HOUSE BILL REPORT
SSB 6259

As Passed House - Amended:
March 5, 2020

Title: An act relating to improving the Indian behavioral health system in this state.

Brief Description: Improving the Indian behavioral health system.

Sponsors: Senate Committee on Behavioral Health Subcommittee to Health & Long Term Care (originally sponsored by Senators McCoy, Hasegawa, Stanford, Wilson, C., Das, Nguyen, Van De Wege and Darneille).

Brief History:
Committee Activity:
Health Care & Wellness: 2/21/20, 2/25/20 [DPA];
Appropriations: 2/29/20, 3/2/20 [DPA(HCW)].
Floor Activity:
Passed House - Amended: 3/5/20, 97-0.

Brief Summary of Substitute Bill
(As Amended by House)

- Directs the Health Care Authority (Authority) to coordinate with the federal Centers for Medicare and Medicaid Services to allow for federal funding for behavioral health aide services.
- Authorizes the Authority to appoint a designated crisis responder upon consultation with a federally recognized Indian tribe or conferring with an Indian health care provider.
- Recognizes that each Indian tribe has jurisdiction as to the involuntary commitment of an American Indian or Alaska Native to an evaluation and treatment facility located within the boundaries of the tribe.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 15 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Caldier, Assistant Ranking

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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.

Minority Member; Chambers, Chopp, Davis, DeBolt, Harris, Maycumber, Riccelli, Robinson, Stonier, Thai and Tharinger.

Staff: Chris Blake (786-7392).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended by Committee on Health Care & Wellness. Signed by 33 members: Representatives Ormsby, Chair; Robinson, 1st Vice Chair; Bergquist, 2nd Vice Chair; Stokesbary, Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Rude, Assistant Ranking Minority Member; Caldier, Chandler, Chopp, Cody, Corry, Dolan, Dye, Fitzgibbon, Hansen, Hoff, Hudgins, Kilduff, Kraft, Macri, Mosbrucker, Pettigrew, Pollet, Ryu, Schmick, Senn, Springer, Steele, Sullivan, Sutherland, Tarleton, Tharinger and Ybarra.

Staff: Andy Toulon (786-7178).

Background:

The Governor's Indian Health Advisory Council.

In 2019 the Governor's Indian Health Advisory Council (Council) was established in statute. The Council consists of representatives from tribes, urban Indian organizations, the Legislature, and the Governor's Office. The Council includes a Reinvestment Committee which is charged with developing the Indian Health Improvement Advisory Plan which must include an assessment of Indian health and health care in Washington and specific recommendations for programs, projects, and activities. Some of the programs, projects, and activities may relate to:

- creating and expanding facilities operated by Indian Health Services, tribes, and urban Indian health programs providing evaluation, treatment, and recovery services for substance use disorders, mental illness, or specialty care;
- improving access to, and utilization of, culturally appropriate primary care, mental health, and substance use disorder and recovery services;
- eliminating barriers to, and maximization of federal funding of, substance use disorder and mental health services in medical assistance programs;
- increasing availability of, and identification of barriers to, crisis and related services under the Involuntary Treatment Act, with recommendations to increase access, including involuntary commitment orders, designated crisis responders, and discharge planning;
- increasing access to quality, culturally appropriate, trauma-informed specialty services, including psychiatric services; and
- developing a community health aide program, including a community health aide certification board for Washington and support for community health aide services.

With respect to activities related to the development of community health aide programs, in 1992 the federal government formally established the Community Health Aide Program (Program) in Alaska. The Program trains persons to become community health aides, develops curricula, and establishes a certification board. Community health aides provide

health care, health promotion, and disease prevention services in American Indian and Alaska Native communities. The federal Affordable Care Act expanded the Program nationally to allow tribes in other states to develop their own programs.

Designated Crisis Responder Responsibilities.

The Involuntary Treatment Act (ITA) sets forth the procedures, rights, and requirements for involuntary behavioral health treatment of adults. Persons may be committed by a court for involuntary behavioral health treatment if they, due to a mental health or substance use disorder, pose a likelihood of serious harm, are gravely disabled, or are in need of assisted outpatient behavioral health treatment.

A designated crisis responder is a mental health professional responsible for investigating and determining whether a person may be in need of involuntary treatment. If the designated crisis responder finds a basis for commitment, the designated crisis responder may detain or petition a court to order detention for the person for up to 72 hours, excluding weekends and holidays, to an evaluation and treatment facility, secure detoxification facility, or approved substance use disorder treatment facility. Designated crisis responders are designated by a county or an entity appointed by a county.

Under the ITA, a designated crisis responder is responsible for conducting an evaluation and investigation based on relevant, credible, and timely information to determine if:

- there is evidence that a referred person may suffer from a mental disorder or substance use disorder;
- there is evidence that the person, as a result of a mental disorder or substance use disorder, presents a likelihood of serious harm to themselves, other people, other's property, or the referred person may be gravely disabled; and
- the referred person refuses to seek appropriate treatment options, and no less restrictive alternative is available.

An evaluation and investigation must occur before a petition for detention is filed. If a designated crisis responder decides not to detain a person for initial detention evaluation and treatment or if 48 hours have passed since a designated crisis responder received a request for investigation and has not taken action to have the person detained, an immediate family member or guardian or conservator of the person may petition the superior court for initial detention.

When a person subject to an involuntary commitment order is discharged from a facility providing involuntary treatment services, including an evaluation and treatment facility, state hospital, acute withdrawal management and stabilization facility, or a substance use disorder treatment program, the facility must notify the designated crisis responder who was responsible for the initial commitment.

Summary of Amended Bill:

Involuntary Treatment Act.

A designated crisis responder may be a mental health professional appointed by the Health Care Authority (Authority) in consultation with a federally recognized Indian tribe or after meeting and conferring with an Indian health care provider. When a designated crisis responder is investigating or evaluating a person for potential initial detention or involuntary outpatient treatment and the designated crisis responder knows the person is an American Indian or Alaska Native from a tribe in Washington, the designated crisis responder must notify the tribe or Indian health care provider as to whether or not a petition will be filed. The notification must occur within three hours and be made to the tribal contact identified in the Authority's tribal crisis coordination plan. Facilities discharging a person who has been subject to an involuntary commitment order must provide notice of the discharge to federally recognized tribes and Indian health care providers who have been appointed by the Authority as designated crisis responders. Tribal courts and Indian health care providers are added to provisions allowing for the disclosure of mental health information.

Each Indian tribe is recognized to have jurisdiction exclusive to the state regarding the involuntary commitment of an American Indian or Alaska Native to an evaluation and treatment facility located within the boundaries of the tribe. The jurisdiction does not apply if a tribe has either consented to concurrent jurisdiction with the state or the tribe has expressly declined to exercise its exclusive jurisdiction. Tribal court orders for involuntary commitment are to be recognized and enforced according to superior court rules governing tribal court jurisdiction. A federally recognized tribe may petition the superior court for the initial detention of a person who is a member of that tribe if the designated crisis responder decides not to detain a person for evaluation and treatment or if 48 hours have passed since receiving a request for investigation.

The Authority, in consultation with the tribes and in coordination with Indian health care providers and the American Indian Health Commission for Washington State, must establish written guidelines for conducting culturally appropriate evaluations of American Indians or Alaska Natives by June 30, 2021.

Beginning October 1, 2020, the Authority must submit an annual report on psychiatric treatment and evaluation and bed utilization for American Indians and Alaska Natives. The report must be made available for review by tribes, urban Indian health programs, and the American Indian Health Commission for Washington State. The Authority must include Indian health care providers in any bed tracking system that it creates.

Tribal Participation in the Community Behavioral Health System.

The Authority must coordinate with the federal Centers for Medicare and Medicaid Services to obtain approval for behavioral health aide services to receive federal funding up to 100 percent. "Behavioral health aides" are defined as counselors, health educators, and advocates who help address individual and community-based behavioral health needs and are certified by a community health aide program of the Indian Health Service or one or more tribal organizations. A behavioral health aide may address behavioral health needs such as alcohol abuse, drug abuse, tobacco abuse, grief, depression, and suicide.

Indian health care providers who have community behavioral health programs are eligible for the grants that are available to behavioral health administrative services organizations and managed care organizations.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for section 203, relating to grants to Indian health care providers who have community behavioral health programs, which takes effect July 1, 2021, and section 303, relating to the jurisdiction of Indian tribes regarding involuntary commitments, which takes effect July 1, 2026.

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) Health care provided and delivered by tribes is the most effective way to support tribal self-determination and ensure active participation by tribal members in their health. Tribal communities are affected by the highest rates of suicide, opiate overdoses, and domestic violence. This bill will help support some of the work that tribes are currently doing in their communities by bringing services to people in their time of need, such as crisis outreach teams. This bill addresses the suicide and addiction crisis among American Indians and Alaska Natives while recognizing the authority of tribal governments to act as a public health authority. This bill will allow access to the Indian Health Improvement Account to fund prevention and postvention activities. Tribal members at high risk for suicide require higher levels of care, but are not being admitted to hospitals. Recognizing the sovereign authority of tribes and the Governor's Indian Health Council as the lead in drafting recommendations is key to getting the appropriate services. Tribes often experience lengthy delays in accessing the services of a designated crisis responder. Indian health care providers must be among the entities eligible to receive available resources for the delivery of behavioral health services. Indian health care provider assessments must be taken into consideration to assure that patients receive culturally competent care. This bill will address stigma, lack of resources, and lack of education. This bill includes pieces from other bills to integrate tribal care and the contemporary health care system.

Health care provided by tribes gets tribal members the right care at the right time in a culturally appropriate manner. This bill is grounded in strengthening the cultural workforce and allowing for a cultural response. Strengthening cultural identity is one of the best preventative mechanisms and one of the best interventions. This bill is an opportunity to place people in facilities and services that are attuned to native people. This bill comes from the stories of loss and grief from all tribal communities and urban communities. Culturally appropriate training must have input from tribes. There are many services that mainstream providers are not able to provide that tribes may offer. Tribal members should be able to receive tribal services that they are familiar with from people who know them. Tribal members who are looking for referrals for mental health services ask for native providers because culture represents values and it is important for patients to feel comfortable with their provider.

(Opposed) None.

Staff Summary of Public Testimony (Appropriations):

(In support) Last session, two Indian health care policy bills passed. One of the bills was designed to capture all of the federal Medicaid match for tribal health care so that the state only pays what it should, and the tribes get the full reimbursement they deserve by treaty and by executive order. The second bill was nursing home reimbursements. The policy of Substitute Senate Bill 6259 is trying to synchronize the system so that Indian health care works on and off the reservation. For the Colville Tribe, some 2,400 people live in Spokane County, so they actually have access to health care. However, for those who live in rural Washington, this might not be the case. The merger of the policy bills in the Senate was positive, and money is not the issue; it's getting the policy right.

(Opposed) None.

Persons Testifying (Health Care & Wellness): Nickolaus Lewis, Lummi Nation; Esther Lucero, Seattle Indian Health Board; Vicki Lowe, American Indian Health Commission; Richard Moses and Michael Moran, Confederated Tribes of the Colville Reservation; and Karen Lizzy and Tanya Marceau, Cowlitz Indian Tribe.

Persons Testifying (Appropriations): Michael Moran, Confederated Tribes of the Colville Reservation.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): None.

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