NOTES from 8/19/19 Meeting

Breakout Groups

<table>
<thead>
<tr>
<th>Intensive Behavioral Health Treatment Facilities</th>
<th>TC3 Rm 224</th>
<th>8:30am-11:30</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-180 Day</td>
<td>TC2 Rm 145</td>
<td>12:30pm – 1:30pm</td>
</tr>
<tr>
<td>Mental Health Peer Respite Centers</td>
<td>TC2 Rm 145</td>
<td>1:30pm – 4:00 pm</td>
</tr>
</tbody>
</table>

Meeting Resources:

- DOH Behavioral Health Agency (BHA) web site
- DOH Residential Treatment Facility (RTF) web site
- HB 1394 text
- Chapter 246-341 WAC for BHAs
- Chapter 246-337 WAC for RTFs

Attachments:

- 4 Corners Letter
- Notes from August 12, 2019 meeting
- WA State Mental Health Facilities Matrix
- Licensing Rules Checklist

Intensive Behavioral Health Treatment Facilities (IBHTF)

1) Introductions, summary of where we left off
   a) Review draft language that SV JT come up with
   b) Review DOH research on need for IBHTF to have RTF/BHA license/certification
   c) Review DD additions to MH Facility Matrix
2) Discuss language pertaining to ability to provide services listed in the bill
   a) Services will drive staffing requirements
3) Discuss four corners letter. Include copy of letter in materials
4) Determine staffing requirements
   a) Definition of clinical team
5) Wrap-up, next steps, and build agenda for next meeting

Discussion notes: IBHTF draft WAC language:

a) Q: The WAC number for this new WAC is listed before E&T? These services come after someone is in an E&T or Long Term facility. It’s more intense than crisis stabilization. Group: make it 1137
b) Q: Should we emphasize long-term anywhere in this? Because otherwise it sounds like super intense short term.
c) Q: Is this based on medical necessity? ITA is not.
d) Q: Clarify whether the person needs to be on an LRA or conditional release to be here.
e) Q: Is there a definition for “Long term?” just 90-180 day?
f) Q: Are these IMDs? NO, according to the budget bill.
g) Q: Only MH? Or SUD also?
h) Q: Can these facilities refuse to accept folks? Because this will also be the same problem we currently have at WSH. If folks can pick & choose – we need a way to identify what does “intensity” really mean? We need to design this so that they have both. Cross reference to
training & certifications for subset populations. What about placement issues – like arson, murder. Need language that says we take folks that can’t go to other facilities.

i) Q: Other states have models for admin dollars for helping with specialties.

j) Q: Because of the uniqueness of individuals I think this service is for ASAM 3.3 – we don’t have any BH WACs that address 3.3.

k) Q: Can people come and go? They are voluntary but there is restricted egress. One model out there: Patients have to ask before they can go. There are examples in LTC settings. We will discuss this more next week. Staffing ratios are pertinent to this because if a person wanders, we need staff to be able to monitor etc. Are these staffed like an E&T? 3.5 million dollars to staff an E&T. Which staff & type of staff? The Council supports broadest definition possible. Rule language doesn’t have specific staffing ratio for E&Ts? Is that defined somewhere else? Admissions during the night drives it, medical staff 24/7. Lowest level medical staff (LPN) is usual for overnight shift. But if you have to have an RN or prescriber available that will be much more expensive. TBI & DD might need 1:1 staffing model.

l) Q: DD & Dementia & MH are hard to mix. Might need a memory care center based on industry standards for dementia, DD care center based on DD, MH based on MH just like WSH.

Questions from the group for HCA:

- Do all IBHTFs need to be non-IMD or is it only the ones funded under the Gov’s budget that have to be non-IMD?
- Definition of IBHTF states that these services are for voluntary patients. Are patients on an LRA considered voluntary?
- Do IBHTF patients need to meet medical necessity? This question was asked by an BHO administrator concerned about people being there long-term and not meeting medical necessity, not being involuntary, and no one willing to pay for them.

DOH will:

- Bring new WAC language changes and research and contact HCA with our questions from this meeting.
- Work on matrix of different patient rights to see overlaps & gaps

90-180 Day Services

1) Introductions, summary of where we left off
2) Check in with partners who didn’t attend last meeting
3) Review DOH draft rule language regarding certification process
4) Wrap-up, next steps, and build agenda for next meeting

Discussion notes: 90-180 draft WAC language:

m) Q: Does LT certification process implicate HCA standards that need to change before we change the rules? We will want to be thoughtful about whether we can use the LT process with changes from HCA report.

n) Q: Some E&Ts might take jail diversions – but we don’t want to address here.

o) Q: did you take out previous WAC requirements that is in the current process – unique stipulations – that language isn’t really being used currently. Site visits verifying is already
existing. What about the fair hearing rights. We don’t think we as (we will go through legal review)
p) Q: There isn’t a ton of statute language around this – so we are sticking with E&T.

DOH will:
• Cancel the rest of the 90-180 day meetings. We accomplished most of what we needed to. Please e-mail Julie between now and mid Sept if you have questions.
• Circulate draft language and will touch base after DOH legal review and will send to DSHS so Melena can circulate to DSHS-BHA/HCA legal review

Mental Health Peer Respite Centers
1) Introductions, summary of where we left off
2) Review HCA answers on Diagnosis codes, reimbursement models
3) Review DOH draft rules
4) Wrap-up, next steps, and build agenda for next meeting

Discussion notes on MHPBC draft WAC:
q) Q: Is Medicaid reimbursement final? Can we go a different way? *ask HCA. BHA licensure is not reflective of peer values. I wish there was a way to create a separate license or create some more time to develop this. We are trying to set up an alternative to treatment, not a type of treatment.

r) Q: Peer services- we need to start on the right foot. There will be a legislative work session on peer services. Is there language saying we have to bring these on line at a certain time? The ideal is that these wouldn’t be Medicaid. Nationally these are funded by grants – the public would appreciate this. My question is if there is exact language in the bill. The door hasn’t closed – maybe this coming session. Timelines aren’t in 1394. Timelines were in the budget bill to HCA and Commerce with dates to stand up facilities.

s) Q: If Senate subcommittee on BH care heard these concerns they would say we don’t need BHA license. Folks stumbled over themselves verbally defining this. Bless them for trying, but it was befuddling to witness them. We should go back to that committee and Kevin Black and talk to them about the chaos which is ensuing. It’s really about what the respites are NOT going to provide that creates the problem. Communicate the concerns to other authorities – our partners. There are so many examples of this that aren’t reimbursed by Medicaid nationally.

t) DOH: What are the benefits of having licensure but no Medicaid? Group: Liability and accountability that is built into licensing. Professionalism standard. It would be interesting to see how other states are licensing their respites that they are running. Health and safety. Recovery residence that HCA is making a registry for -> the whole gamut of things. Do peer respite centers fit into that? Would we have licensed vs unlicensed ones?

u) Q: it is clear that peer respite centers are non-clinical. Everything in BHA WAC is clinical. There are programs that operate homeless shelters that do peer-run employment services. They aren’t under BHAs. Don’t know if that’s Medicaid.

v) Q: In Southwest WA, an agency had to get Medicaid license when southwest went IMC. They were not able to maintain their infrastructure because of requirement around Medicaid licensure and had to give it up. If peer respite is more focused on support services.
Q: In a 2018 study by Live & Learn of Respites, only 5% funding came from Medicaid.

Q: Can we start with a pilot? Not going zero to sixty, but zero to twenty in a grant funded loose licensing that deals with health & safety issues moving towards a Medicaid model or pseudo-Medicaid model.

Q: Two issues: get this MHPRC for Medicaid, and get new legislation and/or pilot to get another kind of license underway that is more appropriate to national model.

Q: Clinical model is not treatment – just coping and not getting at root cause.

Q: We’re adding more barriers by requiring someone to have an assessment or clinical services. Could partner with a true outpatient agency to do assessments and other clinical services. This model is the way to make it work, but is not True North – which is national model.

Q: Respite budgets are 400k-800k (not including house price).

Q: Clubhouses – why don’t these new WACs follow WACs for clubhouse (Consumer-run recovery support). It wouldn’t necessarily give us added flexibility though. This is a standalone program driven by peers. Similarity to Clubhouse in that way. Since we’ve removed the component of RTF, we aren’t worried about the overnight part – just concerned with the services. Clubhouses are not peer-run by definition. There are people who self identify who work there, but management is non-peer, etc. Clubhouses are wonderful and I’m a member – they are certified using international standards. They have a whole separate set of standards that they must abide by. I don’t see peer respite being a type of this. Maybe they could partner with clubhouses. Consumer-run is different than peer-run where consumer run means the participants run the programs. They are operated by the people who use them, but not managed by those people.

Q: Peer respites are usually small, like 5-6 beds, not the whole 16. So the licensing fee shouldn’t be problematic.

Q: Three trainings currently in use for peer respite type things: Hearing voices network, alternative to suicide, intentional peer support. Problem is that these trainings aren’t really available.

Q: Can we use the new definition of “recovery” that was put in 1394. JT/SV open definition section for this.

Q: How are we going to communicate that there is a desire to license people for these who don’t want to receive Medicaid. DOH: I am committed to talking about it in meetings.

Q: regarding AAC: do we need to revisit this? Group says no.

Group questions for HCA:

- If it has to be Medicaid reimbursable, we understand there has to be: an assessment, diagnosis, Individual Service Plan, and clinical services overseen by MHP. Is there any wiggle room for MHPRC?

DOH will:

- Present relevant parts of the MHPRC conversation at the HCA-DOH-DSHS-Commerce coordination meeting later this week
- Bring draft WAC revisions to next meeting
246-341-0110
Behavioral health services—Available certifications.

A behavioral health agency licensed by the department may become certified to provide one or more of the mental health, substance use disorder, and problem and pathological gambling services listed below:

(1) Outpatient:
   (a) Individual mental health treatment services;
   (b) Brief mental health intervention treatment services;
   (c) Group mental health therapy services;
   (d) Family therapy mental health services;
   (e) Rehabilitative case management mental health services;
   (f) Psychiatric medication mental health services and medication support services;
   (g) Day support mental health services;
   (h) Mental health outpatient services provided in a residential treatment facility (RTF);
   (i) Recovery support: Supported employment mental health services;
   (j) Recovery support: Supported employment substance use disorder services;
   (k) Recovery support: Supportive housing mental health services;
   (l) Recovery support: Supportive housing substance use disorder services;
   (m) Recovery support: Peer support mental health services;
   (n) Recovery Support: Mental health peer respite center
   (o) Recovery support: Wraparound facilitation mental health services;
   (p) Recovery support: Applied behavior analysis (ABA) mental health services;
   (q) Consumer-run recovery support: Clubhouse mental health services;
   (r) Substance use disorder level one outpatient services;
   (s) Substance use disorder level two intensive outpatient services;
   (t) Substance use disorder assessment only services;
   (u) Substance use disorder alcohol and drug information school services;
   (v) Substance use disorder information and crisis services;
   (w) Substance use disorder emergency service patrol services;
   (x) Substance use disorder screening and brief intervention services; and
   (y) Problem and pathological gambling services.

(2) Involuntary and court-ordered outpatient services:
   (a) Less restrictive alternative (LRA) or conditional release support behavioral health services;
   (b) Emergency involuntary detention designated crisis responder (DCR) mental health and substance use disorder services;
   (c) Substance use disorder counseling services subject to RCW 46.61.5056; and
   (d) Driving under the influence (DUI) substance use disorder assessment services.

(3) Crisis mental health services:
   (a) Crisis mental health telephone support services;
(b) Crisis mental health outreach services;
(c) Crisis mental health stabilization services; and
(d) Crisis mental health peer support services.
(4) Opioid treatment program (OTP) services.
(5) Withdrawal management, residential substance use disorder treatment, and mental health inpatient services:
   (a) Withdrawal management facility services:
      (i) Withdrawal management services - Adult;
      (ii) Withdrawal management services - Youth;
      (iii) Secure withdrawal management and stabilization services - Adult; and
      (iv) Secure withdrawal management and stabilization services - Youth.
   (b) Residential substance use disorder treatment services:
      (i) Intensive substance use disorder inpatient services;
      (ii) Recovery house services;
      (iii) Long-term treatment services; and
      (iv) Youth residential services.
   (c) Mental health inpatient services:
      (i) Intensive behavioral health treatment services
      (ii) Evaluation and treatment services
      (iv) Child long-term inpatient program services;
      (v) Crisis stabilization unit services;
      (vi) Triage - Involuntary services;
      (vii) Triage - Voluntary services; and
      (viii) Competency evaluation and restoration treatment services.

[Statutory Authority: 2018 c 201 and 2018 c 291. WSR 19-09-062, § 246-341-0110, filed 4/16/19, effective 5/17/19.]

246-341-0365
Agency licensure and certification—Fee requirements.

(1) Payment of licensing and specific program certification fees required under this chapter must be included with the initial application, renewal application, or with requests for other services.
(2) Payment of fees must be made by check, bank draft, electronic transfer, or money order made payable to the department.
(3) The department may refund one-half of the application fee if an application is withdrawn before certification or denial.
(4) Fees will not be refunded when licensure or certification is denied, revoked, or suspended.
(5) The department charges the following fees for approved substance use disorder treatment programs:

<table>
<thead>
<tr>
<th>Application fees for agency certification for approved substance use disorder treatment programs</th>
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<tbody>
<tr>
<td>New agency application</td>
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| Service                                                                 | Fee                                                                 
<table>
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<th></th>
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<tbody>
<tr>
<td>Branch agency application</td>
<td>$500</td>
</tr>
<tr>
<td>Application to add one or more services</td>
<td>$200</td>
</tr>
<tr>
<td>Application to change ownership</td>
<td>$500</td>
</tr>
<tr>
<td>Initial and annual certification fees for withdrawal management, residential, and nonresidential services</td>
<td></td>
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<tr>
<td>Withdrawal management and residential services</td>
<td>$100 per licensed bed, per year, for agencies not renewing certification through deeming</td>
</tr>
<tr>
<td></td>
<td>$50 per licensed bed, per year, for agencies renewing certification through deeming per WAC 246-341-0310</td>
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<tr>
<td>Nonresidential services</td>
<td>$750 per year for agencies not renewing certification through deeming</td>
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<tr>
<td></td>
<td>$200 per year for agencies certified through deeming per WAC 246-341-0310</td>
</tr>
<tr>
<td>Complaint/critical incident investigation fees</td>
<td></td>
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<tr>
<td>All agencies</td>
<td>$1,000 per substantiated complaint investigation and $1,000 per substantiated critical incident investigation that results in a requirement for corrective action</td>
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</table>

(6) Agency providers must annually complete a declaration form provided by the department to indicate information necessary for establishing fees and updating certification information. Required information includes, but is not limited to:

(a) The number of licensed withdrawal management and residential beds; and
(b) The agency provider’s national accreditation status.

(7) The department charges the following fees for approved mental health treatment programs:

<table>
<thead>
<tr>
<th>Services</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial licensing application fee</td>
<td>$1,000 initial licensing fee</td>
</tr>
<tr>
<td>Licensing application fee</td>
<td></td>
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<tr>
<td>Initial and annual licensing fees for agencies not deemed</td>
<td></td>
</tr>
<tr>
<td>Annual service hours provided:</td>
<td></td>
</tr>
<tr>
<td>0-3,999</td>
<td>$728</td>
</tr>
<tr>
<td>4,000-14,999</td>
<td>$1,055</td>
</tr>
<tr>
<td>15,000-29,999</td>
<td>$1,405</td>
</tr>
<tr>
<td>30,000-49,999</td>
<td>$2,105</td>
</tr>
<tr>
<td>50,000 or more</td>
<td>$2,575</td>
</tr>
<tr>
<td>Annual licensing fees for deemed agencies</td>
<td></td>
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<tr>
<td>Deemed agencies</td>
<td>$500 annual licensing fee</td>
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</tbody>
</table>
(8) Agencies providing nonresidential mental health services must report the number of annual service hours provided based on the department's current published "Service Encounter Reporting Instructions for BHOs" and the "Consumer Information System (CIS) Data Dictionary for BHOs."

(a) Existing licensed agencies must compute the annual service hours based on the most recent state fiscal year.

(b) Newly licensed agencies must compute the annual service hours by projecting the service hours for the first twelve months of operation.

(9) Agencies providing mental health peer respite center services, intensive behavioral health treatment services, evaluation and treatment services, and competency evaluation and restoration treatment services must pay the following certification fees:

(a) Ninety dollars initial certification fee, per bed; and

(b) Ninety dollars annual certification fee, per bed.

[Statutory Authority: 2018 c 201 and 2018 c 291. WSR 19-09-062, § 246-341-0365, filed 4/16/19, effective 5/17/19.]

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246-341-0725
Recovery support - Mental health peer respite

(1) Mental health peer respite services are 24 hour, voluntary, short term, non-crisis services, provided in a home-like environment, which focus on recovery and wellness. These services are provided to individuals who are:

(a) At least eighteen years of age;

(b) Experiencing psychiatric distress but who are not detained or involuntarily committed under chapter 71.05 RCW; and

(c) Voluntarily and independently seeking respite services by their own choice.

(2) An agency providing mental health peer respite services must meet the general requirements in WAC 246-341-0718 for recovery support services and WAC 246-341-0724 for peer support services;

(3) An agency providing mental health peer respite services must coordinate with the local crisis system including evaluation and treatment facilities and designated crisis responders.

(4) An agency providing mental health peer respite services must be staffed twenty four hours per day, seven days a week, and be must be peer-run. This includes:
Having a governing body or board with a majority of members who are peers; and

(b) Supervision of services by a Mental Health Professional who is also a certified peer counselor.

(5) An agency must limit services to an individual to a maximum of seven days in a thirty-day period.

(6) Mental health peer respite centers may only provide services that are within the scope of a certified peer counselor with the exception of assessments, and other services which may only be performed by a mental health professional.

(7) Mental health peer respite services must be provided in a building that meets local building and zoning codes appropriate to the number of licensed beds and have policies and procedures that include the following:

(a) Policies regarding kitchen and food storage, including:
   (i) How the domestic kitchen equipment will meet the sanitation requirements of chapter 246-215 WAC;
   (ii) How the agency will provide each resident with adequate storage for perishable and non-perishable food items.

(b) Policies regarding laundry, including how the agency will give residents access to laundry facilities and equipment that is clean and in good repair;

(c) Policies regarding housekeeping, including cleaning, maintenance, and refuse disposal.

(d) Policies regarding how the agency will provide each resident with clean, sanitary bedding and linens that are in good repair.

(e) Policies regarding how each individual’s belongings and medications are securely stored.

(f) Policies regarding how the agency will provide furniture, to include beds and bedframes, and other items appropriate for a home-like setting.

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246-341-1118
Mental health inpatient services—General.

(1) Inpatient services include the following types of behavioral health services certified by the department:

(a) Intensive behavioral health treatment services;

(b) Evaluation and treatment services;

(c) Child long-term inpatient program (CLIP);

(d) Crisis stabilization units;

(e) Triage services; and

(f) Competency evaluation and treatment services.

(2) An agency providing inpatient services to an individual must:

(a) Be a facility licensed by the department under one of the following chapters:

(i) Hospital licensing regulations (chapter 246-320 WAC);

(ii) Private psychiatric and alcoholism hospitals (chapter 246-322 WAC);
(iii) Private alcohol and substance use disorder hospitals (chapter 246-324 WAC); or
(iv) Residential treatment facility (chapter 246-337 WAC).

(b) Be licensed by the department as a behavioral health agency;
(c) Meet the applicable behavioral health agency licensure, certification, administration, personnel, and clinical requirements in WAC 246-341-0100 through 246-341-0650;
(d) Meet the applicable inpatient services requirements in WAC 246-341-1118 through 246-341-1132;
(e) Have policies and procedures to support and implement the specific applicable program-specific requirements; and
(f) If applicable, have policies to ensure compliance with WAC 246-337-110 regarding seclusion and restraint.

(3) The behavioral health agency providing inpatient services must document the development of an individualized annual training plan, to include at least:
(a) Least restrictive alternative options available in the community and how to access them;
(b) Methods of individual care;
(c) Deescalation training and management of assaultive and self-destructive behaviors, including proper and safe use of seclusion and restraint procedures; and
(d) The requirements of chapter 71.05 and 71.34 RCW, this chapter, and protocols developed by the department.

(4) If contract staff are providing direct services, the facility must ensure compliance with the training requirements outlined in subsection (4) of this section.

(5) This chapter does not apply to state psychiatric hospitals as defined in chapter 72.23 RCW or facilities owned or operated by the department of veterans affairs or other agencies of the United States government.

[Statutory Authority: 2018 c 201 and 2018 c 291. WSR 19-09-062, § 246-341-1118, filed 4/16/19, effective 5/17/19.]

246-341-1137
Behavioral health inpatient services—Intensive behavioral health treatment services.

(1) Intensive behavioral health treatment services are intended to assist persons in transitioning to lower levels of care. These services are provided to individuals with behavioral health conditions 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 settings due to one or more of the following:

(a) Self-endangering behaviors that are frequent or difficult to manage;
(b) Intrusive behaviors that put residents or staff at risk;
(c) Complex medication needs, which include psychotropic medications;
(d) A history or likelihood of unsuccessful placements in other community facilities;
(e) A history of frequent or protracted mental health hospitalizations; or
(f) A history of offenses against a person or felony offenses that created substantial damage to property.

(2) In addition to meeting the agency licensure, certification, administration, personnel, and clinical requirements in WAC 246-341-0100 through 246-341-0650, and the applicable inpatient services requirements in WAC 246-341-1118 through 246-341-1132, an agency providing intensive behavioral health treatment services must ensure:

(a) Intensive behavioral health treatment services are only provided in a residential treatment facility licensed under chapter 246-337 WAC.

(b) Services are only provided to persons at least eighteen years of age.

(c) Services are only provided to persons whose primary care need is for a mental health condition.

(d) Twenty four hour supervision of residents.

(3) The facility must develop a staffing model appropriate to the acuity of the residents, including a high staff to patient ratio.

(4) The facility must provide services delivered by a clinical team.

(5) The facility must be able to provide services to individuals with intellectual or developmental disabilities.

(6) The facility must have staffing and training that allows the ability to provide services to individuals with intellectual or developmental disabilities.

(7) The facility will have a psychiatric nurse manager; access to a mental health professional and psychiatric nurse 24/7 not necessarily on site, peer counselors, etc. Ask HCA, or would reimbursement be different given different levels of care an IBHTF wants to provide – either tied to person’s acuity or services agency wants to provide. Also placeholder for MHP specialists for DD or geriatric. Is HCA model the “core team”? Is intensity based on this scope of services? MH specialist might just need to be there all week but not 24/7. Would requiring Bachelor’s level 24/7 be reimbursed accordingly? Usually just AA level or agency affiliate level. Better staff retention if you use AAs.

Mental Health Care Providers.
(8) The facility must provide access to regular psychosocial rehabilitation services, delivered by appropriately credentialed staff, if applicable, including training on:

(a) Skills training in daily living activities;
(b) Social interaction;
(c) Behavioral management;
(d) Impulse control; and
(e) Self-management of medications;

(9) The facility must provide access to or referral to substance use disorder services, and other specialized services, as needed.

(10) The facility must have written policies and procedures related to limited egress that are consistent with the requirements in WAC 246-337-065.

(11) In addition to the resident rights listed in xxx, a facility providing intensive behavioral health treatment services will also ensure that residents are informed of the following rights:

(a) [RCW 71.xx.xxx]

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**246-341-1134**

**Mental health inpatient services—Evaluation and treatment services.**

Evaluation and treatment services are provided for individuals who are detained or are on fourteen, ninety, or one hundred and eighty day commitment orders or those who voluntarily seek mental health treatment. A facility providing evaluation and treatment services may choose to serve persons on short-term commitment orders (fourteen days), long-term commitment orders (ninety or one hundred and eighty days), or both.

(1) In addition to meeting the agency licensure, certification, administration, personnel, and clinical requirements in WAC 246-341-0100 through 246-341-0650, and the applicable inpatient services requirements in WAC 246-341-1118 through 246-341-1132 an agency providing evaluation and treatment services must ensure:

(a) Designation of a physician or other mental health professional as the professional person as defined in RCW 71.05.020 in charge of clinical services at that facility; and

(b) A policy management structure that establishes:

(i) Procedures to assure appropriate and safe transportation for persons who are not approved for admission to his or her residence or other appropriate place;

(ii) Procedures to detain arrested persons who are not approved for admission for up to eight hours so that reasonable attempts can be made to notify law enforcement to return to the facility and take the person back into custody;
(iii) Procedures to assure the rights of individuals to make mental health advance directives, and facility protocols for responding to individual and agent requests consistent with RCW 71.32.150;

(iv) Procedures to ensure that if the facility releases the individual to the community, the facility informs the peace officer of the release within a reasonable period of time after the release if the peace officer has specifically requested notification and has provided contact information to the facility;

(v) Procedures to document that each individual has received evaluations to determine the nature of the disorder and the treatment necessary, including a psychosocial evaluation by a mental health professional; and

(vi) For individuals who are being evaluated as dangerous mentally ill offenders under RCW 72.09.370(7), the professional person in charge of the evaluation and treatment facility must consider filing a petition for a ninety day less restrictive alternative in lieu of a petition for a fourteen-day commitment.

(2) A facility providing evaluation and treatment services may provide treatment for a child on a one hundred and eighty-day inpatient involuntary commitment order only until the child is discharged from the order to the community, or until a bed is available for that child in a child long-term inpatient treatment facility (CLIP). The child cannot be assigned by the CLIP placement team in accordance with RCW 71.34.100 to any facility other than a CLIP facility.

(3) Place holder for future language regarding specific requirements for long-term commitment treatment services such as access to secure outdoor spaces....

[Statutory Authority: 2018 c 201 and 2018 c 291. WSR 19-09-062, § 246-341-1134, filed 4/16/19, effective 5/17/19.]