HOUSE BILL REPORT
E2SHB 1450

As Passed House:
March 9, 2015

Title: An act relating to involuntary outpatient mental health treatment.

Brief Description: Concerning involuntary outpatient mental health treatment.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Jinkins, Rodne, Walkinshaw, Harris, Cody, Goodman, Senn, Walsh, Riccelli, Robinson, Orwall, Moeller, Gregerson, Van De Wege, Ormsby, Clibborn, McBride, Tharinger, Kagi and Stanford).

Brief History:
Committee Activity:
Judiciary: 1/28/15, 2/19/15 [DPS];
Appropriations: 2/26/15, 2/27/15 [DP2S(w/o sub JUDI)].
Floor Activity:
Passed House: 3/9/15, 90-8.

Brief Summary of Engrossed Second Substitute Bill

- Provides that a person meeting the definition of "in need of assisted outpatient mental health treatment" may be committed by a court for involuntary mental health treatment on a less restrictive alternative to an inpatient order.
- Identifies the services that an order for less restrictive alternative treatment under the Involuntary Treatment Act must and may include.
- Provides that a court may commit a person for involuntary mental health treatment on a less restrictive alternative order for up to one year, rather than up to 180 days, if the person's previous commitment term was commitment to a state hospital.
- Requires courts to consider certain information when deciding whether to revoke or modify less restrictive commitment orders.

HOUSE COMMITTEE ON JUDICIARY

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.

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 13 members: Representatives Jinkins, Chair; Kilduff, Vice Chair; Rodne, Ranking Minority Member; Shea, Assistant Ranking Minority Member; Goodman, Haler, Hansen, Kirby, Klippert, Muri, Orwall, Stokesbary and Walkinshaw.

Staff: Omeara Harrington (786-7136).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Judiciary. Signed by 31 members: Representatives Hunter, Chair; Ormsby, Vice Chair; Chandler, Ranking Minority Member; Parker, Assistant Ranking Minority Member; Wilcox, Assistant Ranking Minority Member; Buys, Carlyle, Cody, Condotta, Dent, Dunshee, Fagan, Haler, Hansen, Hudgins, S. Hunt, Jinkins, Kagi, Lytton, MacEwen, Magendanz, Pettigrew, Sawyer, Schmick, Senn, Springer, Stokesbary, Sullivan, Tharinger, Van Werven and Walkinshaw.

Minority Report: Do not pass. Signed by 2 members: Representatives G. Hunt and Taylor.

Staff: Andy Toulon (786-7178).

Background:

Standards for Involuntary Mental Health Treatment.
A person may be committed by a court for involuntary mental health treatment under the Involuntary Treatment Act (ITA) if he or she, due to a mental disorder, poses a likelihood of serious harm or is gravely disabled. "Likelihood of serious harm" means that a person poses a substantial risk of physical harm to self, others, or the property of others, as evidenced by certain behavior, or that a person has threatened the physical safety of another and has a history of one or more violent acts. "Grave disability" means that a person is in danger of serious physical harm due to a failure to provide for his or her own essential human needs, or that a person manifests a severe deterioration in routine functioning, evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions, and is not receiving the care essential for health or safety.

Involuntary Mental Health Commitment Procedures.
The commitment cycle begins with an initial evaluation period of up to 72 hours. Within the initial 72-hour evaluation period, the professional staff of the treatment facility providing the evaluation may petition the court to have the person committed for further mental health treatment. Following a hearing, if the person is found 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. Upon subsequent petitions and hearings, a court may order up to an additional 90 days of commitment, followed by up to 180 days of commitment.

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 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. An LRA order may be modified or revoked if the person is failing to adhere to the terms and conditions of his or her release, is substantially deteriorating or decompensating, or poses a likelihood of serious harm.

At the 180-day order stage, additional grounds exist under which a person may be committed for LRA treatment. These additional grounds do not require the petitioner to show that the person meets either the likelihood of serious harm or grave disability standard and only apply when the petition is for continued LRA treatment for someone currently committed under an LRA. The additional grounds for a petition for continued treatment under the LRA are that:

- the person has been involuntarily committed to detention for mental health treatment during the 36 months preceding the initial detention in the current commitment cycle, excluding any time spent in a mental health facility or in confinement as a result of a criminal conviction;
- the person is unlikely to voluntarily participate in outpatient treatment without an order for LRA treatment, in view of the person's treatment history or current behavior; and
- outpatient treatment that would be provided under an LRA order is necessary to prevent a relapse, decompensation, or deterioration that is likely to result in the person presenting a likelihood of serious harm or the person becoming gravely disabled within a reasonably short period of time.

Successive 180-day inpatient or LRA commitment orders are permissible on the same grounds and pursuant to the same procedures as the original 180-day commitment. However, commitment is not permissible on the alternative grounds to likelihood of serious harm or grave disability if 36 months have passed since the date of discharge from inpatient treatment that preceded the current LRA order.

Summary of Engrossed Second Substitute Bill:

Commitment Based on a Finding of "In Need of Assisted Outpatient Mental Health Treatment."

In addition to likelihood of serious harm and grave disability, a person may be committed for involuntary mental health treatment under the ITA if that person is "in need of assisted outpatient mental health treatment" (in need of AOT). Upon a petition at any stage in the commitment cycle, a court may order a person's commitment on any proven statutory standard. However, commitment for a 72-hour evaluation, if based solely on the person being in need of AOT, may only be for an outpatient evaluation. Similarly, commitment for further treatment, if based solely on the person being in need of AOT, may only be for an LRA order, and may not be for inpatient treatment.

A person is in need of AOT if the person, as a result of a mental disorder:

- has been involuntarily committed to detention for involuntary mental health treatment at least twice during the preceding 36 months, or, if currently committed, the person has been involuntarily committed to detention at least once during the 36 months preceding the initial detention in the current commitment cycle;

- is unlikely to voluntarily participate in outpatient treatment without an LRA order, in view of treatment history or current behavior;
- is unlikely to survive safely in the community without supervision;
- is likely to benefit from LRA treatment; and
- requires outpatient treatment that would be provided under an LRA order to prevent a relapse, decompensation, or deterioration that is likely to result in the person presenting a likelihood of serious harm or the person becoming gravely disabled within a reasonably short period of time.

The 36-month calculation excludes any time spent in a mental health facility or in confinement as a result of a criminal conviction.

Less Restrictive Alternative Treatment.
Less restrictive alternative treatment is defined as a program of individualized treatment in a less restrictive setting that involves certain services identified in statute. LRA treatment must include, at a minimum:
- assignment of a care coordinator;
- an intake evaluation with the LRA provider;
- a psychiatric evaluation;
- medication management;
- a schedule of regular contacts with the provider of LRA treatment services for the duration of the order;
- a transition plan addressing access to continued services at the expiration of the order; and
- an individual crisis plan.

Less restrictive alternative treatment may also include: psychotherapy; nursing; substance abuse counseling; and support for housing, benefits, education, and employment.

A petition seeking a person's commitment to an LRA must set forth a proposed plan for LRA services. In entering an LRA order, the court must identify the services the person committed to the LRA will receive. If the petitioner did not provide a proposed plan for LRA services, the court may postpone the issuance of the order for up to five judicial days and require the petitioner to submit a proposal for LRA services. The court may order additional evaluation of the person if necessary to identify appropriate services.

Regional support network (RSN) contracts must require the RSN to provide statutorily identified services to persons court ordered to LRA treatment who (1) are enrolled in Medicaid and meet RSN access to care standards; or (2) are not enrolled in Medicaid and do not have other insurance to pay for services, if the RSN has adequate available resources to provide the services.

Duration of LRA Orders.
When entering an LRA order for a person eligible for up to 180 days of involuntary mental health treatment, a court may enter an order for up to one year of treatment, rather than for up to 180 days, if the person's previous commitment term was for inpatient treatment in a state hospital. Subsequent orders are for up to 180 days.

Early Release, Modification, and Revocation of LRA Orders.
In deciding whether to modify or revoke a LRA order, the court must consider the person's symptoms and behavior in light of all available evidence concerning the person's historical behavior. Evidence of the person's historical behavior may include information provided by credible witnesses, including family and others with significant contact and history of involvement with the person. If the basis for the revocation petition is that the person has failed to comply with the terms of his or her order, the court must give great weight to information regarding symptoms or behavior that:

- are closely associated with symptoms or behavior that preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts;
- represent a marked and concerning change in the baseline behavior of the person; and
- indicate that without modified terms or return of the person to the facility, continued deterioration is probable.

If a person committed to an LRA based on a finding of in need of AOT is not compliant with the commitment order, is substantially deteriorating or decompensating, or poses a likelihood of serious harm, the order may be modified. However, if inpatient treatment is sought, the inpatient treatment must be initiated under a new petition for involuntary treatment.

An LRA order based on a person being in need of AOT must terminate early in some circumstances. Early termination is required when, in the opinion of the professional person in charge of the LRA treatment provider: (1) the person is prepared to accept voluntary treatment; or (2) the outpatient treatment ordered is no longer necessary to prevent relapse, decompensation, or deterioration that is likely to result in the person presenting a likelihood of serious harm or the person becoming gravely disabled within a reasonably short period of time.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on March 3, 2015.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed, except for sections 2, 12, and 16, which because of prior delayed effective dates, take effect April 1, 2016. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony (Judiciary):

(In support) This kind of bill has been heard in the past. This will get people treatment earlier and will result in fewer mental health and forensic commitments. New York and other states with similar laws have seen success in terms of driving outpatient care. New York's system also invested in housing and wraparound services. Within a year there were savings on inpatient commitments. Net costs declined 50 percent in the first year the assisted outpatient program began, with an additional 13 percent the following year. Whether those figures will transfer to Washington is uncertain. The fiscal note will not reflect those savings, but there is research and data indicating how well it works.

This is an effort to be caring neighbors and community members. It is less restrictive, less expensive, and more humane. Using the least restrictive placement is constitutionally required. People will be intensively monitored. Assisted outpatient mental health treatment is not just a court order, it requires investment in the system and coordination with services. Most of the necessary services exist, but they are far from universal and not as consistently available as they need to be. A fully funded program should involve case management, care coordination, engagement with wraparound services like medication management, housing, substance use disorder treatment, and employment. This can reduce recidivism if it is properly funded, and avoid a revolving door of involuntary treatment and jail stays. It will not be an answer for all people and will not eliminate the need for beds.

(With concerns) Anything to promote outpatient care is a good thing and will lead to dramatic savings. This bill is a good idea, but not as written and should be put off for a stakeholder review. The case law is clear that mental illness without more is not a constitutional basis for commitment; the standard is missing the requisite dangerousness If a person has a commitment history and could meet traditional commitment criteria in the future, they could be committed under this bill. There is a significant deprivation of liberty at stake, even with outpatient treatment. Being required to take psychiatric drugs is intrusive. In terms of structure, it would be better to have this alternative set aside in its own section of the ITA. There are several missing details, including how clients will be contacted, how and where evaluations will take place, and what happens in the event of noncompliance. Other vague areas include the reference to treatment history, which should be limited to mental health treatment history. Kendra's Law and Laura's Law should serve as models.

(Opposed) This introduces a new, lower standard for treatment, that is a large departure from current standards requiring imminent danger. Any involuntary treatment is a significant intrusion on liberty. Constitutional standards have to be met before a commitment takes place. These people have not broken any laws. The definition is too vague and is more appropriate for someone who needs voluntary services.

People may not have good outcomes if forcibly medicated, and there are better outcomes with trauma focused care. People should be able to make their own decision on whether to be on medication, as medication is expensive and often has serious and detrimental side effects. This is akin to chemotherapy. People sometimes decide it is not worth going through with it. It is a different matter when people are posing a danger to others, but when the danger is just to themself, the person should be allowed the dignity to not go through with medical intervention as is the case with every other illness.

(Other) There are counties that have programs like this and are viewing this as an extension. There have been concerns in the past as to whether there would be funding for something like this. There are a lot of moving pieces with the ITA this year. After cutoff, all of those pieces should be looked at in total to see how they all fit together. There is an opportunity here from a budget and resource standpoint, and the Legislature would be remiss to not take advantage of it. Given the capacity of the system, some of this may need to be phased in.

It would be better to invest in community supports, like a warm line. People do not necessarily need crisis treatment, just someone to talk to. Not everyone needs to be

involuntarily treated, but there is a need for more safe places for people who have mental illness.

Staff Summary of Public Testimony (Appropriations):

(In support) At its most basic, this bill commits a person to accept outpatient treatment if they need it, but it also commits the mental health system to providing that treatment. People have been boarding at hospitals because mental health beds are full. There has been a backup of competency evaluations and restorations following arrests. Just like any other illness, early intervention works, and this bill provides an opportunity to provide treatment before something bad happens and the person has to be put in the most expensive treatment settings.

In New York, there are five counties that are providing AOT. Their net costs declined 49 percent in the first year and an additional 27 percent in the second year. There have been similar results in North Carolina. This will not work, however, unless there is an investment in outpatient treatment.

This approach is used in Arizona where someone who is released from a hospitalization is required to receive AOT for a year. This bill allows for the AOT to be provided prior to a hospitalization which will reduce the need for hospital beds. Assisted outpatient treatment costs about $3,500 a month which is cheaper than $30,000 a week in the hospital.

This bill provides treatment in a less restrictive setting. The fiscal implications are therefore positive as well because the services are provided more economically. There are a wealth of studies that have been done on AOT and the consistent finding has been that it substantially reduces psychiatric hospitalizations. Further work is needed on the fiscal note in order to correctly estimate offsets.

(In support with concerns) Assisted outpatient treatment provides a huge difference and allows for treatment to be provided sooner rather than later. New York has a long tradition of very amply funding mental health services so a program like this has a much lower hurdle in terms of saving money. In order for this to work, it must be adequately funded. Significant outreach into the community to engage these individuals requires resources at the community level. Without funding, this will not be any more effective than the current system for ordering less restrictive alternative commitment orders.

(With concerns) The bill does not speak to what happens to people in emergency departments who are determined to need an outpatient mental health evaluation. The bill should be clarified so that once a hospital has met federal regulations for stabilizing a patient, they will be discharged. The original fiscal note understated the number of people who might qualify for these services.

(Opposed) Any outpatient order that is based on prior history will not survive a constitutional challenge. Stakeholders involved in civil commitment courts should be brought together to hammer out a workable, lawful outpatient program.

Persons Testifying (Judiciary): (In support) Representative Jinkins, prime sponsor; and Bob Winslow, Marilyn Roberts, and Seth Dawson, National Alliance on Mental Illness.

(With concerns) Mike De Felice, Washington Defender Association and Washington Association of Criminal Defense Attorneys.

(Opposed) Michael Truog; and Helen Nilon, Behavioral Health and Wellness.

(Other) Brian Enslow, Washington Association of Counties; and Marie Jubie.

Persons Testifying (Appropriations): (In support) Representative Jinkins, prime sponsor; Doug Reuter; and Seth Dawson, National Alliance on Mental Illness.

(In support with concerns) Gregory Robinson, Washington Community Mental Health Council.

(With concerns) Len McComb, Washington State Hospital Association.

(Opposed) Mike De Felice, King County Department of Public Defense.

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

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