SENATE BILL REPORT
3SHB 1713

As Reported by Senate Committee On:
Human Services, Mental Health & Housing, February 25, 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: Passed House: 2/15/16, 82-15.
Committee Activity: Human Services, Mental Health & Housing: 2/22/16, 2/25/16 [DPA-WM].

SENATE COMMITTEE ON HUMAN SERVICES, MENTAL HEALTH & HOUSING

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators O'Ban, Chair; Miloscia, Vice Chair; Darneille, Ranking Minority Member; Hargrove and Padden.

Staff: Kevin Black (786-7747)

Background: A chemical dependency involuntary commitment system (CD ITA) exists for persons who are incapacitated, present a likelihood of serious harm, or are gravely disabled by a substance use disorder. This system is superficially similar to the mental health involuntary commitment system (MH ITA); however, access to this system is 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 operating involuntary commitment facilities located in Skagit and Spokane counties. The scarcity of chemical dependency involuntary treatment beds cause this service to be generally unavailable to patients who do not stipulate that they meet legal criteria for involuntary commitment and spend weeks on a waiting list, waiting to receive this service.

Under the CD ITA, a peace officer or other person designated by the county may take a person into protective custody who appears to be incapacitated or gravely disabled by alcohol or other drugs if the person is in a public place, or has threatened, attempted, or inflicted

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physical harm on themself or another. 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 unless the facility or a designated chemical dependency specialist (DCDS) files a court petition for involuntary treatment.

A DCDS or facility may file this petition in superior court, district court, or another court permitted by court rule. The county prosecuting attorney may, at the discretion of the prosecuting attorney, choose to represent the petitioner. 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, if the person is currently detained, 72 hours excluding weekends and holidays. 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 where the person is committed may subsequently file a petition to extend the commitment for up to 90 additional days.

Minors may also be subject to commitment under the CD ITA. A minor may apply for outpatient substance use disorder treatment on the minor's own behalf at 13 years of age; inpatient substance use disorder treatment requires the consent of the parent unless the child has been declared a child in need of services.

A 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.

Between 2006 and 2009, the Legislature operated Integrated Crisis Response (ICR) pilot programs in Pierce and North Sound Regional Support Networks. ICR combines the investigation and commitment functions of a designated mental health professional (DMHP) and DCDS into a designated crisis responder (DCR). A DCR may commit a person for short-

term involuntary treatment in 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. The Washington State Institute for Public Policy (WSIPP) published an 18-month outcome evaluation of the ICR pilots in 2011 which found that the pilots generated savings of approximately $1.48 for every dollar spent based on reduced hospitalizations and avoidance of higher-cost E&T admissions. Employment rates increased to 45 percent among program participants, compared to 36 percent among a matched control group. The economic benefits of this were not calculated or added into the cost-benefit analysis.

Starting April 1, 2016, DSHS will contract with behavioral health organizations (BHOs), formerly called regional support networks, to oversee the delivery of treatment services to adults and children who have substance disorder treatment needs or severe mental health treatment needs. A BHO may be a county, group of counties, or a nonprofit or for-profit entity. In April 2016, 9 of the 10 BHOs will be county based, with one BHO located in Pierce County operated by a private company. A region in Southwest Washington consisting of Clark and Skamania Counties is designated as an "early adopter" region starting April 1, 2016, where behavioral health services will be integrated with physical health care services for Medicaid patients and qualifying non-Medicaid patients under the administration of managed care organizations.

A business and occupation (B&O) tax exemption allows a regional support network, BHO, or affiliated providers to deduct funds received for the purpose of providing government-funded mental health services from their tax liability. This exemption expires on August 1, 2016.

Summary of Bill (Recommended Amendments): DSHS must establish a phased implementation plan for the statewide implementation ICR in collaboration with BHOs and full integration regions. The plan must be submitted to the Legislature by October 1, 2016. Before ICR may be implemented in a region, the region must update its contract with DSHS or the Health Care Authority (HCA) and demonstrate that it has the capacity to provide ICR services to the residents of its region. ICR requirements must only apply in regions which have implemented ICR. The first regions in the state to implement ICR must do so by April 1, 2018. The last regions in the state to implement ICR must do so by July 1, 2026.

DSHS must develop a transition process for any DMHP or DCDS who wishes to become a DCR in an ICR region, and develop rules combining the functions of DMHPs and DCDSs into DCRs. DCRs must receive chemical dependency and mental health training specific to the duties of a DCR, including diagnosis of substance use dependence and assessment of risk associated with substance use. Definitions are provided for the terms "secure detox facility" and "approved substance disorder treatment program." It is specified that the loss of firearm rights that attends commitment under the MH ITA must apply only to persons committed in ICR regions who are committed for mental health treatment. Children aged 13 to 17 years old in ICR regions who do not meet the definition of "child in need of services" may consent on their own behalf to inpatient substance use disorder treatment.

Physician assistants may petition for the involuntary commitment of MH ITA and ICR patients. The types of practitioners authorized to petition for commitment under the CD ITA

are expanded to include advanced registered nurse practitioners, physician assistants, mental health professionals, and chemical dependency professionals.

Substantive provisions of CD ITA are amended to become similar to MH ITA. The initial court commitment following the 72-hour detention is shortened to 14 days, with the option of a 90-day less restrictive alternative commitment for outpatient treatment, and the burden of proof is lowered to probable cause. A subsequent commitment is available for 90 days of treatment in an inpatient or less restrictive setting upon proof by clear, cogent, and convincing evidence. County prosecutors must represent petitioners for CD ITA treatment and must be reimbursed for the cost of representation by BHOs or full integration regions.

Effective April 1, 2016, administrative provisions related to the state Mental Health Program and state Chemical Dependency Program are combined in chapter 71.24 RCW and renamed the state Behavioral Health Program. Mental Health Advisory Boards and Mental Health Ombuds services provided by BHOs are renamed Behavioral Health Advisory Boards and Behavioral Health Ombuds; these services are extended for the first time to substance use disorder patients and their families. References to chemical dependency, alcoholism, and drug addiction are changed to "substance use disorder" throughout the code.

Effective April 1, 2016, the mental health services B&O tax exemption for BHOs and BHO-affiliated providers is expanded to allow deduction of amounts received for providing government-funded chemical dependency services. The expiration date of this exemption is extended from August 1, 2016, to January 1, 2020.

DSHS and HCA must convene a task force to align regulations between behavioral health and primary care settings and simplify regulations for behavioral health providers. DSHS must collaborate to reduce the costs and burdens associated with excess provider audits, and review its policies related to deeming accreditation by a recognized behavioral health accrediting body as equivalent to meeting licensure requirements.

A guardian of a minor, in addition to a parent, may consent to parent-initiated substance use disorder treatment on behalf of the minor and participate in associated decision-making. A treatment provider that provides outpatient substance use disorder treatment to a minor 13 years of age or older at the request of the minor must notify the parents or guardian of the minor. A minor may not file a superior court petition asking to be released from a course of inpatient parent or guardian-initiated substance use disorder treatment sooner than 14 days after the minor's admission to the facility.

WSIPP must evaluate the effect of ICR implementation and report to the Legislature by December 1, 2020, June 30, 2021, and June 30, 2023. The evaluation must assess efficiency, cost-effectiveness, outcomes for detained persons, and whether the system is sufficiently resourced with involuntary treatment beds, options for less restrictive alternatives, and funds necessary to provide timely and appropriate treatment.

Certain provisions related to substance use disorder programs are repealed, including provisions relating to comprehensive statewide regional treatment programs, an interdepartmental coordinating committee, and the confidentiality of records.

EFFECT OF CHANGES MADE BY HUMAN SERVICES, MENTAL HEALTH & HOUSING COMMITTEE (Recommended Amendments): DSHS must establish a phased implementation plan for the statewide implementation ICR in collaboration with BHOs and full integration regions. The plan must be submitted to the Legislature by October 1, 2016. Before ICR may be implemented in a region, the region must update its contract with DSHS or the HCA and demonstrate that it has the capacity to provide ICR services to the residents of its region. ICR requirements must only be in force in regions which have implemented ICR. The first regions in the state to implement ICR must do so by April 1, 2018. The last regions in the state to implement ICR must do so by July 1, 2026.

Chemical dependency professionals may provide a second signature for a CD ITA or ICR commitment petition. The cost of mandatory representation of the petitioner by a county prosecutor in a CD ITA proceeding must be reimbursed by the BHO or full integration region.

DSHS and HCA must convene a task force to align regulations between behavioral health and primary care settings and simplify regulations for behavioral health providers. DSHS must collaborate to reduce the costs and burdens associated with excess provider audits and review its policies related to deeming accreditation by a recognized behavioral health accrediting body as equivalent to meeting licensure requirements.

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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: We have extended implementation of this bill until 2026 to make it affordable. We need to move it forward to help address the opioid crisis which has bipartisan support. Our jails are full of people not getting the treatment they need. This will lessen the numbers of people who end up in psychiatric care when they really need is substance use treatment, at one fifth of the cost. Physician assistants are graduate-prepared licensed providers with prescriptive authority. It is now more competitive to get into PA school than medical school. PAs face barriers to employment in mental health because of legal restrictions; these should be lifted to avoid confusion in the future. About 30% of persons detained under the mental health law would be more appropriated detained in chemical dependency settings. This is a savings opportunity. Our concern last session about the capacity for chemical dependency detention are alleviated by the extension of the

implementation timeline to 2026. I have written a poem. Because I could not be committed for substance use treatment, I nearly died, and cost the system hundreds of thousands of dollars. I am now clean and sober and going back to school to complete my degree in aerospace engineering. I have worked as a mental health professional since 1968, and worked in a pilot version of this program that operated between 2006-2009. We saved over $7 million just in Medicaid costs, not counting criminal justice savings. This helps you not put people in hospitals who don't belong there. We know that it works. My granddaughter became a psychotic meth addict, and we couldn't find help in Washington because there is no mandate for treatment. She was raped and witnessed acts of violence. We hired strangers to kidnap her and take her to another state for treatment, because there is no commitment law in Washington. How many more families have to go through this? Our son became suicidal because of his addiction, resulting in five emergency calls. He overdosed and was saved in the emergency room, but released the next morning. Finally he went to jail. I was arrested 22 times between the ages of 19 and 28 and was hospitalized six times with over $260,000 of medical bills covered by Medicaid. It took a prison sentence to get me the treatment I needed for the brain disease of addiction. If someone had committed me earlier, this could have been avoided. I am a U.S. Army veteran and work with other veterans. I have many friends with addiction problems, anything to numb the pain. This will activate VA benefits and bring treatment money into the state. In my son's eyes, he did not have a problem. He went to prison following an episode of meth psychosis with no treatment. Imagine how painful it is for a parent to go to the police to set up their child for arrest, just to keep him and the community safe and alive. He is now serving a 5-year sentence in maximum security without treatment, because there are no alternatives for patients who resist treatment. So much heartache and so many criminal justice costs could be avoided with access to involuntary treatment.

OTHER: Do not open the door to having inexperienced individuals sign commitment petitions impacting a person's liberty. The supervising doctor should be required to examine the patient. This bill will add to the boarding crisis. Any actions to increase chemical dependency detentions should be accompanied by adequate funding for treatment beds.

Persons Testifying: PRO: Representative Cody, prime sponsor; Seth Dawson, National Alliance on Mental Illness, NAMI WA; Kate White Tudor, WA Academy of Physician Assistants; Michael Shaw, King County; Joan Miller, WA Council for Behavioral Health; Lauren Davis, Ricky Garcia, Paulette Chaussee, Barry Antos, WA Recovery Alliance; Michelle Karrer, Bradley Johansen, Scot Pondelick, Kathy Frasier, Change Addiction Now.

OTHER: Mike De Felice, WA Defender Assn., WA Assn. of Criminal Defense Attorneys.

Persons Signed In To Testify But Not Testifying: No one.