SENATE BILL REPORT
SB 5649

As Reported by Senate Committee On:
Human Services, Mental Health & Housing, February 19, 2015

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

Brief Description: Concerning involuntary outpatient mental health treatment.

Sponsors: Senators Darneille, Miloscia, Fraser, Keiser, Parlette, Benton, McCoy and Dammeier.

Brief History:
Committee Activity: Human Services, Mental Health & Housing: 2/03/15, 2/19/15 [DPS-WM].

SENATE COMMITTEE ON HUMAN SERVICES, MENTAL HEALTH & HOUSING

Majority Report: That Substitute Senate Bill No. 5649 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators O'Ban, Chair; Miloscia, Vice Chair; Darneille, Ranking Minority Member; Hargrove and Padden.

Staff: Kevin Black (786-7747)

Background: A person may be committed for involuntary treatment under the Involuntary Treatment Act (ITA) if a designated mental health professional (DMHP), following investigation and assessment of the credibility and reliability of witnesses and evidence, finds that a person, as a result of a mental disorder, presents a likelihood of serious harm or is gravely disabled, and that the person has refused or failed to accept appropriate voluntary treatment. Following the initial 72-hour detention period, the facility providing treatment may file a petition asking the court to authorize a 14-day period of further inpatient treatment, or may file a petition asking the court to authorize a 90-day period of involuntary outpatient treatment, known as less-restrictive alterative (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 commitment order. In that case, the court may enter a new commitment order extending LRA treatment for up to 180 days if evidence is available which 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
- outpatient treatment is necessary 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 32-year-old journalist who was murdered in New York City by a person diagnosed with schizophrenia. The criteria for commitment under Kendra's Law bears some similarity with the commitment criteria in the underlying bill; however, differences exist between the two laws. For example, Kendra's Law has a more flexible test for eligibility, and requires the court entering a commitment order to approve a written treatment plan for the person which includes care coordination through case management services or assertive community treatment teams. The New York State Office of Mental Health issued a final report on the status of Kendra's Law in March 2005, which contains additional information about the law.

Summary of Bill (Recommended Substitute): A DMHP or the staff of a treatment facility may file a petition for involuntary treatment under the ITA on the basis that a person is in need of assisted outpatient treatment.

A person is in need of assisted outpatient treatment if the person:
- has a mental disorder;
- 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
- outpatient treatment is necessary 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.

A commitment for assisted outpatient treatment must be for 90 days, or 180 days if the petition is filed to extend a previous commitment period of 90 or 180 days. Only outpatient treatment is available. If a petition for assisted outpatient treatment is filed for a person currently committed for a period of inpatient treatment, the petitioner need only show one court commitment during the preceding 36 months in addition to the current period of commitment.

EFFECT OF CHANGES MADE BY HUMAN SERVICES, MENTAL HEALTH & HOUSING COMMITTEE (Recommended Substitute): Clarifies that if a DMHP files a petition for assisted outpatient treatment for a person who is being held in a hospital emergency department, the person may be released once the hospital has satisfied federal and state legal requirements for appropriate screening and stabilization of patients.

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 Original Bill: PRO: This is a tool to provide the right treatment in the right place in the right time for people who need it. In New York, the investments made in new preventative and outpatient services were quickly offset by reductions in costs for more expensive care. We are open to amendments. We have ignored the needs of persons with mental illness for too long. This bill will create additional system capacity without the need for additional hospital beds. Outpatient treatment is less restrictive, less expensive, and more humane. Investment is required in the underlying services needed for recovery, including case management and care coordination, assertive outreach and engagement, and wraparound services including medication management, medical care, substance abuse treatment, and housing and employment assistance. The services that would support this bill are currently fragmentary and not universally available around the state. Voluntary engagement is always the preferred vehicle for treatment; however, assisted outpatient treatment would be welcome as one more tool to help with engagement and intervention. My daughter's life is at risk and she can't make the decision to accept treatment for herself. Persons with mental illness can grow and heal with less medication when they are treated with kindness, support, and compassion. We need to pay enough to get good therapists working in community mental health centers. My son was released after a 72-hour and 14-day commitments with no support whatsoever and just got worse and worse.

CON: We believe this solution distracts from the need to provide community-based services. Involuntary outpatient is still a significant deprivation of liberty. Research shows that compulsion does not increase the effectiveness of care, and may deter individuals by undermining the therapeutic alliance. We should not rush to drugs as the answer for recovery. We are adamantly opposed to this bill. My experience with being forcibly medicated was traumatic, and stopped me from seeking treatment for many years. Coercive treatment undermines the role of the patient in the therapeutic relationship. Patients wait months for appointments with psychiatrists that are minutes long. This is the wrong solution to our system problems.

OTHER: We support the idea of promoting outpatient treatment. Stakeholders should have the chance to get together to work this out, to study this, and perfect it. Please separate assisted outpatient treatment from inpatient detention options. Please clarify what it means to detain a person for evaluation in this bill.

Persons Testifying: PRO: Bob Winslow, Sandi Ando, Seth Dawson, George Gearhart, Candy Lowery, Charles Huffine, Tim Osborn, National Alliance on Mental Illness WA; Ann Christian, WA Community Mental Health Council.

CON: Shankar Narayan, American Civil Liberties Union of WA; Helen Nilon, Behavioral Health & Wellness; Cindy Olejar, MindFreedom Seattle; Michael Truog, David Culp, citizens.

OTHER: Mike De Felice, WA Defender Assn., WA Assn. of Criminal Defense Lawyers; Chelene Whiteacre, WA State Hospital Assn.