# 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.*

**RCW 71.24.011 Short title.** This chapter may be known and cited as the community behavioral health services act. [2019 c 325 s 1001; 2019 c 314 s 24; 1982 c 204 s 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 s 6008.]

**Declaration—2019 c 314:** See note following RCW 18.22.810.

**RCW 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 s 1002; 2018 c 201 s 4001; 2014 c 225 s 6; 2005 c 503 s 1. Prior: 2001 c 334 s 6; 2001 c 323 s 1; 1999 c 214 s 7; 1991 c 306 s 1; 1989 c 205 s 1; 1986 c 274 s 1; 1982 c 204 s 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.

**Correction of references—2005 c 503:** "The code reviser shall replace all references to "county designated mental health professional" with "designated mental health professional" in the Revised Code of Washington." [2005 c 503 s 16.]

**Savings—2005 c 503:** "This act does not affect any existing right acquired or liability or obligation incurred under the sections amended or repealed in this act or under any rule or order adopted under those sections, nor does it affect any proceeding instituted under those sections." [2005 c 503 s 17.]

**Severability—2005 c 503:** "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [2005 c 503 s 18.]

**Effective date—2001 c 334:** "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 15, 2001]." [2001 c 334 s 10.]

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

**Conflict with federal requirements—1991 c 306:** "If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. The rules under this act shall meet federal requirements that are a necessary condition to the receipt of federal funds by the state.

However, if any part of this act conflicts with such federal requirements, the state appropriation for mental health services provided to children whose mental disorders are discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment program shall be provided through the division of medical assistance and no state funds appropriated to the division of mental health shall be expended or transferred for this purpose." [1991 c 306 s 7.]

**Effective date—1986 c 274 ss 1, 2, 3, 5, and 9:** "Sections 1, 2, 3, 5, and 9 of this act shall take effect on July 1, 1987." [1986 c 274 s 11.]

**RCW 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 purchasing 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 s 1003; 2014 c 225 s 7; 2006 c 333 s 102; 2001 c 323 s 4.]

**Effective date—2019 c 325 ss 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 s 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 s 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 s 101.]

**Severability—2006 c 333:** "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [2006 c 333 s 402.]

**Part headings not law—2006 c 333:** "Part headings used in this act are not part of the law." [2006 c 333 s 403.]

**Effective dates—2006 c 333:** "This act takes effect July 1, 2006, except that sections 101 through 103, 107, 202, and 301 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 [March 29, 2006]." [2006 c 333 s 404.]

**RCW 71.24.025 Definitions.** Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "23-hour crisis relief center" means a community-based facility or portion of a facility which is licensed or certified by the department of health and open 24 hours a day, seven days a week, offering access to mental health and substance use care for no more than 23 hours and 59 minutes at a time per patient, and which accepts all behavioral health crisis walk-ins drop-offs from first responders, and individuals referred through the 988 system regardless of behavioral health acuity, and meets the requirements under RCW 71.24.916.

(2) "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.

(3) "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.

(4) "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.

(5) "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.

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

(7) "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.

(8) "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.

(9) "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).

(10) "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.

(11) "Behavioral health services" means mental health services, substance use disorder treatment services, and co-occurring disorder treatment services as described in this chapter and chapter 71.36 RCW 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.

(12) "Child" means a person under the age of 18 years.

(13) "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 behavioral health 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 12 months. "Substantial gainful activity" shall be defined by the authority by rule consistent with Public Law 92-603, as amended.

(14) "Clubhouse" means a community-based program that provides rehabilitation services and is licensed or certified by the department.

(15) "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.

(16) "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.

(17) "Community support services" means services authorized, planned, and coordinated through resource management services including, at a minimum, assessment, diagnosis, emergency crisis intervention available 24 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.

(18) "Community-based crisis team" means a team that is part of an emergency medical services agency, a fire service agency, a public

health agency, a medical facility, a nonprofit crisis response provider, or a city or county government entity, other than a law enforcement agency, that provides the on-site community-based interventions of a mobile rapid response crisis team for individuals who are experiencing a behavioral health crisis.

(19) "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.

(20) "Coordinated regional behavioral health crisis response system" means the coordinated operation of 988 call centers, regional crisis lines, certified public safety telecommunicators, and other behavioral health crisis system partners within each regional service area.

(21) "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.

(22) "Crisis stabilization services" means services such as 23-hour crisis relief centers, crisis stabilization units, 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, or determine the need for involuntary hospitalization of an individual.

(23) "Crisis stabilization unit" has the same meaning as under RCW 71.05.020.

(24) "Department" means the department of health.

(25) "Designated 988 contact hub" or "988 contact hub" means a state-designated contact center that streamlines clinical interventions and access to resources for people experiencing a behavioral health crisis and participates in the national suicide prevention lifeline network to respond to statewide or regional 988 contacts that meets the requirements of RCW 71.24.890.

(26) "Designated crisis responder" has the same meaning as in RCW 71.05.020.

(27) "Director" means the director of the authority.

(28) "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.

(29) "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(7).

(30) "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 (31) of this section.

(31) "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.

(32) "First responders" includes ambulance, fire, mobile rapid response crisis team, coresponder team, designated crisis responder, fire department mobile integrated health team, community assistance referral and education services program under RCW 35.21.930, and law enforcement personnel.

(33) "Immediate jeopardy" means a situation in which the licensed or certified behavioral health agency'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.

(34) "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).

(35) "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.

(36) "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.

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

(38) "Long-term inpatient care" means inpatient services for persons committed for, or voluntarily receiving intensive treatment for, periods of 90 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.

(39) "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.

(40) "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.

(41) 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.

(42) "Mentally ill persons," "persons who are mentally ill," and "the mentally ill" mean persons and conditions defined in subsections (3), (13), (51), and (52) of this section.

(43) "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.

(44) "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.

(45) "Regional crisis line" means the behavioral health crisis hotline in each regional service area which provides crisis response services 24 hours a day, seven days a week, 365 days a year including but not limited to dispatch of mobile rapid response crisis teams, community-based crisis teams, and designated crisis responders.

(46) "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 (31) of this section but does not meet the full criteria for evidence-based.

(47) "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.

(48) "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.

(49) "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, 24 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.

(50) "Secretary" means the secretary of the department of health.

(51) "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.

(52) "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 applicable, 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, behavioral health 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.

(53) "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.

(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) "Tribe," for the purposes of this section, means a federally recognized Indian tribe. [2024 c 368 s 2; 2024 c 367 s 1; 2024 c 121 s 25. Prior: 2023 c 454 s 1; 2023 c 433 s 1; prior: 2021 c 302 s 402; (2021 c 302 s 401 expired July 1, 2022); prior: 2020 c 256 s 201; 2020 c 80 s 52; prior: 2019 c 325 s 1004; 2019 c 324 s 2; 2018 c 201 s 4002; prior: 2016 sp.s. c 29 s 502; 2016 sp.s. c 29 s 501; 2016 c 155 s 12; prior: 2014 c 225 s 10; 2013 c 338 s 5; 2012 c 10 s 59; 2008 c 261 s 2; 2007 c 414 s 1; 2006 c 333 s 104; prior: 2005 c 504 s 105; 2005 c 503 s 2; 2001 c 323 s 8; 1999 c 10 s 2; 1997 c 112 s 38; 1995 c 96 s 4; prior: 1994 sp.s. c 9 s 748; 1994 c 204 s 1; 1991 c 306 s 2; 1989 c 205 s 2; 1986 c 274 s 2; 1982 c 204 s 3.]

**Reviser's note:** *(1) The term "advanced registered nurse practitioner" was changed to "advanced practice registered nurse" by 2024 c 239 s 1, effective June 30, 2027.

(2) The definitions in this section have been alphabetized pursuant to RCW 1.08.015(2)(k).

(3) This section was amended by 2024 c 121 s 25, 2024 c 367 s 1, and by 2024 c 368 s 2, without reference to one another. All 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 302 s 402:** "Section 402 of this act takes effect July 1, 2022." [2021 c 302 s 407.]

**Expiration date—2021 c 302 s 401:** "Section 401 of this act expires July 1, 2022." [2021 c 302 s 406.]

**Findings—Intent—2021 c 302:** See note following RCW 71.24.890.

**Effective date—2020 c 80 ss 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 s 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.

**Alphabetization—Correction of references—2005 c 504:** See note following RCW 71.05.020.

**Correction of references—Savings—Severability—2005 c 503:** See notes following RCW 71.24.015.

**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 s 1.]

**Alphabetization of section—1999 c 10 s 2:** "The code reviser shall alphabetize the definitions in RCW 71.24.025 and correct any cross-references." [1999 c 10 s 14.]

**Effective date—1995 c 96:** See note following RCW 71.24.400.

**Severability—Headings and captions not law—Effective date—1994 sp.s. c 9:** See RCW 18.79.900 through 18.79.902.

**Conflict with federal requirements—1991 c 306:** See note following RCW 71.24.015.

**Effective date—1986 c 274 ss 1, 2, 3, 5, and 9:** See note following RCW 71.24.015.

**RCW 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, tribes, combinations of counties, or other entities, to establish and operate community behavioral health programs. [2024 c 209 s 29; 2019 c 325 s 1005; 2018 c 201 s 4003; 2005 c 503 s 3; 2001 c 323 s 9; 1999 c 10 s 3; 1982 c 204 s 6; 1973 1st ex.s. c 155 s 5; 1972 ex.s. c 122 s 30; 1971 ex.s. c 304 s 7; 1967 ex.s. c 111 s 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.

**Correction of references—Savings—Severability—2005 c 503:** See notes following RCW 71.24.015.

**Purpose—Intent—1999 c 10:** See note following RCW 71.24.025.

**Effective date—1972 ex.s. c 122:** "Chapter 122, Laws of 1972 extraordinary session shall be effective January 1, 1975." [1973 c 92 s 1; 1972 ex.s. c 122 s 31.]

**RCW 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, state opioid treatment authority, 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. [2023 c 51 s 31. Prior: 2021 c 263 s 16; 2021 c 263 s 8; 2020 c 256 s 202; 2019 c 325 s 1006; 2018 c 201 s 4004; 2016 sp.s. c 29 s 503; 2015 c 269 s 8; 2014 c 225 s 11; 2013 c 200 s 24; 2011 c 148 s 4; prior: 2008 c 267 s 5; 2008 c 261 s 3; prior: 2007 c 414 s 2; 2007 c 410 s 8; 2007 c 375 s 12; 2006 c 333 s 201; prior: 2005 c 504 s 715; 2005 c 503 s 7; prior: 2001 c 334 s 7; 2001 c 323 s 10; 1999 c 10 s 4; 1998 c 245 s 137; prior: 1991 c 306 s 3; 1991 c 262 s 1; 1991 c 29 s 1; 1990 1st ex.s. c 8 s 1; 1989 c 205 s 3; 1987 c 105 s 1; 1986 c 274 s 3; 1982 c 204 s 4.]

**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 ss 1-9 and 11-13:** See note following RCW 71.05.010.

**Effective date—2013 c 200:** See note following RCW 70.02.010.

**Certification of triage facilities—Effective date—2011 c 148:** See notes following RCW 71.05.020.

**Intent—Findings—2008 c 261:** See note following RCW 71.24.025.

**Short title—2007 c 410:** See note following RCW 13.34.138.

**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.

**Alphabetization—Correction of references—2005 c 504:** See note following RCW 71.05.020.

**Correction of references—Savings—Severability—2005 c 503:** See notes following RCW 71.24.015.

**Effective date—2001 c 334:** See note following RCW 71.24.015.

**Purpose—Intent—1999 c 10:** See note following RCW 71.24.025.

**Conflict with federal requirements—1991 c 306:** See note following RCW 71.24.015.

**Effective date—1987 c 105:** "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 July 1, 1987." [1987 c 105 s 2.]

**Effective date—1986 c 274 ss 1, 2, 3, 5, and 9:** See note following RCW 71.24.015.

**RCW 71.24.037 Licensed or certified behavioral health agencies—Minimum standards—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; and (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.

(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 chapters 71.34 and 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) No licensed or certified behavioral health agency may advertise or represent itself as a licensed or certified behavioral health agency if approval has not been granted or has been denied, suspended, revoked, or canceled.

(4) Licensure or certification as a behavioral health agency 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 agency 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.

(5) Licensure or certification as a licensed or certified behavioral health agency 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.

(6) 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.

(7) Licensed or certified behavioral health agencies may not provide types of services for which the licensed or certified behavioral health agency has not been certified. Licensed or certified behavioral health agencies may provide services for which approval has been sought and is pending, if approval for the services has not been previously revoked or denied.

(8) The department shall maintain and periodically publish a current list of licensed or certified behavioral health agencies.

(9)(a) Licensed or certified behavioral health agencies providing voluntary inpatient or residential substance use disorder treatment services or withdrawal management services:

(i) Must comply with the policy submission and mandatory reporting requirements established in RCW 71.24.847; and

(ii) May not prohibit a person from receiving services at or being admitted to the agency based solely on prior instances of the person releasing the person's self from the facility prior to a clinical determination that the person had completed treatment.

(b) This subsection (9) does not apply to hospitals licensed under chapter 70.41 RCW and psychiatric hospitals licensed under chapter 71.12 RCW.

(10)(a) A licensed or certified behavioral health agency shall provide each patient seeking treatment for opioid use disorder or alcohol use disorder, whether receiving inpatient or outpatient treatment, with education related to pharmacological treatment options specific to the patient's diagnosed condition. The education must include an unbiased explanation of all recognized forms of treatment approved by the federal food and drug administration, as required under RCW 7.70.050 and 7.70.060, that are clinically appropriate for the patient. Providers may use the patient shared decision-making tools for opioid use disorder and alcohol use disorder developed by the addictions, drug, and alcohol institute at the University of Washington. If the patient elects a clinically appropriate pharmacological treatment option, the behavioral health agency shall support the patient with the implementation of the pharmacological treatment either by direct provision of the medication or by a warm handoff referral, if the treating provider is unable to directly provide the medication.

(b) Unless it meets the requirements of (a) of this subsection, a behavioral health agency may not:

(i) Advertise that it treats opioid use disorder or alcohol use disorder; or

(ii) Treat patients for opioid use disorder or alcohol use disorder, regardless of the form of treatment that the patient chooses.

(c)(i) Failure to meet the education requirements of (a) of this subsection may be an element of proof in demonstrating a breach of the duty to secure an informed consent under RCW 7.70.050.

(ii) Failure to meet the education and facilitation requirements of (a) of this subsection may be the basis of a disciplinary action under this section.

(d) This subsection does not apply to licensed behavioral health agencies that are units within a hospital licensed under chapter 70.41 RCW or a psychiatric hospital licensed under chapter 71.12 RCW. [2024 c 366 s 4; 2024 c 121 s 26; 2023 c 454 s 2. Prior: 2019 c 446 s 23; 2019 c 325 s 1007; 2018 c 201 s 4005; 2017 c 330 s 2; 2016 sp.s. c 29 s 505; 2001 c 323 s 11; 1999 c 10 s 5.]

**Reviser's note:** This section was amended by 2024 c 121 s 26 and by 2024 c 366 s 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).

**Findings—Intent—2024 c 366:** See note following RCW 71.24.847.

**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 s 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.

**RCW 71.24.038 Investigations and inspections—Violations—Penalties.** (1) 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.

(2) The department shall conduct inspections of licensed or certified behavioral health agencies, including reviews of records and documents required to be maintained under this chapter or rules adopted under this chapter.

(3) Each licensed or certified behavioral health agency shall file with the department or the authority upon request data, statistics, schedules, medical records, and other information the department or the authority reasonably requires. A licensed or certified behavioral health agency 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.

(4) The authority shall use the data provided in subsection (3) of this section to evaluate each program that admits children to inpatient substance use disorder treatment upon application of their parents. The evaluation shall be done at least once every 12 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.

(5) Any settlement agreement entered into between the department and licensed or certified behavioral health agencies 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 agency did not commit one or more of the violations.

(6) In cases in which a licensed or certified behavioral health agency that is in violation of licensing or certification standards attempts to transfer or sell the behavioral health agency 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 agency 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 agency's license or certification or issue a new license or certification to the behavioral health provider.

(7) In any case in which the department finds that a licensed or certified behavioral health agency has failed or refused to comply with the requirements of this chapter or the standards or rules adopted under this chapter, 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 licensed or certified behavioral health agency 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 licensed or certified behavioral health agency 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 licensed or certified behavioral health agency cannot demonstrate to the department that it has access to sufficient internal expertise.

(b)(i) In accordance with the department's authority under RCW 43.70.095, the department may assess a civil fine of up to $3,000 per violation on a licensed or certified behavioral health agency when the department determines the licensed or certified behavioral health agency 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 licensed or certified behavioral health agency 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 licensed or certified behavioral health agencies and to offset costs associated with licensing, certification, or enforcement of behavioral health agencies.

(iii) The department shall adopt in rules under this chapter specific fine amounts in relation to the severity of the noncompliance and at an adequate level to be a deterrent to future 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) The department may suspend new intake or admission of a specific category or categories of individuals receiving behavioral health services 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 licensed or certified behavioral health agency written

notification upon identifying deficient practices or conditions that constitute an immediate jeopardy, and the licensed or certified behavioral health agency shall have 24 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 practices or conditions that constitute immediate jeopardy are not verified by the department as having been corrected within the same 24-hour period, the department may issue the limited stop placement.

(ii) When the department imposes a limited stop placement, the licensed or certified behavioral health agency may not accept any new individuals in the category or categories subject to the limited stop placement until the limited stop placement is terminated.

(iii) The department shall conduct a follow-up inspection within five business days or within the time period requested by the licensed or certified behavioral health agency 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 licensed or certified behavioral health agency has taken intermediate action to address the immediate jeopardy; and

(B) The licensed or certified behavioral health agency establishes the ability to maintain correction of the violation previously found deficient.

(d) The department may suspend new intake or admission of individuals receiving behavioral health services as related to the violation 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 individuals.

(i) Prior to imposing a stop placement, the department shall provide a licensed or certified behavioral health agency written notification upon identifying deficient practices or conditions that constitute an immediate jeopardy. The licensed or certified behavioral health agency shall have 24 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 practices or conditions that constitute an immediate jeopardy are not verified by the department as having been corrected within the same 24-hour period, the department may issue the stop placement.

(ii) When the department imposes a stop placement, the licensed or certified behavioral health agency may not accept any new individuals receiving behavioral health services until the stop placement is terminated.

(iii) The department shall conduct a follow-up inspection within five business days or within the time period requested by the licensed or certified behavioral health agency if more than five business days is needed to verify the violation necessitating the stop placement has been corrected.

(iv) The stop placement shall be terminated when:

(A) The department verifies the violation necessitating the stop placement has been corrected or the department determines that the licensed or certified behavioral health agency has taken intermediate action to address the immediate jeopardy; and

(B) The licensed or certified behavioral health agency establishes the ability to maintain correction of the violation previously found deficient.

(e) The department may suspend a specific category or categories of behavioral health services as related to the violation by imposing a limited stop service. This may only be done if the department finds that noncompliance results in immediate jeopardy.

(i) Prior to imposing a limited stop service, the department shall provide a licensed or certified behavioral health agency written notification upon identifying deficient practices or conditions that constitute an immediate jeopardy. The licensed or certified behavioral health agency shall have 24 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 practices or conditions that constitute immediate jeopardy are not verified by the department as having been corrected within the same 24-hour period, the department may issue the limited stop service.

(ii) When the department imposes a limited stop service, the licensed or certified behavioral health agency may not provide the services in the category or categories subject to the limited stop service to any new or existing individuals, unless otherwise allowed by the department, until the limited stop service is terminated.

(iii) The department shall conduct a follow-up inspection within five business days or within the time period requested by the licensed or certified behavioral health agency if more than five business days is needed to verify the violation necessitating the limited stop service has been corrected.

(iv) The limited stop service shall be terminated when:

(A) The department verifies the violation necessitating the limited stop service has been corrected or the department determines that the licensed or certified behavioral health agency has taken intermediate action to address the immediate jeopardy; and

(B) The licensed or certified behavioral health agency establishes the ability to maintain correction of the violation previously found deficient.

(f) The department may suspend, revoke, or refuse to renew a license.

(8)(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, limited stop service, 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, include a copy of the department's notice, be served on and received by the department within 28 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, limited stop service, 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 14 days of making the request. The licensee must request the show cause hearing within 28 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 shall 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 shall provide the licensee with all documentation that supports the department's immediate suspension or immediate imposition of conditions.

(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 90 days of the licensee's request.

(9) When the department determines an alleged violation, if true, would constitute an immediate jeopardy, and the licensee fails to cooperate with the department's investigation of such an alleged violation, the department may impose an immediate limited stop placement, immediate stop placement, immediate limited stop service, immediate imposition of conditions, or immediate suspension.

(a) When the department imposes an immediate limited stop placement, immediate stop placement, immediate limited stop service, immediate imposition of conditions, or immediate suspension for failure to cooperate, a licensee is entitled to a show cause hearing before a presiding officer within 14 days of making the request. The licensee must request the show cause hearing within 28 days of receipt of the notice of an immediate limited stop placement, immediate stop placement, immediate limited stop service, immediate imposition of conditions, or immediate suspension for failure to cooperate. At the show cause hearing the department has the burden of demonstrating that more probably than not the alleged violation, if true, would constitute an immediate jeopardy and the licensee failed to cooperate with the department's investigation.

(b) At the show cause hearing, the presiding officer may consider the notice and documents supporting the immediate limited stop placement, immediate stop placement, immediate limited stop service, immediate imposition of conditions, or immediate suspension for failure to cooperate, and the licensee's response and shall 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 shall provide the licensee with all documentation that supports the department's immediate action for failure to cooperate.

(c) If the presiding officer determines the alleged violation, if true, does not constitute an immediate jeopardy or determines that the

licensee cooperated with the department's investigation, the presiding officer may overturn the immediate action for failure to cooperate.

(d) If the presiding officer determines the allegation, if true, would constitute an immediate jeopardy and the licensee failed to cooperate with the department's investigation, the immediate action for failure to cooperate shall remain in effect pending a full hearing.

(e) If the presiding officer sustains the immediate action for failure to cooperate, the licensee may request an expedited full hearing on the merits of the department's action. A full hearing must be provided within 90 days of the licensee's request. [2024 c 121 s 27.]

**RCW 71.24.045 Behavioral health administrative services organization powers and duties.** (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 24 hours a day, seven days a week, 365 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;

(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; and

(viii) Duties under RCW 71.24.432;

(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 and tribal government entities to ensure that policies do not result in an adverse shift of persons with mental illness into state, local, and tribal 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.

(5) The behavioral health administrative services organization shall comply and ensure their contractors comply with the tribal crisis coordination plan agreed upon by the authority and tribes for coordination of crisis services, care coordination, and discharge and transition planning with tribes and Indian health care providers applicable to their regional service area. [2024 c 368 s 3; 2024 c 209 s 30; 2022 c 210 s 27; (2022 c 210 s 26 expired October 1, 2022). Prior: 2021 c 263 s 17; 2021 c 202 s 15; 2019 c 325 s 1008; prior: 2018 c 201 s 4006; 2018 c 175 s 7; 2016 sp.s. c 29 s 421; 2014 c 225 s 13; 2014 c 225 s 12; 2006 c 333 s 105; 2005 c 503 s 8; 2001 c 323 s 12; 1992 c 230 s 5; prior: 1991 c 363 s 147; 1991 c 306 s 5; 1991 c 29 s 2; 1989 c 205 s 4; 1986 c 274 s 5; 1982 c 204 s 5.]

**Reviser's note:** This section was amended by 2024 c 209 s 30 and by 2024 c 368 s 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).

**Effective date—2022 c 210 s 27:** "Section 27 of this act takes effect October 1, 2022." [2022 c 210 s 35.]

**Expiration date—2022 c 210 s 26:** "Section 26 of this act expires October 1, 2022." [2022 c 210 s 34.]

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

**Effective date—2021 c 202 ss 15-17:** "Sections 15 through 17 of this act take effect October 1, 2022." [2021 c 202 s 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.

**Correction of references—Savings—Severability—2005 c 503:** See notes following RCW 71.24.015.

**Effective date—1992 c 230 s 5:** "Section 5 of this act shall take effect July 1, 1995." [1992 c 230 s 8.]

**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.

**Conflict with federal requirements—1991 c 306:** See note following RCW 71.24.015.

**Effective date—1986 c 274 ss 1, 2, 3, 5, and 9:** See note following RCW 71.24.015.

**RCW 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 Washington 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;

(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; and

(iv) The first approach skills training program to provide brief, evidence-based behavioral therapy for youth and families with common mental health concerns.

(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. [2024 c 358 s 1; 2021 c 126 s 1; 2020 c 291 s 1; 2019 c 325 s 1009. Prior: 2018 c 288 s 2; 2018 c 201 s 4007; 2014 c 225 s 35; 2007 c 359 s 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.

**Captions not law—2007 c 359:** See note following RCW 71.36.005.

**RCW 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 s 2.]

**RCW 71.24.063 Partnership access lines—Psychiatric consultation lines—Data collection.** (1) The University of Washington department of psychiatry and behavioral sciences shall collect the following information for the partnership access line for moms described in RCW 71.24.061(3)(a)(ii), 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 authority shall collect the following information for the program called the mental health referral service for children and teens described in RCW 71.24.061 (3)(a)(iii), and the partnership access line described in RCW 71.24.061(3)(a)(i), in coordination with Seattle children's hospital 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.

(3) The authority shall collect the following information for the first approach skills training program (FAST) described in RCW 71.24.061(3)(a)(iv), in coordination with Seattle children's hospital to administer the program:

(a) The number of providers trained;

(b) The number of clinics supported;

(c) The number of ongoing consultation training sessions delivered;

(d) The utilization rates of the FAST website video and materials; and

(e) Updates on all new materials created, such as new translations, for the program. [2024 c 358 s 2; 2020 c 291 s 3.]

**RCW 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), the psychiatric consultation line described in RCW 71.24.062, and the first approach skills training program described in RCW 71.24.061(3)(a)(iv) 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 determined and defined by the authority, the University of Washington, and Seattle children's hospital. [2024 c 358 s 3; 2020 c 291 s 4.]

**RCW 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 s 5.]

***Reviser's note:** RCW 71.24.061 was amended by 2021 c 126 s 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."

**RCW 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 s 6.]

**RCW 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 s 7.]

**RCW 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 s 1010; 2018 c 201 s 4008; 2014 c 225 s 14; 2012 c 117 s 442; 2005 c 503 s 9; 1982 c 204 s 7; 1967 ex.s. c 111 s 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.

**Correction of references—Savings—Severability—2005 c 503:** See notes following RCW 71.24.015.

**RCW 71.24.112 Health engagement hubs pilot program.** (1)(a) The authority shall implement a pilot program for health engagement hubs by August 1, 2024. The pilot program will test the functionality and operability of health engagement hubs, including whether and how to incorporate and build on existing medical, harm reduction, treatment, and social services in order to create an all-in-one location where people who use drugs can access such services.

(b) Subject to amounts appropriated, the authority shall establish pilot programs on at least two sites, with one site located in an urban area and one located in a rural area.

(c) The authority shall report on the pilot program results, including recommendations for expansion, and rules and payment structures, to the legislature no later than August 1, 2026.

(2) The authority shall develop payment structures for health engagement hubs by June 30, 2024. Subject to the availability of funds appropriated for this purpose, and to the extent allowed under federal law, the authority shall direct medicaid managed care organizations to adopt a value-based bundled payment methodology in contracts with health engagement hubs and other opioid treatment providers. The authority shall not implement this requirement in managed care contracts unless expressly authorized by the legislature.

(3) A health engagement hub is intended to:

(a) Serve as an all-in-one location where people 18 years of age or older who use drugs can access a range of medical, harm reduction, treatment, and social services;

(b) Be affiliated with existing syringe service programs, federally qualified health centers, community health centers, overdose prevention sites, safe consumption sites, patient-centered medical homes, tribal behavioral health programs, peer run organizations such as clubhouses, services for unhoused people, supportive housing, and opioid treatment programs including mobile and fixed-site medication units established under an opioid treatment program, or other appropriate entity;

(c) Provide referrals or access to methadone and other medications for opioid use disorder;

(d) Function as a patient-centered medical home by offering high-quality, cost-effective patient-centered care, including wound care;

(e) Provide harm reduction services and supplies; and

(f) Provide linkage to housing, transportation, and other support services. [2023 sp.s. c 1 s 26.]

**RCW 71.24.113 Grant program—Employment and education opportunities for persons recovering from a substance use disorder.** Subject to funding provided for this specific purpose, the authority shall establish a grant program for providers of employment, education, training, certification, and other supportive programs

designed to provide persons recovering from a substance use disorder with employment and education opportunities. The grant program shall employ a low-barrier application and give priority to programs that engage with Black, indigenous, persons of color, and other historically underserved communities. [2023 sp.s. c 1 s 27.]

**RCW 71.24.115 Recovery navigator programs.** (1) Each behavioral health administrative services organization shall establish recovery navigator programs with the goal of providing law enforcement and other criminal legal system personnel with a credible alternative to further legal system involvement for criminal activity that stems from unmet behavioral health needs or poverty. The programs shall work to improve community health and safety by reducing individuals' involvement with the criminal legal system through the use of specific human services tools and in coordination with community input. Each program must include a dedicated project manager and be governed by a policy coordinating group comprised, in alignment with the core principles, of local executive and legislative officials, public safety agencies, including police and prosecutors, and civil rights, public defense, and human services organizations.

(2) The recovery navigator programs shall be organized on a scale that permits meaningful engagement, collaboration, and coordination with local law enforcement and municipal agencies through the policy coordinating groups. The programs 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. Recovery navigator programs must serve and prioritize individuals who are actually or potentially exposed to the criminal legal system with respect to unlawful behavior connected to substance use or other behavioral health issues.

(3) By June 30, 2024, the authority shall revise its uniform program standards for behavioral health administrative services organizations to follow in the design of their recovery navigator programs to achieve fidelity with the core principles. 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 for participants' legal cases that may precede or follow referral to the program. The uniform program standards must incorporate the law enforcement assisted diversion framework for diversion at multiple points of engagement with the criminal legal system, including prearrest, prebooking, prefiling, and for ongoing case conferencing with law enforcement, prosecutors, community stakeholders, and program case managers. 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, provide for referrals from a broad range

of sources, and require prioritization of those who are or likely will be exposed to the criminal legal system related to their behavioral health challenges. In addition to accepting referrals from law enforcement and courts of limited jurisdiction, 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, so that individuals are engaged as early as possible 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 and courts of limited jurisdiction.

(4) 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 continuation of and, as required by this section, the revisions to and reorganization of the recovery navigator programs they fund. 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 recovery navigator programs funded by behavioral health administrative services organizations. The authority shall arrange for technical assistance to be provided by the LEAD national support bureau to all behavioral health administrative services organizations, the authority, contracted providers, and independent stakeholders and partners, such as prosecuting attorneys and law enforcement.

(5) 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.

(6) 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.

(7) No civil liability may be imposed by any court on the state or its officers or employees, an appointed or elected official, public employee, public agency as defined in RCW 4.24.470, combination of units of government and its employees as provided in RCW 36.28A.010, nonprofit community-based organization, tribal government entity, tribal organization, or urban Indian organization, based on the administration of a recovery navigator program except upon proof of bad faith or gross negligence.

(8) For the purposes of this section, the term "core principles" means the core principles of a law enforcement assisted diversion program, as established by the law enforcement assisted diversion national support bureau in its toolkit, as it existed on July 1, 2023. [2023 sp.s. c 1 s 25; 2021 c 311 s 2.]

**Effective date—2021 c 311 ss 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 s 26.]

**RCW 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 s 3.]

**Effective date—2021 c 311 ss 1-11 and 13-21:** See note following RCW 71.24.115.

**RCW 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 s 4.]

**Effective date—2021 c 311 ss 1-11 and 13-21:** See note following RCW 71.24.115.

**RCW 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 s 5.]

**Effective date—2021 c 311 ss 1-11 and 13-21:** See note following RCW 71.24.115.

**RCW 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 s 203; 2019 c 325 s 1011; 2018 c 201 s 4009; 2014 c 225 s 36; 2001 c 323 s 14; 1987 c 505 s 65; 1986 c 274 s 9; 1982 c 204 s 9.]

**Effective date—2020 c 256 s 203:** "Section 203 of this act takes effect July 1, 2021." [2020 c 256 s 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.

**Effective date—1986 c 274 ss 1, 2, 3, 5, and 9:** See note following RCW 71.24.015.

**RCW 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 s 1012; 2018 c 201 s 4010; 2014 c 225 s 37; 2011 c 343 s 6; 2001 c 323 s 15; 1989 c 205 s 7; 1982 c 204 s 10; 1967 ex.s. c 111 s 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.

**RCW 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 s 20.]

**RCW 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 s 1013; 2018 c 201 s 4011; 1982 c 204 s 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.

**RCW 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 s 1014; 2018 c 201 s 4012; 1999 c 10 s 8; 1982 c 204 s 12; 1967 ex.s. c 111 s 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.

**RCW 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 s 1015; 2018 c 201 s 4013; 2014 c 225 s 49; 2005 c 503 s 10; 1982 c 204 s 13; 1967 ex.s. c 111 s 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.

**Correction of references—Savings—Severability—2005 c 503:** See notes following RCW 71.24.015.

**RCW 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 s 1016; 2014 c 225 s 38; 2001 c 323 s 16; 1982 c 204 s 14; 1967 ex.s. c 111 s 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.

**RCW 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 s 1017; 1986 c 274 s 10.]

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

**RCW 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 s 1018; 2018 c 201 s 4014; 2016 sp.s. c 29 s 522; 2015 c 269 s 10; 2014 c 225 s 39; 2008 c 261 s 4; 2006 c 333 s 106; 2005 c 503 s 11; 2001 c 323 s 17. Prior: 1999 c 214 s 8; 1999 c 10 s 9; 1994 c 204 s 2; 1992 c 230 s 6; prior: 1991 c 295 s 3; 1991 c 262 s 2; 1991 c 29 s 3; 1989 c 205 s 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 ss 10 and 14:** "Sections 10 and 14 of this act take effect April 1, 2016." [2015 c 269 s 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.

**Correction of references—Savings—Severability—2005 c 503:** See notes following RCW 71.24.015.

**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.

**Evaluation of transition to regional systems—1989 c 205:** See note following RCW 71.24.015.

**RCW 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 s 3. Prior: 2021 c 157 s 4; 2021 c 100 s 1; 2019 c 325 s 1019; 2017 c 202 s 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 s 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 s 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.

**RCW 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 s 1021; 2018 c 201 s 4021; 2014 c 225 s 42; 2006 c 333 s 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.

**RCW 71.24.380 Purchase of behavioral health services—Contracting—Requirements.** (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) The authority must contract with the department of commerce for the provision of behavioral health consumer advocacy services delivered to individuals enrolled in a managed care organization by the advocacy organization selected by the state office of behavioral health consumer advocacy established in RCW 71.40.030. The contract shall require the authority to reimburse the department of commerce for the behavioral health consumer advocacy services delivered to individuals enrolled in a 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. [2023 c 51 s 32; 2021 c 202 s 16; 2019 c 325 s 1022; 2018 c 201 s 4022; 2014 c 225 s 5.]

**Effective date—2021 c 202 ss 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.

**RCW 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 s 1046.]

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

**RCW 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 s 3.]

**Finding—Intent—2022 c 215:** See note following RCW 70.320.020.

**RCW 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) Occupational therapy;

(x) Partial hospitalization and intensive outpatient programs for persons under 21 years of age; and

(xi) 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, occupational therapy, 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. [2023 c 113 s 1; 2022 c 94 s 1. Prior: 2019 c 325 s 1023; 2019 c 264 s 6; prior: 2018 c 201 s 4023; 2018 c 175 s 6; 2016 sp.s. c 29 s 510; 2014 c 225 s 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.

**RCW 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 s 4024; 2001 c 323 s 18; 1999 c 10 s 10; 1995 c 96 s 1; 1994 c 259 s 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.

**Effective date—1995 c 96:** "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 shall take effect immediately [April 18, 1995]." [1995 c 96 s 5.]

**RCW 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 s 1024; 2018 c 201 s 4025; 2014 c 225 s 53; 2001 c 323 s 19; 1999 c 10 s 11; 1995 c 96 s 2; 1994 c 259 s 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.

**Effective date—1995 c 96:** See note following RCW 71.24.400.

**RCW 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 s 4026; 1999 c 10 s 12; 1995 c 96 s 3; 1994 c 259 s 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.

**Effective date—1995 c 96:** See note following RCW 71.24.400.

**RCW 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 s 1025; 2018 c 201 s 4027; 2014 c 225 s 17; 2001 c 323 s 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.

**RCW 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 s 1026; 2018 c 201 s 4028; 2014 c 225 s 54; 2001 c 323 s 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.

**RCW 71.24.432 Coordination with regional crisis response systems—Regional protocols—Recommendations.** Behavioral health administrative services organizations shall use their authorities under RCW 71.24.045 to establish coordination within the behavioral health crisis response system in each regional service area including, but not limited to, establishing comprehensive protocols for dispatching mobile rapid response crisis teams and community-based crisis teams. In furtherance of this:

(1) The behavioral health administrative services organization may convene regional behavioral health crisis response system partners and stakeholders within available resources for the purpose of establishing clear regional protocols which memorialize expectations, understandings, lines of communication, and strategies for optimizing crisis response in the regional service area. The regional protocols must describe how crisis response partners will share information consistent with data-sharing requirements under RCW 71.24.890, including real-time information sharing between 988 contact hubs, regional crisis lines, or their successors, to create a seamless delivery system that is person-centered;

(2) Behavioral health administrative services organizations shall submit regional protocols created under subsection (1) of this section to the authority for approval. If the authority does not respond within 90 days of submission, the regional protocols shall be considered approved until such time as the behavioral health administrative services organization and the authority agree to updated protocols. A behavioral health administrative services organization must notify the authority by January 1, 2025, if it does not intend to develop and submit regional protocols;

(3) A behavioral health administrative services organization may recommend to the department the 988 contact hub or hubs which it determines to be the best fit for partnership and implementation of regional protocols in its regional service area among candidates which are able to meet necessary state and federal requirements. The 988 contact hub or hubs recommended by the behavioral health administrative services organization must be able to connect to the

culturally appropriate behavioral health crisis response services established under this chapter;

(4) The department may designate additional 988 contact hubs recommended by a behavioral health administrative services organization within available resources and when the addition of more hubs is consistent with the rules adopted under RCW 71.24.890 and a need identified in regional protocols. If the department declines to designate a 988 contact hub that has been recommended by a behavioral health administrative services organization, the department shall provide a written explanation of its reasons to the behavioral health administrative services organization;

(5) The department and the authority shall provide support to a behavioral health administrative services organization in the development of protocols under subsection (1) of this section upon request by the behavioral health administrative services organization;

(6) Regional protocols established under subsection (1) of this section must be in writing and, once approved, copies shall be provided to the department, authority, and state 911 coordination office. The regional protocols should be updated as needed and at intervals of no longer than three years; and

(7) For the purpose of subsection (1) of this section, partners and stakeholders in the coordinated regional behavioral health crisis response system include but are not limited to regional crisis lines, 988 contact hubs, certified public safety telecommunicators, local governments, tribal governments, first responders, co-response teams, mobile rapid response crisis teams, hospitals, organizations representing persons with lived experience, and behavioral health agencies. [2024 c 368 s 1.]

**RCW 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 s 5010; 2014 c 225 s 64; 2013 c 338 s 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 s 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 s 111.]

**RCW 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 s 1027; 1997 c 342 s 1.]

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

**Severability—1997 c 342:** "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1997 c 342 s 6.]

**RCW 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 s 1028; 2018 c 201 s 4029; 2014 c 225 s 43; 1997 c 342 s 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.

**Severability—1997 c 342:** See note following RCW 71.24.450.

**RCW 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 s 1029; 2018 c 201 s 4030; 1999 c 10 s 13; 1997 c 342 s 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.

**Severability—1997 c 342:** See note following RCW 71.24.450.

**RCW 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 s 7; 2019 c 325 s 1030; 2018 c 201 s 4031; 2014 c 225 s 44; 2009 c 319 s 1; 1999 c 214 s 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.

**RCW 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 s 8; 2019 c 325 s 1031; 2018 c 201 s 4032; 2014 c 225 s 45; 2009 c 319 s 2; 2002 c 173 s 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.

**RCW 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 s 1032; 2018 c 201 s 4033; 2015 c 269 s 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 ss 1-9 and 11-13:** See note following RCW 71.05.010.

**RCW 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 s 1033; 2018 c 201 s 4034; 2016 c 154 s 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.

**RCW 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 s 512; 2005 c 504 s 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.

**Alphabetization—Correction of references—2005 c 504:** See note following RCW 71.05.020.

**RCW 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 s 1034; 2018 c 201 s 4036; 2014 c 225 s 22; 1989 c 270 s 5; 1988 c 193 s 2; 1972 ex.s. c 122 s 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.

**RCW 71.24.522 Substance use disorder—Training for parents of adolescents and transition age youth.** (1) The authority, in

consultation with the department of children, youth, and families, shall develop a training for parents of adolescents and transition age youth with substance use disorders by June 30, 2024, which training must build on and be consistent and compatible with existing training developed by the authority for families impacted by substance use disorder, and addressing the following:

(a) Science and education related to substance use disorders and recovery;

(b) Adaptive and functional communication strategies for communication with a loved one about their substance use disorder, including positive communication skills and strategies to influence motivation and behavioral change;

(c) Self-care and means of obtaining support;

(d) Means to obtain opioid overdose reversal medication when appropriate and instruction on proper use; and

(e) Suicide prevention.

(2) The authority and the department of children, youth, and families shall make this training publicly available, and the department of children, youth, and families must promote the training to licensed foster parents and caregivers, including any tribally licensed foster parents and tribal caregivers. [2023 sp.s. c 1 s 20.]

**RCW 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 s 4037; 1989 c 270 s 7. Formerly RCW 70.96A.043.]

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

**RCW 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 s 4038; 2016 sp.s. c 29 s 515; 1989 c 270 s 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.

**RCW 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 s 1035; 2018 c 201 s 4039; 2016 sp.s. c 29 s 504; 2014 c 225 s 23; 2001 c 13 s 2; 1989 c 270 s 6; 1979 ex.s. c 176 s 7; 1972 ex.s. c 122 s 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.

**Severability—1979 ex.s. c 176:** See note following RCW 46.61.502.

**RCW 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 s 1036; 2018 c 201 s 4040; 2016 sp.s. c 29 s 516; 1999 c 197 s 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.

**Legislative recognition—1999 c 197:** "The legislature recognizes the utility of drug court programs in reducing recidivism and assisting the courts by diverting potential offenders from the normal course of criminal trial proceedings." [1999 c 197 s 7.]

**Severability—1999 c 197:** See note following RCW 9.94A.030.

**RCW 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 s 1037; 2018 c 201 s 4041; 2014 c 225 s 25; 1989 c 270 s 18; 1972 ex.s. c 122 s 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.

**RCW 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 antiracism; 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 s 1.]

**Effective date—2021 c 311 ss 1-11 and 13-21:** See note following RCW 71.24.115.

**RCW 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 s 26; 1989 c 270 s 12. Formerly RCW 70.96A.085.]

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

**RCW 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 s 1038; 2018 c 201 s 4042; 2016 sp.s. c 29 s 517; 1989 c 270 s 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.

**RCW 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 s 26; 2017 c 297 s 11; 2016 sp.s. c 29 s 506; 2005 c 70 s 2; 1995 c 312 s 46; 1990 c 151 s 5. Prior: 1989 c 270 s 19; 1989 c 175 s 131; 1972 ex.s. c 122 s 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 s 2; 2005 c 70 s 1.]

**Short title—1995 c 312:** See note following RCW 13.32A.010.

**Effective date—1989 c 175:** See note following RCW 34.05.010.

**RCW 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 facility or a form of treatment will have available and use other appropriate treatment. [2019 c 325 s 1039; 2018 c 201 s 4043; 2014 c 225 s 27; 1989 c 270 s 23; 1972 ex.s. c 122 s 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.

**RCW 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 s 518; 1989 c 270 s 30; 1972 ex.s. c 122 s 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.

**RCW 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 s 30; 1989 c 270 s 32; 1972 ex.s. c 122 s 19. Formerly RCW 70.96A.190.]

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

**RCW 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 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. 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. [2024 c 179 s 1; 2023 c 475 s 941. Prior: 2022 c 297 s 964; 2022 c 157 s 18; 2021 c 334 s 989; 2020 c 357 s 917; prior: 2019 c 415 s 980; 2019 c 325 s 1040; 2019 c 314 s 27; prior: 2018 c 205 s 2; 2018 c 201 s 4044; 2017 3rd sp.s. c 1 s 981; 2016 sp.s. c 29 s 511; prior: 2015 3rd sp.s. c 4 s 968; 2015 c 291 s 10; 2013 2nd sp.s. c 4 s 990; 2011 2nd sp.s. c 9 s 910; 2011 1st sp.s. c 40 s 34; prior: 2009 c 479 s 50; 2009 c 445 s 1; 2008 c 329 s 918; 2003 c 379 s 11; 2002 c 290 s 4. Formerly RCW 70.96A.350.]

**Effective date—2023 c 475:** See note following RCW 16.76.030.

**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 s 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.

**Effective dates—2011 2nd sp.s. c 9:** See note following RCW 28B.50.837.

**Application—Recalculation of community custody terms—2011 1st sp.s. c 40:** See note following RCW 9.94A.501.

**Effective date—2009 c 479:** See note following RCW 2.56.030.

**Severability—Effective date—2008 c 329:** See notes following RCW 28B.105.110.

**Severability—Effective dates—2003 c 379:** See notes following RCW 9.94A.728.

**Effective date—2002 c 290 ss 1, 4-6, 12, 13, 26, and 27:** "Sections 1, 4 through 6, 12, 13, 26, and 27 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 [April 1, 2002]." [2002 c 290 s 32.]

**Intent—2002 c 290:** See note following RCW 9.94A.517.

**RCW 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 s 28; 2017 c 297 s 12; 2016 sp.s. c 29 s 519; 2001 c 242 s 1; 1995 c 321 s 1; 1989 c 270 s 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.

**RCW 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 s 13.]

**Findings—Intent—2017 c 297:** See note following RCW 18.22.800.

**RCW 71.24.589 Law enforcement assisted diversion—Grant program.** (1) Subject to funds appropriated by the legislature, the authority shall administer a grant program 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) The authority must partner with the law enforcement assisted diversion national support bureau to award contracts, subject to appropriation, for jurisdictions in the state of Washington for law enforcement assisted diversion. Cities, counties, and tribes, subdivisions thereof, public development authorities, and community-based organizations demonstrating support from necessary public partners, may serve as the lead agency applying for funding. Funds may be used to scale existing projects, and to invite additional jurisdictions to launch law enforcement assisted diversion programs.

(3) The program must provide for securing comprehensive technical assistance from law enforcement assisted diversion implementation experts to develop and implement a law enforcement assisted diversion program in a way that ensures fidelity to the research-based law enforcement assisted diversion model. Sufficient funds must be allocated from grant program funds to secure technical assistance for the authority and for the implementing jurisdictions.

(4) The key elements of a law enforcement assisted diversion program 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) 24 hours per day and seven days per week response to law enforcement for arrest diversions; and

(h) Prosecutorial support for diversion services.

(5) No civil liability may be imposed by any court on the state or its officers or employees, an appointed or elected official, public employee, public agency as defined in RCW 4.24.470, combination of units of government and its employees as provided in RCW 36.28A.010, nonprofit community-based organization, tribal government entity, tribal organization, or urban Indian organization, based on the administration of a law enforcement assisted diversion program or activities carried out within the purview of a grant received under this program except upon proof of bad faith or gross negligence. [2023 sp.s. c 1 s 13; 2019 c 314 s 29.]

**Declaration—2019 c 314:** See note following RCW 18.22.810.

**RCW 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 an opioid treatment 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 only to the extent that such reasonable conditional use requirements applied to opioid treatment programs are similarly applied to other essential public facilities and health care settings. 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) Provide public notice to all appropriate media outlets in the community in which the facility is proposed to be located that states the applicant is proposing a facility in that community.

(2) No city or county legislative authority may impose a maximum capacity for an opioid treatment program.

(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 program 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 31 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) A mobile or fixed-site medication unit may be established as part of a licensed opioid treatment program.

(8) 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, including methadone; and

(b) Provides a comprehensive range of medical and rehabilitative services. [2023 sp.s. c 1 s 14; 2019 c 314 s 30; 2018 c 201 s 4045; 2017 c 297 s 14; 2001 c 242 s 2; 1995 c 321 s 2; 1989 c 270 s 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 ss 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 s 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.

**RCW 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 s 25.]

**Declaration—2019 c 314:** See note following RCW 18.22.810.

**RCW 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 s 4.]

**Effective date—2021 c 273 ss 2-4:** See note following RCW 70.41.480.

**Findings—Intent—2021 c 273:** See note following RCW 70.41.480.

**RCW 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 s 31; 2018 c 201 s 4046; 2017 c 297 s 16; 2003 c 207 s 6; 2001 c 242 s 3; 1998 c 245 s 135; 1995 c 321 s 3; 1989 c 270 s 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 ss 14 and 16:** See note following RCW 71.24.590.

**Findings—Intent—2017 c 297:** See note following RCW 18.22.800.

**RCW 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 s 32.]

**Declaration—2019 c 314:** See note following RCW 18.22.810.

**RCW 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 s 33.]

**Declaration—2019 c 314:** See note following RCW 18.22.810.

**RCW 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 s 34.]

**Declaration—2019 c 314:** See note following RCW 18.22.810.

**RCW 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 s 1041; 2018 c 201 s 4047. Prior: 1989 c 271 s 308; 1959 c 85 s 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.

**Severability—1989 c 271:** See note following RCW 9.94A.510.

**RCW 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 s 4048; 1998 c 245 s 136; 1995 c 54 s 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 s 1.]

**RCW 71.24.610 Interagency agreement on prenatal substance exposure programs.** The authority, the department of social and health services, the department, the department of corrections, the department of children, youth, and families, 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 other prenatal substance exposures, and for women who are at high risk of having children with fetal alcohol exposure or other prenatal substance exposures.

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. [2023 c 288 s 5; 2018 c 201 s 4049; 1995 c 54 s 3. Formerly RCW 70.96A.510.]

**Findings—2023 c 288:** See note following RCW 41.05.810.

**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.

**RCW 71.24.612 Prenatal substance exposure—Recommendations.** (1) By June 1, 2024, the authority shall submit to the legislature recommendations on ways to increase access to diagnoses, treatment, services, and supports for children who were exposed to alcohol or other substances during pregnancy and their families and caregivers. In creating the recommendations, the authority shall consult with service providers, medical professionals with expertise in diagnosing and treating prenatal substance exposure, families of children who were exposed to alcohol or other substances during pregnancy, communities affected by prenatal substance exposure, and advocates.

(2) The recommendations adopted under subsection (1) of this section shall, at a minimum, address:

(a) Increasing the availability of evaluation and diagnosis services for children and youth for fetal alcohol spectrum disorders and other prenatal substance disorders, including assuring an adequate payment rate for the interdisciplinary team required for diagnosis and developing sufficient capacity in rural and urban areas so that every child is able to access diagnosis services; and

(b) Increasing the availability of treatment for fetal alcohol spectrum disorders and other prenatal substance disorders for all children and youth including all treatments and services recommended by the federal centers for disease control and prevention. The authority shall review all barriers to accessing treatment and make recommendations on removing those barriers, including recommendations related to the definition of medical necessity, prior authorization requirements for diagnosis and treatment services, and limitations of treatment procedure codes and insurance coverage. [2023 c 288 s 3.]

**Findings—2023 c 288:** See note following RCW 41.05.810.

**RCW 71.24.614 Prenatal substance exposure—Contracting.** Subject to the availability of amounts appropriated for this specific purpose, the authority shall contract with a statewide nonprofit entity with expertise in fetal alcohol spectrum disorders and experience in supporting parents and caregivers to offer free support groups for individuals living with fetal alcohol spectrum disorders and their parents and caregivers. [2023 c 288 s 4.]

**Findings—2023 c 288:** See note following RCW 41.05.810.

**RCW 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 s 4050; 2003 c 207 s 7; 1997 c 338 s 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.

**Severability—Effective dates—1997 c 338:** See notes following RCW 5.60.060.

**RCW 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)(i) 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.

(ii) 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. Beginning January 1, 2025, if a managed care organization authorizes inpatient or residential substance use disorder treatment services pursuant to (a)(i) of this subsection following the initial medical necessity review process under (c)(iii) of this subsection, the length of the initial authorization may not be less than 14 days from the date that the patient was admitted to the behavioral health agency. Any subsequent reauthorization that the managed care organization approves after the first 14 days must continue for no less than seven days prior to requiring further reauthorization. Nothing prohibits a managed care organization from requesting information to assist with a seamless transfer under this subsection.

(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. In a review for inpatient or residential substance use disorder treatment services, a managed care organization may not make a determination that a patient does not meet medical necessity criteria based primarily on the patient's length of abstinence. If the patient's abstinence from substance use was due to incarceration, hospitalization, or inpatient treatment, a managed care organization may not consider the patient's length of abstinence in determining medical necessity. 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)(a) 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.

(b) Beginning January 1, 2025, for inpatient or residential substance use disorder treatment services, the managed care organization may not consider the patient's length of stay at the behavioral health agency when making decisions regarding the authorization to continue care at the behavioral health agency.

(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. [2024 c 366 s 8; 2020 c 345 s 4.]

**Findings—Intent—2024 c 366:** See note following RCW 71.24.847.

**Findings—Intent—2020 c 345:** See note following RCW 41.05.526.

**RCW 71.24.619 Standard set of criteria—Authority review.** When updated versions of the ASAM Criteria, treatment criteria for addictive, substance related, and co-occurring conditions, inclusive of adolescent and transition age youth versions, are published by the American society of addiction medicine, the health care authority and the office of the insurance commissioner shall jointly determine whether to use the updated version, and, if so, the date upon which

the updated version must begin to be used by medicaid managed care organizations, carriers, and other relevant entities. Both agencies shall post notice of their decision on their websites. For purposes of the ASAM Criteria, 4th edition, medicaid managed care organizations and carriers shall begin to use the updated criteria no later than January 1, 2026, unless the health care authority and the office of the insurance commissioner jointly determine that it should not be used. [2024 c 366 s 12.]

**Findings—Intent—2024 c 366:** See note following RCW 71.24.847.

**RCW 71.24.621 Withdrawal management services—Requirements for limiting medication usage.** (1) If a behavioral health provider or licensed or certified behavioral health agency that provides withdrawal management services to a patient seeks to discontinue usage or reduce dosage amounts of a medication, including a psychotropic medication, that the patient has been using in accordance with the directions of a prescribing health care provider, the withdrawal management provider shall engage in individualized, patient-centered, shared decision making, using nonjudgmental and compassionate communication and, with the consent of the patient, make a good faith effort to consult the prescribing health care provider. A withdrawal management provider may not, by philosophy or practice, categorically require all patients to discontinue all psychotropic medications, including benzodiazepines and medications for attention deficit hyperactivity disorder.

(2) This section does not apply to hospitals licensed under chapter 70.41 RCW and psychiatric hospitals licensed under chapter 71.12 RCW. [2024 c 366 s 5.]

**Findings—Intent—2024 c 366:** See note following RCW 71.24.847.

**RCW 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 s 1042; 2018 c 201 s 4052; 2016 sp.s. c 29 s 521; 1992 c 205 s 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.

**Part headings not law—Severability—1992 c 205:** See notes following RCW 13.40.010.

**RCW 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 s 1043; 2018 c 201 s 4053; 2016 sp.s. c 29 s 513; 2014 c 225 s 77; 2005 c 504 s 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.

**Alphabetization—Correction of references—2005 c 504:** See note following RCW 71.05.020.

**RCW 71.24.635 Cannabis consumption—Health care provider guidance—Promotion of reduction and cessation programs for populations at risk of serious complications—Request for proposal—Report. *(Expires December 31, 2028.)*** (1) Subject to amounts appropriated for this specific purpose, the health care authority must issue a request for proposal and contract with an entity to develop, implement, test, and evaluate guidance and health interventions for health care providers and patients at risk for developing serious complications due to cannabis consumption who are seeking care in emergency departments, primary care settings, behavioral health settings, other health care facilities, and for use by state poison control and recovery hotlines to promote cannabis use reduction and cessation for the following populations:

(a) Youth and adults at high risk of adverse mental health impacts from use of high THC cannabis;

(b) Youth and adults who have experienced a cannabis-induced first episode psychosis but do not have a diagnosis of a psychotic disorder; and

(c) Youth and adults who have a diagnosed psychotic disorder and use cannabis.

(2) The health care authority must submit a preliminary report to the appropriate committees of the legislature summarizing the progress toward developing and testing health interventions and recruiting patients and health care facilities to participate by December 1, 2025. The health care authority must provide a progress report on initial outcomes of the health interventions for participating patients and health care facilities by July 1, 2027. The health care authority must submit a final report to the appropriate committees of the legislature summarizing the results of the interventions and any recommendations for implementation of health interventions by December 1, 2028.

(3) A contract entered under the authorization in this section must include, in the scope of work, data gathering on adverse health impacts occurring in Washington associated with consumption of high THC cannabis, and data gathered must be included in the reports submitted to the legislature under this section.

(4) This section expires December 31, 2028. [2024 c 360 s 5.]

**Finding—Intent—2024 c 360:** See notes following RCW 69.50.357.

**RCW 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 s 4054; 2016 sp.s. c 29 s 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.

**RCW 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 s 4055; 2016 sp.s. c 29 s 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.

**RCW 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 s 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 s 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.

**RCW 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 s 403; 2019 c 324 s 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 s 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.

**RCW 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 clubhouse, 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 s 4057; 2016 sp.s. c 29 s 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.

**RCW 71.24.657 Recovery residences—Funding—Voucher program—Outreach—Training.** Subject to the availability of funds appropriated for this specific purpose, the authority shall:

(1) Make sufficient funding available to support establishment of an adequate and equitable stock of recovery residences in each region of the state;

(2) Establish a voucher program to allow accredited recovery housing operators to hold bed space for individuals who are waiting for treatment;

(3) Conduct outreach to underserved and rural areas to support the development of recovery housing, including adequate resources for women, LGBTQIA+ communities, Black, indigenous, and other people of color communities, immigrant communities, and youth; and

(4) Develop a training for housing providers by January 1, 2024, to assist them with providing appropriate service to LGBTQIA+ communities, Black, indigenous, and other people of color communities, and immigrant communities, including consideration of topics like harassment, communication, antiracism, diversity, and gender-affirming behavior, and ensure applicants for grants or loans related to recovery residences receive access to the training. [2023 sp.s. c 1 s 17.]

**RCW 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 s 5.]

**Findings—2019 c 264:** See note following RCW 41.05.760.

**RCW 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 s 307.]

**RCW 71.24.670 Substance use disorder treatment facilities and entities—Record sharing.** Any substance use disorder treatment facilities and entities that provide behavioral health services where the department of children, youth, and families is investigating child abuse or neglect, as provided for under RCW 26.44.210, shall share records and any other information that is relevant to the department of children, youth, and families' investigation. Any records or information shared with the department of children, youth, and families retains any confidentiality protections under state or federal law. [2023 c 441 s 5.]

**Finding—Intent—2023 c 441:** See note following RCW 74.15.325.

**RCW 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 s 6.]

***Reviser's note:** RCW 71.24.310 was repealed by 2019 c 325 s 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.

**RCW 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 s 9.]

**Findings—2021 c 243:** See note following RCW 74.09.670.

**RCW 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 s 4.]

**Findings—2021 c 243:** See note following RCW 74.09.670.

**RCW 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 s 18.]

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

**RCW 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 s 1044; 2014 c 225 s 46; 2013 c 230 s 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.

**RCW 71.24.847 Transfer of clients—Policy and statistic reporting.** (1)(a) By October 1, 2024, each licensed or certified behavioral health agency providing voluntary inpatient or residential substance use disorder treatment services or withdrawal management services shall submit to the department any policies that the agency maintains regarding the transfer or discharge of a person without the

person's consent from a facility providing those services. The policies that agencies must submit include any policies related to situations in which the agency transfers or discharges a person without the person's consent, therapeutic progressive disciplinary processes that the agency maintains, and procedures to assure safe transfers and discharges when a patient is discharged without the patient's consent. Behavioral health agencies that do not maintain such policies must provide an attestation to this effect.

(b) By April 1, 2025, the department shall adopt a model policy for licensed or certified behavioral health agencies providing voluntary inpatient or residential substance use disorder treatment services or withdrawal management services to consider when adopting policies related to the transfer or discharge of a person without the person's consent from a facility providing those services. In developing the model policy, the department shall consider the policies submitted by agencies under (a) of this subsection and establish factors to be used in making a decision to transfer or discharge a person without the person's consent. Factors may include, but are not limited to, the person's medical condition, the clinical determination that the person no longer requires treatment or withdrawal management services at the facility, the risk of physical injury presented by the person to the person's self or to other persons at the facility, the extent to which the person's behavior risks the recovery goals of other persons at the facility, and the extent to which the agency has applied a therapeutic progressive disciplinary process. The model policy must include provisions addressing the use of an appropriate therapeutic progressive disciplinary process and procedures to assure safe transfers and discharges of a patient who is discharged without the patient's consent.

(2)(a) Beginning July 1, 2025, every licensed or certified behavioral health agency providing voluntary inpatient or residential substance use disorder treatment services or withdrawal management services shall submit a report to the department for each instance in which a person receiving services either: (i) Was transferred or discharged from the facility by the agency without the person's consent; or (ii) released the person's self from the facility prior to a clinical determination that the person had completed treatment.

(b) The department shall adopt rules to implement the reporting requirement under (a) of this subsection, using a standard form. The rules must require that the agency provide a description of the circumstances related to the person's departure from the facility, including whether the departure was voluntary or involuntary, the extent to which a therapeutic progressive disciplinary process was applied, the patient's self-reported understanding of the reasons for discharge, efforts that were made to avert the discharge, and efforts that were made to establish a safe discharge plan prior to the patient leaving the facility.

(3) Patient health care information contained in reports submitted under subsection (2) of this section is exempt from disclosure under RCW 42.56.360.

(4) This section does not apply to hospitals licensed under chapter 70.41 RCW and psychiatric hospitals licensed under chapter 71.12 RCW. [2024 c 366 s 2.]

**Findings—Intent—2024 c 366:** "(1) The legislature finds that ensuring that individuals with substance use disorders can enter into and complete residential addiction treatment is an important public policy objective. Substance use disorder providers forcing patients to leave treatment prematurely and insurance authorization barriers both present impediments to realizing this goal.

(2) The legislature further finds that patients with substance use disorders should be provided information regarding and access to the full panoply of treatment options for their condition, as would be the case with any other life-threatening disease. Pharmacotherapies are incredibly effective and severely underutilized tools in the treatment of opioid use disorder and alcohol use disorder. The federal food and drug administration has approved three medications for the treatment of opioid use disorder and three medications for the treatment of alcohol use disorder. Only 37 percent of individuals with opioid use disorder and nine percent of individuals with alcohol use disorder receive medication to treat their condition.

(3) Therefore, it is the intent of the legislature to reduce forced patient discharges from residential addiction treatment, to remove arbitrary insurance authorization barriers to residential addiction treatment, and to ensure that patients with opioid use disorder and alcohol use disorder receive access to care that is consistent with clinical best practices." [2024 c 366 s 1.]

**RCW 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 s 4060; 2014 c 225 s 8.]

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

**RCW 71.24.852 Intensive behavioral health treatment facilities—Resident rights and access to ombuds services—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 s 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.

**RCW 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 s 1.]

**RCW 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, including but not limited to the data-sharing needs of behavioral health system partners.

(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. [2023 c 292 s 3; 2019 c 325 s 1047.]

**Findings—Intent—2023 c 292:** See note following RCW 74.09.871.

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

**RCW 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 s 1045; 2017 c 207 s 2.]

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

**Contingent effective date—2017 c 207 s 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 s 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 s 1.]

**RCW 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 s 5032.]

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

**RCW 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 s 4062.]

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

**RCW 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 s 1.]

**RCW 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 s 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 s 1.]

**RCW 71.24.890 National 988 system—Designated 988 contact hubs—Technology and platform development—Agency collaboration.** (1) Establishing the state designated 988 contact hubs and enhancing the crisis response system will require collaborative work between the department, the authority, and regional system partners within their respective roles. The department shall have primary responsibility for designating 988 contact hubs, and shall seek recommendations from the behavioral health administrative services organizations to determine which 988 contact hubs best meet regional needs. The authority shall have primary responsibility for developing, implementing, and facilitating coordination of the crisis response system and services to support the work of the designated 988 contact hubs, regional crisis lines, and other coordinated regional behavioral health crisis response system partners. In any instance in which one agency is identified as the lead, the expectation is that agency will communicate and collaborate 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 988 contact hubs 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. Contracts with the 988 contact hubs:

(a) May provide funding to support designated 988 contact hubs to enter into limited partnerships with the public safety answering point to increase the coordination and transfer of behavioral health calls received by certified public safety telecommunicators that are better addressed by clinic interventions provided by the 988 system. Tax revenue may be used to support partnerships. These partnerships with 988 and public safety may be expanded to include regional crisis lines administered by behavioral health administrative services organizations;

(b) Shall require that 988 contact hubs enter into data-sharing agreements, when appropriate, with the department, the authority, regional crisis lines, and applicable regional behavioral health administrative services organizations to provide reports and client level data regarding 988 contact hub calls, as allowed by and in compliance with existing federal and state law governing the sharing and use of protected health information. Data-sharing agreements with regional crisis lines must include real-time information sharing. All coordinated regional behavioral health crisis response system partners must share dispatch time, arrival time, and disposition for behavioral health calls referred for outreach by each region consistent with any regional protocols developed under RCW 71.24.432. The department and the authority shall establish requirements for 988 contact hubs to report data to regional behavioral health administrative services organizations for the purposes of maximizing medicaid reimbursement, as appropriate, and implementing this chapter and chapters 71.05 and 71.34 RCW. The behavioral health administrative services organization may use information received from the 988 contact hubs in administering crisis services for the assigned regional service area, contracting with a sufficient number of licensed or certified providers for crisis services, establishing and maintaining quality assurance processes, maintaining patient tracking, and developing and implementing strategies to coordinate care for individuals with a history of frequent crisis system utilization.

(3) The department shall adopt rules by January 1, 2025, to establish standards for designation of crisis call centers as designated 988 contact hubs. The department shall collaborate with the authority, other agencies, and coordinated regional behavioral health crisis response system partners 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 behavioral health administrative services organizations and the crisis response improvement strategy committee created in RCW 71.24.892.

(4) The department shall designate 988 contact hubs considering the recommendations of behavioral health administrative services organizations by January 1, 2026. The designated 988 contact hubs shall provide connections to crisis intervention services, triage, care coordination, and referrals for individuals contacting the 988 contact hubs from any jurisdiction within Washington 24 hours a day, seven days a week, using the system platform developed under

subsection (5) of this section. The department may not designate more than a total of four 988 contact hubs without legislative approval.

(a) To be designated as a 988 contact hub, the applicant must demonstrate to the department the ability to comply with the requirements of this section and to contract to provide 988 contact hub services. If a 988 contact hub fails to substantially comply with the contract, data-sharing requirements, or approved regional protocols developed under RCW 71.24.432, the department may revoke the designation of the 988 contact hub and, after consulting with the affected behavioral health administrative services organization, may designate a 988 contact hub recommended by a behavioral health administrative services organization which is able to meet necessary state and federal requirements.

(b) The contracts entered shall require designated 988 contact 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 for callers that need additional clinical interventions, 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) Train employees on agricultural community cultural competencies for suicide prevention, which may include sharing resources with callers that are specific to members from the agricultural community. The training must prepare staff to provide appropriate assessments, interventions, and resources to members of the agricultural community. Employees may make warm transfers and referrals to a crisis hotline that specializes in working with members from the agricultural community, provided that no person contacting 988 shall be transferred or referred to another service if they are currently in crisis and in need of emotional support;

(v) Prominently display 988 crisis hotline information on their websites and social media, including a description of what the caller should expect when contacting the crisis call center and a description of the various options available to the caller, including call lines specialized in the behavioral health needs of veterans, American Indian and Alaska Native persons, Spanish-speaking persons, and LGBTQ populations. The website may also include resources for programs and services related to suicide prevention for the agricultural community;

(vi) 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;

(vii) Collaborate with coordinated regional behavioral health crisis response system partners within the 988 contact hub's regional service area to develop protocols under RCW 71.24.432, including protocols related to the dispatching of mobile rapid response crisis teams and community-based crisis teams endorsed under RCW 71.24.903;

(viii) 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; and

(ix) Enter into data-sharing agreements with the department, the authority, regional crisis lines, and applicable behavioral health administrative services organizations to provide reports and client level data regarding 988 contact hub calls, as allowed by and in compliance with existing federal and state law governing the sharing and use of protected health information, which shall include sharing real-time information with regional crisis lines. The department and the authority shall establish requirements that the designated 988 contact hubs report data to regional behavioral health administrative services organizations for the purposes of maximizing medicaid reimbursement, as appropriate, and implementing this chapter and chapters 71.05 and 71.34 RCW including, but not limited to, administering crisis services for the assigned regional service area, contracting with a sufficient number of licensed or certified providers for crisis services, establishing and maintaining quality assurance processes, maintaining patient tracking, and developing and implementing strategies to coordinate care for individuals with a history of frequent crisis system utilization.

(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 designated 988 contact 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 department and the authority must include designated 988 contact hubs, regional crisis lines, and behavioral health administrative services organizations in the decision-making process for selecting any technology platforms that will be used to operate the system. No decisions made by the department or the authority shall interfere with the routing of the 988 contact hubs calls, texts, or chat as part of Washington's active agreement with the administrator of the national suicide prevention lifeline or 988 administrator that routes 988 contacts into Washington's system. The technologies developed must include:

(a) A new technologically advanced behavioral health and suicide prevention crisis call center system platform for use in 988 contact hubs designated by the department under subsection (4) of this section. This platform, which shall be implemented as soon as possible and fully funded by January 1, 2026, 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 designated 988 contact 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 and recliner chairs, including but not limited to crisis stabilization services, 23-hour crisis relief centers, 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 designated 988 contact hubs to actively collaborate with regional crisis lines, 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 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 designated 988 contact hub;

(c) 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 designated 988 contact hub;

(d) 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

(e) When appropriate, consultation with tribal governments to ensure coordinated care in government-to-government relationships, and access to dedicated services to tribal members.

(7) 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 designated 988 contact 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 contact hub or a regional crisis line 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 behavioral health administrative services organizations in coordination with designated 988 contact 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 contact hubs to linguistically and culturally competent care.

(8) The department shall monitor trends in 988 crisis hotline caller data, as reported by designated 988 contact hubs under subsection (4)(b)(ix) of this section, and submit an annual report to the governor and the appropriate committees of the legislature summarizing the data and trends beginning December 1, 2027.

(9) Subject to authorization by the national 988 administrator and the availability of amounts appropriated for this specific purpose, any Washington state subnetwork of the 988 crisis hotline dedicated to the crisis assistance needs of American Indian and Alaska Native persons shall offer services by text, chat, and other similar methods of communication to the same extent as does the general 988

crisis hotline. The department shall coordinate with the substance abuse and mental health services administration for the authorization. [2024 c 368 s 4; 2024 c 364 s 1. Prior: 2023 c 454 s 5; 2023 c 433 s 16; 2021 c 302 s 102.]

**Reviser's note:** This section was amended by 2024 c 364 s 1 and by 2024 c 368 s 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).

**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 s 101.]

**RCW 71.24.892 National 988 system—Crisis response improvement strategy committee—Membership—Steering committee—Reports.** ***(Expires December 31, 2026.)*** (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)(a) Through January 1, 2025, the behavioral health institute at Harborview medical center shall facilitate and provide staff support to the steering committee and to the crisis response improvement strategy committee. The behavioral health institute may contract for the provision of these services.

(b) Beginning January 2, 2025, the authority shall facilitate and provide staff support to the steering committee and to the crisis response improvement strategy committee. The authority may contract for the provision of these services.

(3) The steering committee shall consist of the five members specified as serving on the steering committee in this subsection and one additional member who has been appointed to serve pursuant to the criteria in either (j), (k), (l), or (m) of this subsection. 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 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 designated 988 contact hubs; mobile rapid response crisis teams and community-based crisis teams endorsed under RCW 71.24.903; 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 that designated 988 contact 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 designated 988 contact 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 mobile rapid response crisis teams and community-based crisis teams endorsed under RCW 71.24.903 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 designated 988 contact 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 and community-based crisis teams endorsed under RCW 71.24.903, 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;

(f) A 988 geolocation subcommittee, to examine privacy issues related to federal planning efforts to route 988 crisis hotline calls based on the person's location, rather than area code, including ways to implement the federal efforts in a manner that maintains public and clinical confidence in the 988 crisis hotline. The 988 geolocation subcommittee must include persons with lived experience with behavioral health conditions as well as representatives of crisis call centers, the behavioral health interests of persons of color, and behavioral health providers; and

(g) 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 designated 988 contact hubs to the governor and appropriate policy and fiscal committees of the legislature by January 1, 2023, and January 1, 2024. The steering committee shall provide its final report to the governor and the appropriate policy and fiscal committees of the legislature by January 1, 2025.

(12) This section expires December 31, 2026. [2024 c 364 s 2; 2023 c 454 s 6; 2021 c 302 s 103.]

**Effective date—2021 c 302 s 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 s 408.]

**Findings—Intent—2021 c 302:** See note following RCW 71.24.890.

**RCW 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 s 105.]

**Findings—Intent—2021 c 302:** See note following RCW 71.24.890.

**RCW 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 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 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 designated 988 contact 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. [2023 c 454 s 7; 2021 c 302 s 108.]

**Findings—Intent—2021 c 302:** See note following RCW 71.24.890.

**RCW 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 Washington technology solutions, 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. [2024 c 54 s 60; 2021 c 302 s 109.]

**Findings—Intent—2021 c 302:** See note following RCW 71.24.890.

**RCW 71.24.899 National 988 system—Informational materials—Social media campaign.** The department shall develop informational materials and a social media campaign related to the 988 crisis hotline, including call, text, and chat options, and other crisis hotline lines for veterans, American Indians and Alaska Natives, and other populations. The informational materials must include appropriate information for persons seeking services at behavioral health clinics and medical clinics, as well as media audiences and students at K-12 schools and higher education institutions. The department shall make the informational materials available to behavioral health clinics, medical clinics, media, K-12 schools, higher education institutions, and other relevant settings. The informational materials shall be made available to professionals during training in suicide assessment, treatment, and management under RCW 43.70.442. To tailor the messages of the informational materials and the social media campaign, the department must consult with tribes, the American Indian health commission of Washington state, the native and strong lifeline, the Washington state department of veterans affairs, representatives of agricultural communities, and

persons with lived experience related to mental health issues, substance use disorder issues, a suicide attempt, or a suicide loss. [2023 c 454 s 3.]

**RCW 71.24.903 Mobile rapid response crisis team endorsement.** (1) By April 1, 2024, the authority shall establish standards for issuing an endorsement to any mobile rapid response crisis team or community-based crisis team that meets the criteria under either subsection (2) or (3) of this section, as applicable. The endorsement is a voluntary credential that a mobile rapid response crisis team or community-based crisis team may obtain to signify that it maintains the capacity to respond to persons who are experiencing a significant behavioral health emergency requiring an urgent, in-person response. The attainment of an endorsement allows the mobile rapid response crisis team or community-based crisis team to become eligible for performance payments as provided in subsection (10) of this section.

(2) The authority's standards for issuing an endorsement to a mobile rapid response crisis team or a community-based crisis team must consider:

(a) Minimum staffing requirements to effectively respond in-person to individuals experiencing a significant behavioral health emergency. Except as provided in subsection (3) of this section, the team must include appropriately credentialed and supervised staff employed by a licensed or certified behavioral health agency and may include other personnel from participating entities listed in subsection (3) of this section. The team shall include certified peer counselors as a best practice to the extent practicable based on workforce availability. The team may include fire departments, emergency medical services, public health, medical facilities, nonprofit organizations, and city or county governments. The team may not include law enforcement personnel;

(b) Capabilities for transporting an individual experiencing a significant behavioral health emergency to a location providing appropriate level crisis stabilization services, as determined by regional transportation procedures, such as crisis receiving centers, crisis stabilization units, and triage facilities. The standards must include vehicle and equipment requirements, including minimum requirements for vehicles and equipment to be able to safely transport the individual, as well as communication equipment standards. The vehicle standards must allow for an ambulance or aid vehicle licensed under chapter 18.73 RCW to be deemed to meet the standards; and

(c) Standards for the initial and ongoing training of personnel and for providing clinical supervision to personnel.

(3) The authority must adjust the standards for issuing an endorsement to a community-based crisis team under subsection (2) of this section if the team is comprised solely of an emergency medical services agency, whether it is part of a fire service agency or a private entity, that is located in a rural county in eastern Washington with a population of less than 60,000 residents. Under the adjusted standards, until January 1, 2030, the authority shall exempt a team from the personnel standards under subsection (2)(a) of this section and issue an endorsement to a team if:

(a) The personnel assigned to the team have met training requirements established by the authority under subsection (2)(c) of this section, as those requirements apply to emergency medical service and fire service personnel, including completion of the three-hour

training in suicide assessment, treatment, and management under RCW 43.70.442;

(b) The team operates under a memorandum of understanding with a licensed or certified behavioral health agency to provide direct, real-time consultation through a behavioral health provider employed by a licensed or certified behavioral health agency while the team is responding to a call. The consultation may be provided by telephone, through remote technologies, or, if circumstances allow, in person; and

(c) The team does not include law enforcement personnel.

(4) Prior to issuing an initial endorsement or renewing an endorsement, the authority shall conduct an on-site survey of the applicant's operation.

(5) An endorsement must be renewed every three years.

(6) The authority shall establish forms and procedures for issuing and renewing an endorsement.

(7) The authority shall establish procedures for the denial, suspension, or revocation of an endorsement.

(8)(a) The decision of a mobile rapid response crisis team or community-based crisis team to seek endorsement is voluntary and does not prohibit a nonendorsed team from participating in the crisis response system when (i) responding to individuals who are not experiencing a significant behavioral health emergency that requires an urgent in-person response or (ii) responding to individuals who are experiencing a significant behavioral health emergency that requires an urgent in-person response when there is not an endorsed team available.

(b) The decision of a mobile rapid response crisis team not to pursue an endorsement under this section does not affect its obligation to comply with any standards adopted by the authority with respect to mobile rapid response crisis teams.

(c) The decision of a mobile rapid response crisis team not to pursue an endorsement under this section does not affect its responsibilities and reimbursement for services as they may be defined in contracts with managed care organizations or behavioral health administrative services organizations.

(9) The costs associated with endorsement activities shall be supported with funding from the statewide 988 behavioral health crisis response and suicide prevention line account established in RCW 82.86.050.

(10) The authority shall establish an endorsed mobile rapid response crisis team and community-based crisis team performance program with receipts from the statewide 988 behavioral health crisis response and suicide prevention line account.

(a) Subject to funding provided for this specific purpose, the performance program shall:

(i) Issue establishment grants to support mobile rapid response crisis teams and community-based crisis teams seeking to meet the elements necessary to become endorsed under either subsection (2) or (3) of this section;

(ii) Issue performance payments in the form of an enhanced case rate to mobile rapid response crisis teams and community-based crisis teams that have received an endorsement from the authority under either subsection (2) or (3) of this section; and

(iii) Issue supplemental performance payments in the form of an enhanced case rate higher than that available in (a)(ii) of this subsection (10) to mobile rapid response crisis teams and community-

based crisis teams that have received an endorsement from the authority under either subsection (2) or (3) of this section and demonstrate to the authority that for the previous three months they met the following response time and in route time standards:

(A) Between January 1, 2025, through December 31, 2026:

(I) Arrive to the individual's location within 30 minutes of being dispatched by the designated 988 contact hub, at least 80 percent of the time in urban areas;

(II) Arrive to the individual's location within 40 minutes of being dispatched by the designated 988 contact hub, at least 80 percent of the time in suburban areas; and

(III) Be in route within 15 minutes of being dispatched by the designated 988 contact hub, at least 80 percent of the time in rural areas; and

(B) On and after January 1, 2027:

(I) Arrive to the individual's location within 20 minutes of being dispatched by the designated 988 contact hub, at least 80 percent of the time in urban areas;

(II) Arrive to the individual's location within 30 minutes of being dispatched by the designated 988 contact hub, at least 80 percent of the time in suburban areas; and

(III) Be in route within 10 minutes of being dispatched by the designated 988 contact hub, at least 80 percent of the time in rural areas.

(b) The authority shall design the program in a manner that maximizes the state's ability to receive federal matching funds.

(11) The authority shall contract with the actuaries responsible for development of medicaid managed care rates to conduct an analysis and develop options for payment mechanisms and levels for rate enhancements under subsection (10) of this section. The authority shall consult with staff from the office of financial management and the fiscal committees of the legislature in conducting this analysis. The payment mechanisms must be developed to maximize leverage of allowable federal medicaid match. The analysis must clearly identify assumptions, include cost projections for the rate level options broken out by fund source, and summarize data used for the cost analysis. The cost projections must be based on Washington state specific utilization and cost data. The analysis must identify low, medium, and high ranges of projected costs associated for each option accounting for varying scenarios regarding the numbers of teams estimated to qualify for the enhanced case rates and supplemental performance payments. The analysis must identify costs for both medicaid clients, and for state-funded nonmedicaid clients paid through contracts with behavioral health administrative services organizations. The analysis must account for phasing in of the number of teams that meet endorsement criteria over time and project annual costs for a four-year period associated with each of the scenarios. The authority shall submit a report summarizing the analysis, payment mechanism options, enhanced performance payment and supplemental performance payment rate level options, and related cost estimates to the office of financial management and the appropriate committees of the legislature by December 1, 2023.

(12) The authority shall conduct a review of the endorsed community-based crisis teams established under subsection (3) of this section and report to the governor and the health policy committees of the legislature by December 1, 2028. The report shall provide information about the engagement of the community-based crisis teams

receiving an endorsement under subsection (3) of this section and their ability to provide a timely and appropriate response to persons experiencing a behavioral health crisis and any recommended changes to the teams to better meet the needs of the community including personnel requirements, training standards, and behavioral health provider consultation. [2023 c 454 s 9.]

**RCW 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 s 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 s 1.]

**RCW 71.24.906 National 988 system—Needs assessment—Recommendations—Report.** (1) The authority and behavioral health administrative services organizations, in collaboration with the University of Washington, the Harborview behavioral health institute, the Washington council for behavioral health, and the statewide 988 coordinator, shall plan for regional collaboration among behavioral health providers and first responders working within the 988 crisis response and suicide prevention system, standardize practices and protocols, and develop a needs assessment for trainings. Under leadership by the authority and behavioral health administrative services organizations this work shall be divided as described in this section.

(2) The University of Washington, through the Harborview behavioral health institute, shall develop an assessment of training needs, a mapping of current and future funded crisis response providers, and a comprehensive review of all behavioral health training required in statute and in rule. The training needs assessment, mapping of crisis providers, and research on existing training requirements must be completed by June 30, 2024. The Harborview behavioral health institute may contract for all or any portion of this work. The Harborview behavioral health institute shall consult with, at a minimum, the following key stakeholders:

(a) At least two representatives from the behavioral health administrative services organizations, one from each side of the Cascade crest;

(b) At least three crisis services providers identified by the Washington council for behavioral health, one from each side of the Cascade crest, and one dedicated to serving communities of color;

(c) A representative of crisis call centers;

(d) The authority and the department;

(e) At least two members who are persons with lived experience related to mental health issues, substance use disorder issues, a suicide attempt, or a suicide loss;

(f) A representative of a statewide organization of field experts consisting of first responders, behavioral health professionals, and project managers working in co-response programs in Washington; and

(g) Advocates for and organizations representing persons with developmental disabilities, veterans, American Indians and Alaska Native populations, LGBTQ populations, and persons connected with the agricultural community, as deemed appropriate by each stakeholder

group, including persons with lived experience related to mental health issues, substance use disorder issues, a suicide attempt, or a suicide loss.

(3) The authority and behavioral health services organizations, in collaboration with the stakeholders specified in subsection (1) of this section, shall develop recommendations for establishing crisis workforce and resilience training collaboratives that would offer voluntary regional trainings for behavioral health providers, peers, first responders, co-responders, 988 contact center personnel, designated 988 contact hub personnel, 911 operators, regional leaders, and interested members of the public, specific to a geographic region and the population they serve as informed by the needs assessment. The collaboratives shall encourage the development of foundational and advanced skills and practices in crisis response as well as foster regional collaboration. The recommendations must:

(a) Include strategies for better coordination and integration of 988-specific training into the broader scope of behavioral health trainings that are already required;

(b) Identify effective trainings to explain how the 988 system works with the 911 emergency response system, trauma-informed care, secondary trauma, suicide protocols and practices for crisis responders, supervisory best practices for first responders, lethal means safety, violence assessments, cultural competency, and essential care for serving individuals with serious mental illness, substance use disorder, or co-occurring disorders;

(c) Identify best practice approaches to working with veterans, intellectually and developmentally disabled populations, youth, LGBTQ populations, communities of color, agricultural communities, and American Indian and Alaska Native populations;

(d) Identify ways to provide the designated 988 contact hubs and other crisis providers with training that is tailored to the agricultural community using training that is agriculture-specific with information relating to the stressors unique to persons connected with the agricultural community such as weather conditions, financial obligations, market conditions, and other relevant issues. When developing the recommendations, consideration must be given to national experts, such as the AgriSafe network and other entities;

(e) Identify ways to promote a better informed and more involved community on topics related to the behavioral health crisis system by increasing public access to and participation in trainings on the topics identified in (b) and (c) of this subsection (3), including through remote audiovisual technology;

(f) Establish suggested protocols for ways to sustain the collaboratives as new mobile rapid response crisis teams and community-based crisis teams endorsed under RCW 71.24.903, co-responder teams, and crisis facilities are funded and operationalized;

(g) Discuss funding needs to sustain the collaboratives and support participation in attending the trainings; and

(h) Offer a potential timeline for implementing the collaboratives on a region-by-region basis.

(4) The authority shall submit a report on the items developed in this section to the governor and the appropriate committees of the legislature by December 31, 2024. [2023 c 454 s 11.]

**RCW 71.24.907 National 988 system—Limitation of liability.** (1) No act or omission related to the dispatching decisions of any crisis call center staff or designated 988 contact hub staff with endorsed mobile rapid response crisis team and community-based crisis team dispatching responsibilities done or omitted in good faith within the scope of the individual's employment responsibilities with the crisis call center or designated 988 contact hub and in accordance with dispatching procedures adopted both by the behavioral health administrative services organization and the crisis call center or the designated 988 contact hub and approved by the authority shall impose liability upon:

(a) The clinical staff of the crisis call center or designated 988 contact hub or their clinical supervisors;

(b) The crisis call center or designated 988 contact hub or its officers, staff, or employees;

(c) Any member of a mobile rapid response crisis team or community-based crisis team endorsed under RCW 71.24.903;

(d) The certified public safety telecommunicator or the certified public safety telecommunicator's supervisor; or

(e) The public safety answering point or its officers, staff, or employees.

(2) No act or omission in the provision of crisis stabilization services, professional on-site community-based intervention, outreach, de-escalation, stabilization, resource connection, or follow-up support, and delivered under the clinical supervision of a mental health professional or an approved medical program director or their delegate, to a person who is experiencing a behavioral health crisis, and which is done or omitted in good faith within the scope of the individual's employment responsibilities, shall impose liability upon:

(a) Any staff of an endorsed or nonendorsed mobile rapid response crisis team or community-based crisis team, including teams operated by tribes, or staff of a crisis stabilization unit or a 23-hour crisis relief center, including facilities operated by tribes;

(b) Any officer of a public, private, or tribal agency, the superintendent, any professional person in charge or their professional designee, or any attending staff of any such agency; or

(c) Any federal, tribal, state, county, city, other local governmental unit, or contracted behavioral health agency, or employees of such units or agencies.

(3) This section shall apply to any act or omission by any person or entity listed in subsection (2) of this section involved in the transport of patients to behavioral health services, facilities providing crisis stabilization services, or other needed crisis services.

(4) This section shall not apply to any act or omission which constitutes either gross negligence or willful or wanton misconduct. [2024 c 370 s 1; 2023 c 454 s 13.]

**RCW 71.24.908 Data integration platform to support diversion efforts—Development and implementation—Exempt from public disclosure.** (1) The authority must develop and implement a data integration platform by June 30, 2025, to support recovery navigator programs, law enforcement assisted diversion programs, arrest and jail alternative programs, and similar diversion efforts. The data integration platform shall:

(a) Serve as a statewide common database available for tracking diversion efforts across the state;

(b) Serve as a data collection and management tool for practitioners, allowing practitioners to input data and information relating to the utilization and outcomes of pretrial diversions, including whether such diversions were terminated, were successfully completed and resulted in dismissal, or are still ongoing;

(c) Assist in standardizing definitions and practices; and

(d) Track pretrial diversion participants by race, ethnicity, gender, gender expression or identity, disability status, and age.

(2) If possible, the authority must leverage and interact with existing platforms already in use in efforts funded by the authority. The authority must establish a quality assurance process for behavioral health administrative services organizations and employ data validation for fields in the data collection workbook. The authority must engage and consult with the law enforcement assisted diversion national support bureau on data integration approaches, platforms, quality assurance protocols, and validation practices.

(3) Information submitted to the data integration platform is exempt from public disclosure requirements under chapter 42.56 RCW. [2023 sp.s. c 1 s 22.]

**RCW 71.24.909 Washington state institute for public policy study on recovery navigator programs and law enforcement assisted diversion programs.** (1) The authority shall contract with the Washington state institute for public policy to conduct a study of the long-term effectiveness of the recovery navigator programs under RCW 71.24.115 and law enforcement assisted diversion programs under RCW 71.24.589 implemented in Washington state, with reports due by June 30, 2028, June 30, 2033, and June 30, 2038, and an assessment as described under subsection (2) of this section. The Washington state institute for public policy shall collaborate with the authority and the substance use recovery services advisory committee under RCW 71.24.546 on the topic of data collection and to determine the parameters of the report, which shall include:

(a) Recidivism rates for recovery navigator and law enforcement assisted diversion program participants, including a comparison between individuals who did and did not use the pretrial diversion program under RCW 69.50.4017, and outcomes for these individuals;

(b) Trends or disparities in utilization of the recovery navigator and LEAD programs and outcomes based on race, ethnicity, gender, gender expression or identity, disability status, age, and other appropriate characteristics; and

(c) Recommendations, if any, for modification and improvement of the recovery navigator program or law enforcement assisted diversion programs.

(2)(a) The Washington state institute for public policy shall, in consultation with the authority and other key stakeholders, conduct a descriptive assessment of the current status of statewide recovery navigator programs and the degree to which the implementation of these programs reflects fidelity to the core principles of the law enforcement assisted diversion program as established by the law enforcement assisted diversion national support bureau in its toolkit as it existed on July 1, 2023, which shall include:

(i) The results of the law enforcement assisted diversion standards fidelity index analysis, conducted by an independent

research scientist with expertise in law enforcement assisted diversion evaluation, including findings with respect to each standard assessed, for each recovery navigator program, in each behavioral health administrative services organization region;

(ii) Reports on utilization of technical support from the law enforcement assisted diversion national support bureau by recovery navigator program contractors, the authority, and behavioral health administrative services organizations; and

(iii) Barriers to achieving fidelity to core principles.

(b) The report shall also describe law enforcement assisted diversion programs in Washington state that are not affiliated with recovery navigator programs.

(c) The report may include recommendations for changes to recovery navigator programs reported by recovery navigator program administrators, stakeholders, or participants.

(d) The authority, behavioral health administrative services organizations, and other recovery navigator program administrators shall cooperate with the institute in making this assessment.

(e) The institute shall submit this assessment to the governor and relevant committees of the legislature by June 30, 2024.

(3) The authority shall cooperate with the Washington state institute for public policy to provide data for the assessment and reports under this section.

(4) The authority must establish an expedited preapproval process by August 1, 2023, that allows requests for the use of data to be forwarded to the Washington state institutional review board without delay when the request is made by the Washington state institute for public policy for the purpose of completing a study that has been directed by the legislature. [2023 sp.s. c 1 s 24.]

**RCW 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 provider 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 s 22.]

**Effective date—2022 c 263:** See note following RCW 43.371.100.

**RCW 71.24.911 Statewide behavioral health treatment and recovery support services mapping tool.** Subject to funding provided for this specific purpose, the authority must collaborate with the department and the department of social and health services to expand the Washington recovery helpline and the recovery readiness asset tool to provide a dynamically updated statewide behavioral health treatment and recovery support services mapping tool that includes a robust resource database for those seeking services and a referral system to be incorporated within the locator tool to help facilitate the connection between an individual and a facility that is currently accepting new referrals. The tool must include dual interface capability, one for public access and one for internal use and management. [2023 sp.s. c 1 s 28.]

**RCW 71.24.912 Work group—Systems, policies, and processes related to intake, screening, and assessment for substance use disorders.** (1) The authority shall convene a work group to recommend changes to systems, policies, and processes related to intake, screening, and assessment for substance use disorder services, with the goal to broaden the workforce capable of administering substance use disorder assessments and to make the assessment process as brief as possible, including only what is necessary to manage utilization and initiate care. The assessment shall be low barrier, person-centered, and amenable to administration in diverse health care settings and by a range of health care professionals. The assessment shall consider the person's self-identified needs and preferences when evaluating direction of treatment and may include different components based on the setting, context, and past experience with the client.

(2) The work group must include care providers, payors, people who use drugs, individuals in recovery from substance use disorder, and other individuals recommended by the authority. The work group shall present its recommendations to the governor and appropriate committees of the legislature by December 1, 2024. [2023 sp.s. c 1 s 36.]

**RCW 71.24.913 Substance use disorders—Comprehensive assessments, reports.** (1) The authority is responsible for providing regular assessments of the prevalence of substance use disorders and interactions of persons with substance use disorder with service providers, nonprofit service providers, first responders, health care facilities, and law enforcement agencies. Beginning in 2026, the annual report required in subsection (3)(a) of this section shall include a comprehensive assessment of the information described in this subsection for the prior calendar year.

(2)(a) The authority shall identify the types and sources of data necessary to implement the appropriate means and methods of gathering data to provide the information required in subsection (1) of this section.

(b) The authority must provide a preliminary inventory report to the governor and the legislature by December 1, 2023, and a final inventory report by December 1, 2024. The reports must:

(i) Identify existing types and sources of data available to the authority to provide the information required in subsection (1) of this section and what data are necessary but currently unavailable to the authority;

(ii) Include recommendations for new data connections, new data-sharing authority, and sources of data that are necessary to provide the information required in subsection (1) of this section; and

(iii) Include recommendations, including any necessary legislation, regarding the development of reporting mechanisms between the authority and service providers, nonprofit service providers, health care facilities, law enforcement agencies, and other state agencies to gather the information required in subsection (1) of this section.

(3)(a) Beginning July 1, 2024, and each July 1st thereafter until July 1, 2028, the authority shall provide an implementation report to the governor and the legislature regarding recovery residences, recovery navigator programs, the health engagement pilot programs, and

the law enforcement assisted diversion grants program. The report shall include:

(i) The number of contracts awarded to law enforcement assisted diversion programs, including the amount awarded in the contract, and the names and service locations of contract recipients;

(ii) The location of recovery residences, recovery navigator programs, health engagement hub pilot programs, and law enforcement assisted diversion programs;

(iii) The scope and nature of services provided by recovery navigator programs, health engagement hub pilot programs, and law enforcement assisted diversion programs;

(iv) The number of individuals served by recovery residences, recovery navigator programs, health engagement hub pilot programs, and law enforcement assisted diversion programs;

(v) If known, demographic data concerning the utilization of these services by overburdened and underrepresented communities; and

(vi) The number of grants awarded to providers of employment, education, training, certification, and other supportive programs, including the amount awarded in each grant and the names of provider grant recipients, as provided for in RCW 71.24.113.

(b) The data obtained by the authority under this section shall be integrated with the Washington state institute for public policy report under RCW 71.24.909.

(4) Beginning in the July 1, 2027, report in subsection (3)(a) of this section, the authority shall provide:

(a) The results and effectiveness of the authority's collaboration with the department of health and the department of social and health services to expand the Washington recovery helpline and recovery readiness asset tool to provide a dynamically updated statewide behavioral health treatment and recovery support services mapping tool, including the results and effectiveness with respect to overburdened and underrepresented communities, in accordance with RCW 71.24.911;

(b) The results and effectiveness of the authority's development and implementation of a data integration platform to support recovery navigator programs and to serve as a common database available for diversion efforts across the state, including the results and effectiveness with respect to overburdened and underrepresented communities, as provided in RCW 71.24.908;

(c) The effectiveness and outcomes of training developed and provided by the authority in consultation with the department of children, youth, and families, as provided in RCW 71.24.522; and

(d) The effectiveness and outcomes of training developed by the authority for housing providers, as provided in RCW 71.24.657(4). [2023 sp.s. c 1 s 38.]

**RCW 71.24.915 Crisis continuum of care forum.** Behavioral health administrative services organizations in their role as regional behavioral health system leaders, in partnership with the authority, shall convene an annual crisis continuum of care forum, led by the behavioral health administrative services organizations, with participation from partners serving regional service areas, including managed care organizations, behavioral health providers, mobile rapid response crisis teams, 988 call center hubs, counties, tribes, and other regional partners, to identify and develop collaborative regional-based solutions which may include capital infrastructure

requests, local capacity building, or community investments including joint funding opportunities, innovative and scalable pilot initiatives, or other funder and stakeholder partnerships. The authority shall provide funding for this annual crisis continuum of care forum. Behavioral health administrative services organizations and the authority shall jointly submit recommendations, as appropriate, supporting these efforts to the joint legislative executive committee on behavioral health. [2023 c 454 s 12.]

**RCW 71.24.916 23-hour crisis relief centers—Licensing and certification—Rules—Standards.** (1) The secretary shall license or certify 23-hour crisis relief centers that meet state minimum standards. The department shall create rules in consultation with the authority by January 1, 2024, to develop standards for licensure or certification of 23-hour crisis relief centers.

(a) The rules, at a minimum, must require the 23-hour crisis relief center to:

(i) Offer walk-in options and drop-off options for first responders and persons referred through the 988 system, without a requirement for medical clearance for these individuals. The facility must be structured to have the capacity to accept admissions 90 percent of the time when the facility is not at its full capacity, and to have a no-refusal policy for law enforcement, with instances of declined admission and the reasons for the declines tracked and made available to the department;

(ii) Provide services to address mental health and substance use crisis issues;

(iii) Maintain capacity to screen for physical health needs, deliver minor wound care for nonlife-threatening wounds, and provide care for most minor physical or basic health needs that can be addressed without need for medical diagnosis or health care prescriber orders, with an identified pathway to transfer the person to more medically appropriate services if needed;

(iv) Be staffed 24 hours a day, seven days a week, with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community, which includes access to a prescriber and the ability to dispense medications appropriate for 23-hour crisis relief center clients;

(v) Screen all individuals for suicide risk and engage in comprehensive suicide risk assessment and planning when clinically indicated;

(vi) Screen all individuals for violence risk and engage in comprehensive violence risk assessment and planning when clinically indicated;

(vii) Limit patient stays to a maximum of 23 hours and 59 minutes except for patients waiting on a designated crisis responder evaluation or making an imminent transition to another setting as part of an established aftercare plan. Exceptions to the time limit made under this subsection shall not cause a 23-hour crisis relief center to be classified as a residential treatment facility under RCW 71.12.455;

(viii) Maintain relationships with entities capable of providing for reasonably anticipated ongoing service needs of clients, unless the licensee itself provides sufficient services; and

(ix) When appropriate, coordinate connection to ongoing care.

(b) The rules, at a minimum, must develop standards for determining medical stability before an emergency medical services drop-off.

(c) The rules must include standards for the number of recliner chairs that may be licensed or certified in a 23-hour crisis relief center and the appropriate variance for temporarily exceeding that number in order to provide the no-refusal policy for law enforcement.

(d) The department shall specify physical environment standards for the construction review process that are responsive to the unique characteristics of the types of interventions used to provide care for all levels of acuity in facilities operating under the 23-hour crisis relief center model. In a 23-hour crisis relief center which proposes to serve both child and adult clients in the same facility, these standards must include separate internal entrances, spaces, and treatment areas such that no contact occurs between child and adult 23-hour crisis relief center clients.

(e) The department shall coordinate with the authority and department of social and health services to establish rules that prohibit facilities that are licensed or required to be licensed under chapter 18.51, 18.20, 70.97, 72.36, or 70.128 RCW from discharging or transferring a resident to a 23-hour crisis relief center.

(f) The department shall coordinate with the authority to establish rules that prohibit a hospital that is licensed under chapter 70.41 RCW from discharging or transferring a patient to a 23-hour crisis relief center unless the hospital has a formal relationship with the 23-hour crisis relief center.

(g) The authority shall take steps necessary to make 23-hour crisis relief center services, including on-site physical health care, eligible for medicaid billing to the maximum extent allowed by federal law.

(2) By March 31, 2025, the secretary shall amend licensure and certification rules for 23-hour crisis relief clinics in consultation with the authority and the department of children, youth, and families to create standards for licensure or certification of 23-hour crisis relief centers which provide services to children. To meet the needs of children in crisis and their families, 23-hour crisis relief centers treating children must, in addition to meeting the requirements of subsection (1) of this section:

(a) Not treat children in a shared space or allow them to have contact with adult clients;

(b) Be structured to meet the crisis needs of children ages eight and over and their families;

(c) Have written policies and procedures defining how different age groups will be appropriately separated;

(d) Provide resources to connect children and their families with behavioral health supports;

(e) Coordinate with the department of children, youth, and families for children who do not need inpatient care and are unable to be discharged to home;

(f) Address discharge planning for a child who is at risk of dependency, out-of-home placement, or homelessness; and

(g) Be staffed 24 hours a day, seven days a week, with a pediatric multidisciplinary team.

(3) The secretary shall solicit input from stakeholders when engaging in rule making under subsection (2) of this section. [2024 c 367 s 2; 2023 c 433 s 2.]

**Rules—2023 c 433 s 2:** "When making rules under section 2 of this act, the department of health shall consult with stakeholders including, but not limited to: The Washington council for behavioral health; WAADAC, the voice for Washington state addiction professionals persons with lived experience of behavioral health crisis; family members with lived experience of caring for someone in behavioral health crisis; the Washington state hospital association; the American college of emergency physicians; behavioral health administrative services organizations; the Washington association of designated crisis responders; the Washington association of sheriffs and police chiefs; and an individual or entity representing emergency medical services." [2023 c 433 s 22.]

**RCW 71.24.920 Certified peer specialists—Courses of instruction—Duties.** (1)(a) By January 1, 2025, the authority must develop a course of instruction to become a certified peer specialist under chapter 18.420 RCW. The course must be approximately 80 hours in duration and based upon the curriculum offered by the authority in its peer counselor training as of July 23, 2023, as well as additional instruction in the principles of recovery coaching and suicide prevention. The authority shall establish a peer engagement process to receive suggestions regarding subjects to be covered in the 80-hour curriculum beyond those addressed in the peer counselor training curriculum and recovery coaching and suicide prevention curricula, including the cultural appropriateness of the 80-hour training. The education course must be taught by certified peer specialists. The education course must be offered by the authority with sufficient frequency to accommodate the demand for training and the needs of the workforce. The authority must establish multiple configurations for offering the education course, including offering the course as an uninterrupted course with longer class hours held on consecutive days for students seeking accelerated completion of the course and as an extended course with reduced daily class hours, possibly with multiple days between classes, to accommodate students with other commitments. Upon completion of the education course, the student must pass an oral examination administered by the course trainer.

(b) The authority shall develop an expedited course of instruction that consists of only those portions of the curriculum required under (a) of this subsection that exceed the authority's certified peer counselor training curriculum as it exists on July 23, 2023. The expedited training shall focus on assisting persons who completed the authority's certified peer counselor training as it exists on July 23, 2023, to meet the education requirements for certification under RCW 18.420.050.

(2) By January 1, 2025, the authority must develop a training course for certified peer specialists providing supervision to certified peer specialist trainees under RCW 18.420.060.

(3)(a) By July 1, 2025, the authority shall offer a 40-hour specialized training course in peer crisis response services for individuals employed as peers who work with individuals who may be experiencing a behavioral health crisis. When offering the training course, priority for enrollment must be given to certified peer specialists employed in a crisis-related setting, including entities identified in (b) of this subsection. The training shall incorporate best practices for responding to 988 behavioral health crisis line

calls, as well as processes for co-response with law enforcement when necessary.

(b) Beginning July 1, 2025, any entity that uses certified peer specialists as peer crisis responders, may only use certified peer specialists who have completed the training course established by (a) of this subsection. A behavioral health agency that uses certified peer specialists to work as peer crisis responders must maintain the records of the completion of the training course for those certified peer specialists who provide these services and make the records available to the state agency for auditing or certification purposes.

(4) By July 1, 2025, the authority shall offer a course designed to inform licensed or certified behavioral health agencies of the benefits of incorporating certified peer specialists and certified peer specialist trainees into their clinical staff and best practices for incorporating their services. The authority shall encourage entities that hire certified peer specialists and certified peer specialist trainees, including licensed or certified behavioral health agencies, hospitals, primary care offices, and other entities, to have appropriate staff attend the training by making it available in multiple formats.

(5) The authority shall:

(a) Hire clerical, administrative, investigative, and other staff as needed to implement this section to serve as examiners for any practical oral or written examination and assure that the examiners are trained to administer examinations in a culturally appropriate manner and represent the diversity of applicants being tested. The authority shall adopt procedures to allow for appropriate accommodations for persons with a learning disability, other disabilities, and other needs and assure that staff involved in the administration of examinations are trained on those procedures;

(b) Develop oral and written examinations required under this section. The initial examinations shall be adapted from those used by the authority as of July 23, 2023, and modified pursuant to input and comments from the *Washington state peer specialist advisory committee. The authority shall assure that the examinations are culturally appropriate;

(c) Prepare, grade, and administer, or supervise the grading and administration of written examinations for obtaining a certificate;

(d) Approve entities to provide the educational courses required by this section and approve entities to prepare, grade, and administer written examinations for the educational courses required by this section. In establishing approval criteria, the authority shall consider the recommendations of the *Washington state peer specialist advisory committee;

(e) Develop examination preparation materials and make them available to students enrolled in the courses established under this section in multiple formats, including specialized examination preparation support for students with higher barriers to passing the written examination; and

(f) The authority shall administer, through contract, a program to link eligible persons in recovery from behavioral health challenges who are seeking employment as peers with employers seeking to hire peers, including certified peer specialists. The authority must contract for this program with an organization that provides peer workforce development, peer coaching, and other peer supportive services. The contract must require the organization to create and maintain a statewide database which is easily accessible to eligible

persons in recovery who are seeking employment as peers and potential employers seeking to hire peers, including certified peer specialists. The program must be fully implemented by July 1, 2024.

(6) For the purposes of this section, the term "peer crisis responder" means a peer specialist certified under chapter 18.420 RCW who has completed the training under subsection (3) of this section whose job involves responding to behavioral health emergencies, including those dispatched through a 988 crisis hotline or the 911 system. [2023 c 469 s 13.]

***Reviser's note:** 2023 c 469 s 4, which established the Washington state certified peer specialist advisory committee, was vetoed by the governor.

**RCW 71.24.922 Certified peer specialists—Supervision caseload reduction.** Behavioral health agencies must reduce the caseload for approved supervisors who are providing supervision to certified peer specialist trainees seeking certification under chapter 18.420 RCW, in accordance with standards established by the *Washington state certified peer specialist advisory committee. [2023 c 469 s 14.]

***Reviser's note:** 2023 c 469 s 4, which established the Washington state certified peer specialist advisory committee, was vetoed by the governor.

**RCW 71.24.924 Certified peer specialists—Billing.** (1) Beginning January 1, 2027, a person who engages in the practice of peer support services and who bills a health carrier or medical assistance or whose employer bills a health carrier or medical assistance for those services must hold an active credential as a certified peer specialist or certified peer specialist trainee under chapter 18.420 RCW.

(2) A person who is registered as an agency affiliated counselor under chapter 18.19 RCW who engages in the practice of peer support services and whose agency, as defined in RCW 18.19.020, bills medical assistance for those services must hold a certificate as a certified peer specialist or certified peer specialist trainee under chapter 18.420 RCW no later than January 1, 2027. [2023 c 469 s 15.]