FINAL BILL REPORT
E3SHB 1713

C 29 L 16 E 1
Synopsis as Enacted

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).

House Committee on Judiciary
House Committee on Appropriations
Senate Committee on Human Services, Mental Health & Housing
Senate Committee on Ways & Means

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.

Involuntary Treatment of Adults.
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

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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 may be 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.

Integrated Crisis Response and Involuntary Treatment Pilot Program.
The Integrated Crisis Response and Involuntary Treatment Pilot Program (ICR) 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 followed 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.

Minor-Initiated and Parent-Initiated Treatment.

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 mental health treatment or request and receive outpatient mental health treatment. The minor may only be admitted if the professional person in charge of the facility believes the minor is in need of inpatient treatment, and the facility administrator must notify the minor's parents of the admission. 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.

Administration of Chemical Dependency and Mental Health Services.

Integration of Behavioral Health Services Purchasing.
Historically, the DSHS contracted with regional support networks to oversee the delivery of mental health services for adults and children suffering from mental illness or severe emotional disturbance. A regional support network could be a county, group of counties, or a nonprofit or for-profit entity. Regional support networks were paid by the state on a capitation basis and funding was adjusted based on caseload. The regional support networks contracted with local providers to provide an array of mental health services, monitored the activities of local providers, and oversee the distribution of funds under the state managed care plan.

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

In 2014 legislation was enacted directing the DSHS to integrate the purchase of chemical dependency services and mental health services. Beginning April, 2016, the integrated services are to be provided primarily through managed care contracts. The integrated system is administered on a regional level through entities called "behavioral health organizations."

Business and Occupational Tax Deduction for Provision of Government-Funded Mental Health Services.
Nonprofit 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.

Licensure and Regulation of Medical Care and Behavioral Health Providers.
Different regulatory, licensure, and certification requirements apply to providers in the fields of medical 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 requires 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:

"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 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 may not 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.

Providers of minor-initiated chemical dependency treatment may notify a minor's parents of the minor's request for treatment if the provider determines that notice is in the best interest of the minor in achieving recovery.

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

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. 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 include minor-initiated and parent-initiated substance use disorder treatment. 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 substance use disorders;
- 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. 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."

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

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. The treatment must 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.

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, and requirements related to the confidentiality of records.

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.

The task force convened by the DSHS and the HCA must also consider means of providing parental notification when a minor requests chemical dependency treatment, consistent with federal privacy laws and the best interests of the minor and the minor's parents. The task force must provide a report to the Legislature by December 1, 2016.

Votes on Final Passage:

2015 Regular Session

House	63	35	
Senate	48	1	(Senate amended)
House			(House refused to concur)

2015 First Special Session
House 61 34

2016 Regular Session
House 82 15

2016 First Special Session
House 82 13
Senate 40 2 (Senate amended)
House 89 5 (House concurred)

Effective: June 28, 2016
April 1, 2016 (Sections 501, 503-532, and 701)
April 1, 2018 (Sections 201-210, 212, 214-224, 226-232, 234-237, 239-242, 244-267, 269, 271, 273, 274, 276, 278, 279, 281, 401-429, and 502)
July 1, 2026 (Sections 211, 213, 225, 233, 238, 243, 268, 270, 272 275, 277, and 280)