SENATE BILL REPORT
ESHB 1713

As of March 30, 2015

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 Judiciary (originally sponsored by Representatives Cody, Harris, Jinkins, Moeller, Tharinger, Appleton, Ortiz-Self and Pollet).

Brief History: Passed House: 3/09/15, 63-35.
Committee Activity: Human Services, Mental Health & Housing: 3/23/15.

SENATE COMMITTEE ON HUMAN SERVICES, MENTAL HEALTH & HOUSING

Staff: Kevin Black (786-7747)

Background: An involuntary commitment system exists for persons who are incapacitated, present a likelihood of serious harm, or are gravely disabled by substance use disorders. While this system is superficially similar to the mental health commitment system under the Involuntary Treatment Act (ITA), access to this system is sharply limited and may be entirely unavailable in some regions of the state. The state purchases 144 involuntary treatment beds for persons with substance use disorders from a single vendor with involuntary commitment facilities located in Skagit and Spokane counties. Due to the scarcity of beds, patients who enter this system stipulate that they meet involuntary commitment criteria and may spend weeks on a waiting list waiting to receive this service.

Chemical dependency involuntary commitment statutes provide that a peace officer or other person designated by the county may take a person who appears to be incapacitated or gravely disabled by alcohol or other drugs and is in a public place, or who has threatened, attempted, or inflicted physical harm on themself or another, into protective custody. The person must be brought to a treatment program certified by the Department of Social and Health Services (DSHS) within eight hours, or taken to an emergency medical service customarily used for incapacitated persons. Upon arrival the person must be examined by a qualified person, and may be admitted for treatment or referred to another health program. The person may be detained for up to 72 hours, after which the person must be released

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unless the facility or a designated chemical dependency specialist (DCDS) files an involuntary treatment petition.

A DCDS or treatment program may file a court petition for involuntary chemical dependency treatment in superior court, district court, or another court permitted by court rule. A DCDS must conduct an investigation and evaluate the specific facts and the reliability and credibility of information supporting detention. The petition must allege that (1) as a result of chemical dependency the person presents a likelihood of serious harm or is gravely disabled; (2) the person has been admitted for detoxification sobering services, or chemical dependency treatment twice within the preceding 12 months and is in need of a more sustained treatment program; or (3) the person is chemically dependent and has threatened, attempted, or inflicted physical harm on another and is likely to inflict physical harm on another unless committed. The petition must be accompanied by a certificate from a licensed physician who has examined the person within five days before submission of the petition, unless the person has refused to submit to a medical examination. A court hearing must be scheduled within seven days, or 72 hours excluding weekends and holidays if the person is currently detained. If the court is convinced by clear, cogent, and convincing evidence that grounds for involuntary commitment have been established, the court may commit the person to an approved treatment program for up to 60 days if a program is available and able to provide adequate and appropriate treatment. The facility may file a petition to extend the commitment for up to 90 additional days. The county prosecuting attorney may, at the discretion of the prosecuting attorney, choose to represent the petitioning DCDS or treatment program.

Special commitment rules exist for minors that are analogous to the ITA system. A minor may apply for substance use disorder treatment on their own behalf at 13 years of age. A parent may bring a minor child to a certified treatment program and request an assessment without the consent of the minor. If an assessment reveals a medical necessity for treatment, the minor may be held for treatment without consent at the direction of the parent, subject to court review if the minor petitions for release.

Under the ITA, any person who is court committed for 14, 90, or 180 days of involuntary mental health treatment is prohibited from possession of a firearm under state and federal law. No similar provision exists for persons committed for involuntary chemical dependency treatment.

A physician assistant or osteopathic physician assistant is a person licensed to practice medicine to a limited extent under the supervision of a licensed physician or licensed osteopathic physician.

Substance use disorder is a diagnostic term used by the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published in 2013 by the American Psychiatric Association. This diagnostic term combines the characteristics of both substance abuse and substance dependence used in the previous edition (DSM-IV), and reflects current professional usage.

In August 2014, the Washington Supreme Court reviewed statutes and regulations relating to ITA detention, and determined in the *In re D.W.* decision that the current statutes and

regulations under the ITA do not permit a person to be detained outside a regularly certified evaluation and treatment facility (E&T) based on a lack of room at a certified E&T facility. E&T certification limits admissions to certified capacity, so commitments under the ITA were effectively limited to circumstances in which space is available. Since then, DSHS amended its single bed certification regulation to allow for detention for mental health treatment at a facility which is willing and able to provide timely and appropriate mental health treatment. Apart from this circumstance, detentions under the ITA are disallowed when no certified treatment bed is available.

Between 2006 and 2009, the Legislature established Integrated Crisis Response pilot programs in Pierce and North Sound Regional Support Networks. These pilots combined the investigation and commitment functions of a designated mental health professional (DMHP) and DCDS into a classification called designated crisis responder (DCR). A DCR could commit a person for short-term involuntary treatment to an E&T for treatment of a mental disorder or to a secure detoxification facility for treatment of a substance use disorder. Funding was discontinued for the pilots at the start of the recession. An evaluation of the long-term outcomes of the Integrated Crisis Response pilots was published in 2011 by the Washington Institute for Public Policy (WSIPP) and found that the program achieved cost savings resulting primarily from fewer admissions to state and community psychiatric hospitals.

Summary of Bill: This legislation makes changes to involuntary commitment laws that are effective in 90 days, effective on April 1, 2017, and effective on July 1, 2019.

Starting in 90 days, the involuntary chemical dependency commitment statutes are amended. A commitment petition must be signed by two professionals which may include examining licensed physicians, physician assistants, or psychiatric advanced registered nurse practitioners, or one of the foregoing and an examining mental health professional. The petition must state that there is no less-restrictive alternative (LRA) to detention available that is in the best interest of the person or others. The DCDS or program may seek an LRA order. The standard of proof for the first commitment is changed to a preponderance of the evidence and the length of inpatient commitment is shortened to up to 14 days. A second commitment petition for up to 90 days may be filed before the end of the 14-day period, using the clear, cogent, and convincing evidence standard. The petition may be filed and the court may order treatment only if an approved treatment program is available. The county prosecuting attorney must represent the petitioning DCDS or program. The chemical dependency involuntary commitment statutes are all repealed on April 1, 2017.

Starting April 1, 2017, the ITA is amended to integrate involuntary chemical dependency commitment provisions with mental health commitment provisions, in a fashion similar to the Integrated Crisis Response Pilots. Commitment criteria, language, and procedures follow the ITA. References to DMHPs are changed to DCRs, which combine the functions of a DMHP and DCDS. A physician assistant or osteopathic physician assistant is permitted to petition for all forms of commitment in place of a physician or psychiatric advanced registered nurse practitioner. The firearm prohibition resulting from ITA commitment is extended to encompass commitments for treatment of a substance use disorder that are based on use of a controlled substance as defined in federal law. The limitation on firearm rights must be strictly construed to apply only if firearm rights would be limited under federal law.

Language is added stating that a DCR may not petition for commitment for substance use disorder treatment if there is no space available in a certified facility. This language is removed on July 1, 2019, without the addition of language that would permit commitments for substance use disorder to occur if no space is available in a certified facility.

A new definition of secure detoxification facility is established requiring evaluation, assessment, and discharge assistance at the facility to be provided by certified chemical dependency professionals. Secure detoxification facilities must be certified by DSHS.

Long-term state-funded approved substance use disorder treatment programs must be established for minors. The designated placement committee composed of children's mental health specialists established by DSHS which is used to place children in long-term E&T facilities must be expanded to admit chemical dependency professionals.

DSHS must develop and enact a rule establishing requirements for DCRs by April 1, 2017. Minimum credentialing standards for DCRs are provided; however, DSHS is authorized to establish exceptions by rule. DSHS must develop a transition process for DMHPs and DCDSs to be converted to DCRs and require behavioral health organizations to provide training to DCRs.

WSIPP must evaluate the effect of integration of the involuntary treatment systems for substance use disorders and mental health and make preliminary reports to the Legislature by December 1, 2019, and June 30, 2020. WSIPP must provide a final report by June 30, 2022. The evaluation must assess the extent to which integration has improved the efficiency, effectiveness, and outcomes of the crisis system, whether integration is cost effective considering the impact on other systems, and whether the integrated crisis system has been sufficiently resourced with treatment beds, LRA options, and state funding.

This act may be known and cited as Ricky Garcia's Act.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

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

Staff Summary of Public Testimony: PRO: The delayed effective date is due to the costs and difficulty of ramping up capacity in the involuntary chemical dependency system. Providers have recordkeeping responsibilities which make it complicated to manage dual treatment responsibilities in the current system. There is no intention to create any controversy surrounding gun rights. My friend nearly died due to substance use disorder, after a long series of hospitalizations. There is no parity between the crisis systems for mental health and substance abuse. Nothing can be done for persons with a substance use disorder. They go to psychiatric hospitals, prisons, and the morgue. Sometimes you need someone to say no for you when you can't say no for yourself. Recovery happens if there is a chance for it to happen. I committed my son for involuntary mental health treatment because there was

no option for involuntary chemical dependency treatment. The judge dismissed the case and I felt so hopeless. In Pierce County there are 64 beds for mental health and none available for chemical dependency. There is a four to five week waiting list for the involuntary chemical dependency treatment beds in Skagit County; families are being told to just hold on. The Integrated Crisis Response Pilots had documented positive outcomes. We need to integrate these two systems and save lives. Our son died of an overdose. Others have died after being sent home because there was no option for involuntary chemical dependency treatment. Sending someone to an out-of-state program can cost $20,000. This bill must be funded for it to work. Aligning the mental health and chemical dependency systems will make sure that people have access to appropriate treatment to meet their individual needs. The secure detox option is important, and can be a bridge to longer residential treatment. There are 900 drug overdose deaths in Washington every year and 1000 suicides; some of which are chemical dependency related. This policy aligns with Senate Bill 6312. People with chemical dependency disorders are being treated inappropriately in the mental health system. King County has a provider ready to go ahead with secure detox if it is funded. There is a high correlation between mental illness and substance abuse. This law would lessen the number of people who receive commitments for mental illness. Substance abuse treatment is much more economical than mental health treatment. The studies provide data proving this policy works.

CON: We oppose the unintended consequence from merging these two systems of the loss of firearms rights. Please adopt an amendment to resolve this issue. We are not otherwise opposed to the intent and purpose of this bill.

OTHER: Please remove the section of the bill that would take away prosecutor discretion whether or not to represent designated chemical dependency specialists in involuntary chemical dependency treatment hearings. It makes no sense to move this policy forward unless the secure detoxification facilities are funded.

Persons Testifying: PRO: Representative Cody, prime sponsor; Lauren Davis, Rosario Sanchez, King County Alcoholism and Substance Abuse Administrative Board; Glen Kelley, Designated Chemical Dependency Specialist, Pierce County; Barry Antos, behavioral health professional; John Gahagan, Science and Management of Addictions Foundation; Gregory Robinson, WA Community Mental Health Council; Nick Federici, Pioneer Human Services; Jim Vollendroff, King County Mental Health, Chemical Abuse and Dependency Services Division; Seth Dawson, National Alliance on Mental Illness; Brian Enslow, WA State Assn. of Counties; Eleanor Owen, Ricky Garcia, citizens.

CON: Brian Judy, National Rifle Assn. WA State Liaison; Adina Hicks, Protect Our Gun Rights WA; William Burris, Gun Owners Action League.

OTHER: Tom McBride, WA Assn. of Prosecuting Attorneys; Jane Beyer, DSHS.

Persons Signed in to Testify But Not Testifying: No one.