SENATE BILL REPORT
E2SHB 1450

As of March 27, 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: Passed House: 3/09/15, 90-8.
Committee Activity: Human Services, Mental Health & Housing: 3/23/15.

SENATE COMMITTEE ON HUMAN SERVICES, MENTAL HEALTH & HOUSING

Staff: Kevin Black (786-7747)

Background: The Involuntary Treatment Act (ITA) allows a designated mental health professional (DMHP) to detain a person when the DMHP finds that the person, as a result of a mental disorder, presents a likelihood of serious harm or is gravely disabled, and that the person has refused voluntary treatment. Likelihood of serious harm means a substantial risk that the person will inflict serious harm on himself, herself, or others as evidenced by behavior which caused such harm or places another person in reasonable fear of sustaining such harm. Gravely disabled means that the person is in danger of serious physical harm from a failure to provide for that person's essential human needs of health or safety, or manifests severe deterioration in routine functioning and is not receiving such care as is essential for the person's health or safety.

Following the initial 72-hour detention period under the ITA, the facility providing treatment may file a petition asking the court to authorize up to 14 days of additional inpatient treatment, or may file a petition asking the court to authorize a 90-day period of involuntary outpatient treatment, known as less-restrictive alternative (LRA) treatment. A petition for inpatient or LRA treatment must be based on likelihood of serious harm or grave disability; however, a lower standard is available for a petition to extend LRA treatment if the person is already receiving treatment pursuant to an LRA order. In that case, the court may enter an order extending LRA treatment for up to 180 days if evidence indicates that the person:

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- has been court committed for inpatient treatment twice in the preceding 36 months, excluding time spent in inpatient treatment or in confinement as a result of a criminal conviction;
- in view of treatment history or current behavior, is unlikely to voluntarily participate in outpatient treatment without a court order; and
- has outpatient treatment necessary as to prevent a relapse, decompensation, or deterioration that is likely to result in the person meeting the standard for inpatient commitment within a reasonably short period of time.

The term assisted outpatient treatment refers to a model for court-ordered involuntary outpatient treatment developed in New York State and enacted in 1999, popularly known as Kendra's Law. This model is named after Kendra Webdale, a journalist who was murdered in New York City by a person diagnosed with schizophrenia.

Summary of Bill: LRA Treatment. LRA treatment is defined as a program of individualized treatment in a less-restrictive setting which includes, at a minimum, the following services:

- assignment of a care coordinator;
- an intake evaluation with the treatment provider;
- a psychiatric evaluation;
- medication management;
- a schedule of regular contacts with the treatment provider for the duration of the order;
- a transition plan addressing access to continued services at the expiration of the LRA order; and
- an individual crisis plan.

According to this definition, LRA treatment may, but need not, also include psychotherapy, nursing, substance abuse counseling, and support for housing, benefits, education, and employment. No court may fashion or approve, nor may a petitioning treatment facility propose, an LRA order unless these LRA requirements are met. An LRA order must be proposed by the petitioner. If during a detention hearing for 14, 90, or 180 days the court finds that an LRA is appropriate, but the petitioner has not proposed an LRA, the court may postpone the issuance of its order for up to five judicial days and require the petitioner to submit a proposal for LRA services.

The Department of Social and Health Services must require regional support networks (RSNs) to provide LRA services to persons enrolled in Medicaid if they meet RSN access to care standards, and require RSNs to provide LRA services to persons who are not enrolled in Medicaid and do not have insurance which covers LRA services if the RSN has adequate available resources to provide the services.

Additional criteria are provided for the court to review when considering whether to revoke an LRA order. After a period of commitment at a state hospital, a court may enter an LRA order for up to one year, instead of 180 days.

Assisted Outpatient Mental Health Treatment. A DMHP or facility treating a person detained for involuntary commitment may petition superior court for an involuntary commitment

order on the basis that a person is in need of assisted outpatient mental health treatment (AOMHT). In need of AOMHT means that a person, as the result of a mental disorder:

- has been committed by a court to ITA detention at least twice in the last 36 months, or if currently committed, has been committed once during the 36 months that preceded the current commitment period, excluding time spent in a mental health facility or criminal confinement;
- is unlikely to voluntarily participate in outpatient treatment without an LRA order;
- is unlikely to survive safely in the community without supervision;
- is likely to benefit from LRA treatment; and
- requires LRA treatment to prevent a relapse, decompensation, or deterioration that is likely to result in the person presenting a likelihood of serious harm or becoming gravely disabled within a reasonably short period of time.

A commitment order based on a finding that a person is in need of AOMHT must be an LRA order. If a person does not follow the terms of an LRA order based on AOMHT, or experiences deterioration or decompensation, a DMHP may file a revocation petition asking the court to modify the terms of the LRA, but neither the court or DMHP may place the person in detention for inpatient treatment unless a new petition is filed under the ITA alleging that the person meets detention criteria.

An LRA order based on a finding that a person is in need of AOMHT must be terminated when in the opinion of the provider the person is prepared to accept voluntary treatment, or AOMHT is no longer necessary to prevent a relapse, decompensation, or deterioration that is likely to result in the person meeting ITA detention criteria within a reasonably short period of time. A 36-month time limit on renewals of LRA treatment based on AOMHT criteria is removed.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: I proposed this bill to get more outpatient treatment services into our community, and assisted outpatient treatment is a good way to do that. It makes sense to make the same services available to all persons with LRA orders. New York has been able to use this to significantly drive down their need for inpatient beds. It is pointless to pass an outpatient treatment bill if we don't provide treatment and services to the persons who are ordered to receive it. We must adequately fund these services. Outreach is required to establish relationships with involuntary patients. Intervening before a person meets detention criteria will lead to more effective treatment and provide relief for the crisis system. This bill will take pressure off the ITA system. I support the provision that stops people from being thrown off their LRA order after 36 months.

CON: Maryland has decided against assisted outpatient treatment. Increased spending on psychiatric drugs has not improved public mental health. Recovery is better without

medication. Drugs can contribute to loss of control and make self harm more likely. Please fund upstream alternatives and respites instead that do not involve coercion. The bill as written would not survive constitutional challenge. Please amend the bill to require proof of substantial deterioration before assisted outpatient treatment may be ordered. We support community-based intervention, prevention, and recovery, but involuntary commitment is not the answer. Please create a more rigorous standard by requiring a finding of current dangerousness before treatment may be ordered. The burden of proof should be and clear and convincing evidence. This bill creates an endless commitment situation.

OTHER: We appreciate the focus on outpatient treatment and not just inpatient detention. We prefer the House version for its definition and clarity provided around how an outpatient system must be implemented. New investments should support outpatient community treatment in equal measures with detention.

Persons Testifying: PRO: Representative Jinkins, prime sponsor; Gregory Robinson, WA Community Mental Health Council; Chelene Whiteaker, WA State Hospital Assn; Doug Reuter, Eleanor Owen, citizens.

CON: Chris Kaasa, American Civil Liberties Union of WA; Mike De Felice, King County Dept. of Public Defense, WA Defender Assn., WA Assn. of Criminal Defense Lawyers; Steven Pearce, Citizens Commission on Human Rights; Michael Truog, citizen.

OTHER: Jane Beyer, Dept. of Social and Health Services; Jim Vollendroff, King County Mental Health and Substance Abuse; Brian Enslow, WA State Assn. of Counties.

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