendations must include:

(a) How these interventions could be supported in hospitals, birthing centers, or other appropriate sites of care and descriptions as to current barriers in providing these interventions;

(b) Estimates of the costs needed to support this enhanced set of services; and

(c) Mechanisms for funding the services. [2019 c 314 § 25.]

Declaration—2019 c 314: See note following RCW 18.22.810.

71.24.594 Opioid overdose reversal medications—Education—Distribution—Labeling—Liability. (1) For any client presenting with symptoms of an opioid use disorder, or who reports recent use of opioids outside legal authority, all licensed or certified behavioral health agencies that provide individuals treatment for mental health or substance use disorder, withdrawal management, secure withdrawal management, evaluation and treatment, or opioid treatment programs must during the client's intake, discharge, or treatment plan review, as appropriate:

(a) Inform the client about opioid overdose reversal medication and ask whether the client has opioid overdose reversal medication; and

(b) If a client does not possess opioid overdose reversal medication, unless the behavioral health provider determines using clinical and professional judgment that opioid overdose reversal medication is not appropriate, the behavioral health provider must:

(i) Prescribe the client opioid overdose reversal medication or utilize the statewide naloxone standing order; and

(ii) Assist the client in directly obtaining opioid overdose reversal medication as soon as practical by:

(A) Directly dispensing the opioid overdose reversal medication, if authorized by state law;

(B) Partnering with a pharmacy to obtain the opioid overdose reversal medication on the client's behalf and distributing the opioid overdose reversal medication to the client;

(C) Assisting the client in utilizing a mail order pharmacy or pharmacy that mails prescription drugs directly to the behavioral health agency or client and distributing the opioid overdose reversal medication to the client, if necessary;

(D) Obtaining and distributing opioid overdose reversal medication through the bulk purchasing and distribution program established in RCW 70.14.170; or

(E) Using any other resources or means authorized by state law to provide opioid overdose reversal medication.

(2) Until the opioid overdose reversal medication bulk purchasing and distribution program established in RCW 70.14.170 is operational, if a behavioral health agency listed in subsection (1) of this section dispenses, distributes, or otherwise assists the client in directly obtaining the opioid overdose reversal medication such that the agency is the billing entity, the behavioral health agency must:

(a) For clients enrolled in medical assistance under chapter 74.09 RCW, bill the client's medicaid benefit for the client's opioid overdose reversal medication utilizing the appropriate billing codes established by the health care authority;

(b) For clients with available health insurance coverage other than medical assistance under chapter 74.09 RCW, bill the client's health plan for the cost of the opioid overdose reversal medication;

(c) For clients who are not enrolled in medical assistance under chapter 74.09 RCW and do not have any other available health insurance coverage, bill the health care authority for the cost of the client's opioid overdose reversal medication.

(3) A pharmacy that dispenses opioid overdose reversal medication through a partnership or relationship with a behavioral health agency as described in subsection (1) of

this section must bill the health care authority for the cost of the client's opioid overdose reversal medication for clients that are not enrolled in medical assistance under chapter 74.09 RCW and do not have any other available health insurance coverage.

(4) The labeling requirements of RCW 69.41.050 and 18.64.246 do not apply to opioid overdose reversal medication dispensed or delivered in accordance with this section.

(5) A person who is provided opioid overdose reversal medication under this section must be provided information and resources about medication for opioid use disorder and harm reduction strategies and services which may be available, such as substance use disorder treatment services and substance use disorder peer counselors. This information should be available in all languages relevant to the communities that the behavioral health agency serves.

(6) The individual or entity that dispenses, distributes, or delivers an opioid overdose reversal medication in accordance with this section shall ensure that the directions for use are provided.

(7) Actions taken in compliance with subsection (1) of this section by an entity that provides only mental health treatment may not be construed as the entity holding itself out as providing or in fact providing substance use disorder diagnosis, treatment, or referral for treatment for purposes of state or federal law.

(8) A behavioral health agency, its employees, and providers are immune from suit in any action, civil or criminal, or from professional or other disciplinary action, for action or inaction in compliance with this section.

(9) For purposes of this section, "opioid overdose reversal medication" has the meaning provided in RCW 69.41.095. [2021 c 273 § 4.]

Effective date—2021 c 273 §§ 2-4: See note following RCW 70.41.480.

Findings—Intent—2021 c 273: See note following RCW 70.41.480.

71.24.595 Statewide treatment and operating standards for opioid treatment programs—Evaluation and report. (1) To achieve more medication options, the authority must work with the department and the authority's medicaid managed care organizations, to eliminate barriers and promote access to effective medications known to address opioid use disorders at state-certified opioid treatment programs. Medications include, but are not limited to: Methadone, buprenorphine, and naltrexone. The authority must encourage the distribution of naloxone to patients who are at risk of an opioid overdose.

(2) The department, in consultation with opioid treatment program service providers and counties and cities, shall establish statewide treatment standards for licensed or certified opioid treatment programs. The department shall enforce these treatment standards. The treatment standards shall include, but not be limited to, reasonable provisions for all appropriate and necessary medical procedures, counseling requirements, urinalysis, and other suitable tests as needed to ensure compliance with this chapter.

(3) The department, in consultation with opioid treatment programs and counties, shall establish statewide operating standards for certified opioid treatment programs. The department shall enforce these operating standards. The operating standards shall include, but not be limited to, reasonable provisions necessary to enable the department and counties to monitor certified or licensed opioid treatment programs for compliance with this chapter and the treatment standards authorized by this chapter and to minimize the impact of the opioid treatment programs upon the business and residential neighborhoods in which the program is located.

(4) The department shall analyze and evaluate the data submitted by each treatment program and take corrective action where necessary to ensure compliance with the goals and standards enumerated under this chapter. Opioid treatment programs are subject to the oversight required for other substance use disorder treatment programs, as described in this chapter. [2019 c 314 § 31; 2018 c 201 § 4046; 2017 c 297 § 16; 2003 c 207 § 6; 2001 c 242 § 3; 1998 c 245 § 135; 1995 c 321 § 3; 1989 c 270 § 22. Formerly RCW 70.96A.420.]

Declaration—2019 c 314: See note following RCW 18.22.810.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Contingent effective date—2017 c 297 §§ 14 and 16: See note following RCW 71.24.590.

Findings—Intent—2017 c 297: See note following RCW 18.22.800.

71.24.597 Opioid overdose reversal medication—Coordinated purchasing and distribution. By October 1, 2019, the authority must work with the department, the accountable communities of health, and community stakeholders to develop a plan for the coordinated purchasing and distribution of opioid overdose reversal medication across the state of Washington. The plan must be developed in consultation with the University of Washington's alcohol and drug abuse institute and community agencies participating in the federal demonstration grant titled Washington state project to prevent prescription drug or opioid overdose. [2019 c 314 § 32.]

Declaration—2019 c 314: See note following RCW 18.22.810.

71.24.598 Drug overdose response team. (1) The department, in coordination with the authority, must develop a strategy to rapidly deploy a response team to a local community identified as having a high number of fentanyl-related or other drug overdoses by the local emergency management system, hospital emergency department, local health jurisdiction, law enforcement agency, or surveillance data. The response team must provide technical assistance and other support to the local health jurisdiction, health care clinics, hospital emergency departments, substance use disorder treatment providers, and other community-based organizations, and are expected to increase the local capacity to provide medication-assisted treatment and overdose education.

(2) The department and the authority must reduce barriers and promote medication treatment therapies for opioid use disorder in emergency departments and same-day referrals to opioid treatment programs, substance use disorder treatment facilities, and community-based medication treatment prescribers for individuals experiencing an overdose. [2019 c 314 § 33.]

Declaration—2019 c 314: See note following RCW 18.22.810.

71.24.599 Opioid use disorder—City and county jails—Funding. (1) Subject to funds appropriated by the legislature, or approval of a section 1115 demonstration waiver from the federal centers for medicare and medicaid services, to fund opioid treatment medications for persons eligible for medicaid at or during the time of incarceration and juvenile detention facilities, the authority shall establish a methodology for distributing funds to city and county jails to provide medication for the treatment of opioid use disorder to individuals in the custody of the facility in any status. The authority must prioritize funding for the services required in (a) of this subsection. To the extent that funding is provided, city and county jails must:

(a) Provide medication for the treatment of opioid use disorder to individuals in the custody of the facility, in any status, who were receiving medication for the treatment of opioid use disorder through a legally authorized medical program or by a valid prescription immediately before incarceration; and

(b) Provide medication for the treatment of opioid use disorder to incarcerated individuals not less than thirty days before release when treatment is determined to be medically appropriate by a health care practitioner.

(2) City and county jails must make reasonable efforts to directly connect incarcerated individuals receiving medication for the treatment of opioid use disorder to an appropriate provider or treatment site in the geographic region in which the individual will reside before release. If a connection is not possible, the facility must document its efforts in the individual's record. [2019 c 314 § 34.]

Declaration—2019 c 314: See note following RCW 18.22.810.

71.24.600 Inability to contribute to cost of services no bar to admission—Authority may limit admissions for nonmedicaid clients. The authority shall not refuse admission for diagnosis, evaluation, guidance[,] or treatment to any applicant because it is determined that the applicant is financially unable to contribute fully or in part to the cost of any services or facilities available under the community behavioral health program.

For nonmedicaid clients, through its contracts with the behavioral health administrative services organizations, the authority may limit admissions of such applicants or modify its programs in order to ensure that expenditures for services or programs do not exceed amounts appropriated by the legislature and are allocated by the authority for such services or programs. For nonmedicaid clients, the authority may establish admission priorities in the event that the number of eligible applicants exceeds the limits set by the authority. [2019 c 325 § 1041; 2018 c 201 § 4047. Prior: 1989 c 271 § 308; 1959 c 85 § 15. Formerly RCW 70.96A.430, 70.96.150.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Additional notes found at www.leg.wa.gov

71.24.605 Fetal alcohol screening and assessment services. The authority shall contract with the University of Washington fetal alcohol syndrome clinic to provide fetal alcohol exposure screening and assessment services. The University indirect charges shall not exceed ten percent of the total contract amount. The contract shall require the University of Washington fetal alcohol syndrome clinic to provide the following services:

(1) Training for health care staff in community-based fetal alcohol exposure clinics to ensure the accurate diagnosis of individuals with fetal alcohol exposure and the development and implementation of appropriate service referral plans;

(2) Development of written or visual educational materials for the individuals diagnosed with fetal alcohol exposure and their families or caregivers;

(3) Systematic information retrieval from each community clinic to (a) maintain diagnostic accuracy and reliability across all community clinics, (b) facilitate the development of effective and efficient screening tools for population-based identification of individuals with fetal alcohol exposure, (c) facilitate identification of the most clinically efficacious and cost-effective educational, social, vocational, and health service interventions for individuals with fetal alcohol exposure;

(4) Based on available funds, establishment of a network of community-based fetal alcohol exposure clinics across the state to meet the demand for fetal alcohol exposure diagnostic and referral services; and

(5) Preparation of an annual report for submission to the authority, the department of health, the department of social and health services, the department of corrections, and the office of the superintendent of public instruction which includes the information retrieved under subsection (3) of this section. [2018 c 201 § 4048; 1998 c 245 § 136; 1995 c 54 § 2. Formerly RCW 70.96A.500.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Findings—Purpose—1995 c 54: "The legislature finds that fetal alcohol exposure is among the leading known causes of mental retardation in the children of our state. The legislature further finds that individuals with undiagnosed fetal alcohol exposure suffer substantially from secondary disabilities such as child abuse and neglect, separation from families, multiple foster placements, depression, aggression, school failure, juvenile detention, and job instability. These secondary disabilities come at a high cost to the individuals, their family, and society. The legislature finds that these problems can be reduced substantially by early diagnosis and receipt of appropriate, effective intervention.

The purpose of this act is to support current public and private efforts directed at the early identification of and intervention into the problems associated with fetal alcohol exposure through the creation of a fetal alcohol exposure clinical network." [1995 c 54 § 1.]

71.24.610 Interagency agreement on fetal alcohol exposure programs. The authority, the department of social and health services, the department of health, the department of corrections, and the office of the superintendent of public instruction shall execute an interagency agreement to ensure the coordination of identification, prevention, and intervention programs for children who have fetal alcohol exposure, and for women who are at high risk of having children with fetal alcohol exposure.

The interagency agreement shall provide a process for community advocacy groups to participate in the review and development of identification, prevention, and intervention programs administered or contracted for by the agencies executing this agreement. [2018 c 201 § 4049; 1995 c 54 § 3. Formerly RCW 70.96A.510.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Findings—Purpose—1995 c 54: See note following RCW 71.24.605.

71.24.615 Chemical dependency treatment expenditures—Prioritization. The authority shall prioritize expenditures for treatment provided under RCW 13.40.165. The authority shall provide funds for inpatient and outpatient treatment providers that are the most successful, using the standards developed by the University of Washington under section 27, chapter 338, Laws of 1997. The authority may consider variations between the nature of the programs provided and clients served but must provide funds first for those programs that demonstrate the greatest success in treatment within categories of treatment and the nature of the persons receiving treatment. [2018 c 201 § 4050; 2003 c 207 § 7; 1997 c 338 § 28. Formerly RCW 70.96A.520.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Finding—Evaluation—Report—1997 c 338: See note following RCW 13.40.0357.

Additional notes found at www.leg.wa.gov

71.24.618 Withdrawal management services—Substance use disorder treatment services—Prior authorization—Utilization review—Medical necessity review. (1) Beginning January 1, 2021, a managed care organization may not require an enrollee to obtain prior authorization for withdrawal management services or inpatient or residential substance use disorder treatment services in a behavioral health agency licensed or certified under RCW 71.24.037.

(2)(a) Beginning January 1, 2021, a managed care organization must:

(i) Provide coverage for no less than two business days, excluding weekends and holidays, in a behavioral health agency that provides inpatient or residential substance use disorder treatment prior to conducting a utilization review; and

(ii) Provide coverage for no less than three days in a behavioral health agency that provides withdrawal management services prior to conducting a utilization review.

(b) The managed care organization may not require an enrollee to obtain prior authorization for the services specified in (a) of this subsection as a condition for payment of services prior to the times specified in (a) of this subsection. Once the times specified in (a) of this subsection have passed, the managed care organization may initiate utilization management review procedures if the behavioral health agency continues to provide services or is in the process of arranging for a seamless transfer to an appropriate facility or lower level of care under subsection (6) of this section.

(c)(i) The behavioral health agency under (a) of this subsection must notify an enrollee's managed care organization as soon as practicable after admitting the enrollee, but not later than twenty-four hours after admitting the enrollee. The time of notification does not reduce the requirements established in (a) of this subsection.

(ii) The behavioral health agency under (a) of this subsection must provide the managed care organization with its initial assessment and initial treatment plan for the enrollee within two business days of admission, excluding weekends and holidays, or within three days in the case of a behavioral health agency that provides withdrawal management services.

(iii) After the time period in (a) of this subsection and receipt of the material provided under (c)(ii) of this subsection, the managed care organization may initiate a medical necessity review process. Medical necessity review must be based on the standard set of criteria established under RCW 41.05.528. If the health plan determines within one business day from the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the managed care organization's medical necessity review is completed more than one business day after [the] start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection, the managed care organization must pay for the services delivered from the time of admission until the time at which the medical necessity review is completed and the agency is advised of the decision in writing.

(3) The behavioral health agency shall document to the managed care organization the patient's need for continuing care and justification for level of care placement following the current treatment period, based on the standard set of criteria established under RCW 41.05.528, with documentation recorded in the patient's medical record.

(4) Nothing in this section prevents a health carrier from denying coverage based on insurance fraud.

(5) If the behavioral health agency under subsection (2)(a) of this section is not in the enrollee's network:

(a) The managed care organization is not responsible for reimbursing the behavioral health agency at a greater rate than would be paid had the agency been in the enrollee's network; and

(b) The behavioral health agency may not balance bill, as defined in RCW 48.43.005.

(6) When the treatment plan approved by the managed care organization involves transfer of the enrollee to a different facility or to a lower level of care, the care coordination unit of the managed care organization shall work with the current agency to make arrangements for a seamless transfer as soon as possible to an appropriate and available facility or level of care. The managed care organization shall pay the agency for the cost of care at the current facility until the seamless transfer to the different facility or lower level of care is complete. A seamless transfer to a lower level of care may include same day or next day appointments for outpatient care, and does not include payment for nontreatment services, such as housing services. If placement with an agency in the managed care organization's network is not available, the managed care organization shall pay the current agency at the service level until a seamless transfer arrangement is made.

(7) The requirements of this section do not apply to treatment provided in out-of-state facilities.

(8) For the purposes of this section "withdrawal management services" means twenty-four hour medically managed or medically monitored detoxification and assessment and

treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery. [2020 c 345 § 4.]

Findings—Intent—2020 c 345: See note following RCW 41.05.526.

71.24.625 Uniform application of chapter—Training for designated crisis responders. The authority shall ensure that the provisions of this chapter are applied by behavioral health administrative services organizations and managed care organizations in a consistent and uniform manner. The authority shall also ensure that, to the extent possible within available funds, the designated crisis responders are specifically trained in adolescent substance use disorder issues, the substance use disorder commitment laws, and the criteria for commitment. [2019 c 325 § 1042; 2018 c 201 § 4052; 2016 sp.s. c 29 § 521; 1992 c 205 § 306. Formerly RCW 70.96A.905.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.24.630 Integrated, comprehensive screening and assessment process for substance use and mental disorders. (1) The authority shall maintain an integrated and comprehensive screening and assessment process for substance use and mental disorders and co-occurring substance use and mental disorders.

(a) The process adopted shall include, at a minimum:

(i) An initial screening tool that can be used by intake personnel systemwide and which will identify the most common types of co-occurring disorders;

(ii) An assessment process for those cases in which assessment is indicated that provides an appropriate degree of assessment for most situations, which can be expanded for complex situations;

(iii) Identification of triggers in the screening that indicate the need to begin an assessment;

(iv) Identification of triggers after or outside the screening that indicate a need to begin or resume an assessment;

(v) The components of an assessment process and a protocol for determining whether part or all of the assessment is necessary, and at what point; and

(vi) Emphasis that the process adopted under this section is to replace and not to duplicate existing intake, screening, and assessment tools and processes.

(b) The authority shall consider existing models, including those already adopted by other states, and to the extent possible, adopt an established, proven model.

(c) The integrated, comprehensive screening and assessment process shall be implemented statewide by all substance use disorder and mental health treatment providers and designated crisis responders.

(2) The authority shall provide for adequate training to effect statewide implementation and, upon request, shall report the rates of co-occurring disorders [and] the stage of screening or assessment at which the co-occurring disorder was identified to the appropriate committees of the legislature.

(3) The authority shall establish performance-based contracts with managed care organizations and behavioral health administrative services organizations and implement the integrated screening and assessment process. [2019 c 325 § 1043; 2018 c 201 § 4053; 2016 sp.s. c 29 § 513; 2014 c 225 § 77; 2005 c 504 § 601. Formerly RCW 70.96C.010.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2014 c 225: See note following RCW 71.24.016.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Additional notes found at www.leg.wa.gov

71.24.640 Standards for certification or licensure of evaluation and treatment facilities. The secretary shall license or certify evaluation and treatment facilities that meet state minimum standards. The standards for certification or licensure of evaluation and treatment facilities by the department must include standards relating to maintenance of good physical and mental health and other services to be afforded persons pursuant to this chapter and chapters 71.05 and 71.34 RCW, and must otherwise assure the effectuation of the purposes of these chapters. [2018 c 201 § 4054; 2016 sp.s. c 29 § 507.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.24.645 Standards for certification or licensure of crisis stabilization units. The secretary shall license or certify crisis stabilization units that meet state minimum standards. The standards for certification or licensure of crisis stabilization units by the department must include standards that:

(1) Permit location of the units at a jail facility if the unit is physically separate from the general population of the jail;

(2) Require administration of the unit by mental health professionals who direct the stabilization and rehabilitation efforts; and

(3) Provide an environment affording security appropriate with the alleged criminal behavior and necessary to protect the public safety. [2018 c 201 § 4055; 2016 sp.s. c 29 § 508.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.24.647 Standards for certification or licensure of triage facilities. The secretary shall license or certify triage facilities that meet state minimum standards. The standards for certification or licensure of triage facilities by the depart-

ment must include standards related to the ability to assess and stabilize an individual or determine the need for involuntary commitment of an individual. [2018 c 201 § 4056.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.24.648 Standards for certification or licensure of intensive behavioral health treatment facilities. The secretary shall license or certify intensive behavioral health treatment facilities that meet state minimum standards. The secretary must establish rules working with the authority and the department of social and health services to create standards for licensure or certification of intensive behavioral health treatment facilities. The rules, at a minimum, must:

(1) Clearly define clinical eligibility criteria in alignment with how "intensive behavioral health treatment facility" is defined in RCW 71.24.025;

(2) Require twenty-four hour supervision of residents;

(3) Establish staffing requirements that provide an appropriate response to the acuity of the residents, including a clinical team and a high staff to patient ratio;

(4) Establish requirements for the ability to provide services and an appropriate level of care to individuals with intellectual or developmental disabilities. The requirements must include staffing and training;

(5) Require access to regular psychosocial rehabilitation services including, but not limited to, skills training in daily living activities, social interaction, behavior management, impulse control, and self-management of medications;

(6) Establish requirements for the ability to use limited egress;

(7) Limit services to persons at least eighteen years of age; and

(8) Establish resident rights that are substantially similar to the rights of residents in long-term care facilities. [2019 c 324 § 3.]

Findings—Intent—2019 c 324: "The legislature finds that there is a need for additional bed capacity and services for individuals with behavioral health needs. The legislature further finds that for many individuals, it is best for them to receive treatment in their communities and in smaller facilities that help them stay closer to home. The legislature further finds that the state hospitals are struggling to keep up with rising demand; there are challenges to finding appropriate placements for patients ready to discharge, and there are a shortage of appropriate facilities for individuals with complex behavioral health needs.

Therefore, the legislature intends to provide more options in the continuum of care for behavioral health clients by creating new facility types and by expanding the capacity of current provider types in the community." [2019 c 324 § 1.]

Mental health drop-in center services pilot program—2019 c 324: See note following RCW 71.24.649.

Report—2019 c 324: See note following RCW 70.38.111.

Recommendations—Residential intensive behavioral health and developmental disability services—2019 c 324: See note following RCW 74.39A.030.

71.24.649 Standards for certification or licensure of mental health peer-run respite centers. The secretary shall license or certify mental health peer-run respite centers that meet state minimum standards. In consultation with the authority and the department of social and health services, the secretary must:

(1) Establish requirements for licensed and certified community behavioral health agencies to provide mental health peer-run respite center services and establish physical plant and service requirements to provide voluntary, short-term, noncrisis services that focus on recovery and wellness;

(2) Require licensed and certified agencies to partner with the local crisis system including, but not limited to, evaluation and treatment facilities and designated crisis responders;

(3) Establish staffing requirements, including rules to ensure that facilities are peer-run;

(4) Limit services to a maximum of seven days in a month;

(5) Limit services to individuals who are experiencing psychiatric distress, but do not meet legal criteria for involuntary hospitalization under chapter 71.05 RCW; and

(6) Limit services to persons at least eighteen years of age. [2021 c 302 § 403; 2019 c 324 § 5.]

Findings—Intent—2021 c 302: See note following RCW 71.24.890.

Mental health drop-in center services pilot program—2019 c 324: "(1) The health care authority shall establish a pilot program to provide mental health drop-in center services. The mental health drop-in center services shall provide a peer-focused recovery model during daytime hours through a community-based, therapeutic, less restrictive alternative to hospitalization for acute psychiatric needs. The program shall assist clients in need of voluntary, short-term, noncrisis services that focus on recovery and wellness. Clients may refer themselves, be brought to the center by law enforcement, be brought to the center by family members, or be referred by an emergency department.

(2) The pilot program shall be conducted in the largest city in a regional service area that has at least nine counties. Funds to support the pilot program shall be distributed through the behavioral health administrative service organization that serves the pilot program.

(3) The pilot program shall begin on January 1, 2020, and conclude July 1, 2022.

(4) By December 1, 2020, the health care authority shall submit a preliminary report to the governor and the appropriate committees of the legislature. The preliminary report shall include a survey of peer mental health programs that are operating in the state, including the location, type of services offered, and number of clients served. By December 1, 2021, the health care authority shall report to the governor and the appropriate committees of the legislature on the results of the pilot program. The report shall include information about the number of clients served, the needs of the clients, the method of referral for the clients, and recommendations on how to expand the program statewide, including any recommendations to account for different needs in urban and rural areas." [2019 c 324 § 12.]

Findings—Intent—2019 c 324: See note following RCW 71.24.648.

Report—2019 c 324: See note following RCW 70.38.111.

Recommendations—Residential intensive behavioral health and developmental disability services—2019 c 324: See note following RCW 74.39A.030.

71.24.650 Standards for certification or licensure of a clubhouse. The secretary shall license or certify clubhouses that meet state minimum standards. The standards for certification or licensure of a clubhouse by the department must at a minimum include:

(1) The facilities may be peer-operated and must be recovery-focused;

(2) Members and employees must work together;

(3) Members must have the opportunity to participate in all the work of the clubhouse, including administration, research, intake and orientation, outreach, hiring, training and evaluation of staff, public relations, advocacy, and evaluation of clubhouse effectiveness;

(4) Members and staff and ultimately the clubhouse director must be responsible for the operation of the club-

house, central to this responsibility is the engagement of members and staff in all aspects of clubhouse operations;

(5) Clubhouse programs must be comprised of structured activities including but not limited to social skills training, vocational rehabilitation, employment training and job placement, and community resource development;

(6) Clubhouse programs must provide in-house educational programs that significantly utilize the teaching and tutoring skills of members and assist members by helping them to take advantage of adult education opportunities in the community;

(7) Clubhouse programs must focus on strengths, talents, and abilities of its members;

(8) The work-ordered day may not include medication clinics, day treatment, or other therapy programs within the clubhouse. [2018 c 201 § 4057; 2016 sp.s. c 29 § 509.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.24.660 Recovery residences—Referrals by licensed or certified service providers. Beginning January 1, 2023, a licensed or certified service provider may not refer a client who is appropriate for housing in a recovery residence, to support the client's recovery from a substance use disorder, to a recovery residence that is not included in the registry of approved recovery residences maintained by the authority under RCW 41.05.760. This section does not otherwise limit the discharge or referral options available for a person in recovery from a substance use disorder to any other appropriate placements or services. [2019 c 264 § 5.]

Findings—2019 c 264: See note following RCW 41.05.760.

71.24.665 Psychiatric treatment, evaluation, and bed utilization for American Indians and Alaska Natives—Report by authority. (1) The authority shall provide an annual report on psychiatric treatment and evaluation and bed utilization for American Indians and Alaska Natives starting on October 1, 2020. The report shall be available for review by the tribes, urban Indian health programs, and the American Indian health commission for Washington state.

(2) Indian health care providers shall be included in any bed tracking system created by the authority. [2020 c 256 § 307.]

71.24.700 Long-term inpatient care and mental health placements—Contracting with community hospitals and evaluation and treatment facilities. (1) The authority and the entities identified in *RCW 71.24.310 and 71.24.380 shall: (a) Work with willing community hospitals licensed under chapters 70.41 and 71.12 RCW and evaluation and treatment facilities licensed or certified under chapter 71.05 RCW to assess their capacity to become licensed or certified to provide long-term inpatient care and to meet the requirements of this chapter; and (b) enter into contracts and payment arrangements with such hospitals and evaluation and treatment facilities choosing to provide long-term mental health placements, to the extent that willing licensed or certified facilities are available.

(2) Nothing in this section requires any community hospital or evaluation and treatment facility to be licensed or certified to provide long-term mental health placements. [2019 c 324 § 6.]

***Reviser's note:** RCW 71.24.310 was repealed by 2019 c 325 § 6004, effective January 1, 2020.

Findings—Intent—2019 c 324: See note following RCW 71.24.648.

Mental health drop-in center services pilot program—2019 c 324: See note following RCW 71.24.649.

Report—2019 c 324: See note following RCW 70.38.111.

Recommendations—Residential intensive behavioral health and developmental disability services—2019 c 324: See note following RCW 74.39A.030.

71.24.710 Reentry services—Work group. (1) The authority shall convene a reentry services work group to consider ways to improve reentry services for persons with an identified behavioral health services need. The work group shall:

(a) Advise the authority on its waiver application under RCW 71.24.715;

(b) Develop a plan to assure notifications of the person's release date, current location, and other appropriate information are provided to the person's managed care organization before the person's scheduled release from confinement, or as soon as practicable thereafter, in accordance with RCW 74.09.555;

(c) Consider the value of expanding, replicating, or adapting the essential elements of the reentry community services program under RCW 72.09.370 and 71.24.470 to benefit new populations, such as:

(i) A larger group of incarcerated persons in the department of corrections than those who currently have the opportunity to participate;

(ii) State hospital patients committed under criminal insanity laws under chapter 10.77 RCW;

(iii) Involuntary treatment patients committed under chapter 71.05 RCW;

(iv) Persons committed to juvenile rehabilitation;

(v) Persons confined in jail; and

(vi) Other populations recommended by the work group;

(d) Consider whether modifications should be made to the reentry community services program;

(e) Identify potential costs and savings for the state and local governments which could be realized through the use of telehealth technology to provide behavioral health services, expansion or replication of the reentry community services program, or other reentry programs which are supported by evidence;

(f) Consider the sustainability of reentry or diversion services provided by pilot programs funded by contempt fines in *Trueblood, et al., v. Washington State DSHS*, No. 15-35462;

(g) Recommend a means of funding expanded reentry services; and

(h) Consider incorporation of peer services into the reentry community services programs.

(2)(a) In addition, the authority shall convene a subcommittee of the work group consisting of a representative of the authority, one representative of each managed care organization contracted with the authority under chapter 74.09 RCW, representatives of the Washington association of sheriffs and

police chiefs, representatives of jails, and other members that the work group determines are appropriate to inform the tasks of the work group.

(b) The subcommittee must:

(i) Determine and make progress toward implementing a process for transmitting real-time location information related to incarcerated individuals to the managed care organization in which the individual is enrolled;

(ii) Develop a process to transmit patient health information between jails and managed care organizations to ensure high quality health care for incarcerated individuals enrolled in a managed care organization; and

(iii) Improve collaboration between the authority, the managed care organizations, and the jails as it pertains to care coordination both when an individual enters custody and upon release.

(c) The subcommittee must submit an initial report to the relevant committees of the legislature by December 1, 2021, and a final report by December 1, 2022. The reports shall evaluate the progress of managed care organizations with respect to meeting their contractual obligations regarding clinical coordination when an individual enters custody as well as care coordination and connection to reentry services upon release, including any corrective action taken by the authority against a managed care organization related to noncompliance. The reports shall also identify any barriers to effective care coordination for individuals in jail and recommendations to overcome those barriers.

(3) The authority shall invite participation in the work group by stakeholders including but not limited to representatives from: Disability rights Washington; behavioral health advocacy organizations; behavioral health peers; reentry community services providers; community behavioral health agencies; advocates for persons with developmental disabilities; the department of corrections; the department of children, youth, and families; the Washington association of sheriffs and police chiefs; prosecutors; defense attorneys; the Washington state association of counties; King county behavioral health and recovery division; the department of social and health services; state hospital employees who serve patients committed under chapters 10.77 and 71.05 RCW; the public safety review panel under RCW 10.77.270; managed care organizations; behavioral health administrative services organizations; jail administrators; the Washington statewide reentry council; the Washington state senate; the Washington state house of representatives; and the Washington state institute for public policy.

(4) The work group must provide a progress report to the governor and appropriate committees of the legislature by July 1, 2022, and a final report by December 1, 2023. [2021 c 243 § 9.]

Findings—2021 c 243: See note following RCW 74.09.670.

71.24.715 Reentry services—Waiver application. (1) The health care authority shall apply for a waiver allowing the state to provide medicaid services to persons who are confined in a correctional institution as defined in RCW 9.94.049 or confined in a state hospital or other treatment facility up to 30 days prior to the person's release or discharge to the community. The purpose is to create continuity of care and provide reentry services.

(2) The health care authority shall consult with the work group established under RCW 71.24.710 about how to optimize the waiver application and its chance of success, including by limiting its scope if deemed appropriate.

(3) The health care authority shall inform the governor and relevant committees of the legislature in writing when the waiver application is submitted and update them as to progress of the waiver at appropriate points.

(4) No provision of this section may be interpreted to require the health care authority to provide medicaid services to persons who are confined in a correctional institution, state hospital, or other treatment facility up to 30 days prior to the person's release or discharge unless the health care authority obtains final approval for its waiver application from the centers for medicare and medicaid services. [2021 c 243 § 4.]

Findings—2021 c 243: See note following RCW 74.09.670.

71.24.720 Less restrictive alternative treatment—Transition teams. The authority shall coordinate with the department of social and health services to offer contracts to community behavioral health agencies to support the nonmedicaid costs entailed in fulfilling the agencies' role as transition team members for a person recommended for conditional release to a less restrictive alternative under RCW 10.77.150, or for a person who qualifies for multidisciplinary transition team services under RCW 71.05.320(6)(a)(i). The authority may establish requirements, provide technical assistance, and provide training as appropriate and within available funding. [2021 c 263 § 18.]

Application—2021 c 263: See note following RCW 10.77.150.

71.24.845 Transfer of clients between behavioral health administrative services organizations—Uniform transfer agreement. The authority, in consultation with the established behavioral health administrative services organizations, shall develop a uniform transfer agreement to govern the transfer of clients between behavioral health administrative services organizations, taking into account the needs of the regional service area. [2019 c 325 § 1044; 2014 c 225 § 46; 2013 c 230 § 1.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective date—2014 c 225: See note following RCW 71.24.016.

71.24.850 Regional service areas—Report—Managed care integration. (1) By December 1, 2018, the department of social and health services and the authority shall report to the governor and the legislature regarding the preparedness of each regional service area to provide mental health services, chemical dependency services, and medical care services to medicaid clients under a fully integrated managed care health system.

(2) By January 1, 2020, the community behavioral health program must be fully integrated in a managed care health system that provides mental health services, chemical dependency services, and medical care services to medicaid clients. [2018 c 201 § 4060; 2014 c 225 § 8.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.24.852 Intensive behavioral health treatment facilities—Resident rights and access to ombuds ser-

vices—Recommendations to governor and legislature. By December 1, 2019, the secretary of health, in consultation with the department of social and health services, the department of commerce, the long-term care ombuds, and relevant stakeholders must provide recommendations to the governor and the appropriate committees of the legislature on providing resident rights and access to ombuds services to the residents of the intensive behavioral health treatment facilities. [2019 c 324 § 4.]

Findings—Intent—2019 c 324: See note following RCW 71.24.648.

Mental health drop-in center services pilot program—2019 c 324: See note following RCW 71.24.649.

Report—2019 c 324: See note following RCW 70.38.111.

Recommendations—Residential intensive behavioral health and developmental disability services—2019 c 324: See note following RCW 74.39A.030.

71.24.855 Finding—Intent—State hospitals. The legislature finds that the growing demand for state hospital beds has strained the state's capacity to meet the demand while providing for a sufficient workforce to operate the state hospitals safely. It is the intent of the legislature that the executive and legislative branches work collaboratively to maximize access to, safety of, and the therapeutic role of the state hospitals to best serve patients while ensuring the safety of patients and employees. [2016 sp.s. c 37 § 1.]

71.24.861 Behavioral health system coordination committee. (1) The legislature finds that ongoing coordination between state agencies, the counties, and the behavioral health administrative services organizations is necessary to coordinate the behavioral health system. To this end, the authority shall establish a committee to meet quarterly to address systemic issues.

(2) The committee established in subsection (1) of this section must be convened by the authority, meet quarterly, and include representatives from:

(a) The authority;

(b) The department of social and health services;

(c) The department;

(d) The office of the governor;

(e) One representative from the behavioral health administrative services organization per regional service area; and

(f) One county representative per regional service area. [2019 c 325 § 1047.]

Effective date—2019 c 325: See note following RCW 71.24.011.

71.24.870 Behavioral health services—Adoption of rules—Audit. (1) Rules adopted by the department relating to the provision of behavioral health services must:

(a) Identify areas in which duplicative or inefficient documentation requirements can be eliminated or streamlined for providers;

(b) Limit prescriptive requirements for individual initial assessments to allow clinicians to exercise professional judgment to conduct age-appropriate, strength-based psychosocial assessments, including current needs and relevant history according to current best practices;

(c) Exempt providers from duplicative state documentation requirements when the provider is following documentation requirements of an evidence-based, research-based, or state-mandated program that provides adequate protection for patient safety; and

(d) Be clear and not unduly burdensome in order to maximize the time available for the provision of care.

(2) Subject to the availability of amounts appropriated for this specific purpose, audits conducted by the department relating to provision of behavioral health services must:

(a) Rely on a sampling methodology to conduct reviews of personnel files and clinical records based on written guidelines established by the department that are consistent with the standards of other licensing and accrediting bodies;

(b) Treat organizations with multiple locations as a single entity. The department must not require annual visits at all locations operated by a single entity when a sample of records may be reviewed from a centralized location;

(c) Share audit results with behavioral health administrative services organizations and managed care organizations to assist with their review process and, when appropriate, take steps to coordinate and combine audit activities;

(d) Not require information to be provided in particular documents or locations when the same information is included or demonstrated elsewhere in the clinical file, except where required by federal law; and

(e) Ensure that audits involving manualized programs such as wraparound with intensive services or other evidence or research-based programs are conducted to the extent practicable by personnel familiar with the program model and in a manner consistent with the documentation requirements of the program. [2019 c 325 § 1045; 2017 c 207 § 2.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Contingent effective date—2017 c 207 § 2: "Section 2 of this act takes effect only if neither Substitute House Bill No. 1388 (including any later amendments or substitutes) nor Substitute Senate Bill No. 5259 (including any later amendments or substitutes) is signed into law by the governor by July 23, 2017." [2017 c 207 § 5.] Neither Substitute House Bill No. 1388 nor Substitute Senate Bill No. 5259 was signed into law by July 23, 2017.

Findings—Intent—2017 c 207: "The legislature finds that a prioritized recommendation of the children's mental health work group, as reported in December 2016, is to reduce burdensome and duplicative paperwork requirements for providers of children's mental health services. This recommendation is consistent with the recommendations of the behavioral health workforce assessment of the workforce training and education coordinating board to reduce time-consuming documentation requirements and the behavioral and primary health regulatory alignment task force to streamline regulations and reduce the time spent responding to inefficient and excessive audits.

The legislature further finds that duplicative and overly prescriptive documentation and audit requirements negatively impact the adequacy of the provider network by reducing workforce morale and limiting the time available for patient care. Such requirements create costly barriers to the efficient provision of services for children and their families. The legislature also finds that current state regulations are often duplicative or conflicting with research-based models and other state-mandated treatment models intended to improve the quality of services and ensure positive outcomes. These barriers can be reduced while creating a greater emphasis on quality, outcomes, and safety.

The legislature further finds that social workers serving children are encumbered by burdensome paperwork requirements which can interfere with the effective delivery of services.

Therefore, the legislature intends to require the department of social and health services to take steps to reduce paperwork, documentation, and audit requirements that are inefficient or duplicative for social workers who serve children and for providers of mental health services to children and families, and to encourage the use of effective treatment models to improve the quality of services." [2017 c 207 § 1.]

71.24.872 Regulatory parity between primary care and behavioral health care settings—Initial documentation requirements for patients—Administrative burdensomeness. (1) The legislature finds that behavioral health integration requires parity in the approach to regulation between primary care providers and behavioral health agencies.

(2) Neither the authority nor the department may provide initial documentation requirements for patients receiving care in a behavioral health agency, either in contract or rule, which are substantially more administratively burdensome to complete than initial documentation requirements in primary care settings, unless such documentation is required by federal law or to receive federal funds. [2019 c 325 § 5032.]

Effective date—2019 c 325: See note following RCW 71.24.011.

71.24.880 Interlocal leadership structure—Transition to fully integrated managed care within a regional service area. (1) The authority shall, upon the request of a county authority or authorities within a regional service area, collaborate with counties to create an interlocal leadership structure that includes participation from counties and the managed health care systems serving that regional service area. The interlocal leadership structure must include representation from physical and behavioral health care providers, tribes, and other entities serving the regional service area as necessary.

(2) The interlocal leadership structure regional organization must be chaired by the counties and jointly administered by the authority, managed health care systems, and counties. It must design and implement the fully integrated managed care model for that regional service area to assure clients are at the center of care delivery and support integrated delivery of physical and behavioral health care at the provider level.

(3) The interlocal leadership structure may address, but is not limited to addressing, the following topics:

(a) Alignment of contracting, administrative functions, and other processes to minimize administrative burden at the provider level to achieve outcomes;

(b) Monitoring implementation of fully integrated managed care in the regional service area, including design of an early warning system to monitor ongoing success to achieve better outcomes and to make adjustments to the system as necessary;

(c) Developing regional coordination processes for capital infrastructure requests, local capacity building, and other community investments;

(d) Identifying, using, and building on measures and data consistent with, but not limited to, RCW 70.320.030 and 41.05.690, for tracking and maintaining regional accountability for delivery system performance; and

(e) Discussing whether the managed health care systems awarded the contract by the authority for a regional service area should subcontract with a county-based administrative service organization or other local organization, which may include and determine, in partnership with that organization, which value-add services will best support a bidirectional system of care.

(4) To ensure an optimal transition, regional service areas that enter as mid-adopters must be allowed a transition period of up to one year during which the interlocal leadership structure develops and implements a local plan, including measurable milestones, to transition to fully integrated managed care. The transition plan may include provisions for the counties' organization to maintain existing contracts during some or all of the transition period if the managed care design begins during 2017 to 2018, with the mid-adopter transition year occurring in 2019.

(5) Nothing in this section may be used to compel contracts between a provider, integrated managed health care system, or administrative service organization.

(6) The interlocal leadership group expires December 1, 2021, unless the interlocal leadership group decides locally to extend it. [2018 c 201 § 4062.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.24.885 Medicaid rate increases—Review authority—Reporting. (1) It is the intent of the legislature that behavioral health medicaid rate increases be grounded with the rate-setting process for the provider type or practice setting.

(2) In implementing a rate increase funded by the legislature, including rate increases provided through managed care organizations, the authority must work with the actuaries responsible for establishing medicaid rates for behavioral health services and managed care organizations responsible for distributing funds to behavioral health services to assure that appropriate adjustments are made to the wraparound with intensive services case rate, as well as any other behavioral health services in which a case rate is used.

(3)(a) The authority shall establish a process for verifying that funds appropriated in the omnibus operating appropriations act for targeted behavioral health provider rate increases, including rate increases provided through managed care organizations, are used for the objectives stated in the appropriation.

(b) The process must: (i) Establish which behavioral health provider types the funds are intended for; (ii) include transparency and accountability mechanisms to demonstrate that appropriated funds for targeted behavioral health provider rate increases are passed through, in the manner intended, to the behavioral health providers who are the subject of the funds appropriated for targeted behavioral health provider rate increases; (iii) include actuarial information provided to managed care organizations to ensure the funds directed to behavioral health providers have been appropriately allocated and accounted for; and (iv) include the participation of managed care organizations, behavioral health administrative services organizations, providers, and provider networks that are the subject of the targeted behavioral health provider rate increases. The process must include a method for determining if the funds have increased access to the behavioral health services offered by the behavioral health providers who are the subject of the targeted provider rate increases.

(c) The process may:

(i) Include a quantitative method for determining if the funds have increased access to behavioral health services offered by the behavioral health providers who received the targeted provider rate increases;

(ii) Ensure the viability of pass-through payments in a capitated rate methodology; and

(iii) Ensure that medicaid rate increases account for the impact of value-based contracting on provider reimbursements and implementations of pass-through payments.

(4) By November 1st of each year, the authority shall report to the committees of the legislature with jurisdiction over behavioral health issues and fiscal matters regarding the established process for each appropriation for a targeted behavioral health provider rate increase, whether the funds were passed through in accordance with the appropriation language, and any information about increased access to behavioral health services associated with the appropriation. The reporting requirement for each appropriation for a targeted behavioral health provider rate increase shall continue for two years following the specific appropriation. [2020 c 285 § 1.]

71.24.887 Training support grants for community mental health providers—Behavioral health workforce pilot program. Subject to the availability of amounts appropriated for this specific purpose, the authority shall establish a behavioral health workforce pilot program and training support grants for community mental health providers including, but not limited to, clinical social workers, licensed mental health counselors, licensed marriage and family therapists, clinical psychologists, and substance abuse treatment providers. The authority must implement these services in partnership with and through the regional accountable communities of health or the University of Washington behavioral health institute.

(1)(a) The intent of the pilot program is to provide incentive pay for individuals serving as clinical supervisors within community behavioral health agencies, state hospitals, and other facilities operated by the department of social and health services. The desired outcomes of the pilot program include increased internships and entry opportunities for new clinicians through recruitment and retention of supervisors. The authority must ensure the pilot program covers three sites serving primarily medicaid clients in both eastern and western Washington. One of the sites must specialize in the delivery of behavioral health services for medicaid enrolled children. Of the remaining two sites, one must offer substance use disorder treatment services.

(b) The authority must provide a report to the office of financial management and the appropriate committees of the legislature by September 30, 2023, on the outcomes of the pilot program. The report must include:

(i) A description of the mechanism for incentivizing supervisor pay and other strategies used at each of the sites;

(ii) The number of supervisors that received bonus pay at each site;

(iii) The number of students or prelicensure clinicians that received supervision at each site;

(iv) The number of supervision hours provided at each site;

(v) Initial reporting on the number of students or prelicensure clinicians who received supervision through the pilot programs that moved into a permanent position with the pilot program or another community behavioral health program in Washington state at the end of their supervision;

(vi) Identification of options for establishing enhancement of supervisor pay through managed care organization payments to behavioral health providers; and

(vii) Recommendations of individual site policy and practice implications for statewide implementation.

(2) The authority shall establish a grant program to mental health and substance use disorder providers that provides flexible funding for training and mentoring of clinicians serving children and youth. The authority must consult with stakeholders, including but not limited to behavioral health experts in services for children and youth, providers, and consumers, to develop guidelines for how the funding could be used, with a focus on evidence-based and promising practices, continuing education requirements, and quality monitoring infrastructure. [2021 c 170 § 3.]

Findings—Intent—2021 c 170: "The legislature finds that there is a compelling and urgent need for coordinated investments in the state's behavioral health workforce. The demand for a qualified behavioral health workforce continues to grow as the availability of services throughout the state does not meet the need. According to the workforce training and education coordinating board's "behavioral health workforce: Barriers and solutions report," Washington ranks 31 out of the 50 states when comparing prevalence of mental illness to access to care. In addition, behavioral health needs have increased since the COVID-19 pandemic began and the need is expected to rise as economic and social hardships continue. Despite increased demand, the legislature finds that there continues to be difficulties in recruiting and retaining professionals who are adequately trained to meet behavioral health needs. Many of these professions require years of training, ranging from some postsecondary education to medical degrees. In addition, the legislature finds that there is significant variation in the geographic distribution of behavioral health providers across the state. Rural and underserved areas face disparities in access to care. High student loan debt loads, better pay, and lighter caseloads can drive behavioral health professionals into private practice or hospital-based settings rather than community-based settings which typically have a higher percentage of medicaid-funded services and higher caseloads.

The legislature finds that there are professions and areas within the behavioral health workforce that are most in need of state investment. The legislature intends to focus coordinated efforts and investments on these areas of greatest need including, but not limited to:

(1) Behavioral health apprenticeships;

(2) Children's mental health professionals;

(3) Peer counselors;

(4) Crisis hotline agents;

(5) Behavioral health residencies for professionals such as psychiatrists, advanced registered nurse practitioners, physician assistants, and pharmacists;

(6) Substance use disorder professionals;

(7) Community mental health workers;

(8) Clinical social workers;

(9) Licensed mental health counselors;

(10) Licensed marriage and family therapists; and

(11) Clinical psychologists.

The legislature also recognizes existing programs that have helped recruit, retain, and grow the behavioral health workforce, such as the Washington health corps, which provides loan repayment to behavioral health professionals, and the Washington state opportunity scholarship, which utilizes a public-private match to fund scholarships for students pursing health fields. Therefore, the legislature intends to increase the behavioral health workforce by expanding on successful existing programs, establishing new ones, and by focusing the efforts of the workforce education investment act." [2021 c 170 § 1.]

71.24.890 National 988 system—Crisis call center hubs—Technology and platform development—Agency collaboration. (1) Establishing the state crisis call center hubs and enhancing the crisis response system will require collaborative work between the department and the authority within their respective roles. The department shall have primary responsibility for establishing and designating the crisis

call center hubs. The authority shall have primary responsibility for developing and implementing the crisis response system and services to support the work of the crisis call center hubs. In any instance in which one agency is identified as the lead, the expectation is that agency will be communicating and collaborating with the other to ensure seamless, continuous, and effective service delivery within the statewide crisis response system.

(2) The department shall provide adequate funding for the state's crisis call centers to meet an expected increase in the use of the call centers based on the implementation of the 988 crisis hotline. The funding level shall be established at a level anticipated to achieve an in-state call response rate of at least 90 percent by July 22, 2022. The funding level shall be determined by considering standards and cost per call predictions provided by the administrator of the national suicide prevention lifeline, call volume predictions, guidance on crisis call center performance metrics, and necessary technology upgrades.

(3) The department shall adopt rules by July 1, 2023, to establish standards for designation of crisis call centers as crisis call center hubs. The department shall collaborate with the authority and other agencies to assure coordination and availability of services, and shall consider national guidelines for behavioral health crisis care as determined by the federal substance abuse and mental health services administration, national behavioral health accrediting bodies, and national behavioral health provider associations to the extent they are appropriate, and recommendations from the crisis response improvement strategy committee created in RCW 71.24.892.

(4) The department shall designate crisis call center hubs by July 1, 2024. The crisis call center hubs shall provide crisis intervention services, triage, care coordination, referrals, and connections to individuals contacting the 988 crisis hotline from any jurisdiction within Washington 24 hours a day, seven days a week, using the system platform developed under subsection (5) of this section.

(a) To be designated as a crisis call center hub, the applicant must demonstrate to the department the ability to comply with the requirements of this section and to contract to provide crisis call center hub services. The department may revoke the designation of any crisis call center hub that fails to substantially comply with the contract.

(b) The contracts entered shall require designated crisis call center hubs to:

(i) Have an active agreement with the administrator of the national suicide prevention lifeline for participation within its network;

(ii) Meet the requirements for operational and clinical standards established by the department and based upon the national suicide prevention lifeline best practices guidelines and other recognized best practices;

(iii) Employ highly qualified, skilled, and trained clinical staff who have sufficient training and resources to provide empathy to callers in acute distress, de-escalate crises, assess behavioral health disorders and suicide risk, triage to system partners, and provide case management and documentation. Call center staff shall be trained to make every effort to resolve cases in the least restrictive environment and without law enforcement involvement whenever possible. Call center staff shall coordinate with certified peer counselors to provide follow-up and outreach to callers in distress as available. It is intended for transition planning to include a pathway for continued employment and skill advancement as needed for experienced crisis call center employees;

(iv) Collaborate with the authority, the national suicide prevention lifeline, and veterans crisis line networks to assure consistency of public messaging about the 988 crisis hotline; and

(v) Provide data and reports and participate in evaluations and related quality improvement activities, according to standards established by the department in collaboration with the authority.

(c) The department and the authority shall incorporate recommendations from the crisis response improvement strategy committee created under RCW 71.24.892 in its agreements with crisis call center hubs, as appropriate.

(5) The department and authority must coordinate to develop the technology and platforms necessary to manage and operate the behavioral health crisis response and suicide prevention system. The technologies developed must include:

(a) A new technologically advanced behavioral health and suicide prevention crisis call center system platform using technology demonstrated to be interoperable across crisis and emergency response systems used throughout the state, such as 911 systems, emergency medical services systems, and other nonbehavioral health crisis services, for use in crisis call center hubs designated by the department under subsection (4) of this section. This platform, which shall be fully funded by July 1, 2023, shall be developed by the department and must include the capacity to receive crisis assistance requests through phone calls, texts, chats, and other similar methods of communication that may be developed in the future that promote access to the behavioral health crisis system; and

(b) A behavioral health integrated client referral system capable of providing system coordination information to crisis call center hubs and the other entities involved in behavioral health care. This system shall be developed by the authority.

(6) In developing the new technologies under subsection (5) of this section, the department and the authority must coordinate to designate a primary technology system to provide each of the following:

(a) Access to real-time information relevant to the coordination of behavioral health crisis response and suicide prevention services, including:

(i) Real-time bed availability for all behavioral health bed types, including but not limited to crisis stabilization services, triage facilities, psychiatric inpatient, substance use disorder inpatient, withdrawal management, peer-run respite centers, and crisis respite services, inclusive of both voluntary and involuntary beds, for use by crisis response workers, first responders, health care providers, emergency departments, and individuals in crisis; and

(ii) Real-time information relevant to the coordination of behavioral health crisis response and suicide prevention services for a person, including the means to access:

(A) Information about any less restrictive alternative treatment orders or mental health advance directives related to the person; and

(B) Information necessary to enable the crisis call center hub to actively collaborate with emergency departments, primary care providers and behavioral health providers within managed care organizations, behavioral health administrative services organizations, and other health care payers to establish a safety plan for the person in accordance with best practices and provide the next steps for the person's transition to follow-up noncrisis care. To establish information-sharing guidelines that fulfill the intent of this section the authority shall consider input from the confidential information compliance and coordination subcommittee established under RCW 71.24.892;

(b) The means to request deployment of appropriate crisis response services, which may include mobile rapid response crisis teams, co-responder teams, designated crisis responders, fire department mobile integrated health teams, or community assistance referral and educational services programs under RCW 35.21.930, according to best practice guidelines established by the authority, and track local response through global positioning technology; and

(c) The means to track the outcome of the 988 call to enable appropriate follow up, cross-system coordination, and accountability, including as appropriate: (i) Any immediate services dispatched and reports generated from the encounter; (ii) the validation of a safety plan established for the caller in accordance with best practices; (iii) the next steps for the caller to follow in transition to noncrisis follow-up care, including a next-day appointment for callers experiencing urgent, symptomatic behavioral health care needs; and (iv) the means to verify and document whether the caller was successful in making the transition to appropriate noncrisis follow-up care indicated in the safety plan for the person, to be completed either by the care coordinator provided through the person's managed care organization, health plan, or behavioral health administrative services organization, or if such a care coordinator is not available or does not follow through, by the staff of the crisis call center hub;

(d) A means to facilitate actions to verify and document whether the person's transition to follow up noncrisis care was completed and services offered, to be performed by a care coordinator provided through the person's managed care organization, health plan, or behavioral health administrative services organization, or if such a care coordinator is not available or does not follow through, by the staff of the crisis call center hub;

(e) The means to provide geographically, culturally, and linguistically appropriate services to persons who are part of high-risk populations or otherwise have need of specialized services or accommodations, and to document these services or accommodations; and

(f) When appropriate, consultation with tribal governments to ensure coordinated care in government-to-government relationships, and access to dedicated services to tribal members.

(7) To implement this section the department and the authority shall collaborate with the *state enhanced 911 coordination office, emergency management division, and military department to develop technology that is demonstrated to be interoperable between the 988 crisis hotline system and crisis and emergency response systems used throughout the state, such as 911 systems, emergency medical services systems, and other nonbehavioral health crisis services, as well as the national suicide prevention lifeline, to assure cohesive interoperability, develop training programs and operations for both 911 public safety telecommunicators and crisis line workers, develop suicide and other behavioral health crisis assessments and intervention strategies, and establish efficient and equitable access to resources via crisis hotlines.

(8) The authority shall:

(a) Collaborate with county authorities and behavioral health administrative services organizations to develop procedures to dispatch behavioral health crisis services in coordination with crisis call center hubs to effectuate the intent of this section;

(b) Establish formal agreements with managed care organizations and behavioral health administrative services organizations by January 1, 2023, to provide for the services, capacities, and coordination necessary to effectuate the intent of this section, which shall include a requirement to arrange next-day appointments for persons contacting the 988 crisis hotline experiencing urgent, symptomatic behavioral health care needs with geographically, culturally, and linguistically appropriate primary care or behavioral health providers within the person's provider network, or, if uninsured, through the person's behavioral health administrative services organization;

(c) Create best practices guidelines by July 1, 2023, for deployment of appropriate and available crisis response services by crisis call center hubs to assist 988 hotline callers to minimize nonessential reliance on emergency room services and the use of law enforcement, considering input from relevant stakeholders and recommendations made by the crisis response improvement strategy committee created under RCW 71.24.892;

(d) Develop procedures to allow appropriate information sharing and communication between and across crisis and emergency response systems for the purpose of real-time crisis care coordination including, but not limited to, deployment of crisis and outgoing services, follow-up care, and linked, flexible services specific to crisis response; and

(e) Establish guidelines to appropriately serve high-risk populations who request crisis services. The authority shall design these guidelines to promote behavioral health equity for all populations with attention to circumstances of race, ethnicity, gender, socioeconomic status, sexual orientation, and geographic location, and include components such as training requirements for call response workers, policies for transferring such callers to an appropriate specialized center or subnetwork within or external to the national suicide prevention lifeline network, and procedures for referring persons who access the 988 crisis hotline to linguistically and culturally competent care. [2021 c 302 § 102.]

***Reviser's note:** The "state enhanced 911 coordination office" was renamed the "state 911 coordination office" by 2022 c 286 § 6 and 2022 c 203 § 9.

Findings—Intent—2021 c 302: "(1) The legislature finds that:

(a) Nearly 6,000 Washington adults and children died by suicide in the last five years, according to the federal centers for disease control and prevention, tragically reflecting a state increase of 36 percent in the last 10 years.

(b) Suicide is now the single leading cause of death for Washington young people ages 10 through 24, with total deaths 22 percent higher than for vehicle crashes.

(c) Groups with suicide rates higher than the general population include veterans, American Indians/Alaska Natives, LGBTQ youth, and people living in rural counties across the state.

(d) More than one in five Washington residents are currently living with a behavioral health disorder.

(e) The COVID-19 pandemic has increased stressors and substance use among Washington residents.

(f) An improved crisis response system will reduce reliance on emergency room services and the use of law enforcement response to behavioral health crises and will stabilize individuals in the community whenever possible.

(g) To accomplish effective crisis response and suicide prevention, Washington state must continue its integrated approach to address mental health and substance use disorder in tandem under the umbrella of behavioral health disorders, consistently with chapter 71.24 RCW and the state's approach to integrated health care. This is particularly true in the domain of suicide prevention, because of the prevalence of substance use as both a risk factor and means for suicide.

(2) The legislature intends to:

(a) Establish crisis call center hubs and expand the crisis response system in a deliberate, phased approach that includes the involvement of partners from a range of perspectives to:

(i) Save lives by improving the quality of and access to behavioral health crisis services;

(ii) Further equity in addressing mental health and substance use treatment and assure a culturally and linguistically competent response to behavioral health crises;

(iii) Recognize that, historically, crisis response placed marginalized communities, including those experiencing behavioral health crises, at disproportionate risk of poor outcomes and criminal justice involvement;

(iv) Comply with the national suicide hotline designation act of 2020 and the federal communications commission's rules adopted July 16, 2020, to assure that all Washington residents receive a consistent and effective level of 988 suicide prevention and other behavioral health crisis response and suicide prevention services no matter where they live, work, or travel in the state; and

(v) Provide higher quality support for people experiencing behavioral health crises through investment in new technology to create a crisis call center hub system to triage calls and link individuals to follow-up care.

(b) Make additional investments to enhance the crisis response system, including the expansion of crisis teams, to be known as mobile rapid response crisis teams, and deployment of a wide array of crisis stabilization services, such as 23-hour crisis stabilization units based on the living room model, crisis stabilization centers, short-term respite facilities, peer-run respite centers, and same-day walk-in behavioral health services. The overall crisis system shall contain components that operate like hospital emergency departments that accept all walk-ins and ambulance, fire, and police drop-offs. Certified peer counselors as well as peers in other roles providing support must be incorporated within the crisis system and along the continuum of crisis care." [2021 c 302 § 101.]

71.24.892 National 988 system—Crisis response improvement strategy committee—Membership—Steering committee—Reports. ***(Expires June 30, 2024.)*** (1) The crisis response improvement strategy committee is established for the purpose of providing advice in developing an integrated behavioral health crisis response and suicide prevention system containing the elements described in this section. The work of the committee shall be received and reviewed by a steering committee, which shall in turn form subcommittees to provide the technical analysis and input needed to formulate system change recommendations.

(2) The office of financial management shall contract with the behavioral health institute at Harborview medical center to facilitate and provide staff support to the steering committee and to the crisis response improvement strategy committee.

(3) The steering committee shall select three cochairs from among its members to lead the crisis response improvement strategy committee. The crisis response improvement strategy committee shall consist of the following members, who shall be appointed or requested by the authority, unless otherwise noted:

(a) The director of the authority, or his or her designee, who shall also serve on the steering committee;

(b) The secretary of the department, or his or her designee, who shall also serve on the steering committee;

(c) A member representing the office of the governor, who shall also serve on the steering committee;

(d) The Washington state insurance commissioner, or his or her designee;

(e) Up to two members representing federally recognized tribes, one from eastern Washington and one from western Washington, who have expertise in behavioral health needs of their communities;

(f) One member from each of the two largest caucuses of the senate, one of whom shall also be designated to participate on the steering committee, to be appointed by the president of the senate;

(g) One member from each of the two largest caucuses of the house of representatives, one of whom shall also be designated to participate on the steering committee, to be appointed by the speaker of the house of representatives;

(h) The director of the Washington state department of veterans affairs, or his or her designee;

(i) The *state enhanced 911 coordinator, or his or her designee;

(j) A member with lived experience of a suicide attempt;

(k) A member with lived experience of a suicide loss;

(l) A member with experience of participation in the crisis system related to lived experience of a mental health disorder;

(m) A member with experience of participation in the crisis system related to lived experience with a substance use disorder;

(n) A member representing each crisis call center in Washington that is contracted with the national suicide prevention lifeline;

(o) Up to two members representing behavioral health administrative services organizations, one from an urban region and one from a rural region;

(p) A member representing the Washington council for behavioral health;

(q) A member representing the association of alcoholism and addiction programs of Washington state;

(r) A member representing the Washington state hospital association;

(s) A member representing the national alliance on mental illness Washington;

(t) A member representing the behavioral health interests of persons of color recommended by Sea Mar community health centers;

(u) A member representing the behavioral health interests of persons of color recommended by Asian counseling and referral service;

(v) A member representing law enforcement;

(w) A member representing a university-based suicide prevention center of excellence;

(x) A member representing an emergency medical services department with a CARES program;

(y) A member representing medicaid managed care organizations, as recommended by the association of Washington healthcare plans;

(z) A member representing commercial health insurance, as recommended by the association of Washington healthcare plans;

(aa) A member representing the Washington association of designated crisis responders;

(bb) A member representing the children and youth behavioral health work group;

(cc) A member representing a social justice organization addressing police accountability and the use of deadly force; and

(dd) A member representing an organization specializing in facilitating behavioral health services for LGBTQ populations.

(4) The crisis response improvement strategy committee shall assist the steering committee to identify potential barriers and make recommendations necessary to implement and effectively monitor the progress of the 988 crisis hotline in Washington and make recommendations for the statewide improvement of behavioral health crisis response and suicide prevention services.

(5) The steering committee must develop a comprehensive assessment of the behavioral health crisis response and suicide prevention services system by January 1, 2022, including an inventory of existing statewide and regional behavioral health crisis response, suicide prevention, and crisis stabilization services and resources, and taking into account capital projects which are planned and funded. The comprehensive assessment shall identify:

(a) Statewide and regional insufficiencies and gaps in behavioral health crisis response and suicide prevention services and resources needed to meet population needs;

(b) Quantifiable goals for the provision of statewide and regional behavioral health crisis services and targeted deployment of resources, which consider factors such as reported rates of involuntary commitment detentions, single-bed certifications, suicide attempts and deaths, substance use disorder-related overdoses, overdose or withdrawal-related deaths, and incarcerations due to a behavioral health incident;

(c) A process for establishing outcome measures, benchmarks, and improvement targets, for the crisis response system; and

(d) Potential funding sources to provide statewide and regional behavioral health crisis services and resources.

(6) The steering committee, taking into account the comprehensive assessment work under subsection (5) of this section as it becomes available, after discussion with the crisis response improvement strategy committee and hearing reports from the subcommittees, shall report on the following:

(a) A recommended vision for an integrated crisis network in Washington that includes, but is not limited to: An integrated 988 crisis hotline and crisis call center hubs; mobile rapid response crisis teams; mobile crisis response units for youth, adult, and geriatric population; a range of crisis stabilization services; an integrated involuntary treatment system; access to peer-run services, including peer-run respite centers; adequate crisis respite services; and data resources;

(b) Recommendations to promote equity in services for individuals of diverse circumstances of culture, race, ethnicity, gender, socioeconomic status, sexual orientation, and for individuals in tribal, urban, and rural communities;

(c) Recommendations for a work plan with timelines to implement appropriate local responses to calls to the 988 crisis hotline within Washington in accordance with the time frames required by the national suicide hotline designation act of 2020;

(d) The necessary components of each of the new technologically advanced behavioral health crisis call center system platform and the new behavioral health integrated client referral system, as provided under RCW 71.24.890, for assigning and tracking response to behavioral health crisis calls and providing real-time bed and outpatient appointment availability to 988 operators, emergency departments, designated crisis responders, and other behavioral health crisis responders, which shall include but not be limited to:

(i) Identification of the components crisis call center hub staff need to effectively coordinate crisis response services and find available beds and available primary care and behavioral health outpatient appointments;

(ii) Evaluation of existing bed tracking models currently utilized by other states and identifying the model most suitable to Washington's crisis behavioral health system;

(iii) Evaluation of whether bed tracking will improve access to all behavioral health bed types and other impacts and benefits; and

(iv) Exploration of how the bed tracking and outpatient appointment availability platform can facilitate more timely access to care and other impacts and benefits;

(e) The necessary systems and capabilities that licensed or certified behavioral health agencies, behavioral health providers, and any other relevant parties will require to report, maintain, and update inpatient and residential bed and outpatient service availability in real time to correspond with the crisis call center system platform or behavioral health integrated client referral system identified in RCW 71.24.890, as appropriate;

(f) A work plan to establish the capacity for the crisis call center hubs to integrate Spanish language interpreters and Spanish-speaking call center staff into their operations, and to ensure the availability of resources to meet the unique needs of persons in the agricultural community who are experiencing mental health stresses, which explicitly addresses concerns regarding confidentiality;

(g) A work plan with timelines to enhance and expand the availability of community-based mobile rapid response crisis teams based in each region, including specialized teams as appropriate to respond to the unique needs of youth, including American Indian and Alaska Native youth and LGBTQ youth, and geriatric populations, including older adults of color and older adults with comorbid dementia;

(h) The identification of other personal and systemic behavioral health challenges which implementation of the 988 crisis hotline has the potential to address in addition to suicide response and behavioral health crises;

(i) The development of a plan for the statewide equitable distribution of crisis stabilization services, behavioral health beds, and peer-run respite services;

(j) Recommendations concerning how health plans, managed care organizations, and behavioral health administrative services organizations shall fulfill requirements to provide assignment of a care coordinator and to provide next-day appointments for enrollees who contact the behavioral health crisis system;

(k) Appropriate allocation of crisis system funding responsibilities among medicaid managed care organizations, commercial insurers, and behavioral health administrative services organizations;

(l) Recommendations for constituting a statewide behavioral health crisis response and suicide prevention oversight board or similar structure for ongoing monitoring of the behavioral health crisis system and where this should be established; and

(m) Cost estimates for each of the components of the integrated behavioral health crisis response and suicide prevention system.

(7) The steering committee shall consist only of members appointed to the steering committee under this section. The steering committee shall convene the committee, form subcommittees, assign tasks to the subcommittees, and establish a schedule of meetings and their agendas.

(8) The subcommittees of the crisis response improvement strategy committee shall focus on discrete topics. The subcommittees may include participants who are not members of the crisis response improvement strategy committee, as needed to provide professional expertise and community perspectives. Each subcommittee shall have at least one member representing the interests of stakeholders in a rural community, at least one member representing the interests of stakeholders in an urban community, and at least one member representing the interests of youth stakeholders. The steering committee shall form the following subcommittees:

(a) A Washington tribal 988 subcommittee, which shall examine and make recommendations with respect to the needs of tribes related to the 988 system, and which shall include representation from the American Indian health commission;

(b) A credentialing and training subcommittee, to recommend workforce needs and requirements necessary to implement chapter 302, Laws of 2021, including minimum education requirements such as whether it would be appropriate to allow crisis call center hubs to employ clinical staff without a bachelor's degree or master's degree based on the person's skills and life or work experience;

(c) A technology subcommittee, to examine issues and requirements related to the technology needed to implement chapter 302, Laws of 2021;

(d) A cross-system crisis response collaboration subcommittee, to examine and define the complementary roles and interactions between mobile rapid response crisis teams, designated crisis responders, law enforcement, emergency medical services teams, 911 and 988 operators, public and private health plans, behavioral health crisis response agencies, nonbehavioral health crisis response agencies, and others needed to implement chapter 302, Laws of 2021;

(e) A confidential information compliance and coordination subcommittee, to examine issues relating to sharing and protection of health information needed to implement chapter 302, Laws of 2021; and

(f) Any other subcommittee needed to facilitate the work of the committee, at the discretion of the steering committee.

(9) The proceedings of the crisis response improvement strategy committee must be open to the public and invite testimony from a broad range of perspectives. The committee shall seek input from tribes, veterans, the LGBTQ community, and communities of color to help discern how well the crisis response system is currently working and recommend ways to improve the crisis response system.

(10) Legislative members of the crisis response improvement strategy committee shall be reimbursed for travel expenses in accordance with RCW 44.04.120. Nonlegislative members are not entitled to be reimbursed for travel expenses if they are elected officials or are participating on behalf of an employer, governmental entity, or other organization. Any reimbursement for other nonlegislative members is subject to chapter 43.03 RCW.

(11) The steering committee, with the advice of the crisis response improvement strategy committee, shall provide a progress report and the result of its comprehensive assessment under subsection (5) of this section to the governor and appropriate policy and fiscal committee of the legislature by January 1, 2022. The steering committee shall report the crisis response improvement strategy committee's further progress and the steering committee's recommendations related to crisis call center hubs to the governor and appropriate policy and fiscal committees of the legislature by January 1, 2023. The steering committee shall provide its final report to the governor and the appropriate policy and fiscal committees of the legislature by January 1, 2024.

(12) This section expires June 30, 2024. [2021 c 302 § 103.]

***Reviser's note:** The "state enhanced 911 coordinator" was renamed the "state 911 coordinator" by 2022 c 203 § 9.

Effective date—2021 c 302 § 103: "Section 103 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 13, 2021]." [2021 c 302 § 408.]

Findings—Intent—2021 c 302: See note following RCW 71.24.890.

71.24.893 National 988 system—Crisis response improvement strategy steering committee. ***(Expires July 1, 2023.)*** (1) The steering committee of the crisis response improvement strategy committee established under RCW 71.24.892 must monitor and make recommendations related to the funding of crisis response services out of the account created in RCW 82.86.050. The crisis response improvement strategy steering committee must analyze:

(a) The projected expenditures from the account created under RCW 82.86.050, taking into account call volume, utilization projections, and other operational impacts;

(b) The costs of providing statewide coverage of mobile rapid response crisis teams or other behavioral health first responder services recommended by the crisis response improvement strategy committee, based on 988 crisis hotline utilization and taking into account existing state and local funding;

(c) Potential options to reduce the tax imposed in RCW 82.86.020, given the expected level of costs related to infrastructure development and operational support of the 988 crisis hotline and crisis call center hubs; and

(d) The viability of providing funding for in-person mobile rapid response crisis services or other behavioral health first responder services recommended by the crisis response improvement strategy committee funded from the account created in RCW 82.86.050, given the expected revenues to the account and the level of expenditures required under (a) of this subsection.

(2) If the steering committee finds that funding in-person mobile rapid response crisis services or other behavioral health first responder services recommended by the crisis response improvement strategy committee is viable from the account given the level of expenditures necessary to support the infrastructure development and operational support of the 988 crisis hotline and crisis call center hubs, the steering committee must analyze options for the location and composition of such services given need and available resources with the requirement that funds from the account supplement, not supplant, existing behavioral health crisis funding.

(3) The work of the steering committee under this section must be facilitated by the behavioral health institute at Harborview medical center through its contract with the office of financial management under RCW 71.24.892 with assistance provided by staff from senate committee services, the office of program research, and the office of financial management.

(4) The steering committee shall submit preliminary recommendations to the governor and the appropriate policy and fiscal committees of the legislature by January 1, 2022, and final recommendations to the governor and the appropriate policy and fiscal committees of the legislature by January 1, 2023.

(5) This section expires on July 1, 2023. [2021 c 302 § 104.]

Findings—Intent—2021 c 302: See note following RCW 71.24.890.

71.24.894 National 988 system—Department reporting—Audit. (1) The department and authority shall provide an annual report regarding the usage of the 988 crisis hotline, call outcomes, and the provision of crisis services inclusive of mobile rapid response crisis teams and crisis stabilization services. The report shall be submitted to the governor and the appropriate committees of the legislature each November beginning in 2023. The report shall include information on the fund deposits and expenditures of the account created in RCW 82.86.050.

(2) The department and authority shall coordinate with the department of revenue, and any other agency that is appropriated funding under the account created in RCW 82.86.050, to develop and submit information to the federal communications commission required for the completion of fee accountability reports pursuant to the national suicide hotline designation act of 2020.

(3) The joint legislative audit and review committee shall schedule an audit to begin after the full implementation of chapter 302, Laws of 2021, to provide transparency as to how funds from the statewide 988 behavioral health crisis response and suicide prevention line account have been expended, and to determine whether funds used to provide acute behavioral health, crisis outreach, and stabilization services are being used to supplement services identified as baseline services in the comprehensive analysis provided under RCW 71.24.892, or to supplant baseline services. The committee shall provide a report by November 1, 2027, which includes recommendations as to the adequacy of the funding provided to accomplish the intent of the act and any other recommendations for alteration or improvement. [2021 c 302 § 105.]

Findings—Intent—2021 c 302: See note following RCW 71.24.890.

71.24.896 National 988 system—Duties owed to public—Independent contractors. (1) When acting in their statutory capacities pursuant to chapter 302, Laws of 2021, the state, department, authority, *state enhanced 911 coordination office, emergency management division, military department, any other state agency, and their officers, employees, and agents are deemed to be carrying out duties owed to the public in general and not to any individual person or class of persons separate and apart from the public. Nothing contained in chapter 302, Laws of 2021 may be construed to evidence a legislative intent that the duties to be performed by the state, department, authority, *state enhanced 911 coordination office, emergency management division, military department, any other state agency, and their officers, employees, and agents, as required by chapter 302, Laws of 2021, are owed to any individual person or class of persons separate and apart from the public in general.

(2) Each crisis call center hub designated by the department under any contract or agreement pursuant to chapter 302, Laws of 2021 shall be deemed to be an independent contractor, separate and apart from the department and the state. [2021 c 302 § 108.]

***Reviser's note:** The "state enhanced 911 coordination office" was renamed the "state 911 coordination office" by 2022 c 286 § 6 and 2022 c 203 § 9.

Findings—Intent—2021 c 302: See note following RCW 71.24.890.

71.24.898 National 988 system—Technical and operational plan. For the purpose of development and implementation of technology and platforms by the department and the authority under RCW 71.24.890, the department and the authority shall create a sophisticated technical and operational plan. The plan shall not conflict with, nor delay, the department meeting and satisfying existing 988 federal requirements that are already underway and must be met by July 16, 2022, nor is it intended to delay the initial planning phase of the project, or the planning and deliverables tied to any grant award received and allotted by the department or the authority prior to April 1, 2021. To the extent that funds are appropriated for this specific purpose, the department and the authority must contract for a consultant to critically analyze the development and implementation technology and platforms and operational challenges to best position the solutions for success. Prior to initiation of a new information technology development, which does not include the initial planning phase of this project or any contracting needed to complete the initial planning phase, the department and authority shall submit the technical and operational plan to the governor, office of financial management, steering committee of the crisis response improvement strategy committee created under RCW 71.24.892, and appropriate policy and fiscal committees of the legislature, which shall include the committees referenced in this section. The plan must be

approved by the office of the chief information officer, the director of the office of financial management, and the steering committee of the crisis response improvement strategy committee, which shall consider any feedback received from the senate ways and means committee chair, the house of representatives appropriations committee chair, the senate environment, energy and technology committee chair, the senate behavioral health subcommittee chair, and the house of representatives health care and wellness committee chair, before any funds are expended for the solutions, other than those funds needed to complete the initial planning phase. A draft technical and operational plan must be submitted no later than January 1, 2022, and a final plan by August 31, 2022.

The plan submitted must include, but not be limited to:

(1) Data management;

(2) Data security;

(3) Data flow;

(4) Data access and permissions;

(5) Protocols to ensure staff are following proper health information privacy procedures;

(6) Cybersecurity requirements and how to meet these;

(7) Service level agreements by vendor;

(8) Maintenance and operations costs;

(9) Identification of what existing software as a service products might be applicable, to include the:

(a) Vendor name;

(b) Vendor offerings to include product module and functionality detail and whether each represent add-ons that must be paid separately;

(c) Vendor pricing structure by year through implementation; and

(d) Vendor pricing structure by year post implementation;

(10) Integration limitations by system;

(11) Data analytic and performance metrics to be required by system;

(12) Liability;

(13) Which agency will host the electronic health record software as a service;

(14) Regulatory agency;

(15) The timeline by fiscal year from initiation to implementation for each solution in chapter 302, Laws of 2021;

(16) How to plan in a manner that ensures efficient use of state resources and maximizes federal financial participation; and

(17) A complete comprehensive business plan analysis. [2021 c 302 § 109.]

Findings—Intent—2021 c 302: See note following RCW 71.24.890.

71.24.905 Co-response services. (1) Subject to the availability of amounts appropriated for this specific purpose, the University of Washington shall, in consultation and collaboration with the co-responder outreach alliance and other stakeholders as appropriate in the field of co-response:

(a) Establish regular opportunities for police, fire, emergency medical services, peer counselors, and behavioral health personnel working in co-response to convene for activities such as training, exchanging information and best practices around the state and nationally, and providing the University of Washington with assistance with activities described in this section;

(b) Subject to the availability of amounts appropriated for this specific purpose, administer a small budget to help defray costs for training and professional development, which may include expenses related to attending or hosting site visits with experienced co-response teams;

(c) Develop an assessment to be provided to the governor and legislature by June 30, 2023, describing and analyzing the following:

(i) Existing capacity and shortfalls across the state in co-response teams and the co-response workforce;

(ii) Current alignment of co-response teams with cities, counties, behavioral health administrative services organizations, and call centers; distribution among police, fire, and EMS-based co-response models; and desired alignment;

(iii) Current funding strategies for co-response teams and identification of federal funding opportunities;

(iv) Current data systems utilized and an assessment of their effectiveness for use by co-responders, program planners, and policymakers;

(v) Current training practices and identification of future state training practices;

(vi) Alignment with designated crisis responder activities;

(vii) Recommendations concerning best practices to prepare co-responders to achieve objectives and meet future state crisis system needs, including those of the 988 system;

(viii) Recommendations to align co-responder activities with efforts to reform ways in which persons experiencing a behavioral health crisis interact with the criminal justice system; and

(ix) Assessment of training and educational needs for current and future co-responder workforce;

(d) Beginning in calendar year 2023, begin development of model training curricula for individuals participating in co-response teams; and

(e) Beginning in calendar year 2023, host an annual statewide conference that draws state and national co-responders.

(2) Stakeholders in the field of co-response may include, but are not limited to, the Washington association of designated crisis responders; state associations representing police, fire, and emergency medical services personnel; the Washington council on behavioral health; the state enhanced 911 system; 988 crisis call centers; and the peer workforce alliance. [2022 c 232 § 2.]

Finding—Purpose—2022 c 232: "The legislature finds that behavioral health co-response has experienced a surge in popularity in Washington state in the past five years. The legislature recognizes the importance of training for those involved in co-responder programs to promote high standards within programs and to enhance the skills of those already working in this field. The purpose of this act is to develop best practice recommendations and a model training curriculum relevant to first responders and behavioral health professionals working on co-response teams, to create ongoing learning opportunities for emerging and established co-response programs, and to develop the workforce to fill future co-responder hiring needs." [2022 c 232 § 1.]

71.24.910 Balance billing violations—Discipline. If the insurance commissioner reports to the department that he or she has cause to believe that a provider licensed under this chapter has engaged in a pattern of violations of RCW 48.49.020 or 48.49.030, and the report is substantiated after investigation, the department may levy a fine upon the pro-

vider in an amount not to exceed $1,000 per violation and take other formal or informal disciplinary action as permitted under the authority of the department. [2022 c 263 § 22.]

Effective date—2022 c 263: See note following RCW 43.371.100.

Chapter 71.28 RCW
INTERSTATE CONTRACTS

Sections

Council for children and families: Chapter 43.121 RCW.

71.28.010 Contracts by boundary counties or cities therein. Any county, or city within a county which is situated on the state boundaries is authorized to contract for mental health services with a county situated in either the states of Oregon or Idaho, located on the boundaries of such states with the state of Washington. [1988 c 176 § 911; 1977 ex.s. c 80 § 44; 1967 c 84 § 1.]

Purpose—Intent—Severability—1977 ex.s. c 80: See notes following RCW 4.16.190.

Chapter 71.32 RCW
MENTAL HEALTH ADVANCE DIRECTIVES

Sections

71.32.010 Legislative declaration—Findings. (1) The legislature declares that an individual with capacity has the ability to control decisions relating to his or her own behavioral health care. The legislature finds that:

(a) Some behavioral health disorders cause individuals to fluctuate between capacity and incapacity;

(b) During periods when an individual's capacity is unclear, the individual may be unable to access needed treatment because the individual may be unable to give informed consent;

(c) Early treatment may prevent an individual from becoming so ill that involuntary treatment is necessary; and

(d) Individuals with behavioral health disorders need some method of expressing their instructions and preferences for treatment and providing advance consent to or refusal of treatment.

(2) The legislature recognizes that a mental health advance directive can be an essential tool for an individual to express his or her choices at a time when the effects of a behavioral health disorder have not deprived him or her of the power to express his or her instructions or preferences.

(3) The legislature further finds that:

(a) A mental health advance directive must provide the individual with a full range of choices;

(b) Individuals with behavioral health disorders have varying perspectives on whether they want to be able to revoke a directive during periods of incapacity;

(c) For a mental health advance directive to be an effective tool, individuals must be able to choose how they want their directives treated during periods of incapacity; and

(d) There must be clear standards so that treatment providers can readily discern an individual's treatment choices.

Consequently, the legislature affirms that, pursuant to other provisions of law, a validly executed mental health advance directive is to be respected by agents, guardians, and other surrogate decision makers, health care providers, professional persons, and health care facilities. [2021 c 287 § 1; 2003 c 283 § 1.]

71.32.020 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Adult" means any individual who has attained the age of majority or is an emancipated minor.

(2) "Agent" has the same meaning as an attorney-in-fact or agent as provided in chapter 11.125 RCW.

(3) "Behavioral health disorder" means a mental disorder, a substance use disorder, or a co-occurring mental health and substance use disorder.

(4) "Capacity" means that a person has not been found to be incapacitated pursuant to this chapter or subject to a guardianship under RCW 11.130.265.

(5) "Court" means a superior court under chapter 2.08 RCW.

(6) "Health care facility" means a hospital, as defined in RCW 70.41.020; an institution, as defined in RCW 71.12.455; a state hospital, as defined in RCW 72.23.010; a nursing home, as defined in RCW 18.51.010; or a clinic that is part of a community behavioral health service delivery system, as defined in RCW 71.24.025.

(7) "Health care provider" means an osteopathic physician licensed under chapter 18.57 RCW, a physician or physician's assistant licensed under chapter 18.71 or 18.71A RCW, or an advanced registered nurse practitioner licensed under RCW 18.79.050.

(8) "Incapacitated" means a person who: (a) Is unable to understand the nature, character, and anticipated results of proposed treatment or alternatives; understand the recognized serious possible risks, complications, and anticipated

benefits in treatments and alternatives, including nontreatment; or communicate his or her understanding or treatment decisions; or (b) has been found to be subject to a guardianship under RCW 11.130.265.

(9) "Informed consent" means consent that is given after a person: (a) Is provided with a description of the nature, character, and anticipated results of proposed treatments and alternatives, and the recognized serious possible risks, complications, and anticipated benefits in the treatments and alternatives, including nontreatment, in language that the person can reasonably be expected to understand; or (b) elects not to be given the information included in (a) of this subsection.

(10) "Long-term care facility" has the same meaning as defined in RCW 43.190.020.

(11) "Mental disorder" means any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions.

(12) "Mental health advance directive" or "directive" means a written document in which the principal makes a declaration of instructions or preferences or appoints an agent to make decisions on behalf of the principal regarding the principal's mental health treatment, or both, and that is consistent with the provisions of this chapter.

(13) "Mental health professional" means a psychiatrist, psychologist, psychiatric nurse, or social worker, and such other mental health professionals as may be defined by rules adopted by the secretary pursuant to the provisions of chapter 71.05 RCW.

(14) "Principal" means a person who has executed a mental health advance directive.

(15) "Professional person" means a mental health professional and shall also mean a physician, registered nurse, and such others as may be defined by rules adopted by the secretary pursuant to the provisions of chapter 71.05 RCW.

(16) "Social worker" means a person with a master's or further advanced degree from a social work educational program accredited and approved as provided in RCW 18.320.010.

(17) "Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using the substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances. [2021 c 287 § 4; (2021 c 287 § 3 expired July 1, 2022); (2021 c 287 § 2 expired January 1, 2022). Prior: 2020 c 312 § 732; 2020 c 80 § 53; 2016 c 209 § 407; 2011 c 89 § 15; 2003 c 283 § 2.]

Reviser's note: The definitions in this section have been alphabetized pursuant to RCW 1.08.015(2)(k).

Effective date—2021 c 287 § 4: "Section 4 of this act takes effect July 1, 2022." [2021 c 287 § 25.]

Effective date—2021 c 287 § 3: "Section 3 of this act takes effect January 1, 2022." [2021 c 287 § 23.]

Expiration date—2021 c 287 § 3: "Section 3 of this act expires July 1, 2022." [2021 c 287 § 24.]

Expiration date—2021 c 287 § 2: "Section 2 of this act expires January 1, 2022." [2021 c 287 § 22.]

Effective dates—2020 c 312: See note following RCW 11.130.915.

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Short title—Application—Uniformity—Federal law application—Federal electronic signatures in global and national commerce act—Application—Dates—Effective date—2016 c 209: See RCW 11.125.010 and 11.125.900 through 11.125.903.

Findings—2011 c 89: See RCW 18.320.005.

Additional notes found at www.leg.wa.gov

71.32.030 Construction of definitions. (1) The definition of informed consent is to be construed to be consistent with that term as it is used in chapter 7.70 RCW.

(2) The definitions of mental disorder, behavioral health disorder, mental health professional, and professional person are to be construed to be consistent with those terms as they are defined in RCW 71.05.020. [2021 c 287 § 5; 2003 c 283 § 3.]

71.32.040 Presumption of capacity. For the purposes of this chapter, an adult is presumed to have capacity. A person who is at least 13 years of age but under the age of majority is considered to have capacity for the purpose of executing a mental health advance directive if the person is able to demonstrate that they are capable of making informed decisions related to behavioral health care. [2021 c 287 § 6; 2003 c 283 § 4.]

71.32.050 Execution of directive—Scope. (1) A person with capacity may execute a mental health advance directive.

(2) A directive executed in accordance with this chapter is presumed to be valid. The inability to honor one or more provisions of a directive does not affect the validity of the remaining provisions.

(3) A directive may include any provision relating to behavioral health treatment or the care of the principal or the principal's personal affairs. Without limitation, a directive may include:

(a) The principal's preferences and instructions for behavioral health treatment;

(b) Consent to specific types of behavioral health treatment;

(c) Refusal to consent to specific types of behavioral health treatment;

(d) Consent to admission to and retention in a facility for behavioral health treatment for up to 14 days;

(e) Descriptions of situations that may cause the principal to experience a behavioral health crisis;

(f) Suggested alternative responses that may supplement or be in lieu of direct behavioral health treatment, such as treatment approaches from other providers;

(g) Appointment of an agent pursuant to chapter 11.125 RCW to make behavioral health treatment decisions on the principal's behalf, including authorizing the agent to provide consent on the principal's behalf to voluntary admission to inpatient behavioral health treatment; and

(h) The principal's nomination of a guardian or limited guardian as provided in RCW 11.125.080 for consideration by the court if guardianship proceedings are commenced.

(4) A directive may be combined with or be independent of a nomination of a guardian or other durable power of attorney under chapter 11.125 RCW, so long as the processes for

each are executed in accordance with its own statutes. [2021 c 287 § 7; 2016 c 209 § 408; 2003 c 283 § 5.]

Short title—Application—Uniformity—Federal law application—Federal electronic signatures in global and national commerce act—Application—Dates—Effective date—2016 c 209: See RCW 11.125.010 and 11.125.900 through 11.125.903.

71.32.060 Execution of directive—Elements—Effective date—Expiration. (1) A directive shall:

(a) Be in writing;

(b) Contain language that clearly indicates that the principal intends to create a directive;

(c) Be dated and signed by the principal or at the principal's direction in the principal's presence if the principal is unable to sign;

(d) Designate whether the principal wishes to be able to revoke the directive during any period of incapacity or wishes to be unable to revoke the directive during any period of incapacity; and

(e) Have the signature acknowledged before a notary public or other individual authorized by law to take acknowledgments, or be witnessed in writing by at least two adults, each of whom shall declare that he or she personally knows the principal, was present when the principal dated and signed the directive, and that the principal did not appear to be incapacitated or acting under fraud, undue influence, or duress.

(2) A directive that includes the appointment of an agent pursuant to a power of attorney under chapter 11.125 RCW shall contain the words "This power of attorney shall not be affected by the incapacity of the principal," or "This power of attorney shall become effective upon the incapacity of the principal," or similar words showing the principal's intent that the authority conferred shall be exercisable notwithstanding the principal's incapacity.

(3) A directive is valid upon execution, but all or part of the directive may take effect at a later time as designated by the principal in the directive.

(4) A directive may:

(a) Be revoked, in whole or in part, pursuant to the provisions of RCW 71.32.080; or

(b) Expire under its own terms. [2021 c 287 § 8; 2016 c 209 § 409; 2003 c 283 § 6.]

Short title—Application—Uniformity—Federal law application—Federal electronic signatures in global and national commerce act—Application—Dates—Effective date—2016 c 209: See RCW 11.125.010 and 11.125.900 through 11.125.903.

71.32.070 Prohibited elements. A directive may not:

(1) Create an entitlement to behavioral health or medical treatment or supersede a determination of medical necessity;

(2) Obligate any health care provider, professional person, or health care facility to pay the costs associated with the treatment requested;

(3) Obligate any health care provider, professional person, or health care facility to be responsible for the nontreatment personal care of the principal or the principal's personal affairs outside the scope of services the facility normally provides;

(4) Replace or supersede the provisions of any will or testamentary document or supersede the provisions of intestate succession;

(5) Be revoked by an incapacitated principal unless that principal selected the option to permit revocation while incapacitated at the time his or her directive was executed; or

(6) Be used as the authority for inpatient admission for more than 14 days in any 21 day period. [2021 c 287 § 9; 2003 c 283 § 7.]

71.32.080 Revocation—Waiver. (1)(a) A principal with capacity may, by written statement by the principal or at the principal's direction in the principal's presence, revoke a directive in whole or in part.

(b) An incapacitated principal may revoke a directive only if he or she elected at the time of executing the directive to be able to revoke when incapacitated.

(2) The revocation need not follow any specific form so long as it is written and the intent of the principal can be discerned. In the case of a directive that is stored in the health care declarations registry created by RCW 70.122.130, the revocation may be by an online method established by the department of health. Failure to use the online method of revocation for a directive that is stored in the registry does not invalidate a revocation that is made by another method described under this section.

(3) The principal shall provide a copy of his or her written statement of revocation to his or her agent, if any, and to each health care provider, professional person, or health care facility that received a copy of the directive from the principal.

(4) The written statement of revocation is effective:

(a) As to a health care provider, professional person, or health care facility, upon receipt. The professional person, health care provider, or health care facility, or persons acting under their direction shall make the statement of revocation part of the principal's medical record; and

(b) As to the principal's agent, upon receipt. The principal's agent shall notify the principal's health care provider, professional person, or health care facility of the revocation and provide them with a copy of the written statement of revocation.

(5) A directive also may:

(a) Be revoked, in whole or in part, expressly or to the extent of any inconsistency, by a subsequent directive; or

(b) Be superseded or revoked by a court order, including any order entered in a criminal matter. A directive may be superseded by a court order regardless of whether the order contains an explicit reference to the directive. To the extent a directive is not in conflict with a court order, the directive remains effective, subject to the provisions of RCW 71.32.150. A directive shall not be interpreted in a manner that interferes with: (i) Incarceration or detention by the department of corrections, in a city or county jail, or by the department of social and health services; or (ii) treatment of a principal who is subject to involuntary treatment pursuant to chapter 10.77, 71.05, 71.09, or 71.34 RCW.

(6) A directive that would have otherwise expired but is effective because the principal is incapacitated remains effective until the principal is no longer incapacitated unless the principal has elected to be able to revoke while incapacitated and has revoked the directive.

(7) When a principal with capacity consents to treatment that differs from, or refuses treatment consented to in, the

provisions of his or her directive, the consent or refusal constitutes a waiver of that provision and does not constitute a revocation of the provision or directive unless the principal also revokes the directive or provision. [2016 sp.s. c 29 § 423; 2006 c 108 § 5; 2003 c 283 § 8.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Finding—Intent—2006 c 108: See note following RCW 70.122.130.

71.32.090 Witnesses. A witness may not be any of the following:

(1) A person designated to make health care decisions on the principal's behalf;

(2) A health care provider or professional person directly involved with the provision of care to the principal at the time the directive is executed;

(3) An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the principal is a patient or resident;

(4) A person who is related by blood, marriage, or adoption to the person or with whom the principal has a dating relationship, as defined in RCW 7.105.010;

(5) A person who is declared to be an incapacitated person; or

(6) A person who would benefit financially if the principal making the directive undergoes mental health treatment. [2021 c 215 § 157; 2003 c 283 § 9.]

Effective date—2022 c 268; 2021 c 215: See note following RCW 7.105.900.

71.32.100 Appointment of agent. (1) If a directive authorizes the appointment of an agent, the provisions of chapter 11.125 RCW and RCW 7.70.065 shall apply unless otherwise stated in this chapter.

(2) The principal who appoints an agent must notify the agent in writing of the appointment.

(3) An agent must act in good faith.

(4) An agent may make decisions on behalf of the principal. Unless the principal has revoked the directive, the decisions must be consistent with the instructions and preferences the principal has expressed in the directive, or if not expressed, as otherwise known to the agent. If the principal's instructions or preferences are not known, the agent shall make a decision he or she determines is in the best interest of the principal.

(5) A person authorized to act as an agent during periods when the principal is incapacitated may act as the principal's personal representative pursuant to the health insurance portability and accountability act, sections 1171 through 1179 of the social security act, 42 U.S.C. Sec. 1320d, as amended, and applicable regulations, to obtain access to the principal's health care information and communicate with the principal's health care provider. This subsection shall be construed to be consistent with chapters 70.02, 70.24, 71.05, and 71.34 RCW, and with federal law regarding health care information.

(6) Unless otherwise provided in the appointment and agreed to in writing by the agent, the agent is not, as a result of acting in the capacity of agent, personally liable for the cost of treatment provided to the principal.

(7) An agent may resign or withdraw at any time by giving written notice to the principal. The agent must also give written notice to any health care provider, professional person, or health care facility providing treatment to the principal. The resignation or withdrawal is effective upon receipt unless otherwise specified in the resignation or withdrawal.

(8) If the directive gives the agent authority to act while the principal has capacity, the decisions of the principal supersede those of the agent at any time the principal has capacity.

(9) An agent's authority terminates when an action is filed for the dissolution or annulment of the agent's marriage to the principal or for their legal separation, or an action is filed for dissolution or annulment of the agent's state registered domestic partnership with the principal or for their legal separation.

(10) Unless otherwise provided in the durable power of attorney, the principal may revoke the agent's appointment as provided under other state law. [2021 c 287 § 10; 2016 c 209 § 410; 2003 c 283 § 10.]

Short title—Application—Uniformity—Federal law application—Federal electronic signatures in global and national commerce act—Application—Dates—Effective date—2016 c 209: See RCW 11.125.010 and 11.125.900 through 11.125.903.

71.32.110 Determination of capacity. (1) For the purposes of this chapter, a principal, agent, professional person, or health care provider may seek a determination whether the principal is incapacitated or has regained capacity.

(2)(a) For the purposes of this chapter, no adult may be declared an incapacitated person except by:

(i) A court, if the request is made by the principal or the principal's agent;

(ii) One mental health professional or substance use disorder professional and one health care provider; or

(iii) Two health care providers.

(b) One of the persons making the determination under (a)(ii) or (iii) of this subsection must be a psychiatrist, physician assistant working with a supervising psychiatrist, psychologist, or a psychiatric advanced registered nurse practitioner.

(3) When a professional person or health care provider requests a capacity determination, he or she shall promptly inform the principal that:

(a) A request for capacity determination has been made; and

(b) The principal may request that the determination be made by a court.

(4) At least one mental health professional, substance use disorder professional, or health care provider must personally examine the principal prior to making a capacity determination.

(5)(a) When a court makes a determination whether a principal has capacity, the court shall, at a minimum, be informed by the testimony of one mental health professional or substance use disorder professional familiar with the principal and shall, except for good cause, give the principal an opportunity to appear in court prior to the court making its determination.

(b) To the extent that local court rules permit, any party or witness may testify telephonically.

(6) When a court has made a determination regarding a principal's capacity and there is a subsequent change in the principal's condition, subsequent determinations whether the principal is incapacitated may be made in accordance with any of the provisions of subsection (2) of this section. [2021 c 287 § 11; 2016 c 155 § 13; 2003 c 283 § 11.]

71.32.120 Action to contest directive. A principal may bring an action to contest the validity of his or her directive. If an action under this section is commenced while an action to determine the principal's capacity is pending, the court shall consolidate the actions and decide the issues simultaneously. [2003 c 283 § 12.]

71.32.130 Determination of capacity—Reevaluations of capacity. (1) An initial determination of capacity must be completed within 48 hours of a request made by a person authorized in RCW 71.32.110. During the period between the request for an initial determination of the principal's capacity and completion of that determination, the principal may not be treated unless he or she consents at the time or treatment is otherwise authorized by state or federal law.

(2)(a)(i) When an incapacitated principal is admitted to inpatient treatment pursuant to the provisions of his or her directive, his or her capacity must be reevaluated within 120 hours or when there has been a change in the principal's condition that indicates that he or she appears to have regained capacity, whichever occurs first.

(ii) When an incapacitated principal has been admitted to and remains in inpatient treatment for more than 120 hours pursuant to the provisions of his or her directive, the principal's capacity must be reevaluated when there has been a change in his or her condition that indicates that he or she appears to have regained capacity.

(iii) When a principal who is being treated on an inpatient basis and has been determined to be incapacitated requests, or his or her agent requests, a redetermination of the principal's capacity the redetermination must be made within 120 hours.

(b) When a principal who has been determined to be incapacitated is being treated on an outpatient basis and there is a request for a redetermination of his or her capacity, the redetermination must be made within five days of the first request following a determination.

(3)(a) When a principal who has appointed an agent for behavioral health treatment decisions requests a determination or redetermination of capacity, the agent must make reasonable efforts to obtain the determination or redetermination.

(b) When a principal who does not have an agent for behavioral health treatment decisions is being treated in an inpatient facility and requests a determination or redetermination of capacity, the mental health professional or health care provider must complete the determination or, if the principal is seeking a determination from a court, must make reasonable efforts to notify the person authorized to make decisions for the principal under RCW 7.70.065 of the principal's request.

(c) When a principal who does not have an agent for behavioral health treatment decisions is being treated on an outpatient basis, the person requesting a capacity determination must arrange for the determination.

(4) If no determination has been made within the time frames established in subsection (1) or (2) of this section, the principal shall be considered to have capacity.

(5) When an incapacitated principal is being treated pursuant to his or her directive, a request for a redetermination of capacity does not prevent treatment. [2021 c 287 § 12; 2003 c 283 § 13.]

71.32.140 Refusal of admission to inpatient treatment—Effect of directive. (1) A principal who:

(a) Chose not to be able to revoke his or her directive during any period of incapacity;

(b) Consented to voluntary admission to inpatient behavioral health treatment, or authorized an agent to consent on the principal's behalf; and

(c) At the time of admission to inpatient treatment, refuses to be admitted, may only be admitted into inpatient behavioral health treatment under subsection (2) of this section.

(2) A principal may only be admitted to inpatient behavioral health treatment under his or her directive if, prior to admission, a member of the treating facility's professional staff who is a physician, physician assistant, or psychiatric advanced registered nurse practitioner:

(a) Evaluates the principal's mental condition, including a review of reasonably available psychiatric and psychological history, diagnosis, and treatment needs, and determines, in conjunction with another health care provider, mental health professional, or substance use disorder professional, that the principal is incapacitated;

(b) Obtains the informed consent of the agent, if any, designated in the directive;

(c) Makes a written determination that the principal needs an inpatient evaluation or is in need of inpatient treatment and that the evaluation or treatment cannot be accomplished in a less restrictive setting; and

(d) Documents in the principal's medical record a summary of the physician's, physician assistant's, or psychiatric advanced registered nurse practitioner's findings and recommendations for treatment or evaluation.

(3) In the event the admitting physician is not a psychiatrist, the admitting physician assistant is not supervised by a psychiatrist, or the advanced registered nurse practitioner is not a psychiatric advanced registered nurse practitioner, the principal shall receive a complete behavioral health assessment by a mental health professional or substance use disorder professional within 24 hours of admission to determine the continued need for inpatient evaluation or treatment.

(4)(a) If it is determined that the principal has capacity, then the principal may only be admitted to, or remain in, inpatient treatment if he or she consents at the time, is admitted for family-initiated treatment under chapter 71.34 RCW, or is detained under the involuntary treatment provisions of chapter 71.05 or 71.34 RCW.

(b) If a principal who is determined by two health care providers or one mental health professional or substance use disorder professional and one health care provider to be incapacitated continues to refuse inpatient treatment, the princi-

pal may immediately seek injunctive relief for release from the facility.

(5) If, at the end of the period of time that the principal or the principal's agent, if any, has consented to voluntary inpatient treatment, but no more than 14 days after admission, the principal has not regained capacity or has regained capacity but refuses to consent to remain for additional treatment, the principal must be released during reasonable daylight hours, unless detained under chapter 71.05 or 71.34 RCW.

(6)(a) Except as provided in (b) of this subsection, any principal who is voluntarily admitted to inpatient behavioral health treatment under this chapter shall have all the rights provided to individuals who are voluntarily admitted to inpatient treatment under chapter 71.05, 71.34, or 72.23 RCW.

(b) Notwithstanding RCW 71.05.050 regarding consent to inpatient treatment for a specified length of time, the choices an incapacitated principal expressed in his or her directive shall control, provided, however, that a principal who takes action demonstrating a desire to be discharged, in addition to making statements requesting to be discharged, shall be discharged, and no principal shall be restrained in any way in order to prevent his or her discharge. Nothing in this subsection shall be construed to prevent detention and evaluation for civil commitment under chapter 71.05 RCW.

(7) Consent to inpatient admission in a directive is effective only while the professional person, health care provider, and health care facility are in substantial compliance with the material provisions of the directive related to inpatient treatment. [2021 c 287 § 13. Prior: 2016 sp.s. c 29 § 424; 2016 c 155 § 14; 2009 c 217 § 12; 2004 c 39 § 2; 2003 c 283 § 14.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Finding—Intent—2004 c 39: "Questions have been raised about the intent of the legislature in cross-referencing RCW 71.05.050 without further clarification in RCW 71.32.140. The legislature finds that because RCW 71.05.050 pertains to a variety of rights as well as the procedures for detaining a voluntary patient for evaluation for civil commitment, and the legislature intended only to address the right of release upon request, there is ambiguity as to whether an incapacitated person admitted pursuant to his or her mental health advance directive and seeking release can be held for evaluation for civil commitment under chapter 71.05 RCW. The legislature therefore intends to clarify the ambiguity without making any change to its intended policy as laid out in chapter 71.32 RCW." [2004 c 39 § 1.]

71.32.150 Compliance with directive—Conditions for noncompliance. (1) Upon receiving a directive, a health care provider, professional person, or health care facility providing treatment to the principal, or persons acting under the direction of the health care provider, professional person, or health care facility, shall make the directive a part of the principal's medical record and shall be deemed to have actual knowledge of the directive's contents.

(2) When acting under authority of a directive, a health care provider, professional person, or health care facility shall act in accordance with the provisions of the directive to the fullest extent possible, unless in the determination of the health care provider, professional person, or health care facility:

(a) Compliance with the provision would violate the accepted standard of care established in RCW 7.70.040;

(b) The requested treatment is not available;

(c) Compliance with the provision would violate applicable law; or

(d) It is an emergency situation and compliance would endanger any person's life or health.

(3)(a) In the case of a principal committed or detained under the involuntary treatment provisions of chapter 10.77, 71.05, 71.09, or 71.34 RCW, those provisions of a principal's directive that, in the determination of the health care provider, professional person, or health care facility, are inconsistent with the purpose of the commitment or with any order of the court relating to the commitment are invalid during the commitment.

(b) Remaining provisions of a principal's directive are advisory while the principal is committed or detained.

The treatment provider is encouraged to follow the remaining provisions of the directive, except as provided in (a) of this subsection or subsection (2) of this section.

(4) In the case of a principal who is incarcerated or committed in a state or local correctional facility, provisions of the principal's directive that are inconsistent with reasonable penological objectives or administrative hearings regarding involuntary medication are invalid during the period of incarceration or commitment. In addition, treatment may be given despite refusal of the principal or the provisions of the directive: (a) For any reason under subsection (2) of this section; or (b) if, without the benefit of the specific treatment measure, there is a significant possibility that the person will harm self or others before an improvement of the person's condition occurs.

(5)(a) If the health care provider, professional person, or health care facility is, at the time of receiving the directive, unable or unwilling to comply with any part or parts of the directive for any reason, the health care provider, professional person, or health care facility shall promptly notify the principal and, if applicable, his or her agent and shall document the reason in the principal's medical record.

(b) If the health care provider, professional person, or health care facility is acting under authority of a directive and is unable to comply with any part or parts of the directive for the reasons listed in subsection (2) or (3) of this section, the health care provider, professional person, or health care facility shall promptly notify the principal and if applicable, his or her agent, and shall document the reason in the principal's medical record.

(6) In the event that one or more parts of the directive are not followed because of one or more of the reasons set forth in subsection (2) or (4) of this section, all other parts of the directive shall be followed.

(7) If no provider-patient relationship has previously been established, nothing in this chapter requires the establishment of a provider-patient relationship. [2016 sp.s. c 29 § 425; 2003 c 283 § 15.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.32.160 Electroconvulsive therapy. Where a principal consents in a directive to electroconvulsive therapy, the health care provider, professional person, or health care facility, or persons acting under the direction of the health care provider, professional person, or health care facility, shall

document the therapy and the reason it was used in the principal's medical record. [2003 c 283 § 16.]

71.32.170 Providers—Immunity from liability—Conditions. (1) For the purposes of this section, "provider" means a private or public agency, government entity, health care provider, professional person, health care facility, or person acting under the direction of a health care provider or professional person, health care facility, or long-term care facility.

(2) A provider is not subject to civil liability or sanctions for unprofessional conduct under the uniform disciplinary act, chapter 18.130 RCW, when in good faith and without negligence:

(a) The provider provides treatment to a principal in the absence of actual knowledge of the existence of a directive, or provides treatment pursuant to a directive in the absence of actual knowledge of the revocation of the directive;

(b) A health care provider or mental health professional determines that the principal is or is not incapacitated for the purpose of deciding whether to proceed according to a directive, and acts upon that determination;

(c) The provider administers or does not administer behavioral health treatment according to the principal's directive in good faith reliance upon the validity of the directive and the directive is subsequently found to be invalid;

(d) The provider does not provide treatment according to the directive for one of the reasons authorized under RCW 71.32.150; or

(e) The provider provides treatment according to the principal's directive. [2021 c 287 § 14; 2003 c 283 § 17.]

71.32.180 Multiple directives, agents—Effect—Disclosure of court orders. (1) Where an incapacitated principal has executed more than one valid directive and has not revoked any of the directives:

(a) The directive most recently created shall be treated as the principal's behavioral health treatment preferences and instructions as to any inconsistent or conflicting provisions, unless provided otherwise in either document.

(b) Where a directive executed under this chapter is inconsistent with a directive executed under any other chapter, the most recently created directive controls as to the inconsistent provisions.

(2) Where an incapacitated principal has appointed more than one agent under chapter 11.125 RCW with authority to make behavioral health treatment decisions, RCW 11.125.400 controls.

(3) The treatment provider shall inquire of a principal whether the principal is subject to any court orders that would affect the implementation of his or her directive. [2021 c 287 § 15; 2016 c 209 § 411; 2003 c 283 § 18.]

Short title—Application—Uniformity—Federal law application—Federal electronic signatures in global and national commerce act—Application—Dates—Effective date—2016 c 209: See RCW 11.125.010 and 11.125.900 through 11.125.903.

71.32.190 Preexisting, foreign directives—Validity. (1) Directives validly executed before July 27, 2003, shall be given full force and effect until revoked, superseded, or expired.

(2) A directive validly executed in another political jurisdiction is valid to the extent permitted by Washington state law. [2003 c 283 § 19.]

71.32.200 Fraud, duress, undue influence—Appointment of guardian. Any person with reasonable cause to believe that a directive has been created or revoked under circumstances amounting to fraud, duress, or undue influence may petition the court for appointment of a guardian for the person or to review the actions of the agent or person alleged to be involved in improper conduct under RCW 11.125.160 or chapter 74.34 RCW. [2021 c 215 § 158; 2016 c 209 § 412; 2003 c 283 § 20.]

Effective date—2022 c 268; 2021 c 215: See note following RCW 7.105.900.

Short title—Application—Uniformity—Federal law application—Federal electronic signatures in global and national commerce act—Application—Dates—Effective date—2016 c 209: See RCW 11.125.010 and 11.125.900 through 11.125.903.

71.32.210 Execution of directive not evidence of behavioral health disorder or lack of capacity. The fact that a person has executed a directive does not constitute an indication of behavioral health disorder or that the person is not capable of providing informed consent. [2021 c 287 § 16; 2003 c 283 § 21.]

71.32.220 Requiring directive prohibited. A person shall not be required to execute or to refrain from executing a directive, nor shall the existence of a directive be used as a criterion for insurance, as a condition for receiving behavioral or physical health services, or as a condition of admission to or discharge from a health care facility or long-term care facility. [2021 c 287 § 17; 2003 c 283 § 22.]

71.32.230 Coercion, threats prohibited. No person or health care facility may use or threaten abuse, neglect, financial exploitation, or abandonment of the principal, as those terms are defined in RCW 74.34.020, to carry out the directive. [2003 c 283 § 23.]

71.32.240 Other authority not limited. A directive does not limit any authority otherwise provided in Title 10, 70, or 71 RCW, or any other applicable state or federal laws to detain a person, take a person into custody, or to admit, retain, or treat a person in a health care facility. [2003 c 283 § 24.]

71.32.250 Long-term care facility residents—Readmission after inpatient behavioral health treatment—Evaluation, report to legislature. (1) If a principal who is a resident of a long-term care facility is admitted to inpatient behavioral health treatment pursuant to his or her directive, the principal shall be allowed to be readmitted to the same long-term care facility as if his or her inpatient admission had been for a physical condition on the same basis that the principal would be readmitted under state or federal statute or rule when:

(a) The treating facility's professional staff determine that inpatient behavioral health treatment is no longer medically necessary for the resident. The determination shall be made in writing by a psychiatrist, physician assistant working

with a supervising psychiatrist, or a psychiatric advanced registered nurse practitioner, or (i) one physician and a mental health professional or substance use disorder professional; (ii) one physician assistant and a mental health professional or substance use disorder professional; or (iii) one psychiatric advanced registered nurse practitioner and a mental health professional or substance use disorder professional; or

(b) The person's consent to admission in his or her directive has expired.

(2)(a) If the long-term care facility does not have a bed available at the time of discharge, the treating facility may discharge the resident, in consultation with the resident and agent if any, and in accordance with a medically appropriate discharge plan, to another long-term care facility.

(b) This section shall apply to inpatient behavioral health treatment admission of long-term care facility residents, regardless of whether the admission is directly from a facility, hospital emergency room, or other location.

(c) This section does not restrict the right of the resident to an earlier release from the inpatient treatment facility. This section does not restrict the right of a long-term care facility to initiate transfer or discharge of a resident who is readmitted pursuant to this section, provided that the facility has complied with the laws governing the transfer or discharge of a resident.

(3) The joint legislative audit and review committee shall conduct an evaluation of the operation and impact of this section. The committee shall report its findings to the appropriate committees of the legislature by December 1, 2004. [2021 c 287 § 18; 2016 c 155 § 15; 2009 c 217 § 13; 2003 c 283 § 25.]

71.32.260 Form. The directive shall be in substantially the following form:

Mental Health Advance Directive of (client name)
With Appointment of (agent name) as
Agent for Mental Health Decisions

PART I.
STATEMENT OF INTENT TO CREATE A
MENTAL HEALTH ADVANCE DIRECTIVE

I, (Client name), being a person with capacity, willfully and voluntarily execute this mental health advance directive so that my choices regarding my mental health care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my mental health care.

PART II.
MY CARE NEEDS - WHAT WORKS FOR ME

In order to assist in carrying out my directive I would like my providers and my agent to know the following information:
I have been diagnosed with (client illnesses both mental health and physical diagnoses) for which I take (list medications).
I am also on the following other medications: (list any other medications for other conditions).
The best treatment method for my illness is (give general overview of what works best for client).
I have/do not have a history of substance abuse. My preferences and treatment options around medication management related to substance abuse are:

PART III.
WHEN THIS DIRECTIVE IS EFFECTIVE

(*You must complete this part for your directive to be valid.)*

I intend that this directive become effective (YOU MUST CHOOSE ONLY ONE):
. . . . . Immediately upon my signing of this directive.
. . . . . If I become incapacitated.
. . . . . When the following circumstances, symptoms, or behaviors occur:

PART IV.
DURATION OF THIS DIRECTIVE

(You must complete this part for your directive to be valid.)

I want this directive to (YOU MUST CHOOSE ONLY ONE):
. . . . . Remain valid and in effect for an indefinite period of time.
. . . . . Automatically expire . . . . . years from the date it was created.

PART V.
WHEN I MAY REVOKE THIS DIRECTIVE

(You must complete this part for this directive to be valid.)

I intend that I be able to revoke this directive (YOU MUST CHOOSE ONLY ONE):
. . . . . Only when I have capacity.
I understand that choosing this option means I may only revoke this directive if I have capacity. I further understand that if I choose this option and become incapacitated while this directive is in effect, I may receive treatment that I specify in this directive, even if I object at the time.

. . . . . Even if I am incapacitated.
I understand that choosing this option means that I may revoke this directive even if I am incapacitated. I further understand that if I choose this option and revoke this directive while I am incapacitated I may not receive treatment that I specify in this directive, even if I want the treatment.

PART VI.
PREFERENCES AND INSTRUCTIONS ABOUT TREATMENT, FACILITIES, AND PHYSICIANS, PHYSICIAN ASSISTANTS, OR ADVANCED REGISTERED NURSE PRACTITIONERS

A. Preferences and Instructions About Physician(s), Physician Assistant(s), or Advanced Registered Nurse Practitioner(s) to be Involved in My Treatment
I would like the physician(s), physician assistant(s), or advanced registered nurse practitioner(s) named below to be involved in my treatment decisions:
I do not wish to be treated by

B. Preferences and Instructions About Other Providers
I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

C. Preferences and Instructions About Medications for Psychiatric Treatment (check all that apply)
. . . . . I consent, and authorize my agent (if appointed) to consent, to the following medications:
. . . . . I do not consent, and I do not authorize my agent (if appointed) to consent, to the administration of the following medications:
. . . . . I am willing to take the medications excluded above if my only reason for excluding them is the side effects which include:
and these side effects can be eliminated by dosage adjustment or other means
. . . . . I am willing to try any other medication the hospital doctor, physician assistant, or advanced registered nurse practitioner recommends.
. . . . . I am willing to try any other medications my outpatient doctor, physician assistant, or advanced registered nurse practitioner recommends.
. . . . . I do not want to try any other medications.
Medication Allergies.
I have allergies to, or severe side effects from, the following:
Other Medication Preferences or Instructions
. . . . . I have the following other preferences or instructions about medications:

D. Preferences and Instructions About Hospitalization and Alternatives
(check all that apply and, if desired, rank "1" for first choice, "2" for second choice, and so on)
. . . . . In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalizations.
. . . . . I would also like the interventions below to be tried before hospitalization is considered:
. . . . . Calling someone or having someone call me when needed.
Name:. . . . . Telephone/text: . . . . . Email: . . . . . .
. . . . . Staying overnight with someone
Name:. . . . . Telephone/text: . . . . . Email: . . . . . .
. . . . . Having a mental health service provider come to see me.
. . . . . Going to a crisis triage center or emergency room.
. . . . . Staying overnight at a crisis respite (temporary) bed.
. . . . . Seeing a service provider for help with psychiatric medications.
. . . . . Other, specify:

Authority to Consent to Inpatient Treatment
I consent, and authorize my agent (if appointed) to consent, to voluntary admission to inpatient mental health treatment for ..... days (not to exceed 14 days).

(Sign one): . . . . . .

. . . . . If deemed appropriate by my agent (if appointed) and treating physician, physician assistant, or advanced registered nurse practitioner

. . . . . .
(Signature)

Or

. . . . . Under the following circumstances (specify symptoms, behaviors, or circumstances that indicate the need for hospitalization)

. . . . . .
(Signature)

. . . . . I do not consent, or authorize my agent (if appointed) to consent, to inpatient treatment

. . . . . .
(Signature)

Hospital Preferences and Instructions
If hospitalization is required, I prefer the following hospitals:
I do not consent to be admitted to the following hospitals:

E. Preferences and Instructions About Preemergency

I would like the interventions below to be tried before use of seclusion or restraint is considered (check all that apply):
. . . . . "Talk me down" one-on-one
. . . . . More medication
. . . . . Time out/privacy
. . . . . Show of authority/force
. . . . . Shift my attention to something else
. . . . . Set firm limits on my behavior
. . . . . Help me to discuss/vent feelings
. . . . . Decrease stimulation
. . . . . Offer to have neutral person settle dispute
. . . . . Other:

F. Preferences and Instructions About Seclusion, Restraint, and Emergency Medications

If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen (choose "1" for first choice, "2" for second choice, and so on):
. . . . . Seclusion
. . . . . Seclusion and physical restraint (combined)
. . . . . Medication by injection
. . . . . Medication in pill or liquid form
In the event that my attending physician, physician assistant, or advanced registered nurse practitioner decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in Part VI C. of this form. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for nonemergency treatment.

G. Preferences and Instructions About Electroconvulsive Therapy (ECT or Shock Therapy)

My wishes regarding electroconvulsive therapy are (sign one):
. . . . . I do not consent, nor authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy

. . . . . .
(Signature)

. . . . . I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy

. . . . . .
(Signature)

. . . . . I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy, but only under the following conditions:

. . . . . .
(Signature)

H. Preferences and Instructions About Who is Permitted to Visit

If I have been admitted to a mental health treatment facility, the following people are not permitted to visit me there:

Name: . . . . . .

Name: . . . . . .

I understand that persons not listed above may be permitted to visit me.

I. Additional Instructions About My Mental Health Care

Other instructions about my mental health care:
In case of emergency, please contact:

Name: . . . . . Address: . . . . .
Work telephone: . . . . . Home telephone: . . . . .
Physician, physician assistant, or advanced registered nurse practitioner: . . . . . Address: . . . . .
Email: . . . . .
Telephone: . . . . .

The following may help me to avoid a hospitalization:
I generally react to being hospitalized as follows:
Staff of the hospital or crisis unit can help me by doing the following:

J. Refusal of Treatment
I do not consent to any mental health treatment.

. . . . . .
(Signature)

PART VII.
DURABLE POWER OF ATTORNEY (APPOINTMENT OF MY AGENT)

(*Fill out this part only if you wish to appoint an agent or nominate a guardian.*)

I authorize an agent to make mental health treatment decisions on my behalf. The authority granted to my agent includes the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service, or procedure, consistent with any instructions and/or limitations I have set forth in this directive. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document **and my agent does not otherwise know my wishes**, I authorize my agent to make the decision that my agent determines is in my best interest. This agency shall not be affected by my incapacity. Unless I state otherwise in this durable power of attorney, I may revoke it unless prohibited by other state law.

HIPAA Release Authority. In addition to the other powers granted by this document, I grant to my Attorney-in-Fact the power and authority to serve as my personal representative for all purposes under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended from time to time, and its regulations. My Attorney-in-Fact will serve as my "HIPAA personal representative" and will exercise this authority at any time that my Attorney-in-Fact is exercising authority under this document.

A. Designation of an Agent

Name: . . . . . Address: . . . . .
Work phone: . . . . . Home/cell phone: . . . . .
Relationship: . . . . . Email: . . . . .

B. Designation of Alternate Agent

If the person named above is unavailable, unable, or refuses to serve as my agent, or I revoke that person's authority to serve as my agent, I hereby appoint the following person as my alternate agent and request that this person be notified immediately when this directive becomes effective or when my original agent is no longer my agent:

Name: . . . . . Address: . . . . .
Work phone: . . . . . Home phone: . . . . .
Relationship: . . . . . Email: . . . . .

C. Limitations on My Agent's Authority
I do not grant my agent the authority to consent on my behalf to the following:
D. Limitations on My Ability to Revoke this Durable Power of Attorney
I choose to limit my ability to revoke this durable power of attorney as follows:
E. Preference as to Court-Appointed Guardian

In the event a court appoints a guardian who will make decisions regarding my mental health treatment, I **nominate** my then-serving agent (or name someone else) **as my guardian**:

Name and contact information (if someone other than agent or alternate):

The appointment of a guardian of my estate or my person or any other decision maker shall not give the guardian or decision maker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as authorized by law.

PART VIII.
OTHER DOCUMENTS

(*Initial all that apply*)

I have executed the following documents that include the power to make decisions regarding health care services for myself:

. . . . . Health care power of attorney (chapter 11.125 RCW)

. . . . . "Living will" (Health care directive; chapter 70.122 RCW)

. . . . . I have appointed more than one agent. I understand that the most recently appointed agent controls except as stated below:

PART IX.
NOTIFICATION OF OTHERS AND CARE OF PERSONAL AFFAIRS

(*Fill out this part only if you wish to provide nontreatment instructions.*)

I understand the preferences and instructions in this part are **NOT** the responsibility of my treatment provider and that no treatment provider is required to act on them.

A. Who Should Be Notified

I desire my agent to notify the following individuals as soon as possible if I am admitted to a mental health facility:

Name: . . . . . Address: . . . . . .
Day telephone: . . . . . Evening telephone: . . . . . .
Name: . . . . . Address: . . . . . .
Day telephone: . . . . . Evening telephone: . . . . . .
Name: . . . . . Address: . . . . . .
Day telephone: . . . . . Evening telephone: . . . . . .

B. Preferences or Instructions About Personal Affairs

I have the following preferences or instructions about my personal affairs (e.g., care of dependents, pets, household) if I am admitted to a mental health treatment facility:

C. Additional Preferences and Instructions:

PART X.
SIGNATURE

By signing here, I indicate that I understand the purpose and effect of this document and that I am giving my informed consent to the treatments and/or admission to which I have consented or authorized my agent to consent in this directive. I intend that my consent in this directive be construed as being consistent with the elements of informed consent under chapter 7.70 RCW.

In witness of this, I have signed on this . . . . . day of . . . . . ., 20. . . .
Signature: . . . . . .

STATE OF WASHINGTON)
) ss.
COUNTY OF . . . . . .)

I certify that I know or have satisfactory evidence that (client name) is the person who appeared before me, and said person acknowledged that he or she signed this Durable Power of Attorney and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in this instrument.

SUBSCRIBED and SWORN to before me this . . . . . day of . . . . . ., 20. . . .

. . . . . .
SIGNATURE OF NOTARY

. . . . . .
PRINT NAME OF NOTARY

NOTARY PUBLIC for the State of Washington at . . . . . .
My commission expires . . . . . .
OR have two witnesses:
Name: . . . . . .

This directive was signed and declared by the "Principal," to be his or her directive, in our presence who, at his or her request, have signed our names below as witnesses. We declare that, at the time of the creation of this instrument, the Principal is personally known to us, and, according to our best knowledge and belief, has capacity at this time and does not appear to be acting under duress, undue influence, or fraud. We further declare that none of us is:

(A) A person designated to make medical decisions on the principal's behalf;

(B) A health care provider or professional person directly involved with the provision of care to the principal at the time the directive is executed;

(C) An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the principal is a patient or resident;

(D) A person who is related by blood, marriage, or adoption to the person, or with whom the principal has a dating relationship as defined in RCW 7.105.010;

(E) An incapacitated person;

(F) A person who would benefit financially if the principal undergoes mental health treatment; or

(G) A minor.

Witness 1 Signature: . . . . . Date: . . . . . .

Printed Name: . . . . . Address: . . . . . .

Telephone: . . . . . .

Witness 2 Signature: . . . . . Date: . . . . . .

Printed Name: . . . . . Address: . . . . . .

Telephone: . . . . . .

PART XI.
RECORD OF DIRECTIVE

I have given a copy of this directive to the following persons:

Name: . . . . . Address: . . . . . .

Day telephone: . . . . . Evening telephone: . . . . . .

Name: . . . . . Address: . . . . . .

Day telephone: . . . . . Evening telephone: . . . . . .

DO NOT FILL OUT PART XII UNLESS YOU INTEND TO REVOKE
THIS DIRECTIVE IN PART OR IN WHOLE

PART XII.
REVOCATION OF THIS DIRECTIVE

(Initial any that apply):

. . . . . I am revoking the following part(s) of this directive (specify):

Date: . . . . . .

. . . . . I am revoking all of this directive.

By signing here, I indicate that I understand the purpose and effect of my revocation and that no person is bound by any revoked provision(s). I intend this revocation to be interpreted as if I had never completed the revoked provision(s).

. . . . . .

(Signature)

Printed Name: . . . . . .

DO NOT SIGN THIS PART UNLESS YOU INTEND TO REVOKE THIS DIRECTIVE IN PART OR IN WHOLE

[2021 c 287 § 19; 2021 c 215 § 159. Prior: 2016 c 209 § 413; 2016 c 155 § 16; 2009 c 217 § 14; 2003 c 283 § 26.]

Reviser's note: This section was amended by 2021 c 215 § 159 and by 2021 c 287 § 19, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2022 c 268; 2021 c 215: See note following RCW 7.105.900.

Short title—Application—Uniformity—Federal law application—Federal electronic signatures in global and national commerce act—Application—Dates—Effective date—2016 c 209: See RCW 11.125.010 and 11.125.900 through 11.125.903.

71.32.270 Family-initiated treatment. Nothing in this chapter restricts the right of a parent to seek behavioral health evaluation and treatment for a nonconsenting adolescent using family-initiated treatment laws under chapter 71.34 RCW. [2021 c 287 § 20.]

71.32.902 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521. For the purposes of this chapter, the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family shall be interpreted as applying equally to state registered domestic partnerships or individuals in state registered domestic partnerships as well as to marital relationships and married per-

sons, and references to dissolution of marriage shall apply equally to state registered domestic partnerships that have been terminated, dissolved, or invalidated, to the extent that such interpretation does not conflict with federal law. Where necessary to implement chapter 521, Laws of 2009, gender-specific terms such as husband and wife used in any statute, rule, or other law shall be construed to be gender neutral, and applicable to individuals in state registered domestic partnerships. [2009 c 521 § 161.]

Chapter 71.34 RCW
BEHAVIORAL HEALTH SERVICES FOR MINORS

(Formerly: Mental health services for minors)

Sections

Court files and records closed—Exceptions: RCW 71.05.620.

71.34.010 Purpose. (1) It is the purpose of this chapter to assure that minors in need of behavioral health care and

treatment receive an appropriate continuum of culturally relevant care and treatment, including prevention and early intervention, self-directed care, parent-directed care, and involuntary treatment. To facilitate the continuum of care and treatment to minors in out-of-home placements, all divisions of the authority and the department that provide behavioral health services to minors shall jointly plan and deliver those services.

(2) It is also the purpose of this chapter to protect the rights of adolescents to confidentiality and to independently seek services for behavioral health disorders. Mental health and substance use disorder professionals shall guard against needless hospitalization and deprivations of liberty, enable treatment decisions to be made in response to clinical needs in accordance with sound professional judgment, and encourage the use of voluntary services. Mental health and substance use disorder professionals shall, whenever clinically appropriate, offer less restrictive alternatives to inpatient treatment. Additionally, all behavioral health care and treatment providers shall assure that minors' parents are given an opportunity to participate in the treatment decisions for their minor children. The behavioral health care and treatment providers shall, to the extent possible, offer services that involve minors' parents or family.

(3)(a) It is the intent of the legislature to enhance continuity of care for minors with serious behavioral health disorders that can be controlled or stabilized in a less restrictive alternative commitment. Within the guidelines stated in *In re LaBelle*, 107 Wn.2d 196 (1986), the legislature intends to encourage appropriate interventions at a point when there is the best opportunity to restore the minor to or maintain satisfactory functioning.

(b) For minors with a prior history or pattern of repeated hospitalizations or law enforcement interventions due to decompensation, the consideration of prior behavioral health history is particularly relevant in determining whether the minor would receive, if released, such care as is essential for his or her health or safety.

(c) Therefore, the legislature finds that for minors who are currently under a commitment order, a prior history of decompensation leading to repeated hospitalizations or law enforcement interventions should be given great weight in determining whether a new less restrictive alternative commitment should be ordered. The court must also consider any school behavioral issues, the impact on the family, the safety of other children in the household, and the developmental age of the minor.

(4) It is also the purpose of this chapter to protect the health and safety of minors suffering from behavioral health disorders and to protect public safety through use of the parens patriae and police powers of the state. Accordingly, when construing the requirements of this chapter the court must focus on the merits of the petition, except where requirements have been totally disregarded, as provided in *In re C.W.*, 147 Wn.2d 259, 281 (2002). A presumption in favor of deciding petitions on their merits furthers both public and private interests because the mental and physical well-being of minors as well as public safety may be implicated by the decision to release a minor and discontinue his or her treatment.

(5) It is also the purpose of this chapter to assure the ability of parents to exercise reasonable, compassionate care and control of their minor children when there is a medical necessity for treatment and without the requirement of filing a petition under this chapter, including the ability to request and receive medically necessary treatment for their adolescent children without the consent of the adolescent. [2020 c 302 § 62; 2020 c 185 § 1; 2019 c 381 § 1; 2018 c 201 § 5001; 1998 c 296 § 7; 1992 c 205 § 302; 1985 c 354 § 1.]

Reviser's note: This section was amended by 2020 c 185 § 1 and by 2020 c 302 § 62, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Short title—2019 c 381: See note following RCW 71.34.500.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

Additional notes found at www.leg.wa.gov

71.34.020 Definitions. *(Contingent expiration date.)*

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Admission" or "admit" means a decision by a physician, physician assistant, or psychiatric advanced registered nurse practitioner that a minor should be examined or treated as a patient in a hospital.

(2) "Adolescent" means a minor thirteen years of age or older.

(3) "Alcoholism" means a disease, characterized by a dependency on alcoholic beverages, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued, and impairment of health or disruption of social or economic functioning.

(4) "Antipsychotic medications" means that class of drugs primarily used to treat serious manifestations of mental illness associated with thought disorders, which includes, but is not limited to, atypical antipsychotic medications.

(5) "Approved substance use disorder treatment program" means a program for minors with substance use disorders provided by a treatment program licensed or certified by the department of health as meeting standards adopted under chapter 71.24 RCW.

(6) "Attending staff" means any person on the staff of a public or private agency having responsibility for the care and treatment of a minor patient.

(7) "Authority" means the Washington state health care authority.

(8) "Behavioral health administrative services organization" has the same meaning as provided in RCW 71.24.025.

(9) "Behavioral health disorder" means either a mental disorder as defined in this section, a substance use disorder as defined in this section, or a co-occurring mental disorder and substance use disorder.

(10) "Child psychiatrist" means a person having a license as a physician and surgeon in this state, who has had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

(11) "Children's mental health specialist" means:

(a) A mental health professional who has completed a minimum of one hundred actual hours, not quarter or semester hours, of specialized training devoted to the study of child development and the treatment of children; and

(b) A mental health professional who has the equivalent of one year of full-time experience in the treatment of children under the supervision of a children's mental health specialist.

(12) "Commitment" means a determination by a judge or court commissioner, made after a commitment hearing, that the minor is in need of inpatient diagnosis, evaluation, or treatment or that the minor is in need of less restrictive alternative treatment.

(13) "Conditional release" means a revocable modification of a commitment, which may be revoked upon violation of any of its terms.

(14) "Co-occurring disorder specialist" means an individual possessing an enhancement granted by the department of health under chapter 18.205 RCW that certifies the individual to provide substance use disorder counseling subject to the practice limitations under RCW 18.205.105.

(15) "Crisis stabilization unit" means a short-term facility or a portion of a facility licensed or certified by the department of health under RCW 71.24.035, such as a residential treatment facility or a hospital, which has been designed to assess, diagnose, and treat individuals experiencing an acute crisis without the use of long-term hospitalization.

(16) "Custody" means involuntary detention under the provisions of this chapter or chapter 10.77 RCW, uninterrupted by any period of unconditional release from commitment from a facility providing involuntary care and treatment.

(17) "Department" means the department of social and health services.

(18) "Designated crisis responder" has the same meaning as provided in RCW 71.05.020.

(19) "Detention" or "detain" means the lawful confinement of a person, under the provisions of this chapter.

(20) "Developmental disabilities professional" means a person who has specialized training and three years of experience in directly treating or working with persons with developmental disabilities and is a psychiatrist, physician assistant working with a supervising psychiatrist, psychologist, psychiatric advanced registered nurse practitioner, or social worker, and such other developmental disabilities professionals as may be defined by rules adopted by the secretary of the department.

(21) "Developmental disability" has the same meaning as defined in RCW 71A.10.020.

(22) "Director" means the director of the authority.

(23) "Discharge" means the termination of hospital medical authority. The commitment may remain in place, be terminated, or be amended by court order.

(24) "Evaluation and treatment facility" means a public or private facility or unit that is licensed or certified by the department of health to provide emergency, inpatient, residential, or outpatient mental health evaluation and treatment services for minors. A physically separate and separately operated portion of a state hospital may be designated as an evaluation and treatment facility for minors. A facility which is part of or operated by the state or federal agency does not require licensure or certification. No correctional institution or facility, juvenile court detention facility, or jail may be an evaluation and treatment facility within the meaning of this chapter.

(25) "Evaluation and treatment program" means the total system of services and facilities coordinated and approved by a county or combination of counties for the evaluation and treatment of minors under this chapter.

(26) "Gravely disabled minor" means a minor who, as a result of a behavioral health disorder, (a) is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.

(27) "Habilitative services" means those services provided by program personnel to assist minors in acquiring and maintaining life skills and in raising their levels of physical, behavioral, social, and vocational functioning. Habilitative services include education, training for employment, and therapy.

(28) "Hearing" means any proceeding conducted in open court that conforms to the requirements of RCW 71.34.910.

(29) "History of one or more violent acts" refers to the period of time five years prior to the filing of a petition under this chapter, excluding any time spent, but not any violent acts committed, in a mental health facility, a long-term substance use disorder treatment facility, or in confinement as a result of a criminal conviction.

(30) "Individualized service plan" means a plan prepared by a developmental disabilities professional with other professionals as a team, for a person with developmental disabilities, which states:

(a) The nature of the person's specific problems, prior charged criminal behavior, and habilitation needs;

(b) The conditions and strategies necessary to achieve the purposes of habilitation;

(c) The intermediate and long-range goals of the habilitation program, with a projected timetable for the attainment;

(d) The rationale for using this plan of habilitation to achieve those intermediate and long-range goals;

(e) The staff responsible for carrying out the plan;

(f) Where relevant in light of past criminal behavior and due consideration for public safety, the criteria for proposed movement to less-restrictive settings, criteria for proposed eventual discharge or release, and a projected possible date for discharge or release; and

(g) The type of residence immediately anticipated for the person and possible future types of residences.

(31)(a) "Inpatient treatment" means twenty-four-hour-per-day mental health care provided within a general hospital, psychiatric hospital, residential treatment facility licensed or certified by the department of health as an evaluation and treatment facility for minors, secure withdrawal management and stabilization facility for minors, or approved substance use disorder treatment program for minors.

(b) For purposes of family-initiated treatment under RCW 71.34.600 through 71.34.670, "inpatient treatment" has the meaning included in (a) of this subsection and any other

residential treatment facility licensed under chapter 71.12 RCW.

(32) "Intoxicated minor" means a minor whose mental or physical functioning is substantially impaired as a result of the use of alcohol or other psychoactive chemicals.

(33) "Judicial commitment" means a commitment by a court pursuant to the provisions of this chapter.

(34) "Kinship caregiver" has the same meaning as in RCW 74.13.031(19)(a).

(35) "Legal counsel" means attorneys and staff employed by county prosecutor offices or the state attorney general acting in their capacity as legal representatives of public behavioral health service providers under RCW 71.05.130.

(36) "Less restrictive alternative" or "less restrictive setting" means outpatient treatment provided to a minor as a program of individualized treatment in a less restrictive setting than inpatient treatment that includes the services described in RCW 71.34.755, including residential treatment.

(37) "Licensed physician" means a person licensed to practice medicine or osteopathic medicine and surgery in the state of Washington.

(38) "Likelihood of serious harm" means:

(a) A substantial risk that: (i) Physical harm will be inflicted by a minor upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by a minor upon another individual, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or (iii) physical harm will be inflicted by a minor upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or

(b) The minor has threatened the physical safety of another and has a history of one or more violent acts.

(39) "Managed care organization" has the same meaning as provided in RCW 71.24.025.

(40) "Medical clearance" means a physician or other health care provider has determined that a person is medically stable and ready for referral to the designated crisis responder.

(41) "Medical necessity" for inpatient care means a requested service which is reasonably calculated to: (a) Diagnose, correct, cure, or alleviate a mental disorder or substance use disorder; or (b) prevent the progression of a mental disorder or substance use disorder that endangers life or causes suffering and pain, or results in illness or infirmity or threatens to cause or aggravate a disability, or causes physical deformity or malfunction, and there is no adequate less restrictive alternative available.

(42) "Mental disorder" means any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions. The presence of alcohol abuse, drug abuse, juvenile criminal history, antisocial behavior, or intellectual disabilities alone is insufficient to justify a finding of "mental disorder" within the meaning of this section.

(43) "Mental health professional" means a psychiatrist, psychiatric advanced registered nurse practitioner, physician assistant working with a supervising psychiatrist, psychologist, psychiatric nurse, social worker, and such other mental health professionals as defined by rules adopted by the secretary of the department of health under this chapter.

(44) "Minor" means any person under the age of eighteen years.

(45) "Outpatient treatment" means any of the nonresidential services mandated under chapter 71.24 RCW and provided by licensed or certified behavioral health agencies as identified by RCW 71.24.025.

(46)(a) "Parent" has the same meaning as defined in RCW 26.26A.010, including either parent if custody is shared under a joint custody agreement, or a person or agency judicially appointed as legal guardian or custodian of the child.

(b) For purposes of family-initiated treatment under RCW 71.34.600 through 71.34.670, "parent" also includes a person to whom a parent defined in (a) of this subsection has given a signed authorization to make health care decisions for the adolescent, a stepparent who is involved in caring for the adolescent, a kinship caregiver who is involved in caring for the adolescent, or another relative who is responsible for the health care of the adolescent, who may be required to provide a declaration under penalty of perjury stating that he or she is a relative responsible for the health care of the adolescent pursuant to chapter 5.50 RCW. If a dispute arises between individuals authorized to act as a parent for the purpose of RCW 71.34.600 through 71.34.670, the disagreement must be resolved according to the priority established under RCW 7.70.065(2)(a).

(47) "Peace officer" means a law enforcement official of a public agency or governmental unit, and includes persons specifically given peace officer powers by any state law, local ordinance, or judicial order of appointment.

(48) "Physician assistant" means a person licensed as a physician assistant under chapter 18.71A RCW.

(49) "Private agency" means any person, partnership, corporation, or association that is not a public agency, whether or not financed in whole or in part by public funds, that constitutes an evaluation and treatment facility or private institution, or hospital, or approved substance use disorder treatment program, that is conducted for, or includes a distinct unit, floor, or ward conducted for, the care and treatment of persons with mental illness, substance use disorders, or both mental illness and substance use disorders.

(50) "Professional person in charge" or "professional person" means a physician, other mental health professional, or other person empowered by an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program with authority to make admission and discharge decisions on behalf of that facility.

(51) "Psychiatric nurse" means a registered nurse who has experience in the direct treatment of persons who have a mental illness or who are emotionally disturbed, such experience gained under the supervision of a mental health professional.

(52) "Psychiatrist" means a person having a license as a physician in this state who has completed residency training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and is board eligible or board certified in psychiatry.

(53) "Psychologist" means a person licensed as a psychologist under chapter 18.83 RCW.

(54) "Public agency" means any evaluation and treatment facility or institution, or hospital, or approved substance use disorder treatment program that is conducted for, or includes a distinct unit, floor, or ward conducted for, the care and treatment of persons with mental illness, substance use disorders, or both mental illness and substance use disorders if the agency is operated directly by federal, state, county, or municipal government, or a combination of such governments.

(55) "Release" means legal termination of the commitment under the provisions of this chapter.

(56) "Resource management services" has the meaning given in chapter 71.24 RCW.

(57) "Responsible other" means the minor, the minor's parent or estate, or any other person legally responsible for support of the minor.

(58) "Secretary" means the secretary of the department or secretary's designee.

(59) "Secure withdrawal management and stabilization facility" means a facility operated by either a public or private agency or by the program of an agency which provides care to voluntary individuals and individuals involuntarily detained and committed under this chapter for whom there is a likelihood of serious harm or who are gravely disabled due to the presence of a substance use disorder. Secure withdrawal management and stabilization facilities must:

(a) Provide the following services:

(i) Assessment and treatment, provided by certified substance use disorder professionals or co-occurring disorder specialists;

(ii) Clinical stabilization services;

(iii) Acute or subacute detoxification services for intoxicated individuals; and

(iv) Discharge assistance provided by certified substance use disorder professionals or co-occurring disorder specialists, including facilitating transitions to appropriate voluntary or involuntary inpatient services or to less restrictive alternatives as appropriate for the individual;

(b) Include security measures sufficient to protect the patients, staff, and community; and

(c) Be licensed or certified as such by the department of health.

(60) "Social worker" means a person with a master's or further advanced degree from a social work educational program accredited and approved as provided in RCW 18.320.010.

(61) "Start of initial detention" means the time of arrival of the minor at the first evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program offering inpatient treatment if the minor is being involuntarily detained at the time. With regard to voluntary patients, "start of initial detention" means the time at which the minor gives notice of intent to leave under the provisions of this chapter.

(62) "Store and forward technology" means use of an asynchronous transmission of a person's medical information from a mental health service provider to the designated crisis responder which results in medical diagnosis, consultation, or treatment.

(63) "Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using the substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances.

(64) "Substance use disorder professional" means a person certified as a substance use disorder professional by the department of health under chapter 18.205 RCW.

(65) "Therapeutic court personnel" means the staff of a mental health court or other therapeutic court which has jurisdiction over defendants who are dually diagnosed with mental disorders, including court personnel, probation officers, a court monitor, prosecuting attorney, or defense counsel acting within the scope of therapeutic court duties.

(66) "Treatment records" include registration and all other records concerning persons who are receiving or who at any time have received services for mental illness, which are maintained by the department, the department of health, the authority, behavioral health organizations and their staffs, and by treatment facilities. Treatment records include mental health information contained in a medical bill including but not limited to mental health drugs, a mental health diagnosis, provider name, and dates of service stemming from a medical service. Treatment records do not include notes or records maintained for personal use by a person providing treatment services for the department, the department of health, the authority, behavioral health organizations, or a treatment facility if the notes or records are not available to others.

(67) "Triage facility" means a short-term facility or a portion of a facility licensed or certified by the department of health under RCW 71.24.035, which is designed as a facility to assess and stabilize an individual or determine the need for involuntary commitment of an individual, and must meet department of health residential treatment facility standards. A triage facility may be structured as a voluntary or involuntary placement facility.

(68) "Video" means the delivery of behavioral health services through the use of interactive audio and video technology, permitting real-time communication between a person and a designated crisis responder, for the purpose of evaluation. "Video" does not include the use of audio-only telephone, facsimile, email, or store and forward technology.

(69) "Violent act" means behavior that resulted in homicide, attempted suicide, injury, or substantial loss or damage to property. [2021 c 264 § 26; (2021 c 264 § 25 expired July 1, 2022). Prior: 2020 c 302 § 63; 2020 c 274 § 50; 2020 c 185 § 2; 2020 c 80 § 54; prior: 2019 c 446 § 24; 2019 c 444 § 17; 2019 c 381 § 2; 2019 c 325 § 2001; 2018 c 201 § 5002; prior: 2016 sp.s. c 29 § 254; 2016 c 155 § 17; 2011 c 89 § 16; 2010 c 94 § 20; 2006 c 93 § 2; 1998 c 296 § 8; 1985 c 354 § 2.]

Effective date—2021 c 264 §§ 21 and 26: See note following RCW 71.05.020.

Effective date—2021 c 264 §§ 25, 27, and 31: "Sections 25, 27, and 31 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect immediately [May 12, 2021]." [2021 c 264 § 39.]

Expiration date—2021 c 264 §§ 20 and 25: See note following RCW 71.05.020.

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Short title—2019 c 381: See note following RCW 71.34.500.

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—2011 c 89: See RCW 18.320.005.

Purpose—2010 c 94: See note following RCW 44.04.280.

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

Additional notes found at www.leg.wa.gov

71.34.020 Definitions. ***(Contingent effective date.)*** Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Admission" or "admit" means a decision by a physician, physician assistant, or psychiatric advanced registered nurse practitioner that a minor should be examined or treated as a patient in a hospital.

(2) "Adolescent" means a minor thirteen years of age or older.

(3) "Alcoholism" means a disease, characterized by a dependency on alcoholic beverages, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued, and impairment of health or disruption of social or economic functioning.

(4) "Antipsychotic medications" means that class of drugs primarily used to treat serious manifestations of mental illness associated with thought disorders, which includes, but is not limited to, atypical antipsychotic medications.

(5) "Approved substance use disorder treatment program" means a program for minors with substance use disorders provided by a treatment program licensed or certified by the department of health as meeting standards adopted under chapter 71.24 RCW.

(6) "Attending staff" means any person on the staff of a public or private agency having responsibility for the care and treatment of a minor patient.

(7) "Authority" means the Washington state health care authority.

(8) "Behavioral health administrative services organization" has the same meaning as provided in RCW 71.24.025.

(9) "Behavioral health disorder" means either a mental disorder as defined in this section, a substance use disorder as defined in this section, or a co-occurring mental disorder and substance use disorder.

(10) "Child psychiatrist" means a person having a license as a physician and surgeon in this state, who has had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

(11) "Children's mental health specialist" means:

(a) A mental health professional who has completed a minimum of one hundred actual hours, not quarter or semester hours, of specialized training devoted to the study of child development and the treatment of children; and

(b) A mental health professional who has the equivalent of one year of full-time experience in the treatment of children under the supervision of a children's mental health specialist.

(12) "Commitment" means a determination by a judge or court commissioner, made after a commitment hearing, that the minor is in need of inpatient diagnosis, evaluation, or treatment or that the minor is in need of less restrictive alternative treatment.

(13) "Conditional release" means a revocable modification of a commitment, which may be revoked upon violation of any of its terms.

(14) "Co-occurring disorder specialist" means an individual possessing an enhancement granted by the department of health under chapter 18.205 RCW that certifies the individual to provide substance use disorder counseling subject to the practice limitations under RCW 18.205.105.

(15) "Crisis stabilization unit" means a short-term facility or a portion of a facility licensed or certified by the department of health under RCW 71.24.035, such as a residential treatment facility or a hospital, which has been designed to assess, diagnose, and treat individuals experiencing an acute crisis without the use of long-term hospitalization.

(16) "Custody" means involuntary detention under the provisions of this chapter or chapter 10.77 RCW, uninterrupted by any period of unconditional release from commitment from a facility providing involuntary care and treatment.

(17) "Department" means the department of social and health services.

(18) "Designated crisis responder" has the same meaning as provided in RCW 71.05.020.

(19) "Detention" or "detain" means the lawful confinement of a person, under the provisions of this chapter.

(20) "Developmental disabilities professional" means a person who has specialized training and three years of experience in directly treating or working with persons with developmental disabilities and is a psychiatrist, physician assistant working with a supervising psychiatrist, psychologist, psychiatric advanced registered nurse practitioner, or social worker, and such other developmental disabilities professionals as may be defined by rules adopted by the secretary of the department.

(21) "Developmental disability" has the same meaning as defined in RCW 71A.10.020.

(22) "Director" means the director of the authority.

(23) "Discharge" means the termination of hospital medical authority. The commitment may remain in place, be terminated, or be amended by court order.

(24) "Evaluation and treatment facility" means a public or private facility or unit that is licensed or certified by the department of health to provide emergency, inpatient, residential, or outpatient mental health evaluation and treatment services for minors. A physically separate and separately operated portion of a state hospital may be designated as an evaluation and treatment facility for minors. A facility which is part of or operated by the state or federal agency does not require licensure or certification. No correctional institution or facility, juvenile court detention facility, or jail may be an evaluation and treatment facility within the meaning of this chapter.

(25) "Evaluation and treatment program" means the total system of services and facilities coordinated and approved by

a county or combination of counties for the evaluation and treatment of minors under this chapter.

(26) "Gravely disabled minor" means a minor who, as a result of a behavioral health disorder, (a) is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety, or (b) manifests severe deterioration from safe behavior evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.

(27) "Habilitative services" means those services provided by program personnel to assist minors in acquiring and maintaining life skills and in raising their levels of physical, behavioral, social, and vocational functioning. Habilitative services include education, training for employment, and therapy.

(28) "Hearing" means any proceeding conducted in open court that conforms to the requirements of RCW 71.34.910.

(29) "History of one or more violent acts" refers to the period of time five years prior to the filing of a petition under this chapter, excluding any time spent, but not any violent acts committed, in a mental health facility, a long-term substance use disorder treatment facility, or in confinement as a result of a criminal conviction.

(30) "Individualized service plan" means a plan prepared by a developmental disabilities professional with other professionals as a team, for a person with developmental disabilities, which states:

(a) The nature of the person's specific problems, prior charged criminal behavior, and habilitation needs;

(b) The conditions and strategies necessary to achieve the purposes of habilitation;

(c) The intermediate and long-range goals of the habilitation program, with a projected timetable for the attainment;

(d) The rationale for using this plan of habilitation to achieve those intermediate and long-range goals;

(e) The staff responsible for carrying out the plan;

(f) Where relevant in light of past criminal behavior and due consideration for public safety, the criteria for proposed movement to less-restrictive settings, criteria for proposed eventual discharge or release, and a projected possible date for discharge or release; and

(g) The type of residence immediately anticipated for the person and possible future types of residences.

(31)(a) "Inpatient treatment" means twenty-four-hour-per-day mental health care provided within a general hospital, psychiatric hospital, residential treatment facility licensed or certified by the department of health as an evaluation and treatment facility for minors, secure withdrawal management and stabilization facility for minors, or approved substance use disorder treatment program for minors.

(b) For purposes of family-initiated treatment under RCW 71.34.600 through 71.34.670, "inpatient treatment" has the meaning included in (a) of this subsection and any other residential treatment facility licensed under chapter 71.12 RCW.

(32) "Intoxicated minor" means a minor whose mental or physical functioning is substantially impaired as a result of the use of alcohol or other psychoactive chemicals.

(33) "Judicial commitment" means a commitment by a court pursuant to the provisions of this chapter.

(34) "Kinship caregiver" has the same meaning as in RCW 74.13.031(19)(a).

(35) "Legal counsel" means attorneys and staff employed by county prosecutor offices or the state attorney general acting in their capacity as legal representatives of public behavioral health service providers under RCW 71.05.130.

(36) "Less restrictive alternative" or "less restrictive setting" means outpatient treatment provided to a minor as a program of individualized treatment in a less restrictive setting than inpatient treatment that includes the services described in RCW 71.34.755, including residential treatment.

(37) "Licensed physician" means a person licensed to practice medicine or osteopathic medicine and surgery in the state of Washington.

(38) "Likelihood of serious harm" means:

(a) A substantial risk that: (i) Physical harm will be inflicted by a minor upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by a minor upon another individual, as evidenced by behavior which has caused harm, substantial pain, or which places another person or persons in reasonable fear of harm to themselves or others; or (iii) physical harm will be inflicted by a minor upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or

(b) The minor has threatened the physical safety of another and has a history of one or more violent acts.

(39) "Managed care organization" has the same meaning as provided in RCW 71.24.025.

(40) "Medical clearance" means a physician or other health care provider has determined that a person is medically stable and ready for referral to the designated crisis responder.

(41) "Medical necessity" for inpatient care means a requested service which is reasonably calculated to: (a) Diagnose, correct, cure, or alleviate a mental disorder or substance use disorder; or (b) prevent the progression of a mental disorder or substance use disorder that endangers life or causes suffering and pain, or results in illness or infirmity or threatens to cause or aggravate a disability, or causes physical deformity or malfunction, and there is no adequate less restrictive alternative available.

(42) "Mental disorder" means any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions. The presence of alcohol abuse, drug abuse, juvenile criminal history, antisocial behavior, or intellectual disabilities alone is insufficient to justify a finding of "mental disorder" within the meaning of this section.

(43) "Mental health professional" means a psychiatrist, psychiatric advanced registered nurse practitioner, physician assistant working with a supervising psychiatrist, psychologist, psychiatric nurse, social worker, and such other mental health professionals as defined by rules adopted by the secretary of the department of health under this chapter.

(44) "Minor" means any person under the age of eighteen years.

(45) "Outpatient treatment" means any of the nonresidential services mandated under chapter 71.24 RCW and pro-

vided by licensed or certified behavioral health agencies as identified by RCW 71.24.025.

(46)(a) "Parent" has the same meaning as defined in RCW 26.26A.010, including either parent if custody is shared under a joint custody agreement, or a person or agency judicially appointed as legal guardian or custodian of the child.

(b) For purposes of family-initiated treatment under RCW 71.34.600 through 71.34.670, "parent" also includes a person to whom a parent defined in (a) of this subsection has given a signed authorization to make health care decisions for the adolescent, a stepparent who is involved in caring for the adolescent, a kinship caregiver who is involved in caring for the adolescent, or another relative who is responsible for the health care of the adolescent, who may be required to provide a declaration under penalty of perjury stating that he or she is a relative responsible for the health care of the adolescent pursuant to chapter 5.50 RCW. If a dispute arises between individuals authorized to act as a parent for the purpose of RCW 71.34.600 through 71.34.670, the disagreement must be resolved according to the priority established under RCW 7.70.065(2)(a).

(47) "Peace officer" means a law enforcement official of a public agency or governmental unit, and includes persons specifically given peace officer powers by any state law, local ordinance, or judicial order of appointment.

(48) "Physician assistant" means a person licensed as a physician assistant under chapter 18.71A RCW.

(49) "Private agency" means any person, partnership, corporation, or association that is not a public agency, whether or not financed in whole or in part by public funds, that constitutes an evaluation and treatment facility or private institution, or hospital, or approved substance use disorder treatment program, that is conducted for, or includes a distinct unit, floor, or ward conducted for, the care and treatment of persons with mental illness, substance use disorders, or both mental illness and substance use disorders.

(50) "Professional person in charge" or "professional person" means a physician, other mental health professional, or other person empowered by an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program with authority to make admission and discharge decisions on behalf of that facility.

(51) "Psychiatric nurse" means a registered nurse who has experience in the direct treatment of persons who have a mental illness or who are emotionally disturbed, such experience gained under the supervision of a mental health professional.

(52) "Psychiatrist" means a person having a license as a physician in this state who has completed residency training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and is board eligible or board certified in psychiatry.

(53) "Psychologist" means a person licensed as a psychologist under chapter 18.83 RCW.

(54) "Public agency" means any evaluation and treatment facility or institution, or hospital, or approved substance use disorder treatment program that is conducted for, or includes a distinct unit, floor, or ward conducted for, the care and treatment of persons with mental illness, substance use disorders, or both mental illness and substance use disorders if the agency is operated directly by federal, state, county, or municipal government, or a combination of such governments.

(55) "Release" means legal termination of the commitment under the provisions of this chapter.

(56) "Resource management services" has the meaning given in chapter 71.24 RCW.

(57) "Responsible other" means the minor, the minor's parent or estate, or any other person legally responsible for support of the minor.

(58) "Secretary" means the secretary of the department or secretary's designee.

(59) "Secure withdrawal management and stabilization facility" means a facility operated by either a public or private agency or by the program of an agency which provides care to voluntary individuals and individuals involuntarily detained and committed under this chapter for whom there is a likelihood of serious harm or who are gravely disabled due to the presence of a substance use disorder. Secure withdrawal management and stabilization facilities must:

(a) Provide the following services:

(i) Assessment and treatment, provided by certified substance use disorder professionals or co-occurring disorder specialists;

(ii) Clinical stabilization services;

(iii) Acute or subacute detoxification services for intoxicated individuals; and

(iv) Discharge assistance provided by certified substance use disorder professionals or co-occurring disorder specialists, including facilitating transitions to appropriate voluntary or involuntary inpatient services or to less restrictive alternatives as appropriate for the individual;

(b) Include security measures sufficient to protect the patients, staff, and community; and

(c) Be licensed or certified as such by the department of health.

(60) "Severe deterioration from safe behavior" means that a person will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior.

(61) "Social worker" means a person with a master's or further advanced degree from a social work educational program accredited and approved as provided in RCW 18.320.010.

(62) "Start of initial detention" means the time of arrival of the minor at the first evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program offering inpatient treatment if the minor is being involuntarily detained at the time. With regard to voluntary patients, "start of initial detention" means the time at which the minor gives notice of intent to leave under the provisions of this chapter.

(63) "Store and forward technology" means use of an asynchronous transmission of a person's medical information from a mental health service provider to the designated crisis responder which results in medical diagnosis, consultation, or treatment.

(64) "Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating that

an individual continues using the substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances.

(65) "Substance use disorder professional" means a person certified as a substance use disorder professional by the department of health under chapter 18.205 RCW.

(66) "Therapeutic court personnel" means the staff of a mental health court or other therapeutic court which has jurisdiction over defendants who are dually diagnosed with mental disorders, including court personnel, probation officers, a court monitor, prosecuting attorney, or defense counsel acting within the scope of therapeutic court duties.

(67) "Treatment records" include registration and all other records concerning persons who are receiving or who at any time have received services for mental illness, which are maintained by the department, the department of health, the authority, behavioral health organizations and their staffs, and by treatment facilities. Treatment records include mental health information contained in a medical bill including but not limited to mental health drugs, a mental health diagnosis, provider name, and dates of service stemming from a medical service. Treatment records do not include notes or records maintained for personal use by a person providing treatment services for the department, the department of health, the authority, behavioral health organizations, or a treatment facility if the notes or records are not available to others.

(68) "Triage facility" means a short-term facility or a portion of a facility licensed or certified by the department of health under RCW 71.24.035, which is designed as a facility to assess and stabilize an individual or determine the need for involuntary commitment of an individual, and must meet department of health residential treatment facility standards. A triage facility may be structured as a voluntary or involuntary placement facility.

(69) "Video" means the delivery of behavioral health services through the use of interactive audio and video technology, permitting real-time communication between a person and a designated crisis responder, for the purpose of evaluation. "Video" does not include the use of audio-only telephone, facsimile, email, or store and forward technology.

(70) "Violent act" means behavior that resulted in homicide, attempted suicide, injury, or substantial loss or damage to property. [2021 c 264 § 28; 2021 c 264 § 27. Prior: 2020 c 302 § 64; 2020 c 302 § 63; 2020 c 274 § 50; 2020 c 185 § 2; 2020 c 80 § 54; prior: 2019 c 446 § 24; 2019 c 444 § 17; 2019 c 381 § 2; 2019 c 325 § 2001; 2018 c 201 § 5002; prior: 2016 sp.s. c 29 § 254; 2016 c 155 § 17; 2011 c 89 § 16; 2010 c 94 § 20; 2006 c 93 § 2; 1998 c 296 § 8; 1985 c 354 § 2.]

Contingent effective date—2021 c 264 §§ 27 and 28; 2020 c 302 §§ 64 and 81: "(1) Sections 64 and 81, chapter 302, Laws of 2020 and, until July 1, 2022, section 27, chapter 264, Laws of 2021 and, beginning July 1, 2022, section 28, chapter 264, Laws of 2021 take effect when the average wait time for children's long-term inpatient placement admission is 30 days or less for two consecutive quarters.

(2) The health care authority must provide written notice of the effective date of sections 64 and 81, chapter 302, Laws of 2020 and sections 27 and 28, chapter 264, Laws of 2021 to affected parties, the chief clerk of the house of representatives, the secretary of the senate, the office of the code reviser, and others as deemed appropriate by the authority." [2021 c 264 § 29; 2020 c 302 § 111.]

Effective date—2021 c 264 §§ 25, 27, and 31: "Sections 25, 27, and 31 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect immediately [May 12, 2021]." [2021 c 264 § 39.]

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Short title—2019 c 381: See note following RCW 71.34.500.

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—2011 c 89: See RCW 18.320.005.

Purpose—2010 c 94: See note following RCW 44.04.280.

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

Additional notes found at www.leg.wa.gov

GENERAL

71.34.300 Evaluation and treatment program for minors—Authority's responsibility. The authority is responsible for development and coordination of the evaluation and treatment program for minors and for coordination of evaluation and treatment services and resources with the community behavioral health program required under chapter 71.24 RCW. [2019 c 325 § 2002; 2018 c 201 § 5003; 2011 c 343 § 7; 1985 c 354 § 14. Formerly RCW 71.34.140.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Intent—Effective date—2011 c 343: See notes following RCW 71.05.730.

71.34.305 Notice to parents, school contacts for referring students to inpatient treatment. School district personnel who contact a behavioral health disorder inpatient treatment program or provider for the purpose of referring a student to inpatient treatment shall provide the parents with notice of the contact within forty-eight hours. [2020 c 302 § 65; 2016 sp.s. c 29 § 255; 1996 c 133 § 6. Formerly RCW 71.34.032.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Short title—Intent—Construction—1996 c 133: See notes following RCW 13.32A.197.

71.34.310 Jurisdiction over proceedings under chapter—Venue. (1) The superior court has jurisdiction over proceedings under this chapter.

(2) A record of all petitions and proceedings under this chapter shall be maintained by the clerk of the superior court in the county in which the petition or proceedings was initiated.

(3) Petitions for commitment shall be filed and venue for hearings under this chapter shall be in the county in which the minor is being detained. [2020 c 302 § 66; 1985 c 354 § 26. Formerly RCW 71.34.250.]

71.34.315 Mental health commissioners—Authority. The judges of the superior court of the county by majority

vote may authorize mental health commissioners, appointed pursuant to RCW 71.05.135, to perform any or all of the following duties:

(1) Receive all applications, petitions, and proceedings filed in the superior court for the purpose of disposing of them pursuant to this chapter or RCW 10.77.094;

(2) Investigate the facts upon which to base warrants, subpoenas, orders to directions in actions, or proceedings filed pursuant to this chapter or RCW 10.77.094;

(3) For the purpose of this chapter, exercise all powers and perform all the duties of a court commissioner appointed pursuant to RCW 2.24.010;

(4) Hold hearings in proceedings under this chapter or RCW 10.77.094 and make written reports of all proceedings under this chapter or RCW 10.77.094 which shall become a part of the record of superior court;

(5) Provide such supervision in connection with the exercise of its jurisdiction as may be ordered by the presiding judge; and

(6) Cause the orders and findings to be entered in the same manner as orders and findings are entered in cases in the superior court. [2013 c 27 § 2; 1989 c 174 § 3. Formerly RCW 71.34.280.]

Additional notes found at www.leg.wa.gov

71.34.320 Transfer of superior court proceedings to juvenile department. For purposes of this chapter, a superior court may transfer proceedings under this chapter to its juvenile department. [1985 c 354 § 28. Formerly RCW 71.34.260.]

71.34.325 Court proceedings under chapter subject to rules of state supreme court. Court procedures and proceedings provided for in this chapter shall be in accordance with rules adopted by the supreme court of the state of Washington. [1985 c 354 § 24. Formerly RCW 71.34.240.]

71.34.330 Attorneys appointed for minors—Compensation. Attorneys appointed for minors under this chapter shall be compensated for their services as follows:

(1) Responsible others shall bear the costs of such legal services if financially able according to standards set by the court of the county in which the proceeding is held.

(2) If all responsible others are indigent as determined by these standards, the behavioral health administrative services organization shall reimburse the county in which the proceeding is held for the direct costs of such legal services, as provided in RCW 71.05.730. [2019 c 325 § 2003; 2014 c 225 § 89; 2011 c 343 § 8; 1985 c 354 § 23. Formerly RCW 71.34.230.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective date—2014 c 225: See note following RCW 71.24.016.

Intent—Effective date—2011 c 343: See notes following RCW 71.05.730.

71.34.335 Court records and files confidential—Availability. The records and files maintained in any court proceeding under this chapter are confidential and available only to the minor, the minor's parent, and the minor's attorney. In addition, the court may order the subsequent release or use of these records or files only upon good cause shown if the court finds that appropriate safeguards for strict confidentiality will be maintained. [1985 c 354 § 21. Formerly RCW 71.34.210.]

71.34.351 Delivery of minor to treatment facilities. A peace officer may take or authorize a minor to be taken into custody and immediately delivered to an appropriate triage facility, crisis stabilization unit, evaluation and treatment facility, secure withdrawal management and stabilization facility, approved substance use disorder treatment program, or the emergency department of a local hospital when he or she has reasonable cause to believe that such minor is suffering from a behavioral health disorder and presents an imminent likelihood of serious harm or is gravely disabled. Until July 1, 2026, a peace officer's delivery of a minor to a secure withdrawal management and stabilization facility or approved substance use disorder treatment program is subject to the availability of a secure withdrawal management and stabilization facility or approved substance use disorder treatment program with adequate space for the minor. [2020 c 302 § 67.]

71.34.355 Rights of minors undergoing treatment—Posting—Waiver—Presumption of incompetency. (1) Absent a risk to self or others, minors treated under this chapter have the following rights, which shall be prominently posted in the evaluation and treatment facility:

(a) To wear their own clothes and to keep and use personal possessions;

(b) To keep and be allowed to spend a reasonable sum of their own money for canteen expenses and small purchases;

(c) To have individual storage space for private use;

(d) To have visitors at reasonable times;

(e) To have reasonable access to a telephone, both to make and receive confidential calls;

(f) To have ready access to letter-writing materials, including stamps, and to send and receive uncensored correspondence through the mails;

(g) To discuss treatment plans and decisions with mental health professionals;

(h) To have the right to adequate care and individualized treatment;

(i) To not be denied access to treatment by spiritual means through prayer in accordance with the tenets and practices of a church or religious denomination in addition to the treatment otherwise proposed;

(j) Not to consent to the administration of antipsychotic medications beyond the hearing conducted pursuant to RCW 71.34.750 or the performance of electroconvulsive treatment or surgery, except emergency lifesaving surgery, upon him or her, unless ordered by a court under procedures described in RCW 71.05.217(1)(j). The minor's parent may exercise this right on the minor's behalf, and must be informed of any impending treatment;

(k) Not to have psychosurgery performed on him or her under any circumstances.

(2)(a) Privileges between minors and physicians, physician assistants, psychologists, or psychiatric advanced registered nurse practitioners are deemed waived in proceedings under this chapter relating to the administration of antipsychotic medications. As to other proceedings under this chap-

ter, the privileges are waived when a court of competent jurisdiction in its discretion determines that such waiver is necessary to protect either the detained minor or the public.

(b) The waiver of a privilege under this section is limited to records or testimony relevant to evaluation of the detained minor for purposes of a proceeding under this chapter. Upon motion by the detained minor or on its own motion, the court shall examine a record or testimony sought by a petitioner to determine whether it is within the scope of the waiver.

(c) The record maker may not be required to testify in order to introduce medical or psychological records of the detained minor so long as the requirements of RCW 5.45.020 are met except that portions of the record which contain opinions as to the detained minor's mental state must be deleted from such records unless the person making such conclusions is available for cross-examination.

(3) No minor may be presumed incompetent as a consequence of receiving an evaluation or voluntary or involuntary treatment for a mental disorder or substance use disorder, under this chapter or any prior laws of this state dealing with mental illness or substance use disorders. [2020 c 302 § 68; 2016 c 155 § 18; 2009 c 217 § 15; 1985 c 354 § 16. Formerly RCW 71.34.160.]

71.34.356 Possessions of minors undergoing treatment. At the time a minor is involuntarily admitted to an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program, the professional person in charge or his or her designee shall take reasonable precautions to inventory and safeguard the personal property of the detained minor. A copy of the inventory, signed by the staff member making it, must be given to the detained minor and must, in addition, be open to inspection to any responsible relative, subject to limitations, if any, specifically imposed by the detained minor. For purposes of this section, "responsible relative" includes the guardian, conservator, attorney, parent, or adult brother or sister of the minor. The facility shall not disclose the contents of the inventory to any other person without the consent of the minor or order of the court. [2020 c 302 § 69.]

71.34.360 No detention of minors after eighteenth birthday—Exceptions. No minor received as a voluntary patient or committed under this chapter may be detained after his or her eighteenth birthday unless the person, upon reaching eighteen years of age, has applied for admission to an appropriate evaluation and treatment facility or unless involuntary commitment proceedings under chapter 71.05 RCW have been initiated: PROVIDED, That a minor may be detained after his or her eighteenth birthday for purposes of completing the fourteen-day diagnosis, evaluation, and treatment. [1985 c 354 § 20. Formerly RCW 71.34.190.]

71.34.365 Release of minor—Requirements. (1) If a minor is not accepted for admission or is released by an inpatient evaluation and treatment facility, the facility shall release the minor to the custody of the minor's parent or other responsible person. If not otherwise available, the facility shall furnish transportation for the minor to the minor's residence or other appropriate place. If the minor has been arrested, the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program shall detain the minor for not more than eight hours at the request of the peace officer. The program or facility shall make reasonable attempts to contact the requesting peace officer during this time to inform the peace officer that the minor is not approved for admission or is being released in order to enable a peace officer to return to the facility and take the minor back into custody.

(2) If the minor is released to someone other than the minor's parent, the facility shall make every effort to notify the minor's parent of the release as soon as possible.

(3) No indigent minor may be released to less restrictive alternative treatment or setting or discharged from inpatient treatment without suitable clothing, and the authority shall furnish this clothing. As funds are available, the director may provide necessary funds for the immediate welfare of indigent minors upon discharge or release to less restrictive alternative treatment. [2020 c 302 § 70; 2018 c 201 § 5004; 1985 c 354 § 17. Formerly RCW 71.34.170.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.34.375 Family-initiated treatment—Notice to parents of available treatment options. (1) If a parent or guardian, for the purpose of mental health treatment, substance use disorder treatment, or evaluation, brings his or her minor child to an evaluation and treatment facility, a hospital emergency room, an inpatient facility licensed under chapter 72.23 RCW, an inpatient facility licensed under chapter 70.41 or 71.12 RCW operating inpatient psychiatric beds for minors, a secure withdrawal management and stabilization facility, or an approved substance use disorder treatment program, the facility is required to promptly provide written and verbal notice of all statutorily available treatment options contained in this chapter. The notice need not be given more than once if written and verbal notice has already been provided and documented by the facility.

(2) The provision of notice must be documented by the facilities required to give notice under subsection (1) of this section and must be accompanied by a signed acknowledgment of receipt by the parent or guardian. The notice must contain the following information:

(a) All current statutorily available treatment options including but not limited to those provided in this chapter; and

(b) The procedures to be followed to utilize the treatment options described in this chapter.

(3) The department of health shall produce, and make available, the written notification that must include, at a minimum, the information contained in subsection (2) of this section. The department of health must revise the written notification as necessary to reflect changes in the law. [2019 c 446 § 25; 2018 c 201 § 5005; 2016 sp.s. c 29 § 256; 2011 c 302 § 1; 2003 c 107 § 1. Formerly RCW 71.34.056.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.34.377 Failure to notify parent or guardian of treatment options—Civil penalty. An evaluation and treatment facility that fails to comply with the requirement to provide verbal and written notice to a parent or guardian of a child under RCW 71.34.375 is subject to a civil penalty of one thousand dollars for each failure to provide adequate notice, unless the evaluation and treatment facility is a hospital licensed under chapter 70.41 RCW or a psychiatric hospital licensed under chapter 71.12 RCW in which case the department of health may enforce the notice requirements using its existing enforcement authority provided in chapters 70.41 and 71.12 RCW. [2011 c 302 § 2.]

71.34.379 Notice to parent or guardian—Treatment options—Policy and protocol adoption—Report. Facilities licensed under chapter 70.41, 71.12, or 72.23 RCW are required to adopt policies and protocols regarding the notice requirements described in RCW 71.34.375. [2019 c 325 § 2004; 2011 c 302 § 5.]

Effective date—2019 c 325: See note following RCW 71.24.011.

71.34.380 Department, department of health, and authority to adopt rules to effectuate chapter. (1) The department, department of health, and the authority shall adopt such rules pursuant to chapter 34.05 RCW as may be necessary to effectuate the intent and purposes of this chapter.

(2) The authority shall evaluate the quality, effectiveness, efficiency, and use of services, procedures and standards for commitment, and establish criteria and procedures for placement and transfer of committed minors.

(3) The department of health shall regulate the evaluation and treatment facilities and programs.

(4) The department shall operate and maintain the child study and treatment center. [2018 c 201 § 5006; 1985 c 354 § 25. Formerly RCW 71.34.800.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.34.385 Uniform application of chapter—Training for designated crisis responders. The authority shall ensure that the provisions of this chapter are applied in a consistent and uniform manner. The authority shall also ensure that, to the extent possible within available funds, the designated crisis responders are specifically trained in adolescent mental health issues, the mental health and substance use disorder civil commitment laws, and the criteria for civil commitment. [2019 c 325 § 2005; 2018 c 201 § 5007; 2016 sp.s. c 29 § 257; 1992 c 205 § 304. Formerly RCW 71.34.805.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.34.387 Online training for behavioral health providers—State law and best practices when providing behavioral health services to children, youth, and families. Subject to the availability of amounts appropriated for this specific purpose, the authority must provide an online training for behavioral health providers regarding state law and best practices when providing behavioral health services to children, youth, and families. The training must be free for providers and must include information related to family-initiated treatment, adolescent-initiated treatment, other treatment services provided under this chapter, and standards for sharing of information about behavioral health services received by an adolescent under RCW 70.02.240 and 70.02.265. [2019 c 381 § 23.]

Short title—2019 c 381: See note following RCW 71.34.500.

71.34.3871 Stakeholder engagement efforts to measure impacts of the adolescent behavioral health care access act (2019 c 381)—Reports to governor and legislature. ***(Expires December 31, 2024.)*** (1) Subject to the availability of amounts appropriated for this specific purpose, the authority must conduct stakeholder engagement efforts with parents, youth, and behavioral health providers to measure the impacts of implementing policies resulting from chapter 381, Laws of 2019 during the first three years of implementation and RCW 71.34.915 and 71.34.918. The stakeholder engagement efforts required under this subsection must include live events soliciting feedback from stakeholders and alternative methods for stakeholders to submit feedback. The first stakeholder engagement efforts must be complete by October 1, 2022, followed by subsequent annual stakeholder engagement efforts completed by July 1, 2023, and by July 1, 2024. The authority must report on the results of the stakeholder engagement efforts annually to the governor and the legislature beginning November 1, 2022. The final report is due November 1, 2024, and must include any recommendations for statutory changes identified as needed based on stakeholder engagement efforts results.

(2) This section expires December 31, 2024. [2022 c 134 § 3; 2019 c 381 § 24.]

Short title—2019 c 381: See note following RCW 71.34.500.

71.34.390 Redirection of Title XIX funds to fund placements within the state. For the purpose of encouraging the expansion of existing evaluation and treatment facilities and the creation of new facilities, the authority shall endeavor to redirect federal Title XIX funds which are expended on out-of-state placements to fund placements within the state. [2018 c 201 § 5008; 1992 c 205 § 303. Formerly RCW 71.34.810.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Additional notes found at www.leg.wa.gov

71.34.395 Availability of treatment does not create right to obtain public funds. The ability of a parent to bring his or her minor child to a licensed or certified evaluation and treatment program for evaluation and treatment does not create a right to obtain or benefit from any funds or resources of the state. The state may provide services for indigent minors to the extent that funds are available. [2018 c 201 § 5009; 1998 c 296 § 21. Formerly RCW 71.34.015.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

71.34.400 Eligibility for medical assistance under chapter 74.09 RCW—Payment by authority. For purposes of eligibility for medical assistance under chapter 74.09 RCW, minors in inpatient mental health or inpatient substance use disorder treatment shall be considered to be part of their parent's or legal guardian's household, unless the minor has been assessed by the authority or its designee as likely to require such treatment for at least ninety consecutive days, or is in out-of-home care in accordance with chapter 13.34 RCW, or the parents are found to not be exercising responsibility for care and control of the minor. Payment for such care by the authority shall be made only in accordance with rules, guidelines, and clinical criteria applicable to inpatient treatment of minors established by the authority. [2018 c 201 § 5010; 2016 sp.s. c 29 § 258; 1998 c 296 § 11. Formerly RCW 71.34.027.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

71.34.405 Liability for costs of minor's treatment and care—Rules. (1) A minor receiving treatment under the provisions of this chapter and responsible others shall be liable for the costs of treatment, care, and transportation to the extent of available resources and ability to pay.

(2) The secretary or director, as appropriate, shall establish rules to implement this section and to define income, resources, and exemptions to determine the responsible person's or persons' ability to pay. [2018 c 201 § 5011; 1985 c 354 § 13. Formerly RCW 71.34.130.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.34.406 Liability of costs of minor's treatment—Involuntary detention—Rules. In addition to the responsibility provided for by RCW 43.20B.330, the parents of a minor person who is involuntarily detained pursuant to this chapter for the purpose of treatment and evaluation outside of a facility maintained and operated by the department shall be responsible for the cost of such care and treatment. In the event that an individual is unable to pay for such treatment or in the event payment would result in a substantial hardship upon the individual or his or her family, then the county of residence of such person shall be responsible for such costs. If it is not possible to determine the county of residence of the person, the cost shall be borne by the county where the person was originally detained. The department, or the authority, as appropriate, shall, pursuant to chapter 34.05 RCW, adopt standards as to (1) inability to pay in whole or in part, (2) a definition of substantial hardship, and (3) appropriate payment schedules. Financial responsibility with respect to services and facilities of the department shall continue to be as provided in RCW 43.20B.320 through 43.20B.360 and 43.20B.370. [2020 c 302 § 102.]

71.34.410 Liability for performance of duties under this chapter limited. (1) No public or private agency or governmental entity, nor officer of a public or private agency, nor the superintendent, or professional person in charge, his or her professional designee or attending staff of any such agency, nor any public official performing functions necessary to the administration of this chapter, nor peace officer responsible for detaining a minor under this chapter, nor any designated crisis responder, nor professional person, nor evaluation and treatment facility, nor secure withdrawal management and stabilization facility, nor approved substance use disorder treatment program shall be civilly or criminally liable for performing actions authorized in this chapter with regard to the decision of whether to admit, release, administer antipsychotic medications, or detain a minor for evaluation and treatment: PROVIDED, That such duties were performed in good faith and without gross negligence.

(2) This section does not relieve a person from giving the required duty to warn or to take reasonable precautions to provide protection from violent behavior where the minor has communicated an actual threat of physical violence against a reasonably identifiable victim or victims. The duty to warn or to take reasonable precautions to provide protection from violent behavior is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel. [2020 c 302 § 71; 2019 c 446 § 27; 2016 sp.s. c 29 § 259; 2005 c 371 § 5; 1985 c 354 § 27. Formerly RCW 71.34.270.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Finding—Intent—Severability—2005 c 371: See notes following RCW 71.34.600.

71.34.415 Judicial services—Civil commitment cases—Reimbursement. A county may apply to its behavioral health administrative services organization for reimbursement of its direct costs in providing judicial services for civil commitment cases under this chapter, as provided in RCW 71.05.730. [2019 c 325 § 2006; 2014 c 225 § 90; 2011 c 343 § 4.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective date—2014 c 225: See note following RCW 71.24.016.

Intent—Effective date—2011 c 343: See notes following RCW 71.05.730.

71.34.420 Evaluation and treatment services—Unavailability—Single bed certification. (1) The authority may use a single bed certification process as outlined in rule to provide additional treatment capacity for a minor suffering from a mental disorder for whom an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program bed is not available. The facility that is the proposed site of the single bed certification must be a facility that is willing and able to provide the person with timely and appropriate treatment either directly or by arrangement with other public or private agencies.

(2) A single bed certification must be specific to the minor receiving treatment.

(3) A designated crisis responder who submits an application for a single bed certification for treatment at a facility that is willing and able to provide timely and appropriate mental health treatment in good faith belief that the single bed certification is appropriate may presume that the single bed certification will be approved for the purpose of completing the detention process and responding to other emergency calls.

(4) The authority may adopt rules implementing this section and continue to enforce rules it has already adopted except where inconsistent with this section. [2020 c 302 § 72; 2018 c 201 § 5012; 2016 sp.s. c 29 § 260; 2015 c 269 § 12.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2015 c 269 §§ 1-9 and 11-13: See note following RCW 71.05.010.

71.34.430 Release of adolescent's mental health information to parent without adolescent's consent. A mental health agency, psychiatric hospital, or evaluation and treatment facility may release mental health information about an adolescent to a parent of the adolescent without the consent of the adolescent by following the limitations and restrictions of RCW 70.02.240 and 70.02.265. [2019 c 381 § 22.]

Short title—2019 c 381: See note following RCW 71.34.500.

71.34.440 Detention of minors—Permission to leave facility. Nothing in this chapter shall prohibit the professional person in charge of a treatment facility, or his or her professional designee, from permitting a minor detained for intensive treatment to leave the facility for prescribed periods during the term of the minor's detention, under such conditions as may be appropriate. [2020 c 302 § 73.]

ADOLESCENT-INITIATED TREATMENT

71.34.500 Self-admission of adolescent for inpatient behavioral health treatment or substance use disorder treatment—Requirements. (1) An adolescent may admit himself or herself to an evaluation and treatment facility for inpatient mental health treatment or an approved substance use disorder treatment program for inpatient substance use disorder treatment without parental consent. The admission shall occur only if the professional person in charge of the facility concurs with the need for inpatient treatment. Parental authorization, or authorization from a person who may consent on behalf of the minor pursuant to RCW 7.70.065, is required for inpatient treatment of a minor under the age of thirteen.

(2) When, in the judgment of the professional person in charge of an evaluation and treatment facility or approved substance use disorder treatment program, there is reason to believe that a minor is in need of inpatient treatment because of a behavioral health disorder, and the facility provides the type of evaluation and treatment needed by the minor, and it is not feasible to treat the minor in any less restrictive setting or the minor's home, the minor may be admitted to the facility.

(3) Written renewal of voluntary consent must be obtained from the applicant no less than once every twelve months. The minor's need for continued inpatient treatments shall be reviewed and documented no less than every one hundred eighty days. [2020 c 302 § 74; 2019 c 381 § 3; 2016 sp.s. c 29 § 261; 2006 c 93 § 3; 2005 c 371 § 2; 1998 c 296 § 14. Formerly RCW 71.34.042.]

Short title—2019 c 381: "This act may be known and cited as the adolescent behavioral health care access act." [2019 c 381 § 25.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Finding—Intent—Severability—2005 c 371: See notes following RCW 71.34.600.

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

71.34.510 Notice to parents of adolescent voluntarily admitted to inpatient treatment—When required—Duties of professional person in charge—Form of notice. (1) The professional person in charge of an evaluation and treatment facility shall provide notice to the parent of an adolescent when the adolescent is voluntarily admitted to inpatient treatment under RCW 71.34.500 solely for mental health treatment and not for substance use disorder treatment, unless the professional person has a compelling reason to believe that such disclosure would be detrimental to the adolescent or contact cannot be made, in which case the professional person must document the reasons in the adolescent's medical record.

(2) The professional person in charge of an evaluation and treatment facility or an approved substance use disorder treatment program shall provide notice to the parent of an adolescent voluntarily admitted to inpatient treatment under RCW 71.34.500 for substance use disorder treatment only if: (a) The adolescent provides written consent to the disclosure of the fact of admission and such other substance use disorder treatment information in the notice; or (b) permitted by federal law.

(3) If the professional person withholds notice to a parent under subsection (1) of this section, or such notice cannot be provided, the professional person in charge of the facility must consult the information that the Washington state patrol makes publicly available under RCW 43.43.510(2) at least once every eight hours for the first seventy-two hours of treatment and once every twenty-four hours thereafter while the adolescent continues to receive inpatient services and until the time that the professional person contacts a parent of the adolescent. If the adolescent is publicly listed as missing, the professional person must immediately notify the department of children, youth, and families of its contact with the youth listed as missing. The notification must include a description of the adolescent's physical and emotional condition.

(4) The notice required under subsections (1) and (2) of this section shall be in the form most likely to reach the parent within twenty-four hours of the adolescent's voluntary admission and shall advise the parent: (a) That the adolescent has been admitted to inpatient treatment; (b) of the location and

telephone number of the facility providing such treatment; (c) of the name of a professional person on the staff of the facility providing treatment who is designated to discuss the adolescent's need for inpatient treatment with the parent; and (d) of the medical necessity for admission. Notification efforts under subsections (1) and (2) of this section shall begin as soon as reasonably practicable, considering the adolescent's immediate medical needs. [2019 c 381 § 4; 1998 c 296 § 15. Formerly RCW 71.34.044.]

Short title—2019 c 381: See note following RCW 71.34.500.

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

71.34.520 Notice of intent to leave inpatient treatment by adolescent voluntarily admitted—Duties of receiving staff member—Time frame for discharge of adolescent. (1) Any adolescent voluntarily admitted to an evaluation and treatment facility or approved substance use disorder treatment program under RCW 71.34.500 may give notice of intent to leave at any time. The notice need not follow any specific form so long as it is written and the intent of the adolescent can be discerned.

(2) The staff member receiving the notice shall date it immediately and record its existence in the adolescent's clinical record.

(a) If the evaluation and treatment facility is providing the adolescent solely with mental health treatment and not substance use disorder treatment, copies of the notice must be sent to the adolescent's attorney, if any, the designated crisis responders, and the parent.

(b) If the evaluation and treatment facility or substance use disorder treatment program is providing the adolescent with substance use disorder treatment, copies of the notice must be sent to the adolescent's attorney, if any, the designated crisis responders, and the parent only if: (i) The adolescent provides written consent to the disclosure of the adolescent's notice of intent to leave and such other substance use disorder information; or (ii) permitted by federal law.

(3) The professional person shall discharge the adolescent from the facility by the second judicial day following receipt of the adolescent's notice of intent to leave. [2019 c 381 § 5; 2016 sp.s. c 29 § 262; 2003 c 106 § 1; 1998 c 296 § 16. Formerly RCW 71.34.046.]

Short title—2019 c 381: See note following RCW 71.34.500.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

71.34.530 Outpatient treatment of adolescent. Any adolescent may request and receive outpatient treatment without the consent of the adolescent's parent. Parental authorization, or authorization from a person who may consent on behalf of the minor pursuant to RCW 7.70.065, is required for outpatient treatment of a minor under the age of thirteen. [2019 c 381 § 6; 2006 c 93 § 4; 1998 c 296 § 12; 1995 c 312 § 52; 1985 c 354 § 3. Formerly RCW 71.34.030.]

Short title—2019 c 381: See note following RCW 71.34.500.

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

Additional notes found at www.leg.wa.gov

FAMILY-INITIATED TREATMENT

71.34.600 Parental request for determination of whether adolescent has a behavioral health disorder requiring inpatient treatment—Adolescent's consent not required for admission, evaluation, and treatment—Duties and obligations of professional person and facility. (1) A parent may bring, or authorize the bringing of, his or her adolescent child to:

(a) An evaluation and treatment facility or an inpatient facility licensed under chapter 70.41, 71.12, or 72.23 RCW and request that the professional person examine the adolescent to determine whether the adolescent has a mental disorder and is in need of inpatient treatment; or

(b) A secure withdrawal management and stabilization facility or approved substance use disorder treatment program and request that a substance use disorder assessment be conducted by a professional person to determine whether the adolescent has a substance use disorder and is in need of inpatient treatment.

(2) The consent of the adolescent is not required for admission, evaluation, and treatment if a parent provides consent.

(3) An appropriately trained professional person may evaluate whether the adolescent has a behavioral health disorder. The evaluation shall be completed within twenty-four hours of the time the adolescent was brought to the facility, unless the professional person determines that the condition of the adolescent necessitates additional time for evaluation. In no event shall an adolescent be held longer than one hundred twenty hours for evaluation. If, in the judgment of the professional person, it is determined it is a medical necessity for the adolescent to receive inpatient treatment, the adolescent may be held for treatment. The facility shall limit treatment to that which the professional person determines is medically necessary to stabilize the adolescent's condition until the evaluation has been completed. Within twenty-four hours of completion of the evaluation, the professional person shall notify the authority if the adolescent is held solely for mental health and not substance use disorder treatment and of the date of admission. If the adolescent is held for substance use disorder treatment only, the professional person shall provide notice to the authority which redacts all patient identifying information about the adolescent unless: (a) The adolescent provides written consent to the disclosure of the fact of admission and such other substance use disorder treatment information in the notice; or (b) permitted by federal law.

(4) No provider is obligated to provide treatment to an adolescent under the provisions of this section except that no provider may refuse to treat an adolescent under the provisions of this section solely on the basis that the adolescent has not consented to the treatment. No provider may admit an adolescent to treatment under this section unless it is medically necessary.

(5) No adolescent receiving inpatient treatment under this section may be discharged from the facility based solely on his or her request.

(6) Prior to the review conducted under RCW 71.34.610, the professional person shall notify the adolescent of his or her right to petition superior court for release from the facility. [2020 c 302 § 76; (2020 c 302 § 75 expired January 1, 2021). Prior: 2019 c 446 § 28; 2019 c 381 § 7; 2018 c 201 § 5013; 2016 sp.s. c 29 § 263; 2007 c 375 § 11; 2005 c 371 § 4; 1998 c 296 § 17. Formerly RCW 71.34.052.]

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Short title—2019 c 381: See note following RCW 71.34.500.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Purpose—Construction—Severability—2007 c 375: See notes following RCW 10.31.110.

Finding—Intent—2005 c 371: "The legislature finds that, despite explicit statements in statute that the consent of a minor child is not required for a parent-initiated admission to inpatient or outpatient mental health treatment, treatment providers consistently refuse to accept a minor aged thirteen or over if the minor does not also consent to treatment. The legislature intends that the parent-initiated treatment provisions, with their accompanying due process provisions for the minor, be made fully available to parents." [2005 c 371 § 1.]

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

Additional notes found at www.leg.wa.gov

71.34.610 Authority's review of medical necessity of inpatient treatment of adolescent admitted to a facility due to parental request—Required considerations in making determination—Procedures for release—At-risk youth petition—Costs—Public funds. (1) The authority shall assure that, for any adolescent admitted to inpatient treatment under RCW 71.34.600, a review is conducted by a physician or other mental health professional who is employed by the authority, or an agency under contract with the authority, and who neither has a financial interest in continued inpatient treatment of the adolescent nor is affiliated with the facility providing the treatment.

(a) For adolescents receiving inpatient treatment, the physician or other mental health professional shall conduct the review not less than seven nor more than fourteen days following the date the adolescent was brought to the facility under RCW 71.34.600 to determine whether it is a medical necessity to continue the adolescent's treatment on an inpatient basis.

(b) For adolescents receiving inpatient treatment in a residential treatment facility, the physician or other mental health professional shall conduct an additional medical necessity review every thirty days after the initial review while the adolescent remains in treatment under RCW 71.34.600.

(2) In making a determination under subsection (1) of this section, the authority shall consider the opinion of the treatment provider, the safety of the adolescent, and the likelihood the adolescent's mental health will deteriorate if released from inpatient treatment. The authority shall consult with the parent in advance of making its determination.

(3) If, after any review conducted by the authority under this section, the authority determines it is no longer a medical necessity for an adolescent to receive inpatient treatment, the authority shall immediately notify the parents and the facility. The facility shall release the adolescent to the parents within twenty-four hours of receiving notice. If the professional person in charge and the parent believe that it is a medical necessity for the adolescent to remain in inpatient treatment, the adolescent shall be released to the parent on the second judicial day following the authority's determination in order to allow the parent time to file an at-risk youth petition under chapter 13.32A RCW. If the authority determines it is a medical necessity for the adolescent to receive outpatient treatment and the adolescent declines to obtain such treatment, such refusal shall be grounds for the parent to file an at-risk youth petition.

(4) If the evaluation conducted under RCW 71.34.600 is done by the authority, the reviews required by subsection (1) of this section shall be done by contract with an independent agency.

(5) The authority may, subject to available funds, contract with other governmental agencies to conduct the reviews under this section. The authority may seek reimbursement from the parents, their insurance, or medicaid for the expense of any review conducted by an agency under contract.

(6) In addition to the review required under this section, the authority may periodically determine and redetermine the medical necessity of treatment for purposes of payment with public funds.

(7) The authority shall communicate review findings under this section with the appropriate medicaid managed care organization contracted by the authority.

(8) Nothing in this section prohibits a managed care organization from conducting medical necessity reviews according to appropriate guidelines based on the level of care being referred to and consistent with the billing guide from the authority. [2020 c 185 § 3; 2019 c 381 § 8; 2018 c 201 § 5014; 1998 c 296 § 9; 1995 c 312 § 56. Formerly RCW 71.34.025.]

Short title—2019 c 381: See note following RCW 71.34.500.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

Additional notes found at www.leg.wa.gov

71.34.620 Adolescent's court petition for release from inpatient treatment facility—Judicial review of medical necessity. Following the review conducted under RCW 71.34.610, an adolescent may petition the superior court for his or her release from the facility. The petition may be filed not sooner than five days following the review. The court shall release the adolescent unless it finds, upon a preponderance of the evidence, that it is a medical necessity for the adolescent to remain at the facility. [2019 c 381 § 9; 1998 c 296 § 19. Formerly RCW 71.34.162.]

Short title—2019 c 381: See note following RCW 71.34.500.

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

71.34.630 Adolescent not released from inpatient treatment facility by court petition—Release within thirty days—Initiation of proceedings to stop release. (1) If the adolescent is receiving inpatient treatment in a hospital setting and is not released as a result of the petition filed under RCW 71.34.620, he or she shall be released not later than thirty days following the later of: (a) The date of the authority's determination under RCW 71.34.610(2); or (b) the filing of a petition for judicial review under RCW 71.34.620, unless a professional person or the designated crisis responder initiates proceedings under this chapter.

(2) If the adolescent receiving treatment in a residential treatment facility is not released as a result of the petition filed under RCW 71.34.620, he or she may remain in a residential treatment facility so long as it continues to be a medical necessity for the adolescent to receive such treatment. [2020 c 185 § 4; 2019 c 381 § 10; 2018 c 201 § 5015; 2016 sp.s. c 29 § 264; 1998 c 296 § 20. Formerly RCW 71.34.164.]

Short title—2019 c 381: See note following RCW 71.34.500.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

71.34.640 Evaluation of treatment of adolescents. The authority shall randomly select and review the information on adolescents who are admitted to inpatient treatment on application of the adolescent's parent regardless of the source of payment, if any, subject to the limitations under RCW 71.34.600(3). The review shall determine whether the adolescents reviewed were appropriately admitted into treatment based on an objective evaluation of the adolescent's condition and the outcome of the adolescent's treatment. [2019 c 381 § 11; 2018 c 201 § 5016; 1996 c 133 § 36; 1995 c 312 § 58. Formerly RCW 71.34.035.]

Short title—2019 c 381: See note following RCW 71.34.500.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Findings—Short title—Intent—Construction—1996 c 133: See notes following RCW 13.32A.197.

Additional notes found at www.leg.wa.gov

71.34.650 Parental request for determination of whether adolescent has a behavioral health disorder requiring outpatient treatment—Adolescent's consent not required for evaluation and certain treatment—Treatment reviews—Discharge. (1) A parent may bring, or authorize the bringing of, his or her adolescent child to a provider of outpatient behavioral health treatment and request that an appropriately trained professional person examine the adolescent to determine whether the adolescent has a behavioral health disorder and is in need of outpatient treatment.

(2) The consent of the adolescent is not required for evaluation if a parent provides consent.

(3) The professional person may evaluate whether the adolescent has a behavioral health disorder and is in need of outpatient treatment.

(4) If a determination is made by a professional person under this section that an adolescent is in need of outpatient behavioral health disorder treatment, a parent of an adolescent may request and receive such outpatient treatment for his or her adolescent without the consent of the adolescent for up to twelve outpatient sessions occurring within a three-month period.

(5) Following the treatment periods under subsection (4) of this section, an adolescent must provide his or her consent for further treatment with that specific professional person.

(6) If a determination is made by a professional person under this section that an adolescent is in need of treatment in a less restrictive setting, including partial hospitalization or intensive outpatient treatment, a parent of an adolescent may request and receive such treatment for his or her adolescent without the consent of the adolescent.

(a) A professional person providing solely mental health treatment to an adolescent under this subsection (6) must convene a treatment review at least every thirty days after treatment begins that includes the adolescent, parent, and other treatment team members as appropriate to determine whether continued care under this subsection is medically necessary.

(b) A professional person providing solely mental health treatment to an adolescent under this subsection (6) shall provide notification of the adolescent's treatment to an independent reviewer at the authority within twenty-four hours of the adolescent's first receipt of treatment under this subsection. At least every forty-five days after the adolescent's first receipt of treatment under this subsection, the authority shall conduct a review to determine whether the current level of treatment is medically necessary.

(c) A professional person providing substance use disorder treatment under this subsection (6) shall convene a treatment review under (a) of this subsection and provide the notification of the adolescent's receipt of treatment to an independent reviewer at the authority as described in (b) of this subsection only if: (i) The adolescent provides written consent to the disclosure of substance use disorder treatment information including the fact of his or her receipt of such treatment; or (ii) permitted by federal law.

(7) Any adolescent admitted to inpatient treatment under RCW 71.34.500 or 71.34.600 shall be discharged immediately from inpatient treatment upon written request of the parent. [2020 c 302 § 77; 2019 c 381 § 12; 2016 sp.s. c 29 § 265; 1998 c 296 § 18. Formerly RCW 71.34.054.]

Short title—2019 c 381: See note following RCW 71.34.500.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

71.34.660 Limitation on liability for admitting or accepting adolescent. An adolescent shall have no cause of action against an evaluation and treatment facility, secure withdrawal management and stabilization facility, approved substance use disorder treatment program, inpatient facility, or provider of outpatient mental health treatment or outpatient substance use disorder treatment for admitting or accepting the adolescent in good faith for evaluation or treat-

ment under RCW 71.34.600 or 71.34.650 based solely upon the fact that the adolescent did not consent to evaluation or treatment if the adolescent's parent has consented to the evaluation or treatment. [2019 c 446 § 29; 2019 c 381 § 13; 2016 sp.s. c 29 § 266; 2005 c 371 § 3.]

Reviser's note: This section was amended by 2019 c 381 § 13 and by 2019 c 446 § 29, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Short title—2019 c 381: See note following RCW 71.34.500.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Finding—Intent—Severability—2005 c 371: See notes following RCW 71.34.600.

71.34.670 "Appropriately trained professional person" defined by rule. The authority shall adopt rules defining "appropriately trained professional person" operating within their scope of practice within Title 18 RCW for the purposes of conducting mental health and substance use disorder evaluations under RCW 71.34.600(3) and 71.34.650(1). [2019 c 325 § 2007; 2018 c 201 § 2001; 2016 sp.s. c 29 § 415; 1998 c 296 § 34. Formerly RCW 43.20A.025.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Intent—Part headings not law—Short title—1998 c 296: See notes following RCW 74.13.025.

71.34.680 Data collection and tracking system for adolescents receiving treatment. The authority shall develop and operate a data collection and tracking system for adolescents receiving family-initiated treatment under RCW 71.34.600 through 71.34.670. In implementing this data collection and tracking system, the authority shall, in collaboration with the department of health, collect information from facilities serving adolescents receiving family-initiated treatment under RCW 71.34.600 through 71.34.670 including, if possible, the following information:

(1) The names of facilities serving adolescents receiving family-initiated treatment under RCW 71.34.600 through 71.34.670;

(2) The number of adolescents receiving family-initiated treatment under RCW 71.34.600 through 71.34.670 who are defined as dependent children under chapter 13.34 RCW;

(3) Demographic information about the adolescents receiving family-initiated treatment under RCW 71.34.600 through 71.34.670;

(4) The diagnosis upon entry for adolescents receiving family-initiated treatment under RCW 71.34.600 through 71.34.670;

(5) Length of stay for adolescents receiving family-initiated treatment under RCW 71.34.600 through 71.34.670; and

(6) Information related to the discharge summary for adolescents receiving family-initiated treatment under RCW 71.34.600 through 71.34.670. [2020 c 185 § 8.]

INVOLUNTARY COMMITMENT

71.34.700 Evaluation of adolescent brought for immediate inpatient treatment—Temporary detention. ***(Effective until July 1, 2026.)*** (1) If an adolescent is brought to an evaluation and treatment facility, secure withdrawal management and stabilization facility with available space, approved substance use disorder treatment program with available space, or hospital emergency room for immediate behavioral health services, the professional person in charge of the facility shall evaluate the adolescent's condition, determine whether the adolescent suffers from a behavioral health disorder, and whether the adolescent is in need of immediate inpatient treatment.

(2) If it is determined under subsection (1) of this section that the adolescent suffers from a behavioral health disorder, inpatient treatment is required, the adolescent is unwilling to consent to voluntary admission, and the professional person believes that the adolescent meets the criteria for initial detention, the facility may detain or arrange for the detention of the adolescent for up to twelve hours, not including time periods prior to medical clearance, in order to enable a designated crisis responder to evaluate the adolescent and commence initial detention proceedings under the provisions of this chapter.

(3) Dismissal of a commitment petition is not the appropriate remedy for a violation of the timeliness requirements of this section, based on the purpose of this chapter under RCW 71.34.010, except in the few cases where the facility staff or the designated crisis responder have totally disregarded the requirements of this section. [2020 c 302 § 78. Prior: 2019 c 446 § 30; 2019 c 381 § 14; 2016 sp.s. c 29 § 267; 1985 c 354 § 4. Formerly RCW 71.34.040.]

Expiration date—2020 c 302 §§ 13, 16, 26, 39, 45, 55, 78, 83, 86, 92, 94, and 97: See note following RCW 71.05.150.

Expiration date—2019 c 446 §§ 4, 6, 8, 11, 14, 30, 32, 34, 37, 39, and 41: See note following RCW 71.05.150.

Expiration date—2019 c 381 §§ 14 and 16: "Sections 14 and 16 of this act expire July 1, 2026." [2019 c 381 § 26.]

Short title—2019 c 381: See note following RCW 71.34.500.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.34.700 Evaluation of adolescent brought for immediate inpatient treatment—Temporary detention. ***(Effective July 1, 2026.)*** (1) If an adolescent is brought to an evaluation and treatment facility, secure withdrawal management and stabilization facility, approved substance use disorder treatment program, or hospital emergency room for immediate behavioral health services, the professional person in charge of the facility shall evaluate the adolescent's condition, determine whether the adolescent suffers from a behavioral health disorder, and whether the adolescent is in need of immediate inpatient treatment.

(2) If it is determined under subsection (1) of this section that the adolescent suffers from a behavioral health disorder, inpatient treatment is required, the adolescent is unwilling to consent to voluntary admission, and the professional person believes that the adolescent meets the criteria for initial detention, the facility may detain or arrange for the detention

of the adolescent for up to twelve hours, not including time periods prior to medical clearance, in order to enable a designated crisis responder to evaluate the adolescent and commence initial detention proceedings under the provisions of this chapter.

(3) Dismissal of a commitment petition is not the appropriate remedy for a violation of the timeliness requirements of this section, based on the purpose of this chapter under RCW 71.34.010, except in the few cases where the facility staff or the designated crisis responder have totally disregarded the requirements of this section. [2020 c 302 § 79. Prior: 2019 c 446 § 31; 2019 c 381 § 15; 2016 sp.s. c 29 § 268; 2016 sp.s. c 29 § 267; 1985 c 354 § 4. Formerly RCW 71.34.040.]

Effective date—2020 c 302 §§ 14, 17, 27, 40, 46, 56, 79, 84, 87, 93, 95, and 98: See note following RCW 71.05.150.

Effective date—2019 c 446 §§ 5, 7, 9, 12, 15, 31, 33, 35, 38, 40, and 42: See note following RCW 71.05.150.

Effective date—2019 c 381 §§ 15 and 17: "Sections 15 and 17 of this act take effect July 1, 2026." [2019 c 381 § 27.]

Short title—2019 c 381: See note following RCW 71.34.500.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.34.705 Evaluation of adolescent brought for immediate inpatient treatment—Considerations. (1) Whenever a designated crisis responder or professional person is conducting an evaluation under this chapter, the designated crisis responder or professional person must consider all reasonably available information from credible witnesses and records regarding:

(a) Historical behavior, including history of one or more violent acts; and

(b) Prior commitments under this chapter.

(2) Credible witnesses may include family members, landlords, neighbors, teachers, school personnel, or others with significant contact and history of involvement with the minor. If the designated crisis responder relies upon information from a credible witness in reaching his or her decision to detain the minor, then he or she must provide contact information for any such witness to the prosecutor. The designated crisis responder or prosecutor shall provide notice of the date, time, and location of the probable cause hearing to such a witness.

(3) Symptoms and behavior of the minor which standing alone would not justify civil commitment may support a finding of grave disability or likelihood of serious harm, when:

(a) Such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts;

(b) These symptoms or behavior represent a marked and concerning change in the baseline behavior of the minor; and

(c) Without treatment, the continued deterioration of the minor is probable.

(4) The authority, in consultation with tribes and in coordination with Indian health care providers and the American Indian health commission of Washington state, shall establish written guidelines by June 30, 2022, for conducting culturally appropriate evaluations of American Indians or Alaska Natives. [2021 c 264 § 30; 2020 c 302 § 80.]

71.34.706 Evaluation of adolescent brought for immediate inpatient treatment—Considerations. ***(Contingent effective date.)*** (1) Whenever a designated crisis responder or professional person is conducting an evaluation under this chapter, the designated crisis responder or professional person must consider all reasonably available information from credible witnesses and records regarding:

(a) Historical behavior, including history of one or more violent acts; and

(b) Prior commitments under this chapter.

(2) Credible witnesses may include family members, landlords, neighbors, teachers, school personnel, or others with significant contact and history of involvement with the minor. If the designated crisis responder relies upon information from a credible witness in reaching his or her decision to detain the minor, then he or she must provide contact information for any such witness to the prosecutor. The designated crisis responder or prosecutor shall provide notice of the date, time, and location of the probable cause hearing to such a witness.

(3) Symptoms and behavior of the minor which standing alone would not justify civil commitment may support a finding of grave disability or likelihood of serious harm, when:

(a) Such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration from safe behavior, or one or more violent acts;

(b) These symptoms or behavior represent a marked and concerning change in the baseline behavior of the minor; and

(c) Without treatment, the continued deterioration of the minor is probable. [2020 c 302 § 81.]

Contingent effective date—2021 c 264 §§ 27 and 28; 2020 c 302 §§ 64 and 81: See note following RCW 71.34.020.

71.34.710 Adolescent who presents likelihood of serious harm or is gravely disabled—Transport to inpatient facility—Petition for initial detention—Notice—Facility to evaluate and admit or release adolescent. ***(Effective until July 1, 2026.)*** (1)(a) When a designated crisis responder receives information that an adolescent as a result of a behavioral health disorder presents a likelihood of serious harm or is gravely disabled, has investigated the specific facts alleged and of the credibility of the person or persons providing the information, and has determined that voluntary admission for inpatient treatment is not possible, the designated crisis responder may take the adolescent, or cause the adolescent to be taken, into custody and transported to an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program providing inpatient treatment.

A secure withdrawal management and stabilization facility or approved substance use disorder treatment program must be available and have adequate space for the adolescent.

(b) If a designated crisis responder decides not to detain an adolescent for evaluation and treatment under RCW 71.34.700(2), or forty-eight hours have elapsed since a designated crisis responder received a request for investigation and the designated crisis responder has not taken action to have

the adolescent detained, an immediate family member or guardian or conservator of the adolescent, or a federally recognized Indian tribe if the person is a member of such tribe, may petition the superior court for the adolescent's detention using the procedures under RCW 71.05.201 and 71.05.203; however, when the court enters an order of initial detention, except as otherwise expressly stated in this chapter, all procedures must be followed as if the order has been entered under (a) of this subsection.

(c) The interview performed by the designated crisis responder may be conducted by video provided that a licensed health care professional or professional person who can adequately and accurately assist with obtaining any necessary information is present with the person at the time of the interview.

(2)(a) Within twelve hours of the adolescent's arrival at the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program, the designated crisis responder shall serve or cause to be served on the adolescent a copy of the petition for initial detention, notice of initial detention, and statement of rights. The designated crisis responder shall file with the court on the next judicial day following the initial detention the original petition for initial detention, notice of initial detention, and statement of rights along with an affidavit of service. The designated crisis responder shall commence service of the petition for initial detention and notice of the initial detention on the adolescent's parent and the adolescent's attorney as soon as possible following the initial detention.

(b) The facility or program may serve the adolescent, notify the adolescent's parents and the adolescent's attorney, and file with the court on the next judicial day following the initial detention the original petition for initial detention, notice of initial detention, and statement of rights along with an affidavit of service when filing with the court at the request of the designated crisis responder.

(3)(a) At the time of initial detention, the designated crisis responder shall advise the adolescent both orally and in writing that if admitted to the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program for inpatient treatment, a commitment hearing shall be held within one hundred twenty hours of the adolescent's provisional acceptance to determine whether probable cause exists to commit the adolescent for further treatment.

(b) The adolescent shall be advised that he or she has a right to communicate immediately with an attorney and that he or she has a right to have an attorney appointed to represent him or her before and at the hearing if the adolescent is indigent.

(4) Subject to subsection (5) of this section, whenever the designated crisis responder petitions for detention of an adolescent under this chapter, an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program providing one hundred twenty hour evaluation and treatment must immediately accept on a provisional basis the petition and the person. Within twenty-four hours of the adolescent's arrival, the facility must evaluate the adolescent's condition and either admit or release the adolescent in accordance with this chapter.

(5) A designated crisis responder may not petition for detention of an adolescent to a secure withdrawal management and stabilization facility or approved substance use disorder treatment program unless there is a secure withdrawal management and stabilization facility or approved substance use disorder treatment program available and that has adequate space for the adolescent.

(6) If an adolescent is not approved for admission by the inpatient evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program, the facility shall make such recommendations and referrals for further care and treatment of the adolescent as necessary.

(7) Dismissal of a commitment petition is not the appropriate remedy for a violation of the timeliness requirements of this section, based on the purpose of this chapter under RCW 71.34.010, except in the few cases where the facility staff or the designated crisis responder have totally disregarded the requirements of this section.

(8) Tribal court orders for involuntary commitment shall be recognized and enforced in accordance with superior court civil rule 82.5.

(9) In any investigation and evaluation of a juvenile under this section in which the designated crisis responder knows, or has reason to know, that the juvenile is an American Indian or Alaska Native who receives medical or behavioral health services from a tribe within this state, the designated crisis responder shall notify the tribe and the Indian health care provider regarding whether or not a petition for initial detention or involuntary outpatient treatment will be filed. Notification shall be made in person or by telephonic or electronic communication to the tribal contact listed in the authority's tribal crisis coordination plan as soon as possible but no later than three hours subject to the requirements in RCW 70.02.230 (2)(ee) and (3). A designated crisis responder may restrict the release of information as necessary to comply with 42 C.F.R. Part 2. [2021 c 264 § 31; 2020 c 302 § 83; (2020 c 302 § 82 expired January 1, 2021). Prior: 2019 c 446 § 32; 2019 c 381 § 16; 2016 sp.s. c 29 § 269; 1995 c 312 § 53; 1985 c 354 § 5. Formerly RCW 71.34.050.]

Expiration date—2021 c 264 §§ 1, 3, 6, 8, 10, 14, 31, and 33: See note following RCW 71.05.150.

Effective date—2021 c 264 §§ 25, 27, and 31: See note following RCW 71.34.020.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 13, 16, 26, 39, 45, 55, 78, 83, 86, 92, 94, and 97: See note following RCW 71.05.150.

Expiration date—2019 c 446 §§ 4, 6, 8, 11, 14, 30, 32, 34, 37, 39, and 41: See note following RCW 71.05.150.

Expiration date—2019 c 381 §§ 14 and 16: See note following RCW 71.34.700.

Short title—2019 c 381: See note following RCW 71.34.500.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.34.710 Adolescent who presents likelihood of serious harm or is gravely disabled—Transport to inpatient facility—Petition for initial detention—Notice—Facility to evaluate and admit or release adolescent. ***(Effective July 1, 2026.)*** (1)(a) When a designated crisis responder receives information that an adolescent as a result of a behavioral health disorder presents a likelihood of serious harm or is gravely disabled, has investigated the specific facts alleged and of the credibility of the person or persons providing the information, and has determined that voluntary admission for inpatient treatment is not possible, the designated crisis responder may take the adolescent, or cause the adolescent to be taken, into custody and transported to an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program providing inpatient treatment.

(b) If a designated crisis responder decides not to detain an adolescent for evaluation and treatment under RCW 71.34.700(2), or forty-eight hours have elapsed since a designated crisis responder received a request for investigation and the designated crisis responder has not taken action to have the adolescent detained, an immediate family member or guardian or conservator of the adolescent, or a federally recognized Indian tribe if the person is a member of such tribe, may petition the superior court for the adolescent's detention using the procedures under RCW 71.05.201 and 71.05.203; however, when the court enters an order of initial detention, except as otherwise expressly stated in this chapter, all procedures must be followed as if the order has been entered under (a) of this subsection.

(c) The interview performed by the designated crisis responder may be conducted by video provided that a licensed health care professional or professional person who can adequately and accurately assist with obtaining any necessary information is present with the person at the time of the interview.

(2)(a) Within twelve hours of the adolescent's arrival at the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program, the designated crisis responder shall serve or cause to be served on the adolescent a copy of the petition for initial detention, notice of initial detention, and statement of rights. The designated crisis responder shall file with the court on the next judicial day following the initial detention the original petition for initial detention, notice of initial detention, and statement of rights along with an affidavit of service. The designated crisis responder shall commence service of the petition for initial detention and notice of the initial detention on the adolescent's parent and the adolescent's attorney as soon as possible following the initial detention.

(b) The facility or program may serve the adolescent, notify the adolescent's parents and the adolescent's attorney, and file with the court on the next judicial day following the initial detention the original petition for initial detention, notice of initial detention, and statement of rights along with an affidavit of service when filing with the court at the request of the designated crisis responder.

(3)(a) At the time of initial detention, the designated crisis responder shall advise the adolescent both orally and in writing that if admitted to the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program for inpatient treatment, a commitment hearing shall be held within one hundred twenty hours of the adolescent's provisional acceptance to determine whether probable cause exists to commit the adolescent for further treatment.

(b) The adolescent shall be advised that he or she has a right to communicate immediately with an attorney and that he or she has a right to have an attorney appointed to represent him or her before and at the hearing if the adolescent is indigent.

(4) Whenever the designated crisis responder petitions for detention of an adolescent under this chapter, an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program providing one hundred twenty hour evaluation and treatment must immediately accept on a provisional basis the petition and the person. Within twenty-four hours of the adolescent's arrival, the facility must evaluate the adolescent's condition and either admit or release the adolescent in accordance with this chapter.

(5) If an adolescent is not approved for admission by the inpatient evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program, the facility shall make such recommendations and referrals for further care and treatment of the adolescent as necessary.

(6) Dismissal of a commitment petition is not the appropriate remedy for a violation of the timeliness requirements of this section, based on the purpose of this chapter under RCW 71.34.010, except in the few cases where the facility staff or the designated crisis responder have totally disregarded the requirements of this section.

(7) Tribal court orders for involuntary commitment shall be recognized and enforced in accordance with superior court civil rule 82.5.

(8) In any investigation and evaluation of a juvenile under this section in which the designated crisis responder knows, or has reason to know, that the juvenile is an American Indian or Alaska Native who receives medical or behavioral health services from a tribe within this state, the designated crisis responder shall notify the tribe and the Indian health care provider regarding whether or not a petition for initial detention or involuntary outpatient treatment will be filed. Notification shall be made in person or by telephonic or electronic communication to the tribal contact listed in the authority's tribal crisis coordination plan as soon as possible but no later than three hours subject to the requirements in RCW 70.02.230 (2)(ee) and (3). A designated crisis responder may restrict the release of information as necessary to comply with 42 C.F.R. Part 2. [2021 c 264 § 32; 2020 c 302 § 84; (2020 c 302 § 82 expired January 1, 2021). Prior: 2019 c 446 § 33; 2019 c 381 § 17; 2016 sp.s. c 29 § 270; 2016 sp.s. c 29 § 269; 1995 c 312 § 53; 1985 c 354 § 5. Formerly RCW 71.34.050.]

Effective date—2021 c 264 §§ 2, 4, 7, 9, 11, 15, 32, and 34: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Effective date—2020 c 302 §§ 14, 17, 27, 40, 46, 56, 79, 84, 87, 93, 95, and 98: See note following RCW 71.05.150.

Effective date—2019 c 446 §§ 5, 7, 9, 12, 15, 31, 33, 35, 38, 40, and 42: See note following RCW 71.05.150.

Effective date—2019 c 381 §§ 15 and 17: See note following RCW 71.34.700.

Short title—2019 c 381: See note following RCW 71.34.500.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.34.720 Examination and evaluation of minor approved for inpatient admission—Referral to a secure withdrawal management and stabilization facility or substance use disorder treatment program—Right to communication, exception—Evaluation and treatment period. ***(Effective until July 1, 2026.)*** (1) Each minor approved by the facility for inpatient admission shall be examined and evaluated by a children's mental health specialist, for minors admitted as a result of a mental disorder, or by a substance use disorder professional or co-occurring disorder specialist, for minors admitted as a result of a substance use disorder, as to the child's mental condition and by a physician, physician assistant, or psychiatric advanced registered nurse practitioner as to the child's physical condition within twenty-four hours of admission. Reasonable measures shall be taken to ensure medical treatment is provided for any condition requiring immediate medical attention.

(2) If, at any time during the involuntary treatment hold and following the initial examination and evaluation, the children's mental health specialist or substance use disorder specialist and the physician, physician assistant, or psychiatric advanced registered nurse practitioner determine that the initial needs of the minor, if detained to an evaluation and treatment facility, would be better served by placement in a secure withdrawal management and stabilization facility or approved substance use disorder treatment program or, if detained to a secure withdrawal management and stabilization facility or approved substance use disorder treatment program, would be better served in an evaluation and treatment facility, then the minor shall be referred to the more appropriate placement for the remainder of the current commitment period without any need for further court review; however a minor may only be referred to a secure withdrawal management and stabilization facility or approved substance use disorder treatment program if there is a secure withdrawal management and stabilization facility or approved substance use disorder treatment program available and that has adequate space for the minor.

(3) The admitting facility shall take reasonable steps to notify immediately the minor's parent of the admission.

(4) During the initial one hundred twenty hour treatment period, the minor has a right to associate or receive communications from parents or others unless the professional person in charge determines that such communication would be seriously detrimental to the minor's condition or treatment and so indicates in the minor's clinical record, and notifies the minor's parents of this determination. A minor must not be denied the opportunity to consult an attorney unless there is an immediate risk of harm to the minor or others.

(5) If the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program admits the minor, it may detain the minor for evaluation and treatment for a period not to exceed one hundred twenty hours from the time of provisional acceptance. The computation of such one hundred twenty hour period shall exclude Saturdays, Sundays, and holidays. This initial treatment period shall not exceed one hundred twenty hours except when an application for voluntary inpatient treatment is received or a petition for fourteen-day commitment is filed.

(6) Within twelve hours of the admission, the facility shall advise the minor of his or her rights as set forth in this chapter. [2021 c 264 § 33; 2020 c 302 § 86; (2020 c 302 § 85 expired January 1, 2021). Prior: 2019 c 446 § 34; 2019 c 444 § 18; 2018 c 201 § 5017; prior: 2016 sp.s. c 29 § 271; 2016 c 155 § 19; 2009 c 217 § 16; 1991 c 364 § 12; 1985 c 354 § 6. Formerly RCW 71.34.060.]

Expiration date—2021 c 264 §§ 1, 3, 6, 8, 10, 14, 31, and 33: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 13, 16, 26, 39, 45, 55, 78, 83, 86, 92, 94, and 97: See note following RCW 71.05.150.

Expiration date—2019 c 446 §§ 4, 6, 8, 11, 14, 30, 32, 34, 37, 39, and 41: See note following RCW 71.05.150.

Expiration dates—2019 c 444 §§ 12 and 18: See note following RCW 43.70.442.

Expiration date—2018 c 201 §§ 3009, 3012, 3026, 5017, and 5020: See note following RCW 71.05.240.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Construction—Conflict with federal requirements—1991 c 364: See notes following RCW 71.05.210.

71.34.720 Examination and evaluation of minor approved for inpatient admission—Referral to a secure withdrawal management and stabilization facility or substance use disorder treatment program—Right to communication, exception—Evaluation and treatment period. ***(Effective July 1, 2026.)*** (1) Each minor approved by the facility for inpatient admission shall be examined and evaluated by a children's mental health specialist, for minors admitted as a result of a mental disorder, or by a substance use disorder professional or co-occurring disorder specialist, for minors admitted as a result of a substance use disorder, as to the child's mental condition and by a physician, physician assistant, or psychiatric advanced registered nurse practitioner as to the child's physical condition within twenty-four hours of admission. Reasonable measures shall be taken to ensure medical treatment is provided for any condition requiring immediate medical attention.

(2) If, at any time during the involuntary treatment hold and following the initial examination and evaluation, the children's mental health specialist or substance use disorder specialist and the physician, physician assistant, or psychiatric advanced registered nurse practitioner determine that the initial needs of the minor, if detained to an evaluation and treatment facility, would be better served by placement in a secure

withdrawal management and stabilization facility or approved substance use disorder treatment program or, if detained to a secure withdrawal management and stabilization facility or approved substance use disorder treatment program, would be better served in an evaluation and treatment facility, then the minor shall be referred to the more appropriate placement for the remainder of the current commitment period without any need for further court review.

(3) The admitting facility shall take reasonable steps to notify immediately the minor's parent of the admission.

(4) During the initial one hundred twenty hour treatment period, the minor has a right to associate or receive communications from parents or others unless the professional person in charge determines that such communication would be seriously detrimental to the minor's condition or treatment and so indicates in the minor's clinical record, and notifies the minor's parents of this determination. A minor must not be denied the opportunity to consult an attorney unless there is an immediate risk of harm to the minor or others.

(5) If the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program admits the minor, it may detain the minor for evaluation and treatment for a period not to exceed one hundred twenty hours from the time of provisional acceptance. The computation of such one hundred twenty hour period shall exclude Saturdays, Sundays, and holidays. This initial treatment period shall not exceed one hundred twenty hours except when an application for voluntary inpatient treatment is received or a petition for fourteen-day commitment is filed.

(6) Within twelve hours of the admission, the facility shall advise the minor of his or her rights as set forth in this chapter. [2021 c 264 § 34; 2020 c 302 § 87; (2020 c 302 § 85 expired January 1, 2021). Prior: 2019 c 446 § 35; 2019 c 444 § 19; 2018 c 201 § 5018; 2016 sp.s. c 29 § 272; 2016 sp.s. c 29 § 271; 2016 c 155 § 19; 2009 c 217 § 16; 1991 c 364 § 12; 1985 c 354 § 6. Formerly RCW 71.34.060.]

Effective date—2021 c 264 §§ 2, 4, 7, 9, 11, 15, 32, and 34: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Effective date—2020 c 302 §§ 14, 17, 27, 40, 46, 56, 79, 84, 87, 93, 95, and 98: See note following RCW 71.05.150.

Effective date—2019 c 446 §§ 5, 7, 9, 12, 15, 31, 33, 35, 38, 40, and 42: See note following RCW 71.05.150.

Effective dates—2019 c 444 §§ 13 and 19: See note following RCW 43.70.442.

Effective date—2018 c 201 §§ 3010, 3013, 3027, 5018, and 5021: See note following RCW 71.05.240.

Findings—Intent—2018 c 201: See note following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Findings—Construction—Conflict with federal requirements—1991 c 364: See notes following RCW 71.05.210.

71.34.730 Petition for fourteen-day commitment—Requirements. (1) The professional person in charge of an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program where a minor has been admitted involuntarily for the initial one hundred twenty hour treatment period under this chapter may petition to have a minor committed to an evaluation and treatment facility, a secure withdrawal management and stabilization facility, or an approved substance use disorder treatment program for fourteen-day diagnosis, evaluation, and treatment.

If the professional person in charge of the facility does not petition to have the minor committed, the parent who has custody of the minor may seek review of that decision in court. The parent shall file notice with the court and provide a copy of the treatment and evaluation facility's report.

(2) A petition for commitment of a minor under this section shall be filed with the superior court in the county where the minor is being detained.

(a) A petition for a fourteen-day commitment shall be signed by:

(i) One physician, physician assistant, or psychiatric advanced registered nurse practitioner; and

(ii) One physician, physician assistant, psychiatric advanced registered nurse practitioner, or mental health professional.

(b) If the petition is for substance use disorder treatment, the petition may be signed by a substance use disorder professional instead of a mental health professional and by an advanced registered nurse practitioner instead of a psychiatric advanced registered nurse practitioner. The person signing the petition must have examined the minor, and the petition must contain the following:

(i) The name and address of the petitioner;

(ii) The name of the minor alleged to meet the criteria for fourteen-day commitment;

(iii) The name, telephone number, and address if known of every person believed by the petitioner to be legally responsible for the minor;

(iv) A statement that the petitioner has examined the minor and finds that the minor's condition meets required criteria for fourteen-day commitment and the supporting facts therefor;

(v) A statement that the minor has been advised of the need for voluntary treatment but has been unwilling or unable to consent to necessary treatment;

(vi) If the petition is for mental health treatment, a statement that the minor has been advised of the loss of firearm rights if involuntarily committed;

(vii) A statement recommending the appropriate facility or facilities to provide the necessary treatment; and

(viii) A statement concerning whether a less restrictive alternative to inpatient treatment is in the best interests of the minor.

(c) A copy of the petition shall be personally served on the minor by the petitioner or petitioner's designee. A copy of the petition shall be provided to the minor's attorney and the minor's parent. [2020 c 302 § 89; (2020 c 302 § 88 expired January 1, 2021); 2020 c 185 § 5; 2019 c 446 § 36. Prior: 2016 sp.s. c 29 § 273; 2016 c 155 § 20; prior: 2009 c 293 § 6; 2009 c 217 § 17; 1995 c 312 § 54; 1985 c 354 § 7. Formerly RCW 71.34.070.]

Reviser's note: This section was amended by 2020 c 185 § 5 and by 2020 c 302 § 89, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Additional notes found at www.leg.wa.gov

71.34.735 Commitment hearing—Continuance or postponement. (1) In any proceeding for involuntary commitment under this chapter, the court may continue or postpone such proceeding for a reasonable time on motion of the respondent for good cause, or on motion of the prosecuting attorney or the attorney general if:

(a) The respondent expressly consents to a continuance or delay and there is a showing of good cause; or

(b) Such continuance is required in the proper administration of justice and the respondent will not be substantially prejudiced in the presentation of the respondent's case.

(2) The court may on its own motion continue the case when required in due administration of justice and when the respondent will not be substantially prejudiced in the presentation of the respondent's case.

(3) The court shall state in any order of continuance or postponement the grounds for the continuance or postponement and whether detention will be extended. [2020 c 302 § 90.]

71.34.740 Commitment hearing—Requirements—Findings by court—Commitment—Release. ***(Effective until July 1, 2026.)*** (1) A commitment hearing shall be held within one hundred twenty hours of the minor's admission, excluding Saturday, Sunday, and holidays, unless a continuance is ordered under RCW 71.34.735.

(2) The commitment hearing shall be conducted at the superior court or an appropriate place at the facility in which the minor is being detained.

(3) At the commitment hearing, the evidence in support of the petition shall be presented by the county prosecutor.

(4) The minor shall be present at the commitment hearing unless the minor, with the assistance of the minor's attorney, waives the right to be present at the hearing.

(5) If the parents are opposed to the petition, they may be represented at the hearing and shall be entitled to court-appointed counsel if they are indigent.

(6) At the commitment hearing, the minor shall have the following rights:

(a) To be represented by an attorney;

(b) To present evidence on his or her own behalf;

(c) To question persons testifying in support of the petition.

(7) If the hearing is for commitment for mental health treatment, the court at the time of the commitment hearing and before an order of commitment is entered shall inform the minor both orally and in writing that the failure to make a good faith effort to seek voluntary treatment as provided in RCW 71.34.730 will result in the loss of his or her firearm rights if the minor is subsequently detained for involuntary treatment under this section.

(8) If the minor has received medication within twenty-four hours of the hearing, the court shall be informed of that fact and of the probable effects of the medication.

(9) For a fourteen-day commitment, the court must find by a preponderance of the evidence that:

(a) The minor has a behavioral health disorder and presents a likelihood of serious harm or is gravely disabled;

(b) The minor is in need of evaluation and treatment of the type provided by the inpatient evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program to which continued inpatient care is sought or is in need of less restrictive alternative treatment found to be in the best interests of the minor or others;

(c) The minor is unwilling or unable in good faith to consent to voluntary treatment; and

(d) If commitment is for a substance use disorder, there is an available secure withdrawal management and stabilization facility or approved substance use disorder treatment program with adequate space for the minor.

(10) If the court finds that the minor meets the criteria for a fourteen-day commitment, the court shall either authorize commitment of the minor for inpatient treatment or for less restrictive alternative treatment upon such conditions as are necessary. If the court determines that the minor does not meet the criteria for a fourteen-day commitment, the minor shall be released.

(11)(a) Nothing in this section prohibits the professional person in charge of the facility from releasing the minor at any time, when, in the opinion of the professional person in charge of the facility, further inpatient treatment is no longer necessary. The release may be subject to reasonable conditions if appropriate.

(b) Whenever a minor is released under this section, the professional person in charge shall within three days, notify the court in writing of the release.

(12) A minor who has been committed for fourteen days shall be released at the end of that period unless a petition for one hundred eighty-day commitment is pending before the court. [2020 c 302 § 92; (2020 c 302 § 91 expired January 1, 2021); 2019 c 446 § 37; 2016 sp.s. c 29 § 274; 2009 c 293 § 7; 1985 c 354 § 8. Formerly RCW 71.34.080.]

Effective date—2020 c 302 §§ 13, 16, 19-23, 26, 32, 34, 36, 39, 55, 59, 76, 83, 86, 89, and 92: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 12, 15, 25, 31, 33, 35, 38, 54, 75, 82, 85, 88, and 91: See note following RCW 71.05.150.

Expiration date—2020 c 302 §§ 13, 16, 26, 39, 45, 55, 78, 83, 86, 92, 94, and 97: See note following RCW 71.05.150.

Expiration date—2019 c 446 §§ 4, 6, 8, 11, 14, 30, 32, 34, 37, 39, and 41: See note following RCW 71.05.150.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.34.740 Commitment hearing—Requirements—Findings by court—Commitment—Release. ***(Effective July 1, 2026.)*** (1) A commitment hearing shall be held within one hundred twenty hours of the minor's admission, excluding Saturday, Sunday, and holidays, unless a continuance is ordered under RCW 71.34.735.

(2) The commitment hearing shall be conducted at the superior court or an appropriate place at the facility in which the minor is being detained.

(3) At the commitment hearing, the evidence in support of the petition shall be presented by the county prosecutor.

(4) The minor shall be present at the commitment hearing unless the minor, with the assistance of the minor's attorney, waives the right to be present at the hearing.

(5) If the parents are opposed to the petition, they may be represented at the hearing and shall be entitled to court-appointed counsel if they are indigent.

(6) At the commitment hearing, the minor shall have the following rights:

(a) To be represented by an attorney;

(b) To present evidence on his or her own behalf;

(c) To question persons testifying in support of the petition.

(7) If the hearing is for commitment for mental health treatment, the court at the time of the commitment hearing and before an order of commitment is entered shall inform the minor both orally and in writing that the failure to make a good faith effort to seek voluntary treatment as provided in RCW 71.34.730 will result in the loss of his or her firearm rights if the minor is subsequently detained for involuntary treatment under this section.

(8) If the minor has received medication within twenty-four hours of the hearing, the court shall be informed of that fact and of the probable effects of the medication.

(9) For a fourteen-day commitment, the court must find by a preponderance of the evidence that:

(a) The minor has a behavioral health disorder and presents a likelihood of serious harm or is gravely disabled;

(b) The minor is in need of evaluation and treatment of the type provided by the inpatient evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program to which continued inpatient care is sought or is in need of less restrictive alternative treatment found to be in the best interests of the minor or others; and

(c) The minor is unwilling or unable in good faith to consent to voluntary treatment.

(10) If the court finds that the minor meets the criteria for a fourteen-day commitment, the court shall either authorize commitment of the minor for inpatient treatment or for less restrictive alternative treatment upon such conditions as are necessary. If the court determines that the minor does not meet the criteria for a fourteen-day commitment, the minor shall be released.

(11)(a) Nothing in this section prohibits the professional person in charge of the facility from releasing the minor at any time, when, in the opinion of the professional person in charge of the facility, further inpatient treatment is no longer necessary. The release may be subject to reasonable conditions if appropriate.

(b) Whenever a minor is released under this section, the professional person in charge shall within three days, notify the court in writing of the release.

(12) A minor who has been committed for fourteen days shall be released at the end of that period unless a petition for one hundred eighty-day commitment is pending before the court. [2020 c 302 § 93; 2019 c 446 § 38; 2016 sp.s. c 29 § 275; 2016 sp.s. c 29 § 274; 2009 c 293 § 7; 1985 c 354 § 8. Formerly RCW 71.34.080.]

Effective date—2020 c 302 §§ 14, 17, 27, 40, 46, 56, 79, 84, 87, 93, 95, and 98: See note following RCW 71.05.150.

Effective date—2019 c 446 §§ 5, 7, 9, 12, 15, 31, 33, 35, 38, 40, and 42: See note following RCW 71.05.150.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.34.750 Petition for one hundred eighty-day commitment—Hearing—Requirements—Findings by court—Commitment order—Release—Successive commitments. ***(Effective until July 1, 2026.)*** (1) At any time during the minor's period of fourteen-day commitment, the professional person in charge may petition the court for an order requiring the minor to undergo an additional one hundred eighty-day period of treatment. The evidence in support of the petition shall be presented by the county prosecutor unless the petition is filed by the professional person in charge of a state-operated facility in which case the evidence shall be presented by the attorney general.

(2) The petition for one hundred eighty-day commitment shall contain the following:

(a) The name and address of the petitioner or petitioners;

(b) The name of the minor alleged to meet the criteria for one hundred eighty-day commitment;

(c) A statement that the petitioner is the professional person in charge of the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program responsible for the treatment of the minor;

(d) The date of the fourteen-day commitment order; and

(e) A summary of the facts supporting the petition.

(3) The petition shall be supported by accompanying affidavits signed by: (a) Two examining physicians, one of whom shall be a child psychiatrist, or two psychiatric advanced registered nurse practitioners, one of whom shall be a child and adolescent or family psychiatric advanced registered nurse practitioner. If the petition is for substance use disorder treatment, the petition may be signed by a substance use disorder professional instead of a mental health professional and by an advanced registered nurse practitioner instead of a psychiatric advanced registered nurse practitioner, or two physician assistants, one of whom must be supervised by a child psychiatrist; (b) one children's mental health specialist and either an examining physician, physician assistant, or a psychiatric advanced registered nurse practitioner; or (c) two among an examining physician, physician assistant, and a psychiatric advanced registered nurse practitioner, one of which needs to be a child psychiatrist, a physician assistant supervised by a child psychiatrist, or a child and adolescent psychiatric nurse practitioner. The affidavits shall describe in detail the behavior of the detained minor which supports the petition and shall state whether a less restrictive alternative to inpatient treatment is in the best interests of the minor.

(4) The petition for one hundred eighty-day commitment shall be filed with the clerk of the court at least three days before the expiration of the fourteen-day commitment period. The petitioner or the petitioner's designee shall within

twenty-four hours of filing serve a copy of the petition on the minor and notify the minor's attorney and the minor's parent. A copy of the petition shall be provided to such persons at least twenty-four hours prior to the hearing.

(5) At the time of filing, the court shall set a date within seven days for the hearing on the petition. If the hearing is not commenced within thirty days after the filing of the petition, including extensions of time requested by the detained person or his or her attorney or the court in the administration of justice under RCW 71.34.735, the minor must be released. The minor or the parents shall be afforded the same rights as in a fourteen-day commitment hearing. Treatment of the minor shall continue pending the proceeding.

(6) For one hundred eighty-day commitment:

(a) The court must find by clear, cogent, and convincing evidence that the minor:

(i) Is suffering from a mental disorder or substance use disorder;

(ii) Presents a likelihood of serious harm or is gravely disabled; and

(iii) Is in need of further treatment that only can be provided in a one hundred eighty-day commitment.

(b) If commitment is for a substance use disorder, the court must find that there is an available approved substance use disorder treatment program that has adequate space for the minor.

(7) In determining whether an inpatient or less restrictive alternative commitment is appropriate, great weight must be given to evidence of a prior history or pattern of decompensation and discontinuation of treatment resulting in: (a) Repeated hospitalizations; or (b) repeated peace officer interventions resulting in juvenile charges. Such evidence may be used to provide a factual basis for concluding that the minor would not receive, if released, such care as is essential for his or her health or safety.

(8)(a) If the court finds that the criteria for commitment are met and that less restrictive treatment in a community setting is not appropriate or available, the court shall order the minor committed to the custody of the director for further inpatient mental health treatment, to an approved substance use disorder treatment program for further substance use disorder treatment, or to a private treatment and evaluation facility for inpatient mental health or substance use disorder treatment if the minor's parents have assumed responsibility for payment for the treatment. If the court finds that a less restrictive alternative is in the best interest of the minor, the court shall order less restrictive alternative treatment upon such conditions as necessary.

(b) If the court determines that the minor does not meet the criteria for one hundred eighty-day commitment, the minor shall be released.

(9) Successive one hundred eighty-day commitments are permissible on the same grounds and under the same procedures as the original one hundred eighty-day commitment. Such petitions shall be filed at least three days prior to the expiration of the previous one hundred eighty-day commitment order. [2020 c 302 § 94; 2020 c 185 § 6. Prior: 2019 c 446 § 39; 2019 c 325 § 2008; prior: 2016 sp.s. c 29 § 276; 2016 c 155 § 21; 2009 c 217 § 18; 1985 c 354 § 9. Formerly RCW 71.34.090.]

Reviser's note: This section was amended by 2020 c 185 § 6 and by 2020 c 302 § 94, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Expiration date—2020 c 302 §§ 13, 16, 26, 39, 45, 55, 78, 83, 86, 92, 94, and 97: See note following RCW 71.05.150.

Expiration date—2020 c 185 § 6: "Section 6 of this act expires July 1, 2026." [2020 c 185 § 9.]

Expiration date—2019 c 446 §§ 4, 6, 8, 11, 14, 30, 32, 34, 37, 39, and 41: See note following RCW 71.05.150.

Expiration date—2019 c 325 § 2008: "Section 2008 of this act expires July 1, 2026." [2019 c 325 § 6006.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.34.750 Petition for one hundred eighty-day commitment—Hearing—Requirements—Findings by court—Commitment order—Release—Successive commitments. ***(Effective July 1, 2026.)*** (1) At any time during the minor's period of fourteen-day commitment, the professional person in charge may petition the court for an order requiring the minor to undergo an additional one hundred eighty-day period of treatment. The evidence in support of the petition shall be presented by the county prosecutor unless the petition is filed by the professional person in charge of a state-operated facility in which case the evidence shall be presented by the attorney general.

(2) The petition for one hundred eighty-day commitment shall contain the following:

(a) The name and address of the petitioner or petitioners;

(b) The name of the minor alleged to meet the criteria for one hundred eighty-day commitment;

(c) A statement that the petitioner is the professional person in charge of the evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program responsible for the treatment of the minor;

(d) The date of the fourteen-day commitment order; and

(e) A summary of the facts supporting the petition.

(3) The petition shall be supported by accompanying affidavits signed by: (a) Two examining physicians, one of whom shall be a child psychiatrist, or two psychiatric advanced registered nurse practitioners, one of whom shall be a child and adolescent or family psychiatric advanced registered nurse practitioner. If the petition is for substance use disorder treatment, the petition may be signed by a substance use disorder professional instead of a mental health professional and by an advanced registered nurse practitioner instead of a psychiatric advanced registered nurse practitioner, or two physician assistants, one of whom must be supervised by a child psychiatrist; (b) one children's mental health specialist and either an examining physician, physician assistant, or a psychiatric advanced registered nurse practitioner; or (c) two among an examining physician, physician assistant, and a psychiatric advanced registered nurse practitioner, one of which needs to be a child psychiatrist, a physician assistant supervised by a child psychiatrist, or a child and adolescent psychiatric nurse practitioner. The affidavits shall describe in detail the behavior of the detained minor which supports the petition and shall state whether a

less restrictive alternative to inpatient treatment is in the best interests of the minor.

(4) The petition for one hundred eighty-day commitment shall be filed with the clerk of the court at least three days before the expiration of the fourteen-day commitment period. The petitioner or the petitioner's designee shall within twenty-four hours of filing serve a copy of the petition on the minor and notify the minor's attorney and the minor's parent. A copy of the petition shall be provided to such persons at least twenty-four hours prior to the hearing.

(5) At the time of filing, the court shall set a date within seven days for the hearing on the petition. If the hearing is not commenced within thirty days after the filing of the petition, including extensions of time requested by the detained person or his or her attorney or the court in the administration of justice under RCW 71.34.735, the minor must be released. The minor or the parents shall be afforded the same rights as in a fourteen-day commitment hearing. Treatment of the minor shall continue pending the proceeding.

(6) For one hundred eighty-day commitment, the court must find by clear, cogent, and convincing evidence that the minor:

(a) Is suffering from a mental disorder or substance use disorder;

(b) Presents a likelihood of serious harm or is gravely disabled; and

(c) Is in need of further treatment that only can be provided in a one hundred eighty-day commitment.

(7) In determining whether an inpatient or less restrictive alternative commitment is appropriate, great weight must be given to evidence of a prior history or pattern of decompensation and discontinuation of treatment resulting in: (a) Repeated hospitalizations; or (b) repeated peace officer interventions resulting in juvenile charges. Such evidence may be used to provide a factual basis for concluding that the minor would not receive, if released, such care as is essential for his or her health or safety.

(8)(a) If the court finds that the criteria for commitment are met and that less restrictive treatment in a community setting is not appropriate or available, the court shall order the minor committed to the custody of the director for further inpatient mental health treatment, to an approved substance use disorder treatment program for further substance use disorder treatment, or to a private treatment and evaluation facility for inpatient mental health or substance use disorder treatment if the minor's parents have assumed responsibility for payment for the treatment. If the court finds that a less restrictive alternative is in the best interest of the minor, the court shall order less restrictive alternative treatment upon such conditions as necessary.

(b) If the court determines that the minor does not meet the criteria for one hundred eighty-day commitment, the minor shall be released.

(9) Successive one hundred eighty-day commitments are permissible on the same grounds and under the same procedures as the original one hundred eighty-day commitment. Such petitions shall be filed at least three days prior to the expiration of the previous one hundred eighty-day commitment order. [2020 c 302 § 95; 2020 c 185 § 7. Prior: 2019 c 446 § 40; 2019 c 325 § 2009; 2016 sp.s. c 29 § 277; 2016 sp.s. c 29 § 276; 2016 c 155 § 21; 2009 c 217 § 18; 1985 c 354 § 9. Formerly RCW 71.34.090.]

Reviser's note: This section was amended by 2020 c 185 § 7 and by 2020 c 302 § 95, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2020 c 302 §§ 14, 17, 27, 40, 46, 56, 79, 84, 87, 93, 95, and 98: See note following RCW 71.05.150.

Effective date—2020 c 185 § 7: "Section 7 of this act takes effect July 1, 2026." [2020 c 185 § 10.]

Effective date—2019 c 446 §§ 5, 7, 9, 12, 15, 31, 33, 35, 38, 40, and 42: See note following RCW 71.05.150.

Effective date—2019 c 325 § 2009: "Section 2009 of this act takes effect July 1, 2026." [2019 c 325 § 6005.]

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.34.755 Less restrictive alternative treatment—Requirements. (1) Less restrictive alternative treatment, at a minimum, must include the following services:

(a) Assignment of a care coordinator;

(b) An intake evaluation with the provider of the less restrictive alternative treatment;

(c) A psychiatric evaluation, a substance use disorder evaluation, or both;

(d) A schedule of regular contacts with the provider of the less restrictive alternative treatment services for the duration of the order;

(e) A transition plan addressing access to continued services at the expiration of the order;

(f) An individual crisis plan;

(g) Consultation about the formation of a mental health advance directive under chapter 71.32 RCW; and

(h) Notification to the care coordinator assigned in (a) of this subsection if reasonable efforts to engage the client fail to produce substantial compliance with court-ordered treatment conditions.

(2) Less restrictive alternative treatment may include the following additional services:

(a) Medication management;

(b) Psychotherapy;

(c) Nursing;

(d) Substance use disorder counseling;

(e) Residential treatment;

(f) Partial hospitalization;

(g) Intensive outpatient treatment;

(h) Support for housing, benefits, education, and employment; and

(i) Periodic court review.

(3) If the minor was provided with involuntary medication during the involuntary commitment period, the less restrictive alternative treatment order may authorize the less restrictive alternative treatment provider or its designee to administer involuntary antipsychotic medication to the person if the provider has attempted and failed to obtain the informed consent of the person and there is a concurring medical opinion approving the medication by a psychiatrist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, or physician or physician assistant in consultation with an independent mental health professional with prescribing authority.

(4) Less restrictive alternative treatment must be administered by a provider that is certified or licensed to provide or coordinate the full scope of services required under the less restrictive alternative order and that has agreed to assume this responsibility.

(5) The care coordinator assigned to a minor ordered to less restrictive alternative treatment must submit an individualized plan for the minor's treatment services to the court that entered the order. An initial plan must be submitted as soon as possible following the intake evaluation and a revised plan must be submitted upon any subsequent modification in which a type of service is removed from or added to the treatment plan.

(6) A care coordinator may disclose information and records related to mental health services pursuant to RCW 70.02.230(2)(k) for purposes of implementing less restrictive alternative treatment.

(7) For the purpose of this section, "care coordinator" means a clinical practitioner who coordinates the activities of less restrictive alternative treatment. The care coordinator coordinates activities with the designated crisis responders that are necessary for enforcement and continuation of less restrictive alternative treatment orders and is responsible for coordinating service activities with other agencies and establishing and maintaining a therapeutic relationship with the individual on a continuing basis. [2022 c 210 § 21. Prior: 2021 c 287 § 21; 2021 c 264 § 16; 2020 c 302 § 96.]

71.34.760 Placement of minor in state evaluation and treatment facility or substance use disorder treatment program—Placement committee—Facility or program to report to committee. (1) If a minor is committed for one hundred eighty-day inpatient treatment and is to be placed in a state-supported program, the director shall accept immediately and place the minor in a state-funded long-term evaluation and treatment facility or state-funded approved substance use disorder treatment program.

(2) The director's placement authority shall be exercised through a designated placement committee appointed by the director and composed of children's mental health specialists and substance use disorder professionals, including at least one child psychiatrist who represents the state-funded, long-term, evaluation and treatment facility for minors and one substance use disorder professional who represents the state-funded approved substance use disorder treatment program. The responsibility of the placement committee will be to:

(a) Make the long-term placement of the minor in the most appropriate, available state-funded evaluation and treatment facility or approved substance use disorder treatment program, having carefully considered factors including the treatment needs of the minor, the most appropriate facility able to respond to the minor's identified treatment needs, the geographic proximity of the facility to the minor's family, the immediate availability of bed space, and the probable impact of the placement on other residents of the facility;

(b) Approve or deny requests from treatment facilities for transfer of a minor to another facility;

(c) Receive and monitor reports required under this section;

(d) Receive and monitor reports of all discharges.

(3) The director may authorize transfer of minors among treatment facilities if the transfer is in the best interests of the minor or due to treatment priorities.

(4) The responsible state-funded evaluation and treatment facility or approved substance use disorder treatment program shall submit a report to the authority's designated placement committee within ninety days of admission and no less than every one hundred eighty days thereafter, setting forth such facts as the authority requires, including the minor's individual treatment plan and progress, recommendations for future treatment, and possible less restrictive treatment. [2019 c 444 § 20; 2018 c 201 § 5019; 2016 sp.s. c 29 § 278; 1985 c 354 § 10. Formerly RCW 71.34.100.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.34.770 Release of minor—Conditional release—Discharge. (1) The professional person in charge of the inpatient treatment facility may authorize release for the minor under such conditions as appropriate. Conditional release may be revoked pursuant to RCW 71.34.780 if leave conditions are not met or the minor's functioning substantially deteriorates.

(2) Minors may be discharged prior to expiration of the commitment period if the treating physician, physician assistant, psychiatric advanced registered nurse practitioner, or professional person in charge concludes that the minor no longer meets commitment criteria. [2016 c 155 § 22; 2009 c 217 § 19; 1985 c 354 § 12. Formerly RCW 71.34.120.]

71.34.780 Minor's failure to adhere to outpatient conditions—Deterioration of minor's functioning—Transport to facility or program—Order of apprehension and detention—Revocation of alternative treatment or conditional release—Hearings. ***(Effective until July 1, 2026.)*** (1) If the professional person in charge of an outpatient treatment program, a designated crisis responder, or the director or secretary, as appropriate, determines that a minor is failing to adhere to the conditions of the court order for less restrictive alternative treatment or the conditions for the conditional release, or that substantial deterioration in the minor's functioning has occurred, the designated crisis responder, or the director or secretary, as appropriate, may order that the minor be taken into custody and transported to an inpatient evaluation and treatment facility, a secure withdrawal management and stabilization facility, or an approved substance use disorder treatment program. A secure withdrawal management and stabilization facility or approved substance use disorder treatment program that has adequate space for the minor must be available.

(2)(a) The designated crisis responder, director, or secretary, as appropriate, shall file the order of apprehension and detention and serve it upon the minor and notify the minor's parent and the minor's attorney, if any, of the detention within two days of return. At the time of service the minor shall be informed of the right to a hearing and to representation by an attorney. The designated crisis responder or the director or

secretary, as appropriate, may modify or rescind the order of apprehension and detention at any time prior to the hearing.

(b) If the minor is involuntarily detained for revocation at an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program in a different county from where the minor was initially detained, the facility or program may file the order of apprehension, serve it on the minor and notify the minor's parents and the minor's attorney at the request of the designated crisis responder.

(3) A petition for revocation of less restrictive alternative treatment shall be filed by the designated crisis responder or the director, secretary, or facility, as appropriate, with the court in the county where the minor is detained. The court shall conduct the hearing in that county. A petition for revocation of conditional release must be filed in the county where the minor is detained. A petition shall describe the behavior of the minor indicating violation of the conditions or deterioration of routine functioning and a dispositional recommendation. The hearing shall be held within seven days of the minor's return. The issues to be determined are whether the minor did or did not adhere to the conditions of the less restrictive alternative treatment or conditional release, or whether the minor's routine functioning has substantially deteriorated, and, if so, whether the conditions of less restrictive alternative treatment or conditional release should be modified or, subject to subsection (4) of this section, whether the minor should be returned to inpatient treatment. Pursuant to the determination of the court, the minor shall be returned to less restrictive alternative treatment or conditional release on the same or modified conditions or shall be returned to inpatient treatment. If the minor is returned to inpatient treatment, RCW 71.34.760 regarding the director's placement responsibility shall apply. The hearing may be waived by the minor and the minor returned to inpatient treatment or to less restrictive alternative treatment or conditional release on the same or modified conditions.

(4) A court may not order the return of a minor to inpatient treatment in a secure withdrawal management and stabilization facility or approved substance use disorder treatment program unless there is a secure withdrawal management and stabilization facility or approved substance use disorder treatment program available with adequate space for the minor. [2020 c 302 § 97; 2019 c 446 § 41; 2018 c 201 § 5020; 2016 sp.s. c 29 § 279; 1985 c 354 § 11. Formerly RCW 71.34.110.]

Expiration date—2020 c 302 §§ 13, 16, 26, 39, 45, 55, 78, 83, 86, 92, 94, and 97: See note following RCW 71.05.150.

Expiration date—2019 c 446 §§ 4, 6, 8, 11, 14, 30, 32, 34, 37, 39, and 41: See note following RCW 71.05.150.

Expiration date—2018 c 201 §§ 3009, 3012, 3026, 5017, and 5020: See note following RCW 71.05.240.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.34.780 Minor's failure to adhere to outpatient conditions—Deterioration of minor's functioning—Transport to facility or program—Order of apprehension and detention—Revocation of alternative treatment or conditional release—Hearings. *(Effective July 1, 2026.)*

(1) If the professional person in charge of an outpatient treatment program, a designated crisis responder, or the director or secretary, as appropriate, determines that a minor is failing to adhere to the conditions of the court order for less restrictive alternative treatment or the conditions for the conditional release, or that substantial deterioration in the minor's functioning has occurred, the designated crisis responder, or the director or secretary, as appropriate, may order that the minor be taken into custody and transported to an inpatient evaluation and treatment facility, a secure withdrawal management and stabilization facility, or an approved substance use disorder treatment program.

(2)(a) The designated crisis responder, director, or secretary, as appropriate, shall file the order of apprehension and detention and serve it upon the minor and notify the minor's parent and the minor's attorney, if any, of the detention within two days of return. At the time of service the minor shall be informed of the right to a hearing and to representation by an attorney. The designated crisis responder or the director or secretary, as appropriate, may modify or rescind the order of apprehension and detention at any time prior to the hearing.

(b) If the minor is involuntarily detained for revocation at an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program in a different county from where the minor was initially detained, the facility or program may file the order of apprehension, serve it on the minor and notify the minor's parents and the minor's attorney at the request of the designated crisis responder.

(3) A petition for revocation of less restrictive alternative treatment shall be filed by the designated crisis responder or the director, secretary, or facility, as appropriate, with the court in the county where the minor is detained. The court shall conduct the hearing in that county. A petition for revocation of conditional release must be filed in the county where the minor is detained. A petition shall describe the behavior of the minor indicating violation of the conditions or deterioration of routine functioning and a dispositional recommendation. The hearing shall be held within seven days of the minor's return. The issues to be determined are whether the minor did or did not adhere to the conditions of the less restrictive alternative treatment or conditional release, or whether the minor's routine functioning has substantially deteriorated, and, if so, whether the conditions of less restrictive alternative treatment or conditional release should be modified or whether the minor should be returned to inpatient treatment. Pursuant to the determination of the court, the minor shall be returned to less restrictive alternative treatment or conditional release on the same or modified conditions or shall be returned to inpatient treatment. If the minor is returned to inpatient treatment, RCW 71.34.760 regarding the director's placement responsibility shall apply. The hearing may be waived by the minor and the minor returned to inpatient treatment or to less restrictive alternative treatment or conditional release on the same or modified conditions. [2020 c 302 § 98; 2019 c 446 § 42; 2018 c 201 § 5021; 2016 sp.s. c 29 § 280; 2016 sp.s. c 29 § 279; 1985 c 354 § 11. Formerly RCW 71.34.110.]

Effective date—2020 c 302 §§ 14, 17, 27, 40, 46, 56, 79, 84, 87, 93, 95, and 98: See note following RCW 71.05.150.

Effective date—2019 c 446 §§ 5, 7, 9, 12, 15, 31, 33, 35, 38, 40, and 42: See note following RCW 71.05.150.

Effective date—2018 c 201 §§ 3010, 3013, 3027, 5018, and 5021: See note following RCW 71.05.240.

Findings—Intent—2018 c 201: See note following RCW 41.05.018.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

71.34.790 Transportation for minors committed to state facility for one hundred eighty-day treatment. Necessary transportation for minors committed to the director under this chapter for one hundred eighty-day treatment shall be provided by the authority in the most appropriate and cost-effective means. [2018 c 201 § 5022; 1985 c 354 § 15. Formerly RCW 71.34.150.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.34.795 Transferring or moving persons from juvenile correctional institutions or facilities to evaluation and treatment facilities. When in the judgment of the department of children, youth, and families the welfare of any person committed to or confined in any state juvenile correctional institution or facility necessitates that the person be transferred or moved for observation, diagnosis, or treatment to an evaluation and treatment facility, the secretary of children, youth, and families or the secretary's designee is authorized to order and effect such move or transfer for a period of up to fourteen days, provided that the secretary notifies the original committing court of the transfer and the evaluation and treatment facility is in agreement with the transfer. No person committed to or confined in any state juvenile correctional institution or facility may be transferred to an evaluation and treatment facility for more than fourteen days unless that person has been admitted as a voluntary patient or committed for one hundred eighty-day treatment under this chapter or ninety-day treatment under chapter 71.05 RCW if eighteen years of age or older. Underlying jurisdiction of minors transferred or committed under this section remains with the state correctional institution. A voluntary admitted minor or minors committed under this section and no longer meeting the criteria for one hundred eighty-day commitment shall be returned to the state correctional institution to serve the remaining time of the underlying dispositional order or sentence. The time spent by the minor at the evaluation and treatment facility shall be credited towards the minor's juvenile court sentence. [2017 3rd sp.s. c 6 § 725; 1985 c 354 § 19. Formerly RCW 71.34.180.]

Effective date—2017 3rd sp.s. c 6 §§ 601-631, 701-728, and 804: See note following RCW 13.04.011.

Conflict with federal requirements—2017 3rd sp.s. c 6: See RCW 43.216.908.

71.34.796 Transfer of person committed to juvenile correction institution to institution or facility for juveniles with behavioral health disorders. When, in the judgment of the department of social and health services, the welfare of any person committed to or confined in any state juvenile correctional institution or facility necessitates that such a person be transferred or moved for observation, diagnosis or treatment to any state institution or facility for the care of juveniles with behavioral health disorders the secretary of the department of social and health services, or his or her designee, is authorized to order and effect such move or transfer: PROVIDED, HOWEVER, That the secretary of the department of social and health services shall adopt and implement procedures to assure that persons so transferred shall, while detained or confined in such institution or facility for the care of juveniles with behavioral health disorders, be provided with substantially similar opportunities for parole or early release evaluation and determination as persons detained or confined in state juvenile correctional institutions or facilities: PROVIDED, FURTHER, That the secretary of the department of social and health services shall notify the original committing court of such transfer. [2020 c 302 § 51; 2018 c 201 § 3024; 1997 c 112 § 36; 1975 1st ex.s. c 199 § 12. Formerly RCW 71.05.525.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

71.34.815 Assisted outpatient treatment—Findings—Petition, court order for less restrictive alternative treatment—Procedure. (1) An adolescent is in need of assisted outpatient treatment if the court finds by clear, cogent, and convincing evidence in response to a petition filed under this section that:

(a) The adolescent has a behavioral health disorder;

(b) Based on a clinical determination and in view of the adolescent's treatment history and current behavior, at least one of the following is true:

(i) The adolescent is unlikely to survive safely in the community without supervision and the adolescent's condition is substantially deteriorating; or

(ii) The adolescent is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or a likelihood of serious harm to the adolescent or to others;

(c) The adolescent has a history of lack of compliance with treatment for his or her behavioral health disorder that has:

(i) At least twice within the 36 months prior to the filing of the petition been a significant factor in necessitating hospitalization of the adolescent, or the adolescent's receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, provided that the 36-month period shall be extended by the length of any hospitalization or incarceration of the adolescent that occurred within the 36-month period;

(ii) At least twice within the 36 months prior to the filing of the petition been a significant factor in necessitating emergency medical care or hospitalization for behavioral health-related medical conditions including overdose, infected abscesses, sepsis, endocarditis, or other maladies, or a significant factor in behavior which resulted in the adolescent's incarceration in a state or local correctional facility; or

(iii) Resulted in one or more violent acts, threats, or attempts to cause serious physical harm to the adolescent or another within the 48 months prior to the filing of the petition, provided that the 48-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred during the 48-month period;

(d) Participation in an assisted outpatient treatment program would be the least restrictive alternative necessary to ensure the adolescent's recovery and stability; and

(e) The adolescent will benefit from assisted outpatient treatment.

(2) The following individuals may directly file a petition for less restrictive alternative treatment on the basis that an adolescent is in need of assisted outpatient treatment:

(a) The director of a hospital where the adolescent is hospitalized or the director's designee;

(b) The director of a behavioral health service provider providing behavioral health care or residential services to the adolescent or the director's designee;

(c) The adolescent's treating mental health professional or substance use disorder professional or one who has evaluated the person;

(d) A designated crisis responder;

(e) A release planner from a juvenile detention or rehabilitation facility; or

(f) An emergency room physician.

(3) A court order for less restrictive alternative treatment on the basis that the adolescent is in need of assisted outpatient treatment may be effective for up to 18 months. The petitioner must personally interview the adolescent, unless the adolescent refuses an interview, to determine whether the adolescent will voluntarily receive appropriate treatment.

(4) The petitioner must allege specific facts based on personal observation, evaluation, or investigation, and must consider the reliability or credibility of any person providing information material to the petition.

(5) The petition must include:

(a) A statement of the circumstances under which the adolescent's condition was made known and the basis for the opinion, from personal observation or investigation, that the adolescent is in need of assisted outpatient treatment. The petitioner must state which specific facts come from personal observation and specify what other sources of information the petitioner has relied upon to form this belief;

(b) A declaration from a physician, physician assistant, or advanced registered nurse practitioner, or the adolescent's treating mental health professional or substance use disorder professional, who has examined the adolescent no more than 10 days prior to the submission of the petition and who is willing to testify in support of the petition, or who alternatively has made appropriate attempts to examine the adolescent within the same period but has not been successful in obtaining the adolescent's cooperation, and who is willing to testify to the reasons they believe that the adolescent meets the criteria for assisted outpatient treatment. If the declaration is provided by the adolescent's treating mental health professional or substance use disorder professional, it must be cosigned by a supervising physician, physician assistant, or advanced registered nurse practitioner who certifies that they have reviewed the declaration;

(c) The declarations of additional witnesses, if any, supporting the petition for assisted outpatient treatment;

(d) The name of an agency, provider, or facility that agrees to provide less restrictive alternative treatment if the petition is granted by the court; and

(e) If the adolescent is detained in a state hospital, inpatient treatment facility, or juvenile detention or rehabilitation facility at the time the petition is filed, the anticipated release date of the adolescent and any other details needed to facilitate successful reentry and transition into the community.

(6)(a) Upon receipt of a petition meeting all requirements of this section, the court shall fix a date for a hearing:

(i) No sooner than three days or later than seven days after the date of service or as stipulated by the parties or, upon a showing of good cause, no later than 30 days after the date of service; or

(ii) If the adolescent is hospitalized at the time of filing of the petition, before discharge of the adolescent and in sufficient time to arrange for a continuous transition from inpatient treatment to assisted outpatient treatment.

(b) A copy of the petition and notice of hearing shall be served, in the same manner as a summons, on the petitioner, the adolescent, the qualified professional whose affidavit accompanied the petition, a current provider, if any, and a surrogate decision maker or agent under chapter 71.32 RCW, if any.

(c) If the adolescent has a surrogate decision maker or agent under chapter 71.32 RCW who wishes to provide testimony at the hearing, the court shall afford the surrogate decision maker or agent an opportunity to testify.

(d) The adolescent shall be represented by counsel at all stages of the proceedings.

(e) If the adolescent fails to appear at the hearing after notice, the court may conduct the hearing in the adolescent's absence; provided that the adolescent's counsel is present.

(f) If the adolescent has refused to be examined by the qualified professional whose affidavit accompanied the petition, the court may order a mental examination of the adolescent. The examination of the adolescent may be performed by the qualified professional whose affidavit accompanied the petition. If the examination is performed by another qualified professional, the examining qualified professional shall be authorized to consult with the qualified professional whose affidavit accompanied the petition.

(g) If the adolescent has refused to be examined by a qualified professional and the court finds reasonable grounds to believe that the allegations of the petition are true, the court may issue a written order directing a peace officer who has completed crisis intervention training to detain and transport the adolescent to a provider for examination by a qualified professional. An adolescent detained pursuant to this subsection shall be detained no longer than necessary to complete the examination and in no event longer than 24 hours. All papers in the court file must be provided to the adolescent's designated attorney.

(7) If the petition involves an adolescent whom the petitioner or behavioral health administrative services organization knows, or has reason to know, is an American Indian or Alaska Native who receives medical or behavioral health services from a tribe within this state, the behavioral health administrative services organization shall notify the tribe and Indian health care provider. Notification shall be made in person or by telephonic or electronic communication to the tribal contact listed in the authority's tribal crisis coordination plan as soon as possible.

(8) A petition for assisted outpatient treatment filed under this section shall be adjudicated under RCW 71.34.740.

(9) After January 1, 2023, a petition for assisted outpatient treatment must be filed on forms developed by the administrative office of the courts. [2022 c 210 § 4.]

71.34.905 Rule making—Access to files and records of court proceedings. The legislature recognizes the inherent authority of the judiciary under Article IV, section 1 of the state Constitution to establish rules regarding access to court records, and respectfully requests the Washington state supreme court to adopt rules regarding potential access for the following entities to the files and records of court proceedings under this chapter and chapter 71.05 RCW:

(1) The department;

(2) The department of health;

(3) The authority;

(4) The state hospitals as defined in RCW 72.23.010;

(5) Any person who is the subject of a petition;

(6) The attorney or guardian of the person;

(7) Resource management services for that person; and

(8) Service providers authorized to receive such information by resource management services. [2020 c 302 § 99.]

71.34.910 Appearance by video technology. For purposes of this chapter, at any hearing the petitioner, the respondent, the witnesses, the interpreters, and the presiding judicial officer may be present and participate either in person or by video, as determined by the court. The term "video" as used in this section includes any functional equivalent. At any hearing conducted by video, the technology used must permit the judicial officer, counsel, all parties, and the witnesses to be able to see, hear, and speak, when authorized, during the hearing; to allow attorneys to use exhibits or other materials during the hearing; and to allow the respondent's counsel to be in the same location as the respondent unless otherwise requested by the respondent or the respondent's counsel. Witnesses in a proceeding may also appear in court through other means, including telephonically, pursuant to the requirements of superior court civil rule 43. Notwithstanding the foregoing, the court, upon its own motion or upon a motion for good cause by any party, may require all parties and witnesses to participate in the hearing in person rather than by video. In ruling on any such motion, the court may allow in-person or video testimony; and the court may consider, among other things, whether the respondent's alleged behavioral health disorder affects the respondent's ability to perceive or participate in the proceeding by video. [2020 c 302 § 100.]

71.34.915 Authority outreach—Law and policy communication—Accessibility. The authority shall dedicate at least one full-time employee to:

(1) Connecting families, behavioral health providers, educators, and other stakeholders with current information about law and policy related to behavioral health services for minors;

(2) Creating shareable content appropriate for communicating policy and resources related to behavioral health services for minors;

(3) Designing and maintaining a communications plan related to behavioral health services for minors involving social media and other forms of direct outreach to providers, families, and youth; and

(4) Monitoring the health care authority website to make sure that the information included on the website is accurate and designed in a manner that is accessible to families. [2022 c 134 § 1.]

71.34.918 Authority outreach—Parent portal—Report to legislature. (1) The authority shall convene stakeholders to design, further define, and implement a parent portal. The authority shall work with stakeholders including Washington state community connectors and consider the website prototype already under development by that organization. The stakeholders convened must additionally include other parents and young adults with relevant lived experience.

(2) As used in this section, "parent portal" means a method for connecting families to their community's service and education infrastructure related to behavioral health services for minors, including services supported or provided by:

(a) A behavioral health provider as defined in RCW 71.24.025 that provides services to minors;

(b) A licensed or certified behavioral health agency as defined in RCW 71.24.025 that provides behavioral health services to minors;

(c) A long-term care facility as defined in RCW 43.190.020 in which minors with behavioral health conditions reside;

(d) The child study and treatment center as identified in RCW 71.34.380;

(e) A facility or agency that receives state funding to provide behavioral health treatment services to minors with a behavioral health condition;

(f) The department of children, youth, and families;

(g) The office of the superintendent of public instruction; and

(h) The department.

(3) By November 1, 2022, the authority shall provide a report to the governor and the appropriate committees of the legislature detailing:

(a) The stakeholder engagement conducted under this section;

(b) The design and further definition of the parent portal; and

(c) Other relevant information about successfully implementing the parent portal, including needed legislative changes or support. [2022 c 134 § 2.]

Chapter 71.36 RCW

COORDINATION OF CHILDREN'S MENTAL HEALTH SERVICES

Sections

71.36.005 Intent. The legislature intends to substantially improve the delivery of children's mental health services in Washington state through the development and implementation of a children's mental health system that:

(1) Values early identification, intervention, and prevention;

(2) Coordinates existing categorical children's mental health programs and funding, through efforts that include elimination of duplicative care plans and case management;

(3) Treats each child in the context of his or her family, and provides services and supports needed to maintain a child with his or her family and community;

(4) Integrates families into treatment through choice of treatment, participation in treatment, and provision of peer support;

(5) Focuses on resiliency and recovery;

(6) Relies to a greater extent on evidence-based practices;

(7) Is sensitive to the unique cultural circumstances of children of color and children in families whose primary language is not English;

(8) Integrates educational support services that address students' diverse learning styles; and

(9) To the greatest extent possible, blends categorical funding to offer more service and support options to each child. [2007 c 359 § 1; 1991 c 326 § 11.]

Additional notes found at www.leg.wa.gov

71.36.010 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Agency" means a state, tribal, or local governmental entity or a private not-for-profit organization.

(2) "Behavioral health administrative services organization" means an entity contracted with the health care authority to administer behavioral health services and programs under RCW 71.24.381, including crisis services and administration of the involuntary treatment act, chapter 71.05 RCW, for all individuals in a defined regional service area under chapter 71.24 RCW.

(3) "Child" means a person under eighteen years of age, except as expressly provided otherwise in state or federal law.

(4) "Consensus-based" means a program or practice that has general support among treatment providers and experts, based on experience or professional literature, and may have anecdotal or case study support, or that is agreed but not possible to perform studies with random assignment and controlled groups.

(5) "County authority" means the board of county commissioners or county executive.

(6) "Early periodic screening, diagnosis, and treatment" means the component of the federal medicaid program established pursuant to 42 U.S.C. Sec. 1396d(r), as amended.

(7) "Evidence-based" means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.

(8) "Family" means a child's biological parents, adoptive parents, foster parents, guardian, legal custodian authorized pursuant to Title 26 RCW, a relative with whom a child has been placed by the department of social and health services, or a tribe.

(9) "Managed care organization" means an organization, having a certificate of authority or certificate of registration from the office of the insurance commissioner, that contracts with the health care authority under a comprehensive risk contract to provide prepaid health care services to enrollees under the authority's managed care programs under chapter 74.09 RCW.

(10) "Promising practice" or "emerging best practice" means a practice that presents, based upon preliminary information, potential for becoming a research-based or consensus-based practice.

(11) "Research-based" means a program or practice that has some research demonstrating effectiveness, but that does not yet meet the standard of evidence-based practices.

(12) "Wraparound process" means a family driven planning process designed to address the needs of children and youth by the formation of a team that empowers families to make key decisions regarding the care of the child or youth in partnership with professionals and the family's natural community supports. The team produces a community-based and culturally competent intervention plan which identifies the strengths and needs of the child or youth and family and defines goals that the team collaborates on achieving with respect for the unique cultural values of the family. The "wraparound process" shall emphasize principles of persistence and outcome-based measurements of success. [2019 c 325 § 2010; 2018 c 201 § 5023. Prior: 2014 c 225 § 91; 2007 c 359 § 2; 1991 c 326 § 12.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

Additional notes found at www.leg.wa.gov

71.36.025 Elements of a children's mental health system. (1) It is the goal of the legislature that the children's mental health system in Washington state include the following elements:

(a) A continuum of services from early identification, intervention, and prevention through crisis intervention and inpatient treatment, including peer support and parent mentoring services;

(b) Equity in access to services for similarly situated children, including children with co-occurring disorders;

(c) Developmentally appropriate, high quality, and culturally competent services available statewide;

(d) Treatment of each child in the context of his or her family and other persons that are a source of support and stability in his or her life;

(e) A sufficient supply of qualified and culturally competent children's mental health providers;

(f) Use of developmentally appropriate evidence-based and research-based practices;

(g) Integrated and flexible services to meet the needs of children who, due to mental illness or emotional or behavioral disturbance, are at risk of out-of-home placement or involved with multiple child-serving systems.

(2) The effectiveness of the children's mental health system shall be determined through the use of outcome-based

performance measures. The health care authority and the evidence-based practice institute established in RCW 71.24.061, in consultation with parents, caregivers, youth, behavioral health administrative services organizations, managed care organizations contracted with the authority under chapter 74.09 RCW, mental health services providers, health plans, primary care providers, tribes, and others, shall develop outcome-based performance measures such as:

(a) Decreased emergency room utilization;

(b) Decreased psychiatric hospitalization;

(c) Lessening of symptoms, as measured by commonly used assessment tools;

(d) Decreased out-of-home placement, including residential, group, and foster care, and increased stability of such placements, when necessary;

(e) Decreased runaways from home or residential placements;

(f) Decreased rates of substance use disorder;

(g) Decreased involvement with the juvenile justice system;

(h) Improved school attendance and performance;

(i) Reductions in school or child care suspensions or expulsions;

(j) Reductions in use of prescribed medication where cognitive behavioral therapies are indicated;

(k) Improved rates of high school graduation and employment; and

(l) Decreased use of mental health services upon reaching adulthood for mental disorders other than those that require ongoing treatment to maintain stability.

Performance measure reporting for children's mental health services should be integrated into existing performance measurement and reporting systems developed and implemented under chapter 71.24 RCW. [2019 c 325 § 2011; 2018 c 201 § 5024; 2014 c 225 § 92; 2007 c 359 § 3.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

Additional notes found at www.leg.wa.gov

71.36.040 Issue identification, data collection, plan revision—Coordination and information sharing with other state agencies. (1) The health care authority shall, within available funds:

(a) Identify internal business operation issues that limit the authority's ability to meet legislative intent to coordinate existing categorical children's mental health programs and funding;

(b) Collect reliable mental health cost, service, and outcome data specific to children. This information must be used to identify best practices and methods of improving fiscal management;

(c) Revise the early and periodic screening diagnosis and treatment plan to reflect the mental health system structure in place as necessary to conform to changes in the structure.

(2) The health care authority and the office of the superintendent of public instruction shall jointly identify school districts where mental health and education systems coordinate services and resources to provide public mental health care for children. The health care authority and the office of the superintendent of public instruction shall work together to share information about these approaches with other school districts, managed care organizations, behavioral health administrative services organizations, and state agencies. [2019 c 325 § 2012; 2018 c 201 § 5025; 2014 c 225 § 93; 2003 c 281 § 2.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2014 c 225: See note following RCW 71.24.016.

Additional notes found at www.leg.wa.gov

71.36.060 Medicaid eligible children in temporary juvenile detention. The health care authority shall explore the feasibility of obtaining a medicaid state plan amendment to allow the state to receive medicaid matching funds for health services provided to medicaid enrolled youth who are temporarily placed in a juvenile detention facility. Temporary placement shall be defined as until adjudication or up to sixty continuous days, whichever occurs first. [2018 c 201 § 5026; 2007 c 359 § 6.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Additional notes found at www.leg.wa.gov

Chapter 71.40 RCW
OFFICE OF BEHAVIORAL HEALTH CONSUMER ADVOCACY

Sections

71.40.010 Findings—Intent. (1) The legislature finds that:

(a) According to the federal substance abuse and mental health services administration's 2019 report, one in five adults in the United States will experience some form of mental illness this year and one in thirteen will need substance use disorder treatment;

(b) Fewer than half of all individuals needing behavioral health treatment receive those services;

(c) An untreated behavioral health need can have long-term negative impacts on an individual's health, well-being, and productivity;

(d) The state has made significant investments in the efficacy of the publicly funded behavioral health system and its providers;

(e) Behavioral health parity is required by both state and federal law;

(f) All patients deserve to be treated and cared for with dignity and respect;

(g) Patients often cross local and administrative boundaries when seeking effective behavioral health care;

(h) Individuals with behavioral health needs are disproportionately involved with the criminal justice system; and

(i) Providing robust community-based services can prevent expensive hospitalizations.

(2) The legislature intends to create the state office of the behavioral health consumer advocacy that shall:

(a) Advocate for all patients seeking privately and publicly funded behavioral health services;

(b) Advocate for all patients receiving inpatient behavioral health services from a behavioral health provider or facility;

(c) Assure that patients are afforded all of the rights given to them by state and federal laws;

(d) Maintain independence and be free from all conflicts of interest;

(e) Provide consistent quality services across the state; and

(f) Retain an office within the boundaries of the region served by each behavioral health administrative services organization. [2021 c 202 § 1.]

71.40.020 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Behavioral health provider or facility" means:

(a) A behavioral health provider, as defined in RCW 71.24.025, to the extent it provides behavioral health services;

(b) A licensed or certified behavioral health agency, as defined in RCW 71.24.025;

(c) A long-term care facility, as defined in RCW 43.190.020, in which adults or children with behavioral health conditions reside;

(d) A state hospital, as defined in RCW 72.23.010; or

(e) A facility or agency that receives funds from the state to provide behavioral health treatment services to adults or children with a behavioral health condition.

(2) "Contracting advocacy organization" means the organization selected by the office pursuant to RCW 71.40.030.

(3) "Department" means the department of commerce.

(4) "Office" means the state office of behavioral health consumer advocacy. [2021 c 202 § 2.]

71.40.030 Office created—Rules. (1) By July 1, 2022, the department shall establish the state office of behavioral health consumer advocacy to provide behavioral health consumer advocacy services to patients, residents, and clients of behavioral health providers or facilities. Prior to the establishment and operation of the office, the department shall solicit recommendations from members of the behavioral health community for options to rename the office and the certified behavioral health consumer advocates in a way that shows respect for the community that the office and the advocates serve. Prior to the office beginning operations, the department must rename the office and the certified behavioral health consumer advocates from the options proposed by the community. The department shall contract with a private nonprofit organization to provide behavioral health consumer advocacy services, according to the standards established by the office. The department shall assure all program and staff support necessary to enable the contracting advocacy organization to effectively protect the interests of persons with behavioral health needs in accordance with this chapter. The department shall select the organization through a competitive bidding process and shall assure that the selected organization (a) has demonstrated financial stability and meets the qualifications for the duties identified in this chapter, and (b) does not have any conflicts of interest that would interfere with the duties identified in this chapter. The department shall encourage persons who have lived experience with behavioral health conditions or who are a family member of a person with behavioral health conditions to apply.

(2) Following the selection of the organization to carry out the ministerial functions of the office, the department shall not initiate the procurement of a new contract except upon a showing of cause. Prior to ending the contract and conducting a new competitive bidding process, the department shall provide an opportunity for comment by the contracting advocacy organization and to appeal the reselection to the department.

(3) The office shall adopt rules to carry out the purposes of this chapter, including:

(a) Establishing standards for the contracting advocacy organization to use when certifying behavioral health consumer advocates;

(b) Establishing procedures consistent with chapter 202, Laws of 2021 for appropriate access by behavioral health consumer advocates to behavioral health providers or facilities; and

(c) Establishing procedures consistent with RCW 71.40.140 to protect the confidentiality of the records of patients, residents, clients, providers, and complainants. [2021 c 202 § 3.]

71.40.040 Duties of office. The state office of behavioral health consumer advocacy shall assure performance of the following activities, as authorized in contract:

(1) Selection of a name for the contracting advocacy organization to use for the advocacy program that it operates pursuant to contract with the office. The name must be selected by the statewide advisory council established in this section and must be separate and distinguishable from that of the office;

(2) Certification of behavioral health consumer advocates by October 1, 2022, and coordination of the activities of the behavioral health consumer advocates throughout the state according to standards adopted by the office;

(3) Provision of training regarding appropriate access by behavioral health consumer advocates to behavioral health providers or facilities according to standards adopted by the office;

(4) Establishment of a toll-free telephone number, website, and other appropriate technology to facilitate access to contracting advocacy organization services for patients, residents, and clients of behavioral health providers or facilities;

(5) Establishment of a statewide uniform reporting system to collect and analyze data relating to complaints and conditions provided by behavioral health providers or facili-

ties for the purpose of identifying and resolving significant problems, with permission to submit the data to all appropriate state agencies on a regular basis;

(6) Establishment of procedures consistent with the standards adopted by the office to protect the confidentiality of the office's records, including the records of patients, residents, clients, providers, and complainants;

(7) Establishment of a statewide advisory council, a majority of which must be composed of people with lived experience, that shall include:

(a) Individuals with a history of mental illness including one or more members from the black community, the indigenous community, or a community of color;

(b) Individuals with a history of substance use disorder including one or more members from the black community, the indigenous community, or a community of color;

(c) Family members of individuals with behavioral health needs including one or more members from the black community, the indigenous community, or a community of color;

(d) One or more representatives of an organization representing consumers of behavioral health services;

(e) Representatives of behavioral health providers and facilities, including representatives of facilities offering inpatient and residential behavioral health services;

(f) One or more certified peer specialists;

(g) One or more medical clinicians serving individuals with behavioral health needs;

(h) One or more nonmedical providers serving individuals with behavioral health needs;

(i) One representative from a behavioral health administrative services organization;

(j) Two parents or caregivers of a child who received behavioral health services, including one parent or caregiver of a child who received complex, multisystem behavioral health services, one parent or caregiver of a child ages one through 12, or one parent or caregiver of a child ages 13 through 17;

(k) Two representatives of medicaid managed care organizations, one of which must provide managed care to children and youth receiving child welfare services;

(l) Other community representatives, as determined by the office; and

(m) One representative from a labor union representing workers who work in settings serving individuals with behavioral health conditions;

(8) Monitoring the development of and recommend improvements in the implementation of federal, state, and local laws, rules, regulations, and policies with respect to the provision of behavioral health services in the state and advocate for consumers;

(9) Development and delivery of educational programs and information statewide to patients, residents, and clients of behavioral health providers or facilities, and their families on topics including, but not limited to, the execution of mental health advance directives, wellness recovery action plans, crisis services and contacts, peer services and supports, family advocacy and rights, family-initiated treatment and other behavioral health service options for minors, and involuntary treatment; and

(10) Reporting to the office, the legislature, and all appropriate public agencies regarding the quality of services, complaints, problems for individuals receiving services from behavioral health providers or facilities, and any recommendations for improved services for behavioral health consumers. [2022 c 134 § 4; 2021 c 202 § 4.]

71.40.050 Duties of certified behavioral health consumer advocates. (1) A certified behavioral health consumer advocate shall:

(a) Identify, investigate, and resolve complaints made by, or on behalf of, patients, residents, and clients of behavioral health providers or facilities relating to administrative action, inaction, or decisions that may adversely affect the health, safety, welfare, and rights of these individuals;

(b) Assist and advocate on behalf of patients, residents, and clients of behavioral health providers or facilities before government agencies and seek administrative, legal, and other remedies on their behalf, if appropriate;

(c) Inform patients, residents, and clients or their representatives about applicable patient and resident rights, and provide information, as appropriate, to patients, residents, clients, family members, guardians, resident representatives, and others regarding the rights of patients and residents;

(d) Make recommendations through the office and the contracting advocacy organization for improvements to the quality of services provided to patients, residents, and clients of behavioral health providers or facilities; and

(e) With the consent of the patient, resident, or client, involve family members, friends, or other designated individuals in the process of resolving complaints.

(2) Nothing in this section shall be construed to grant a certified behavioral health consumer advocate:

(a) Statutory or regulatory licensing or sanctioning authority; or

(b) Binding adjudicative authority. [2021 c 202 § 5.]

71.40.060 Collaboration with department of social and health services. (1) For state hospitals as defined in RCW 72.23.010, the state office of behavioral health consumer advocacy shall work with the department of social and health services to:

(a) Establish specialized training for behavioral health consumer advocates to work with forensic and criminal justice involved populations at the state hospitals;

(b) Create procedures and protocols that ensure that behavioral health consumer advocates have access to all state hospital patients and their families or guardians as needed to perform their duties, including persons who are awaiting admission to the state hospitals while in jail;

(c) Establish guidelines for how the state office of behavioral health consumer advocacy will work and collaborate with existing state employees who serve in an ombuds or advocate role for the state hospitals and ensure all legal requirements for these personnel are maintained; and

(d) Develop a direct reporting structure to the governor's office about any systemic issues that are discovered within the course of the advocates' duties within the state hospitals.

(2) The state office of behavioral health consumer advocacy shall complete this work in collaboration with the department of social and health services by July 1, 2023, and

prior to the deployment of behavioral health consumer advocates within the state hospitals.

(3) The state office of behavioral health consumer advocacy shall make strong efforts to encourage individuals with lived experience specific to the state hospitals to undergo training to fulfill behavioral health consumer advocate positions at the state hospitals. [2021 c 202 § 6.]

71.40.070 Access to behavioral health providers and facilities. (1) The certified behavioral health consumer advocates shall have appropriate access to behavioral health providers or facilities to effectively carry out the provisions of this chapter, with provisions made for the privacy of patients, residents, and clients, according to the rules, policies, and procedures developed under RCW 71.40.030.

(2) Nothing in this chapter restricts, limits, or increases any existing right of any organizations or individuals not described in subsection (1) of this section to enter or provide assistance to patients, residents, and clients of behavioral health providers or facilities.

(3) Nothing in this chapter restricts any right or privilege of a patient, resident, or client of a behavioral health provider or facility to receive visitors of their choice. [2021 c 202 § 7.]

71.40.080 Office contact information—Access. (1) Every behavioral health provider or facility shall post in a conspicuous location a notice providing the toll-free phone number and website of the contracting advocacy organization, as well as the name, address, and phone number of the office of the appropriate local behavioral health consumer advocate and a brief description of the services provided by the contracting advocacy organization. The form of the notice must be approved by the office. This information must also be distributed to the patients, residents, and clients of behavioral health providers or facilities, upon application for behavioral health services and upon admission to a behavioral health provider or facility. The information shall also be provided to the family members and legal guardians of the patients, residents, or clients of a behavioral health provider or facility, as allowed by state and federal privacy laws.

(2) Every behavioral health provider or facility must provide access to a free telephone for the express purpose of contacting the contracting advocacy organization. [2021 c 202 § 8.]

71.40.090 Behavioral health consumer advocates—Certification. The contracting advocacy organization shall develop and submit, for approval by the office, a process to train and certify all behavioral health consumer advocates, whether paid or volunteer, authorized by this chapter as follows:

(1) Certified behavioral health consumer advocates must have training or experience in the following areas:

(a) Behavioral health and other related social services programs, including behavioral health services for minors;

(b) The legal system, including differences in state or federal law between voluntary and involuntary patients, residents, or clients;

(c) Advocacy and supporting self-advocacy;

(d) Dispute or problem resolution techniques, including investigation, mediation, and negotiation; and

(e) All applicable patient, resident, and client rights established by either state or federal law.

(2) A certified behavioral health consumer advocate may not have been employed by any behavioral health provider or facility within the previous twelve months, except as a certified peer specialist or where prior to July 25, 2021, the person has been employed by a regional behavioral health consumer advocate.

(3) No certified behavioral health consumer advocate or any member of a certified behavioral health consumer advocate's family may have, or have had, within the previous twelve months, any significant ownership or financial interest in the provision of behavioral health services. [2022 c 134 § 5; 2021 c 202 § 9.]

71.40.100 Complaints—Review. (1) The contracting advocacy organization shall develop and submit for approval by the office referral procedures for the organization and all certified behavioral health consumer advocates to refer any complaint, in accordance with a mutually established working agreement, to an appropriate state or local government agency. The appropriate agency shall respond to any complaint referred to it by a certified behavioral health consumer advocate, in accordance with a mutually established working agreement.

(2) State agencies shall review a complaint against a behavioral health provider or facility which was referred to it by a certified behavioral health consumer advocate, in accordance with a mutually established working agreement, and shall forward to that certified behavioral health consumer advocate a summary of the results of the review or investigation and action proposed or taken.

(3) State agencies that regulate or contract with behavioral health providers or facilities shall adopt necessary rules to effectively work in coordination with the contracting advocacy organization. [2021 c 202 § 10.]

71.40.110 Working agreements. (1) The contracting advocacy organization shall develop and implement working agreements with the protection and advocacy agency, the long-term care ombuds, the developmental disabilities ombuds, the corrections ombuds, and the children and family ombuds, and work in cooperation to assure efficient, coordinated service.

(2) The contracting advocacy organization shall develop working agreements with each managed care organization, behavioral health administrative services organization, the state psychiatric hospitals, all appropriate state and local agencies, and other such entities as necessary to carry out their duties. Working agreements must include:

(a) The roles of the contracting advocacy organization and the agency or entity in complaint investigations, complaint referral criteria, and a process for sharing information regarding complaint review and investigation, as appropriate; and

(b) Processes and procedures to assure timely and seamless information sharing among all interested parties and that the contracting advocacy organization is responsive to all local information requests. [2021 c 202 § 11.]

71.40.120 Liability—Confidentiality. (1) No certified behavioral health consumer advocate is liable for good faith performance of responsibilities under this chapter.

(2) No discriminatory, disciplinary, or retaliatory action may be taken against an employee or volunteer of a behavioral health provider or facility, or a patient, resident, or client of a behavioral health provider or facility, for any communication made, or information given or disclosed, to aid the certified behavioral health consumer advocate in carrying out duties and responsibilities under this chapter, unless the same was done maliciously or without good faith. This subsection is not intended to infringe on the rights of the employer to supervise, discipline, or terminate an employee or volunteer for other reasons, and shall serve as a defense to any action in libel or slander.

(3) All communications by a certified behavioral health consumer advocate, if reasonably related to the requirements of that individual's responsibilities under this chapter and done in good faith, are privileged and confidential, subject to the procedures established by the office.

(4) A representative of the contracting advocacy organization is exempt from being required to testify in court as to any confidential matters except upon the express consent of the client, resident, or patient that is subject to the court proceedings, or their representatives, as applicable. [2021 c 202 § 12.]

71.40.130 Intent. It is the intent of the legislature that:

(1) Regional behavioral health ombuds programs existing prior to chapter 202, Laws of 2021 be integrated into this new statewide program and the ombuds from those programs be assessed and certified by the contracting advocacy organization as behavioral health consumer advocates, and for the state office of behavioral health consumer advocacy to provide the regional behavioral health ombuds programs with any additional training they may need to meet the requirements of RCW 71.40.050;

(2) There shall be a behavioral health consumer advocate office within the boundaries of the region served by each behavioral health administrative services organization;

(3) Federal medicaid requirements be complied with; and

(4) The department annually expend at least the amount expended on regional behavioral health ombuds services prior to July 25, 2021, on the office and for the procurement of services from the contracting advocacy organization under this chapter. [2021 c 202 § 13.]

71.40.140 Disclosure of records. (1) All records and files of the office, the contracting advocacy organization, and any certified behavioral health consumer advocates related to any complaint or investigation made pursuant to carrying out their duties and the identities of complainants, witnesses, patients, residents, or clients and information that could reasonably identify any of these individuals shall remain confidential unless disclosure is authorized in writing by the subject of the information, or the subject's guardian or legal representative.

(2) No disclosures of records and files related to a complaint or investigation may be made to any organization or individual outside the office or the contracting advocacy organization without the written consent of any named witnesses, complainants, patients, residents, or clients unless the disclosure is made without the identity of any of these individuals and without information that could reasonably identify any of these individuals unless such disclosure is required in carrying out its duties under this chapter.

(3) Notwithstanding subsections (1) and (2) of this section, disclosures of records and files may be made pursuant to a court order.

(4) All disclosures must be compliant with state and federal privacy laws applicable to the type of information that is sought for disclosure. [2021 c 202 § 14.]

Chapter 71.98 RCW
CONSTRUCTION

Sections

71.98.010 Continuation of existing law. The provisions of this title insofar as they are substantially the same as statutory provisions repealed by this chapter and relating to the same subject matter, shall be construed as restatements and continuations, and not as new enactments. [1959 c 25 § 71.98.010.]

71.98.020 Title, chapter, section headings not part of law. Title headings, chapter headings, and section or subsection headings, as used in this title do not constitute any part of the law. [1959 c 25 § 71.98.020.]

71.98.030 Invalidity of part of title not to affect remainder. If any provision of this title, or its application to any person or circumstance is held invalid, the remainder of the title, or the application of the provision to other persons or circumstances is not affected. [1959 c 25 § 71.98.030.]

71.98.040 Repeals and saving. See 1959 c 25 s 71.98.040.

71.98.050 Emergency—1959 c 25. This act is necessary for the immediate preservation of the public peace, health and safety, the support of the state government and its existing public institutions, and shall take effect immediately. [1959 c 25 § 71.98.050.]