SENATE BILL REPORT
E2SHB 1450

As Reported by Senate Committee On:
Human Services, Mental Health & Housing, March 31, 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, 3/31/15 [DPA-WM, w/oRec].

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.

Minority Report: That it be referred without recommendation.
Signed by Senator Padden.

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.

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.

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:

- 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 (Recommended Amendments): 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, residential treatment, 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. LRA treatment must be administered by a provider that is certified or licensed to provide or coordinate the full scope of services required under the LRA order. A definition of the term care coordinator is provided.

The Department of Social and Health Services (DSHS) 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. DSHS must establish caseload

guidelines for care coordinators who supervise LRA orders and guidelines for response times during and immediately following periods of hospitalization or incarceration.

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. An initial evaluation for LRA treatment based on a finding that a person is in need of AOMHT may be conducted by any combination of licensed professionals authorized to file a 90-day commitment petition and must include involvement or consultation with the agency or facility that will provide monitoring or services under the proposed LRA order.

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.

Enforcement, Modification, or Revocation of LRA orders. Agencies or facilities monitoring or providing services under LRA order and DMHPs are authorized to act to enforce, modify, or revoke an LRA order based on specified criteria. Actions must include a flexible range of responses of varying levels of intensity appropriate to the consisted circumstances with the interest of the individual and the public in personal autonomy, safety, recovery, and compliance. Available actions may include, but are not limited to the following:

- counseling, advising, or admonishing the person as to their rights and responsibilities under the court order, and offering appropriate incentives to motivate compliance;
- increasing the intensity of outpatient services provided to the person;
- requesting a court hearing for review and modification of the LRA order – the county prosecutor must assist in requesting this hearing and issuing an appropriate summons to the person;
- requesting transportation of the person to the agency or facility monitoring the LRA order or to a triage facility, crisis stabilization unit, emergency department, or E&T

facility by a peace officer or DMHP for up to 12 hours for the purpose of an evaluation to determine whether modification, revocation, or commitment proceedings are appropriate to stabilize the person and prevent decompensation, deterioration, or physical harm; and
- requesting detention to an E&T facility and initiating revocation proceedings as provided in current law.

Of these options, the last option is not available if the LRA order is solely based on the person being in need of AOMHT. In determining whether to take action under this section, the DMHP, agency, facility, and court must consider factors including information from credible witnesses, historical behavior including past violent acts, and symptoms and behaviors which have previously been associated with incidents of hospitalization, severe deterioration, or violent acts.

EFFECT OF CHANGES MADE BY HUMAN SERVICES, MENTAL HEALTH & HOUSING COMMITTEE (Recommended Amendments): New enforcement, modification, and revocation procedures are provided for LRA orders. DSHS must establish caseload and response time guidelines for care coordinators, which are defined. LRA treatment must be provided by an entity licensed or certified to administer the full scope of treatment required. Provisions are removed allowing the court to postpone issuing a decision following an involuntary commitment hearing for five judicial days and barring the court from imposing an LRA that conforms to legal requirements unless it is proposed by the petitioner.

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 on Engrossed Second Substitute House Bill: 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.