HOUSE BILL REPORT
E2SSB 5649

As Passed House - Amended:
April 14, 2015

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

Brief Description: Concerning the involuntary treatment act.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Darneille, Miloscia, Fraser, Keiser, Parlette, Benton, McCoy and Dammeier).

Brief History:
Committee Activity:
Judiciary: 3/24/15, 4/1/15 [DPA];
Appropriations: 4/6/15, 4/7/15 [DPA(JUDI & APP)].
Floor Activity:
Passed House - Amended: 4/14/15, 90-7.

Brief Summary of Engrossed Second Substitute Bill
(As Amended by House)

- Requires regional support networks to administer an adequate network of evaluation and treatment services to ensure access to treatment, and creates reporting and response procedures for instances in which a person is deemed to meet initial detention criteria but no evaluation and treatment bed is available.
- Allows the Department of Social and Health Services (DSHS) to use the single bed certification process as outlined in rule to provide additional treatment capacity when an evaluation and treatment bed is not available.
- Exempts time prior to medical clearance from the timelines for examinations and initial detention decisions in the Involuntary Treatment Act, and states a presumption that involuntary treatment cases will be decided on their merits rather than dismissed for timeline violations.
- Requires the Washington State Institute for Public Policy to conduct an assessment of the use of the nonemergent detention process and less restrictive alternative orders under the Involuntary Treatment Act.
- Provides the DSHS and the state hospitals with access to files and records of court proceedings involving involuntary treatment, and makes other minor

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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.

changes to the statute regarding access to court files and records in these cases.

HOUSE COMMITTEE ON JUDICIARY

Majority Report: Do pass as amended. Signed by 12 members: Representatives Jinkins, Chair; Kilduff, Vice Chair; Rodne, Ranking Minority Member; Goodman, Haler, Hansen, Kirby, Klippert, Muri, Orwall, Stokesbary and Walkinshaw.

Minority Report: Do not pass. Signed by 1 member: Representative Shea, Assistant Ranking Minority Member.

Staff: Omeara Harrington (786-7136).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended by Committee on Judiciary as further amended by Committee on Appropriations. Signed by 30 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, 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:

Involuntary Mental Health Commitment Procedures.
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.

The commitment cycle begins with an initial evaluation period of up to 72 hours at an evaluation and treatment facility (E&T) initiated by a designated mental health professional (DMHP). In emergency cases, a DMHP may detain a person without a court order if the likelihood of serious harm or grave disability is imminent. In non-emergency cases where

the likelihood of serious harm or grave disability is not imminent, a DMHP may detain a person only upon a court order. An E&T is defined as any facility that can provide directly or by arrangement with other agencies emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and that is certified as such by the Department of Social and Health Services (DSHS). The DSHS contracts with regional support networks (RSNs) to provide E&T services.

Within the initial 72-hour evaluation period, the professional staff of the E&T facility may petition the court to have a person committed for further mental health treatment. Following a hearing, 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 at a state hospital, followed by successive terms of 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 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. 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.

Single Bed Certification.
Under a "single bed certification" the DSHS is authorized by rule to certify a single bed for an ITA detention outside of an E&T in certain circumstances. The Washington Supreme Court recently decided *In re D.W.*, 181 Wn.2d 201 (2014), in which the court determined that the ITA and administrative rules do not allow the DSHS to approve a single bed certification to avoid overcrowding at certified E&T facilities. A single bed certification is only authorized if the person requires a service that is not available at an E&T, such as a medical service, or if being at a community facility would facilitate continuity of the person's care.

The DSHS has enacted emergency rule changes allowing the DSHS to grant a single bed certification to a facility that is willing and able to provide timely and appropriate treatment, either directly or by arrangement with other agencies. Examples of facilities that may be approved for single bed certifications include residential treatment facilities, psychiatric hospitals, hospitals with a psychiatric unit, and hospitals that can provide psychiatric services.

Timelines for Initial Detention Assessments and Decisions.
When a person is held for initial evaluation in an emergency room, triage facility, or crisis stabilization unit, a DMHP must detain the person to an E&T or release the person within six hours of the time that facility staff determines a DMHP evaluation is necessary. When a person is delivered to a facility by law enforcement, a mental health professional must examine the person within three hours of arrival at the facility, and a DMHP must determine within 12 hours of the person's arrival whether the person meets the criteria for a 72-hour initial detention. Each person involuntarily detained and accepted or admitted at an E&T must be examined and evaluated by a combination of two medical professionals within 24

hours including licensed physicians, mental health professionals, and advanced registered nurse practitioners.

A 2002 Washington State Supreme Court Case, *In re C.W.* (147 Wn.2d 259), analyzed violations of the six-hour timeline. The court expressed that the law favors deciding involuntary commitment cases on their merits rather than dismissing them for procedural irregularities, and held that a time violation does not necessarily require dismissal of the commitment proceeding. Dismissal would be appropriate if the requirements of the statute were totally disregarded by hospital staff or by the DMHP.

Access to Court Files and Records.
The files and records of court proceedings regarding involuntary treatment are closed and only accessible to persons and entities listed in statute. Files and records are accessible to: any person who is the subject of an involuntary treatment petition; the subject of the petition's attorney or guardian ad litem; resource management services; and service providers authorized to receive such information by resource management services.

Summary of Amended Bill:

Evaluation and Treatment Capacity.
Regional support networks must provide for an adequate network of E&T services to ensure access to treatment for persons who meet ITA detention criteria. The DSHS must collaborate with RSNs and the Washington State Institute for Public Policy to estimate the capacity needed for E&T services within each regional service area. Each RSN must develop and maintain an adequate plan to provide for E&T service needs.

A DMHP must submit a report to the DSHS within 24 hours if the DMHP determines that an adult or minor meets detention criteria but there are not any E&T beds available and the person cannot be served through a single bed certification or LRA. The DSHS must develop a standardized form for DMHP reports, which, at a minimum, must contain identifying information for the person, identification of the responsible RSN, a list of facilities that refused to admit the person, and other information. The DSHS must promptly share reported information with the responsible RSN and require the RSN to attempt to engage the person in services and report back within seven days.

The DSHS must track and analyze these reports and initiate corrective action when appropriate to ensure each RSN has implemented an adequate plan to provide E&T services. Corrective action may include enforcement of contract remedies and requiring expenditure of reserve funds. An adequate plan may include development of LRAs such as crisis triage, crisis diversion, voluntary treatment, or prevention programs. The DSHS must publish quarterly reports on its website summarizing information submitted by DMHPs and the number of single bed certifications granted by category.

Single Bed Certification.
The DSHS may approve a single bed certification according to the process outlined in rule to provide additional treatment capacity when an E&T bed is not available. Placement must be in a facility that is willing and able to provide timely and appropriate treatment to the detained person. A single bed certification must be specific to the patient receiving

treatment. A DMHP who submits an application for single bed certification in good faith belief that the single bed certification is appropriate may presume that the application will be approved for the purpose of completing the detention process and responding to other emergency calls.

Timelines for Initial Detention Assessments and Decisions.
Time prior to medical clearance does not count against: the three-hour timeline for a mental health professional examination and 12-hour timeline for a DMHP to make a detention decision when a person has been detained by law enforcement; the six-hour timeline for a DMHP's detention decision when a person was not detained by law enforcement; or the 24 hours in which a person admitted to an E&T must be examined. The six-hour and 12-hour timelines for detention decisions begin to run from the time that professional staff notifies the DMHP, rather than from the time of arrival or time the staff deems a DMHP referral is necessary.

"Medical clearance" is defined as the determination by a physician or other health care provider that a person is medically stable and ready for referral to a DMHP.

Dismissal of a commitment petition is not the appropriate remedy for a violation of the timeliness requirements except in cases where the facility staff or designated mental health professional has totally disregarded the requirements. Intent language is added stating that a presumption in favor of deciding petitions on their merits furthers both public and private interests because the individual's mental and physical well-being, as well as public safety, may be implicated by the decision to release the individual and discontinue his or her treatment.

Washington State Institute for Public Policy Study.
The Washington State Institute for Public Policy (WSIPP) is directed to complete a study by December 1, 2015, that includes an assessment of the non-emergent detention process and an analysis of LRA orders under the ITA.

The non-emergent detention assessment must examine the number of non-emergent petitions filed in each county by year, the reasons for variation in the use of the non-emergent detention process, and models used by other states for handling non-emergent commitments.

The analysis of LRA orders must include: differences across counties in the use of LRA orders and the reasons they are or are not used; monitoring practices; and the rates of, grounds for, and outcomes of petitions for revocation or modification of LRA orders. The analysis must also include a systematic review of research literature on the effectiveness of alternatives to involuntary hospitalization and approaches used in other states to monitor and enforce LRA orders, and the costs associated with those approaches.

Access to Court Files and Records.
In addition to persons and entities listed in current law, the DSHS and the state hospitals may access files and records of involuntary treatment court proceedings. Current law is amended to allow guardians, rather than guardians ad litem, to access records. It is specified that the access granted to resource management services pertains to resource management services for the person who is the subject of the petition.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed, except sections 10 and 14, which due to prior delayed effective dates take effect April 1, 2016, and sections 1 through 9 and 11 through 13, relating to adequate evaluation and treatment services, single bed certification, and timelines for initial detention decisions and assessments, which take effect immediately. However, section 15 of the bill, relating to a Washington State Institute for Public Policy study on the implementation of certain aspects of the Involuntary Treatment Act, is null and void if this section is not funded in the budget.

Staff Summary of Public Testimony (Judiciary):

(In support) Quickly after this bill goes into effect there will be a reduced workload for DMHPs, savings for courts, and a reduction in the number of beds needed. People will be treated earlier and receive medication. The House language is better because it has the provisions of House Bill 1287 built into it, and contains a provision removing the automatic ejection of people off of an LRA order after three years. The current three-year expiration results in people having to decompensate and start the process over from the beginning.

Assisted outpatient treatment is a good idea, and the additional services offered could make a big difference for people who do not meet current commitment criteria. There should be some reduction in need for beds over time. Caution is warranted, however, because it has to be adequately funded.

The data reporting aspect of the bill should be supported. The Supreme Court's decision that boarding a patient without mental health treatment is illegal has had unintended consequences on the ground. Currently, there is no data being collected and no way to know when this is happening. The portions of the bill exempting time prior to medical clearance from timelines are also good.

(With concerns) With respect to the assisted outpatient treatment portion of the bill, the language in the House companion bill should be used with some alterations. There should be a requirement of a current manifestation of symptoms, as well as a clear and convincing evidence standard rather than a preponderance of the evidence standard. This measure needs full funding if it passes. In funding this, the Legislature should take the per-patient cost in the New York system and apply that to the number of patients the DSHS estimates under this bill.

(Opposed) The state's duty to ensure that there are an adequate number of E&T beds has been confirmed by the courts. The single bed certification provisions in the bill could allow the DSHS to avoid that obligation through a new single bed certification process. Some facilities listed in the bill may not provide the same level of treatment as an E&T and there is no assurance that treatment is adequate. The Supreme Court has said that treatment must be sufficient to provide realistic opportunity to be cured. The system needs to be funded appropriately, rather than establishing new single bed certification mechanisms.

Staff Summary of Public Testimony (Appropriations):

(In support) Section 3 of the bill includes a data reporting piece on how frequently there are situations when no beds are available. This is important for making sure there is good information to provide a basis for future investment decisions. Section 6 which excludes time required for medical clearance from the statutory timelines has minimal fiscal impact but is good policy.

(Opposed) There was a Washington state Supreme Court ruling that psychiatric boarding is unlawful and that individuals detained by the state have a constitutional right to receive individualized treatment. Rather than having individuals go to certified evaluation and treatment facilities where individuals get these types of services, this bill allows for the Department of Social and Health Services to adopt rules that could result in people being sent to settings where they would not receive adequate treatment. For example, it would allow for overcrowding in facilities that are already at capacity, which would result in substandard treatment for everyone. Instead of creating new mechanisms for single bed certifications as a way of getting around the court ruling, evaluation and treatment services should be funded adequately.

Persons Testifying (Judiciary): (In support) Doug Reuter; Gregory Robinson, Washington Community Mental Health Council; and Chelene Whiteaker, Washington State Hospital Association.

(With concerns) Bob Cooper, Washington Defender Association and Washington Association of Criminal Defense Lawyers.

(Opposed) Chris Kaasa, American Civil Liberties Union.

Persons Testifying (Appropriations): (In support) Lisa Thatcher, Washington State Hospital Association.

(Opposed) Shankar Narayan, American Civil Liberties Union of Washington.

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

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