SENATE BILL REPORT
E2SSB 5763

As Passed Senate, March 10, 2005

Title: An act relating to the omnibus treatment of mental and substance abuse disorders act of 2005.

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).

Brief History:
Committee Activity: Human Services & Corrections: 2/10/05, 2/24/05 [DPS-WM].
Ways & Means: 3/7/05, 3/7/05 [DP2S, w/oRec].
Passed Senate: 3/10/05, 37-12.

SENATE COMMITTEE ON HUMAN SERVICES & CORRECTIONS

Majority Report: That Substitute Senate Bill No. 5763 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Hargrove, Chair; Regala, Vice Chair; Brandland, Carrell, McAuliffe and Thibaudeau.

Staff: Fara Daun (786-7459)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 5763 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Prentice, Chair; Doumit, Vice Chair; Fraser, Vice Chair; Brandland, Fairley, Pflug, Pridemore, Rasmussen, Regala, Roach, Rockefeller and Thibaudeau.

Minority Report: That it be referred without recommendation.

Signed by Senators Zarelli, Ranking Minority Member; Hewitt, Parlette and Schoesler.

Staff: Chelsea Buchanan (786-7446)

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 consolations related to managing behavior, assessment, and regulations, including consultation at the state hospitals for long-term care providers.

Summary of Bill: The legislation is divided into nine 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; merging duplicative and scattered confidentiality provisions to clarify the exceptions to the confidentiality of mental health records; and updating the statutory language governing the administration of involuntary medications under administrative orders to meet Constitutional requirements.

Parts 2 and 3: Unified Involuntary Treatment Act (ITA). A three step process is established that creates a single, unified ITA for mental health and chemical dependency, for both adults and children, to be completed in 2009. The single act will provide a single standard and process for mental health and chemical dependency involuntary commitment.

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.

Part 2 also includes a pilot evaluation by WSIPP of existing and established clubhouse model rehabilitative programs for increases in employment and independence and reductions in need for inpatient services. The WSIPP is to report by December 1, 2007.

Step three-implementation. The existing Involuntary Treatment Acts are replaced with one Involuntary Treatment Act, effective July 1, 2009. Effectively, this creates a new entitlement for involuntary chemical dependency treatment, where none presently exists. This provision is null and void if specific funding is not provided by the Legislature by June 30, 2009.

Parts 4 and 5: 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 also assess the cost effectiveness of converting unused nursing home facilities to residential chemical dependency treatment facilities and report to the Legislature by September 1, 2005. If cost effective, DSHS has authority to convert these facilities, subject to capital appropriations for this purpose.

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 medically 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 a specifically provided for that purpose.

Part 6: 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 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 7: 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 a 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.

Beginning in 2007, vendor rate increases for mental health and chemical dependency providers must be prioritized to those providers who maximize the use of evidence-based and research-based practices, unless the legislature provides otherwise.

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

Part 9: 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 portion of the bill that creates a new Involuntary Treatment Act as of fiscal year 2010 is null and void if specific funding is not provided by June 30, 2009.

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.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: The bill contains several effective dates. Please refer to part 8 of the bill.

Testimony For (Human Services & Corrections): Mental illness is not a choice, but it can be treated. This bill represents a significant step to a better system and its integrated comprehensive approach in a time of constrained resources takes a long view. It is challenging and it is the right direction; we are pleased and impressed with the legislation and will work with staff on specific language concerns. The integrated screening and assessment process is important. Some providers are already doing this. It is required in chemical dependency programs. There is a real need for vendor rate increases as treatment providers are on the verge of collapse and continue only due to their commitment to the issue. Specialized courts have proven effective and expansion is a positive step. The placement of a chemical dependency specialist in DCFS offices is important; the state has missed the boat by not doing this before. We need to expand our efforts to decriminalize mental illness and the trend to add more forensic beds while cutting civil beds should be reversed. We need statewide crisis intervention training for law enforcement because it is a best practice and reduces tragedies. Early screening and treatment leads to recovery and avoids criminal justice involvement. It is important to ensure that we don't lose what we have while moving to something new. This will be challenging to implement. Recognizing that updating the involuntary medications provisions is necessary, the specific panel composition may be too rigid for practical application and there may be some safety issues around emergency situations where the process needs to be refined. It should be clarified that the pilot projects will not take funding from existing programs. The local taxing authority is good, but the legislature should recognize that small counties will not draw enough from this to fund programs. It is important that, under the unified involuntary treatment provisions, the right provider is making the petition decision. If the state buys institutions, the state must ensure that contracted vendors will have an equal opportunity to get a client and those facilities will not be favored. Chemical dependency vendor rates are so low that it is cheaper to leave a bed empty than fill with a client. The suspension versus termination provisions are very important. It is vital that the bill continue to address the mental health needs of children. It is not clear on the ratio of beds to remain at the state hospital. The Public Consulting Group is doing a study of facilities, and the expanded services facilities are part of that study. It will be important to meet federal reporting requirments under the suspension of Medicaid benefits. The timelines are overly optimistic but will work with staff. This is critical for the aid of the street youth in the state. We need to place more emphasis on children in out of home care and this bill does that.

Testimony Against (Human Services & Corrections): None.

Who Testified (Human Services & Corrections): PRO: Beth Danhardt, Triumph Treatment Services, Washington State Women's Coalition; Jim Adams, NAMI Washington; Jean Wessman, Washington State Association of Counties; Neal Shanbeck, Sr., Evergreen Counseling Center; Linda Grant, Association of Alcoholism & Addiction Programs, Evergreen Manor; Seth Dawson, Washington State Psychiatric Association; Joshua Ginzler, University of Washington (testifying as a private citizen); Laurie Lippold, Children's Home

Society. OTHER: Martha Harden-Cesar, Superior Court Judges Association; Jefferey Uuyek, Washington State Hospital Association; Tim Brown, Assistant Secretary, DSHS Health and Rehabilitative Services Administration.

Testimony For (Ways & Means): This bill is the work product of many entities from the state, local, and federal level. The Bush administration's Federal Health and Human Services Substance Abuse and Mental Health Services Administration (SAMSA) emphasizes assessment, treatment, and involuntary commitment that crosses traditional systems, and advocates for use of best practices, and other items. Many of these approaches are encompassed in this bill. The state is wasting money doing things the way it is doing them now. People with mental health are overrepresented in jails and prisons, in foster care, and dependency proceedings. Spending more on substance abuse and mental health will produce better outcomes and will benefit the public, taxpayers, and victims. It's time to make an investment; we can't afford not to do this. Rural and urban sheriffs and jail administrators are very supportive of the local taxing option and more treatment, to prevent the "frequent fliers" in the criminal justice system. The bill is supported by NAMI-Washington. Substance abuse and mental health problems bring many families into the child welfare system; this bill will have an impact on helping those people. Harborview is supportive but is still concerned about some provisions, including the need for additional hearings for involuntary medication issues, and is working with the sponsor and staff. DSHS feels that some of its concerns have been addressed in the proposed second substitute, but still has some concerns and will work with staff. Section 102 might have an impact on efficiently running state hospitals.

Testimony Against (Ways & Means): None.

Who Testified (Ways & Means): PRO: Senator Hargrove, prime sponsor; Seth Dawson, NAMI-Washington; Laurie Lippold; Children's Home Society; Tim Brown, DSHS. OTHER: Jackie Der; Harborview.

House Amendment(s): The House amendments struck the following: Part 3, which created a single, unified involuntary treatment act in 2009; the sections addressing the administration of involuntary medication, local government taxing authority, the requirement for expedited medical assistance eligibility determinations and Medicaid reinstatement for persons leaving confinement; the study by the Washington State Institute of Public Policy to determine the net present value of the costs avoided by paying for treatment, the study of the clubhouse model of rehabilitation; and the capital study related to whether disused nursing homes could be effectively converted to treatment facilities.

The amendments also changed county designated mental health professionals to designated mental health professionals who are state certified, a new certification.

With regard to new chapter establishing enhanced services facilities, the amendments do the following: add requirements to the resident rights provisions while striking the application of the rights section to persons involuntarily committed to these facilities; add resident rights and facility requirements to the section that defines who is eligible for admission; add an entitlement to an advocate of the resident's choice; add rights and requirements related to expanded community services programs; and establishes procedural requirements for an assessment that is no longer in the bill.

The House amendments also add within available funds or appropriated funds language in several places in the bill and add sections to the null and void clause.

Passed House: 73-22.