HOUSE BILL REPORT
E3SHB 1713

As Passed House:
March 29, 2016

Title: An act relating to integrating the treatment systems for mental health and chemical dependency.

Brief Description: Integrating the treatment systems for mental health and chemical dependency.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Cody, Harris, Jinkins, Moeller, Tharinger, Appleton, Ortiz-Self and Pollet).

Brief History:
Committee Activity:
Judiciary: 2/3/15, 2/19/15 [DPS], 1/26/16 [DP2S];
Appropriations: 2/26/15, 2/27/15 [DPS(JUDI-A APP)], 2/3/16, 2/8/16 [DP3S(w/o sub JUDI)].
Floor Activity:
Passed House: 3/9/15, 63-35.
Senate Amended.
Passed Senate: 4/15/15, 48-1.
First Special Session
Floor Activity:
Passed House: 4/29/15, 61-34.
Floor Activity:
Passed House: 2/15/16, 82-15.
Floor Activity:
Passed House: 3/29/16, 82-13.

Brief Summary of Engrossed Third Substitute Bill

- Makes certain short-term changes to the involuntary chemical dependency treatment provisions that largely parallel corresponding involuntary mental health treatment provisions.
- Integrates the involuntary treatment provisions and systems for chemical dependency and mental health, and integrates other provisions pertaining to minor-initiated and parent-initiated chemical dependency and mental health treatment for minors, effective April 1, 2018.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

- Directs a Washington State Institute for Public Policy study to evaluate the effect of the integration of the involuntary treatment systems for chemical dependency and mental health.
- Recodifies provisions related to the administration of local substance use disorder programs into the community mental health system administration code, effective April 1, 2016.
- Delays the expiration date of a business and occupation tax deduction for amounts received for providing mental health services under a government-funded program, and expands the deduction to apply to provision of chemical dependency services.
- Requires the Department of Social and Health Services to convene a task force with the Health Care authority to align regulations between behavioral health and primary care settings, and collaborate with other agencies to review certain processes related to audits, licensing, and contracting.

HOUSE COMMITTEE ON JUDICIARY

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass. Signed by 12 members: Representatives Jinkins, Chair; Kilduff, Vice Chair; Rodne, Ranking Minority Member; Goodman, Haler, Hansen, Kirby, Klippert, Kuderer, Muri, Orwall and Stokesbary.

Minority Report: Do not pass. Signed by 1 member: Representative Shea, Assistant Ranking Minority Member.

Staff: Omeara Harrington (786-7136).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The third substitute bill be substituted therefor and the third substitute bill do pass and do not pass the substitute bill by Committee on Judiciary. Signed by 26 members: Representatives Dunshee, Chair; Ormsby, Vice Chair; Wilcox, Assistant Ranking Minority Member; Cody, Dent, Fitzgibbon, Haler, Hansen, Harris, Hudgins, S. Hunt, Jinkins, Kagi, Lytton, Magendanz, Manweller, Pettigrew, Robinson, Sawyer, Schmick, Senn, Springer, Stokesbary, Sullivan, Tharinger and Walkinshaw.

Minority Report: Do not pass. Signed by 5 members: Representatives Chandler, Ranking Minority Member; Buys, MacEwen, Taylor and Van Werven.

Minority Report: Without recommendation. Signed by 2 members: Representatives Parker, Assistant Ranking Minority Member; Condotta.

Staff: Andy Toulon (786-7178).

Background:

Involuntary Mental Health Treatment.
Under the involuntary mental health treatment systems for both minors and adults, a person may be committed for involuntary mental health treatment if he or she poses a likelihood of serious harm or is gravely disabled. The likelihood of serious harm or grave disability must be due to a mental disorder.

Jurisdiction over involuntary mental health treatment proceedings is with the superior court. County prosecutors represent petitioners, unless the petitioner is a state facility, in which case the Attorney General provides representation.

Adult System.
The Involuntary Treatment Act (ITA) sets forth the procedures, rights, and requirements for involuntary mental health treatment of adults. Under the ITA, designated mental health professionals (DMHPs) are responsible for investigating whether or not a person should be detained to an evaluation and treatment facility for an initial 72-hour evaluation. The professional staff of the treatment facility providing the 72-hour evaluation may petition the court to have the person committed for further mental health treatment. A petition must be signed by certain combinations of two examining professionals, including physicians, mental health professionals, and psychiatric advanced registered nurse practitioners.

Following a hearing, if the person is found by a preponderance of the evidence to pose a likelihood of serious harm or be gravely disabled, the court may order the person to be involuntarily committed for up to 14 days of additional treatment at an evaluation and treatment facility. Upon subsequent petitions and hearings, if commitment criteria are met by clear, cogent, and convincing evidence, a court may order up to an additional 90 days of commitment, followed by up to 180 days of commitment. Successive 180-day orders are permissible on the same grounds and pursuant to the same procedures as the original 180-day commitment. Inpatient commitment on an order allowing up to 90 or up to 180 days of treatment takes place at a state hospital.

When entering an order for up to 14, 90, or 180 days of treatment, if the court finds that the person poses a likelihood of serious harm or is gravely disabled, but that treatment in a less restrictive alternative (LRA) than detention is in the best interest of the person or others, the court must order an appropriate less restrictive course of treatment rather than inpatient treatment. Less restrictive alternative treatment is for up to 90 days if ordered instead of a 14- or 90-day inpatient order, and is for up to 180 days if ordered instead of a 180-day inpatient order.

Involuntary Mental Health Treatment of Minors.
The provisions governing involuntary mental health treatment of minors over the age of 13 are in parallel with the ITA in most respects. A DMHP, upon a determination that commitment standards are met, may seek a minor's initial 72-hour detention. Upon subsequent petitions and court orders, a minor may be committed for a term of up to 14 days of treatment, followed by successive orders of up to 180 days of treatment.

Initial and 14-day treatment takes place at an evaluation and treatment facility that provides treatment services for minors. Subsequent treatment is in the custody of the Department of Social and Health Services (DSHS), or at a private facility if the minor's parents have

assumed responsibility for payment. The court must order LRA treatment rather than inpatient treatment if it is in the best interest of the minor.

Involuntary Chemical Dependency Treatment.
An adult or minor may be committed for involuntary chemical dependency treatment upon petition of a Designated Chemical Dependency Specialist (DCDS), a hearing, and a finding by clear, cogent, and convincing evidence that the person, due to chemical dependency, poses a likelihood of serious harm or is gravely disabled. The petition of the DCDS must be accompanied by a certificate of a licensed physician who has examined the person within the previous five days, or documentation that the person refused an examination. A petition may only be filed, and the court may only order involuntary treatment, if placement in a chemical dependency program is available and deemed appropriate.

In some cases, a person is detained prior to the DCDS filing for involuntary treatment. A person who is found to be incapacitated or gravely disabled by alcohol or other drugs at the time of, or following, admission to an approved treatment program may be detained for no longer than 72 hours, unless a petition is filed for involuntary commitment.

Persons committed as chemically dependent are committed for a term of 60 days, unless sooner discharged, and upon a subsequent petition and hearing, for a term of 90 days, unless sooner discharged. A treating facility may conditionally release a committed person in appropriate circumstances.

Jurisdiction over involuntary chemical dependency treatment proceedings is with the superior court, district court, or other court identified in court rule. The county prosecutor may, but is not obligated to, represent petitioners in involuntary chemical dependency treatment proceedings.

Minor-Initiated and Parent-Initiated Treatment.

Mental Health System.
In the mental health system, a minor age 13 or older may, without parental consent, admit himself or herself to an evaluation and treatment facility for inpatient treatment or request and receive outpatient treatment. The administrator of a facility to which a minor has been admitted for inpatient treatment must notify the minor's parents of the admission. The minor may only be admitted if the professional person in charge of the facility believes the minor is in need of inpatient treatment. A minor voluntarily admitted to inpatient treatment may give notice of intent to leave at any time. Parental consent is needed for inpatient or outpatient treatment of a minor under 13 years old.

A parent may bring his or her minor child to an evaluation and treatment facility and request an evaluation for inpatient treatment, or to an outpatient provider and request an examination for the need for outpatient treatment. The consent of the minor is not required, and, if admitted for medically necessary inpatient treatment, the minor may not be discharged based solely on his or her request. The minor may petition the court for release from the facility.

Chemical Dependency System.

The provisions for minor-initiated and parent-initiated chemical dependency treatment of minors are similar to those pertaining to mental health treatment. However, parental consent is required for inpatient chemical dependency treatment of a minor.

Integrated Crisis Response and Involuntary Treatment Pilot Program.
The Integrated Crisis Response and Involuntary Treatment Pilot Program (ICR), created by 2005 legislation, established an integrated crisis response system at two pilot sites. The ICR authorized involuntary detention and treatment of adults meeting the likelihood of serious harm or grave disability standard due to either a chemical dependency or a mental disorder. Detentions were performed by a "designated crisis responder" (DCR) with the authority and training to detain in either the chemical dependency or mental health system.

The ICR chapter paralleled the procedures and standards in the ITA with respect to emergency and non-emergency detentions. Additionally, the ICR created a 14-day inpatient commitment order and 90-day LRA order for chemical dependency treatment. Initial detentions and 14-day commitments for chemically dependent persons were to a "secure detoxification facility or other certified chemical dependency provider." Secure detoxification facility was defined as a publicly or privately operated facility, or program of an agency, providing acute and subacute detoxification services for intoxicated persons and that includes security measures sufficient to protect the patients, staff, and community.

In line with the ITA, prosecutors were required to represent petitioners for commitments based on chemical dependency under the ICR.

Administration of Chemical Dependency and Mental Health Services.

Community Mental Health System.
The DSHS contracts with regional support networks to oversee the delivery of mental health services for adults and children who suffer from mental illness or severe emotional disturbance. A regional support network may be a county, group of counties, or a nonprofit or for-profit entity. Currently, 10 of the 11 regional support networks are county-based; one is operated by a private entity.

Regional support networks are paid by the state on a capitation basis and funding is adjusted based on caseload. The regional support networks contract with local providers to provide an array of mental health services, monitor the activities of local providers, and oversee the distribution of funds under the state managed care plan.

Approximately 40 percent of the state's resources for community mental health services are supported by federal Medicaid funding. Receipt of these funds is conditioned upon compliance with federal requirements.

Non-profit health or social welfare organizations and behavioral health organizations may qualify for a business and occupation (B&O) tax deduction for amounts received for providing mental health services under a government-funded program. This tax deduction is scheduled to expire on August 1, 2016.

Chemical Dependency Services.

The DSHS contracts with counties to provide outpatient chemical dependency prevention, treatment, and support services, either directly or by subcontracting with certified providers. The DSHS determines chemical dependency service priorities for those activities funded by the DSHS.

Behavioral Health System Integration.
In 2014 the Legislature passed legislation that directs the DSHS to integrate the purchase of chemical dependency services and mental health services. The integrated services are to be provided primarily through managed care contracts which must begin by April 1, 2016. The integrated system will be administered on a regional level through entities called "behavioral health organizations."

Licensure and Regulation of Primary Care and Behavioral Health Providers.
Different regulatory, licensure, and certification requirements apply to providers in the fields of primary care, mental health, and chemical dependency. Depending on the type of provider and whether the activity relates to contracting or licensing, the regulatory activities may be conducted by either the Department of Health (DOH), the DSHS, or the Health Care Authority (HCA). License holders and contractors may also undergo audits from the federal government, county authorities, and other entities. State law enacted in 2001 has required the DSHS to deem entities as compliant with state minimum standards for licensed behavioral health providers if they are accredited by behavioral health accrediting organizations that are recognized by and have a current agreement with the DSHS.

Summary of Engrossed Third Substitute Bill:

"Ricky Garcia's Act" is enacted.

Short-Term Changes to the Chemical Dependency Involuntary Treatment System.
Changes are made to the chemical dependency involuntary treatment system, which remain in effect until April 1, 2018.

A 14-day chemical dependency commitment order replaces the current 60-day order, and will issue upon the court's finding that commitment criteria are met by a preponderance of the evidence. The ability of the petitioner to file, and of the court to order commitment, remains subject to available space in an approved treatment program.

Upon a hearing for a 14-day or 90-day order, if the court finds that the criteria for commitment are met, but that placement in a less restrictive setting than inpatient treatment is in the best interest of the person or others, the court must enter an order for up to 90 days of LRA treatment and cannot order inpatient treatment. If the program designated to provide less restrictive treatment is different than the program providing initial involuntary treatment, the designated program must agree in writing to assume the responsibility.

The list of qualified examining professionals that may sign a petition for 14-day or 90-day treatment includes physicians, psychiatric advanced registered nurse practitioners, mental health professionals, and physician assistants. An authorized combination of two professionals must sign the petition.

Prosecutors must represent petitioners in chemical dependency commitment proceedings.

Integrated Treatment System for Substance Use Disorders and Mental Health.
References to "chemical dependency" and related terms are changed to "substance use disorder."

The involuntary mental health and involuntary substance use disorder treatment systems for minors and adults are integrated, and the minor-initiated and parent-initiated mental health and substance use disorder treatment provisions are integrated, effective April 1, 2018.

Involuntary Treatment.
The ITA and the provisions pertaining to involuntary mental health treatment for minors are amended to include commitments for substance use disorders. Statutes governing involuntary chemical dependency commitment are repealed. Substance use disorder commitment (formerly "chemical dependency commitment") follows the same procedures, rights, requirements, and timelines as mental health commitment.

Designated mental health professionals and DCDSs are replaced by DCRs. The DSHS, by rule, must combine the functions of a DMHP and DCDS by establishing a DCR who is authorized to conduct investigations, detain persons for up to 72 hours to the proper facility, and carry out other functions. To qualify as a DCR, a person must have received chemical dependency training as determined by the DSHS and be a:

- psychiatrist, psychologist, psychiatric advanced registered nurse practitioner, or social worker;
- person with a master's or further advanced degree in counseling or social science with at least two years of experience in direct treatment of persons with mental illness or emotional disturbance;
- person who meets certain waiver criteria as identified in statute, or as approved by the DSHS; or
- person who has been granted an exception of the minimum requirements of a mental health professional by the DSHS, consistent with agency rules.

The DSHS must develop a transition process for persons who are a DMHP or DCDS prior to the integration to become DCRs.

Initial detentions and 14-day commitments based on substance use disorders take place at secure detoxification facilities or approved substance use disorder treatment programs. For longer commitments, involuntary substance use disorder treatment takes place at an approved substance use disorder treatment program. Commitment to a secure detoxification facility or approved substance use disorder treatment program is contingent upon facility or program availability and adequate space until July 1, 2026. The DSHS must ensure that at least one secure detoxification facility is operational by April 1, 2018, and that an additional secure detoxification facility is operational by April 1, 2019. If at any time during the implementation of secure detoxification facility capacity, federal funding becomes unavailable for federal match for services provided in these facilities, the DSHS must discontinue the expansion pending further direction by the Legislature.

The superior court has jurisdiction over involuntary treatment proceedings for mental health and substance use disorders. Prosecutors represent all petitioners, including petitioners for involuntary substance use disorder treatment, unless the petitioner is a state facility, in which case the Attorney General represents the petitioner.

Minor-Initiated and Parent-Initiated Treatment of Minors.
Provisions regarding minor-initiated mental health treatment and parent-initiated mental health treatment are amended to included minor-initiated and parent-initiated substance use disorder treatment. Current statutes governing minor-initiated and parent-initiated chemical dependency treatment are repealed.

Washington State Institute for Public Policy Study.
The Washington State Institute for Public Policy (WSIPP) must evaluate the effect of the integration of the involuntary treatment systems for substance use disorders and mental health. Preliminary reports are due to the Legislature by December 1, 2020, and June 30, 2021, and a final report must be submitted by June 30, 2023. The evaluation must include an assessment of whether the integrated system:

- has increased efficiency of evaluation and treatment of persons involuntarily detained for chemical dependency;
- is cost-effective, including impacts on health care, housing, employment, and criminal justice costs;
- results in better outcomes for involuntarily detained persons;
- increases the effectiveness of the crisis response system statewide;
- has an impact on commitments based upon mental disorders;
- has been sufficiently resourced; and
- has diverted a significant number of individuals from the mental health system whose risk results from substance abuse, including associated net savings.

Integration of Administrative Provisions Related to Substance Use Disorders and Mental Health.
Administrative provisions related to substance use disorders and mental health are integrated, effective April 1, 2016.

Provisions related to the administration of local substance use disorder programs are recodified into the community mental health system administration code. The DSHS' authorities related to substance use disorders are merged with its authority regarding mental health, including contracting, the use of federal funds, and coordinating behavioral health programs.

Elements of substance use disorder programs are made requirements of programs administered by behavioral health organizations, including required services such as withdrawal management, residential treatment, and outpatient treatment, and optional services such as peer support, supported housing, supported employment, crisis diversion, and recovery support services. It is specified that the treatment is to be provided primarily through managed care contracts, except for services and funding provided through the Criminal Justice Treatment Account.

Mental health advisory boards established by behavioral health organizations are renamed "behavioral health advisory boards" and must include representation from consumers of both substance use disorder services and mental health services and their families.

The DSHS' licensing authority related to establishing minimum standards for licensed service providers is clarified to apply to behavioral health service providers, specifically, those licensed to provide mental health services, substance use disorder treatment services, or services to persons with co-occurring disorders.

Certain provisions related to substance use disorder programs are repealed, including the establishment of a discrete program for substance use disorders, the establishment of an interdepartmental coordinating committee, requirements related to the confidentiality of records, and other provisions.

References to "chemical dependency" are changed to "substance use disorder." References to the "state mental health program" are changed to the "state behavioral health program." References to "behavioral health disorders" are changed to "mental health disorder, substance use disorders, or both."

The mental health services B&O tax deduction is expanded, enabling non-profit health or social welfare organizations to qualify for a B&O tax deduction for amounts received for providing chemical dependency services under a government-funded program. The expiration date for the B&O tax deduction is extended from August 1, 2016, to January 1, 2020.

The DSHS and the HCA must convene a task force to align regulations between behavioral health and primary care settings and simplify regulations for behavioral health providers. Additionally, the DSHS must collaborate with the HCA, the DOH, and other appropriate government partners to reduce unneeded costs and burdens to health plans and providers associated with excessive audits, the licensing process, and contracting. The DSHS must also review its practices related to deeming accreditation by a recognized behavioral health accrediting body as equivalent to meeting licensure requirements to determine compliance with statute and standard practices. The DSHS and the HCA must report their progress to the Legislature by December 15, 2016.

Appropriation: None.

Fiscal Note: Available.

Effective Date: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for sections 501, 503 through 532, and 701, relating to integration and recodification of the administrative provisions for substance use disorders and mental health, which take effect April 1, 2016; sections 201 through 210, 212, 214 through 224, 226 through 232, 234 through 237, 239 through 242, 244 through 267, 269, 271, 273, 274, 276, 278, 279, 281, 401 through 429, and 502, relating to integration of the treatment systems for substance use disorders and mental health, and repealed sections, which take effect April 1, 2018; and sections 211, 213, 225, 233, 238, 243, 268, 270, 272, 275, 277, and 280, relating to expiring the language stating that commitments to secure detoxification facilities and

approved substance use disorder treatment programs are subject to facility availability and available space, which take effect July 1, 2026. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony (Judiciary):

See House Bill Report in the 2015 Legislative Session.

Staff Summary of Public Testimony (Appropriations):

(In support) Mental health and substance abuse are highly correlated, with estimates as high as 70 percent of this population has a co-occurring mental health and substance use disorder. This bill would reduce the number of people who end up in the state psychiatric hospitals because they will instead be placed in substance abuse treatment beds, which are about one-fifth the cost of psychiatric inpatient services. The National Center and Addiction and Substance Abuse estimates that addiction costs totaled over $450 billion across the nation in 2005 but of the dollars spent, 95.5 cents go to the wreckage and after-the-fact consequences only 1.9 cents on the dollar goes to treatment and prevention.

There were some concerns last year with requiring involuntary treatment when there are not enough secure detox facilities available. The bill version before the committee this year extends the date to 2026 which will allow time to get the needed facilities up and running. Assuming the secure detox facilities are built and funded, there will be savings to both the state and the counties.

There are significant costs associated with failing to provide involuntary treatment for substance abuse. As an example, over a one year period, one individual who suffered multiple drug overdoses and suicide attempts had three intensive care stays, six psychiatric hospitalizations, 75 emergency room visits, dozens of responses from police and fire department teams, and countless ambulance transports. This resulted in hundreds of thousands of dollars in costs for medical care and first responders. Over a nine-year period, another individual incurred costs of over $260,000 in medical bills covered by Medicaid, 22 arrests, and two years of jail costs related to substance abuse issues. It took a prison sentence for this individual to receive substance abuse treatment. Involuntary chemical dependency treatment would have avoided significant criminal justice and medical costs.

From 2006 to 2009, the Legislature funded a pilot project on secure detox facilities, and there was a study from the Washington State Institute for Public Policy that reported savings from hospitalizations and avoidance of days in mental health facilities more than offset the costs of secure detox. There was a second study that showed that in the year following involuntary treatment for chemical dependency, clients exhibited a 53 percent decrease in the use of detox services, a 33 percent decrease in the use of crisis mental health services, a 44 percent drop in inpatient psychiatric care, and a 29 percent drop in medical service use. The group of 544 patients in the study saved the state over $7.1 million in the three years following treatment. With the current shortage of psychiatric beds, it is fiscally prudent to treat chemically dependent individuals in the less expensive substance abuse treatment system instead of keeping them inappropriately placed in psychiatric facilities.

One local law enforcement agency in the state began tracking data on officer interactions of persons with behavioral health crises in May 2015. Since that time period, there have been approximately 25 to 26 contacts per day and they are on track to exceed 10,000 such encounters this year. Approximately 22 percent of the subjects with behavioral health crises are related to chemical dependency issues. Of this group of subjects, the individuals were detained a little over 36 percent of the time. Over 3 percent of the subjects with chemical dependency crises had prior military service. Approximately 17 percent of the subjects with chemical dependency crises did not meet criteria for involuntary treatment and refused referral to other services.

Currently, when an officer detains someone, that person is taken to the hospital where he or she cannot be assessed until sober. If the person does not present the same behaviors when sober, he or she is released. There are cases where law enforcement has multiple encounters with the same person in a 24-hour period because every time they are brought to the hospital, they are released as soon as they sober up. This bill will save money from repeated emergency room billings, jail bookings, and emergency response from police and fire departments.

Parents are unable to commit their children with substance abuse issues for involuntary treatment. Parents beg for their children to be incarcerated because there is not an appropriate place to treat them. This results in thousands of dollars of medical bills and other avoidable costs. There are costs with moving the bill but also costs of not moving the bill. Law enforcement officers are faced with having to decide whether to leave someone in crisis because of a behavioral health issue or take them to jail. Aligning appropriate treatment in the appropriate settings will reduce costs at all levels.

(Opposed) None.

Persons Testifying (Judiciary): See House Bill Report in the 2015 Legislative Session.

Persons Testifying (Appropriations): Seth Dawson, National Alliance on Mental Health-Washington; Gregory Robinson, Washington Council for Behavioral Health; Michael Shaw, King County; Lauren Davis, Washington Recovery Alliance; Daniel Nelson, Seattle Police Department; Bradley Johansen; Christopher Salinas; and Brian Enslow, Washington State Association of Counties.

Persons Signed In To Testify But Not Testifying (Judiciary): None.

Persons Signed In To Testify But Not Testifying (Appropriations): None.