FINAL BILL REPORT
E2SSB 5763

PARTIAL VETO
C 504 L 05
Synopsis as Enacted

Brief Description: Creating the omnibus treatment of mental and substance abuse disorders act of 2005.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Hargrove, Stevens, Regala, Brandland, Thibaudeau, Carrell, Brown, Keiser, Fairley, McAuliffe, Rasmussen, Kline, Kohl-Welles and Franklin).

Senate Committee on Human Services & Corrections
Senate Committee on Ways & Means
House Committee on Health Care
House Committee on Appropriations

Background: Under current law, Washington State has separate Involuntary Treatment Acts (ITAs) for persons who are gravely disabled or a danger to self or others as a result of chemical dependency or mental illness. The ITA for mental health is an entitlement; courts and prosecutors must act to civilly commit persons who meet ITA criteria. The ITA for chemical dependency is permissive.

The Joint Legislative and Executive Task Force on Mental Health Services and Funding (Task Force) convened in 2004 to review, among other things, residential and inpatient mental health treatment capacity and the impacts of federal changes in Medicaid Funding. The Task Force considered these issues for both children and adults and both the civil mental health system and the interaction with the criminal justice system with regards to mentally ill persons held in jails and delays in the competency examination and restoration process.

In addition to receiving staff reports and public testimony over six months, the Task Force reviewed reports and recommendations by: the Cross-System Crisis Response Initiative (CSCR Initiative); the Department of Social & Health Services (DSHS); and the Public Consulting Group inpatient and residential capacity report, prepared in compliance with SB 6358. The Task Force also engaged in a "priorities of government" process with stakeholders for evaluating current practice, system improvement initiatives, and potential cost savings initiatives.

The Task Force recommended that: (1) funds lost due to the changes in interpretation of Medicaid law be replaced by state funds, to the maximum extent possible, with conditions to be imposed by the Legislature; and (2) additional funds, to the extent available, be directed to: (a) the shortage of inpatient and residential capacity; (b) retaining existing community beds; and (c) meeting forensic evaluation and bed needs.

The Task Force made the following policy recommendations:

1) DSHS should not close state hospital beds until additional residential capacity is added in the community;
2) DSHS should suspend, rather than terminate Medicaid eligibility for confined persons and expedite Medicaid eligibility determinations for persons being released from jails, prisons, and the hospitals;
3) the legislature should give greater direction in the use of non-Medicaid funds;
4) the legislature should authorize the statewide use of mental health courts;
5) DSHS and the Regional Support Networks should develop contingency plans for the potential loss of some or all of the state-only funds in the 2005-07 biennium;
6) the legislature should require the use of evidence-based practice and promote recovery from mental illnesses; and
7) the legislature should extend the Task Force into the 2005-07 biennium.

The CSCR Initiative resulted from work that began in 2003 with a broad task force co-convened by DSHS and the counties with the purpose of making meaningful changes to the way that service systems respond to adults in mental health and chemical dependency crisis. The CSCR Initiative made the following findings:

1) there is no single, effective crisis response system;
2) every field responding to crisis is experiencing difficulty;
3) the Involuntary Treatment Act (ITA) has become an over-burdened default response which affects jails and hospitals;
4) people in crisis are not adequately being served; and
5) crisis response services are, themselves, in crisis.

Based on these findings, the CSCR Initiative made the following recommendations which were adopted by the DSHS and the counties in the CSCR Initiative:

1) revise the ITA to create a combined crisis response for all identified populations that is available 24 hours per day, 7 days per week;
2) establish safe, secure detoxification capacity;
3) implement intensive case management for persons with chemical dependency;
4) create hospital diversion beds for adults with medical and behavioral issues, persons with developmental disabilities, and provide in-home stabilization;
5) develop cross-system crisis plans for persons under court ordered treatment and DOC supervision and other persons at risk; and
6) provide training and consultations related to managing behavior, assessment, and regulations, including consultation at the state hospitals for long-term care providers.

Summary: The legislation is divided into eight parts that cover six major areas.

Part 1: General provisions and amendments to current mental health statutes. These amendments include merging many existing sections granting rights to involuntarily committed persons into one section which can be provided to the committed person and merging duplicative and scattered confidentiality provisions to clarify the exceptions to the confidentiality of mental health records.

Part 2: Crisis and Commitment. The first two steps of a three step process to create a single, unified involuntary treatment act (ITA) for mental health and chemical dependency are pilot

projects and evaluation. The intent section includes the intent for future legislative action to create a unified ITA to provide a single standard and process for mental health and chemical dependency involuntary commitment following the results of the pilot projects.

Step one - Pilot programs. Part 2 includes two pilot programs, each to be implemented in a rural and an urban community. The first pilot program combines the initial detention process of adults with chemical dependency and mental disorders through the use of a designated crisis responder with authority to initiate civil commitment proceedings. It also creates secure detoxification facilities for detention. The second pilot provides for intensive case management of chemically dependent persons who are high utilizers of emergency, crisis, and correctional facilities, to reduce treatment through use of appropriate services. The requirement for services under the pilots expires March 1, 2008.

Step two - Evaluation. The Washington State Institute for Public Policy (WSIPP) is required to evaluate the two pilots above to determine whether the pilots: have increased efficiency; are cost effective; result in better outcomes; increase the effectiveness of the crisis response systems in the two locations; and whether a unified involuntary treatment act would be effective for the systems and the individuals. The WSIPP must report to the Legislature by December 1, 2008.

Parts 3 and 4: Service expansion and addressing treatment gaps. DSHS must expand chemical dependency treatment for Medicaid eligible persons with incomes under 200 percent of poverty to 40 percent of the identified need by 2006, and to 60 percent of the identified need by 2007. The identified need was calculated in 2003 by Washington State University. DSHS must also contract for chemical dependency services at every office of the division of Children and Family Services.

DSHS must develop and expand comprehensive treatment programs for pregnant and parenting mothers, within funds appropriated for this purpose.

A new type of licensure is created for a residential treatment facility called an Enhanced Services Facility (ESF). The ESF is designed to respond to gaps in residential mental health treatment capacity for persons who qualify for this level of treatment but are ineligible for placement because of their individual history, behavior generated by disease, or treatment needs. DSHS may contract for ESF services only to the extent that funds are specifically provided for that purpose.

Part 5: Interaction with the justice system. The interaction of the treatment systems with the criminal and civil justice system is addressed in five ways:

1) Counties that enact the one-tenth of one percent sales tax authorized by the bill must establish family therapeutic courts for families involved in dependency and termination proceedings.
2) The authority of counties to establish mental health courts and drug courts is clarified.
3) DSHS must enter into interlocal agreements with jails, the department of corrections, and institutions for mental diseases to facilitate eligibility determinations for medical assistance upon release from confinement. DSHS is authorized to use medical records that jails have prepared if those are available.

4) DSHS must reduce waiting times for competency evaluation and restoration to the maximum extent possible using funds appropriated for this purpose, and report to the Legislature by January 1, 2006, on alternatives to reduce waiting times and address increases in the forensic population.
5) The Joint Legislative Audit and Review Committee must study whether facilities exist that would be appropriate and cost-effective to convert and use as regional jails for confined persons with mental disorders.
6) The collaboration provisions of SB 6358, enacted in 2004, are amended to clarify the information sharing and collaborative processes.

Part 6: Best practices and collaboration. Requirements are established in three broad areas and requires some new services for children.

Area one. DSHS must adopt a comprehensive, integrated screening and assessment process for mental illness and chemical dependency by January 1, 2006 with implementation to be completed systemwide not later than January 1, 2007. DSHS must establish penalties for failure to implement this process beginning July 2007.

Area two. DSHS must develop a matrix or set of matrices of services for adults and children based on maximizing:

1) evidence based, research based, and consensus based practices;
2) principles of recovery, independence, and employment;
3) collaboration with consumer based programs; and
4) individual participation in treatment decisions to the maximum extent possible, including providing information and technical assistance for the preparation of mental health advance directives.

DSHS must work with the University of Washington and consult with stakeholders in developing the matrix, which should build on existing work done by the department. DSHS must require use of the matrix or set of matrices by contract and provide penalties for failure to comply.

Area three. DSHS must try to arrange services for children who need mental health treatment but who are not eligible for Medicaid or regional support network (RSN) services.

The WSIPP must conduct a study of the net present cost of treatment versus non-treatment for mentally ill and chemically dependent persons.

Part 7: Technical. This section includes contingent repealers and those sections that correct cross-references to repealed sections.

Part 8: Fiscal and miscellaneous provisions.

County legislative authorities are authorized to levy a 1/10 of 1 percent sales tax dedicated to new and expanded therapeutic courts for dependency proceedings, and new and expanded mental health and chemical dependency treatment services.

The mental health ombudsman must be independent of the RSN.

The individual sections of the bill that require pilot projects, new state chemical dependency treatment, chemical dependency services for child welfare offices, studies by JLARC and the WSIPP, and integrated mental health/chemical dependency assessments are null and void if specific funding is not provided for them individually, referencing them by section number, by June 20, 2005.

Votes on Final Passage:

Senate	37	12	
House	73	22	(House amended)
Senate			(Senate refused to concur)

Conference Committee

House	67	31
Senate	32	16

Effective: July 1, 2005

July 1, 2006 (Section 503)

Section 301 of this act is null and void because funding in the budget was at a lower level than required in the bill.

Partial Veto Summary: An intent section and repealer were vetoed. In addition, vetoes removed the requirements for DSHS to develop a matrix of best practices and to assess and arrange for services for children in out-of-home care who are in need of mental health treatment but do not meet the threshold for treatment through the mental health division.