SHB 1773: Assisted outpatient treatment for persons with behavioral health disorders

SHB 1773 is an unnecessary expansion of Assisted Outpatient Treatment (AOT) and will result in fewer people being able to access needed behavioral health treatment, not more. We support expansion of evidence-based practices that work on a voluntary basis with people who have trouble engaging in treatment such as Assertive Community Treatment. Washington is experiencing a shortage of accessible crisis services and behavioral health treatment for those who want and need it *(see SHB 1286, 2SHB 1860 and 2SHB 1865)*. Given the state's struggle to provide a robust continuum of voluntary services to meet current demand, it does not make sense to invest in a costly system of coercive care.

- **Expansion of AOT adds little to existing Least Restrictive Alternative (LRA) process and greatly expands and muddies an intervention that significantly deprives liberty and threatens individuals' rights.** The current involuntary commitment system already provides for an LRA order to compel people to engage in outpatient care to avoid further hospitalization. Unfortunately, many individuals cannot discharge from a treatment facility on an LRA due the lack of outpatient service providers. Any deficiencies in this system should be fixed before considering adding a costly new one.
- **More funding must be dedicated to staffing for community-based treatment and after-care in the community.** WDA and WACDL understand how difficult it is for families to have a lack of access to treatment for those they love. During the hearing, one person testifying spoke of how her son had done well when actively supervised on a least restrictive alternative (LRA). With appropriately staffed local agencies, it is possible to effectively monitor LRA's and to seek to renew LRA's when a person needs to continued monitoring in the community. Very few agencies ask to renew LRA's.[1] Due to lack of staffing, some large jurisdictions are unable to monitor LRA's and most smaller jurisdictions have no such capabilities. Patients are often terminated from treatment while on their LRA for missing appointments, without the agency making attempts to locate the patient or reschedule the contact: these are "cost-effective" decisions made by treatment agencies. Funding for additional staff and establishing housing opportunities must be available if we want to effectively assist the most vulnerable.
- **This proposal is the antithesis of maintaining the civil rights of those with behavioral health issues.** We continue to chip away at the civil rights of those with mental health issues and this proposal is yet another step towards labelling those with behavioral health issues as too dangerous to have the freedoms of life in the United States. This bill removes the 2nd Amendment Rights of those with mental health issues who do not need hospital level of care. It does not comport with many aspects of the legislative intent of RCW 71.05/71.34: specifically, this bill increases legal disabilities that arise from such commitment and does not safeguard individual rights. This bill will disproportionately impact indigent individuals and may result in individuals who did not receive adequate mental health care in the custody of DOC being subject to both community custody supervision and further reporting to a court.

[1] For instance, Spokane County has a regular docket where treating agencies will petition to renew LRA's. This can be a very effective tool. Spokane County is an exception to the standard operating procedures in most jurisdictions.

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- **SHB 1773 requires a court to speculate in various ways as to a person's behavioral health disorder. Current Washington law provides clear timelines.** While testimony in the hearing before the house indicated that 90 days was not a sufficient period for an LRA, WDA/WACDL disagrees. As noted above, an established LRA can be renewed through a petition process. A mandated 18 months of supervision is excessive
- **SHB 1773 removes the power to assess eligibility and file AOT petitions away from the expertise of Designated Crisis Responders (DCRs).** DCRs are trained professionals who respond to people in crisis, investigate their circumstances and history, make determinations about risk and available treatment, and understand the court system. SHB 1773 entrusts this critical and complicated job to a number of new system players, without guaranteeing the training and experience necessary.
- **SHB 1773 extends this forced treatment to adolescents aged 13 to 17, raising legal and ethical questions about the kind of care we deliver to children.** This bill ignores the well-established scholarship finding that juveniles are not miniature adults. To take a person who is experiencing the angst of development and label the individual for the next 18 months is not supported by science. WDA/WACDL agree with the individual who testified before the committee that we should not enact such legislation without further study.
- **SHB 1773 will drain resources from already-struggling treatment and court systems. If it is passed, its substantial costs will fall on counties and the local BH-ASOs.** SHB 1773 adds cumbersome new legal process to courts and demands much more of treatment providers. It is unclear how local jurisdictions will implement and pay for the complicated and lengthy AOT hearings, or the 18 months of ongoing court oversight. BH-ASOs currently cover the cost of ITA proceedings using the same budget that is needed to cover non-Medicaid treatment. Thus, increasing court costs by requiring more AOT hearings and supervision will pull limited resources away from actual treatment. True low barrier, voluntary treatment that meets people where they are at is both person-centered and a much more efficient use of funds. WDA/WACDL note that the costs of attorneys to defendant against this process was not included within the fiscal note. The Washington State Supreme Court enacted mandatory caseload limits on ITA cases. Attorneys must be provided and that will result in additional costs.
- **WDA/WACDL request a seat at the table when such legislation is being contemplated.** Despite the fact that our advocacy for our clients sometimes requires us to oppose involuntary treatment in the course of our representation, we do support improving access to treatment and resources for those with mental illness. Our state continues to fail our most vulnerable and given the inability to appropriately staff community behavioral health organizations, many go untreated. As of 2020, Washington was one of the lowest ranked states in providing access to care. See Ranking the States | Mental Health America (mhanational.org). See also information from 2016, Washington trails the nation in mental health treatment | Crosscut. We'd like to work together on a better solution.

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