# SENATE BILL REPORT
# E2SSB 5649

As Amended by House, 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**: Human Services, Mental Health & Housing: 2/03/15, 2/19/15 [DPS-WM].
Ways & Means: 2/25/15, 2/27/15 [DP2S, w/oRec].
Passed Senate: 3/04/15, 46-3.
Passed House: 4/14/15, 90-7.

## 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)

## SENATE COMMITTEE ON WAYS & MEANS

**Majority Report**: That Second Substitute Senate Bill No. 5649 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Hill, Chair; Braun, Vice Chair; Dammeier, Vice Chair; Hargrove, Ranking Member; Keiser, Assistant Ranking Member on the Capital Budget; Ranker, Ranking Minority Member, Operating; Bailey, Becker, Billig, Brown, Conway, Fraser, Hasegawa, Hatfield, Hewitt, Kohl-Welles, O'Ban, Padden, Parlette, Rolfes, Schoesler and Warnick.

**Minority Report**: That it be referred without recommendation.

Signed by Senator Honeyford, Vice Chair, Capital Budget Chair.

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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.*

**Staff**: Sandy Stith (786-7710)

**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. The ITA requires persons to be detained to an evaluation and treatment facility (E&T). An E&T is defined as any facility which 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 which is certified as such by the Department of Social and Health Services (DSHS).

When a person is held for initial evaluation in an emergency room, triage facility, or crisis stabilization unit, the 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, or within 12 hours from arrival at the facility if the person was brought in by a peace officer.

In August the Washington Supreme Court decided *In re D.W.*, 181 Wn.2d 201 (2014), in which the court determined that current statutes and rules under the ITA do not allow DSHS to temporarily certify single E&T beds unless the person requires a service which is not available at an E&T, and do not authorize single bed certification based on lack of room at a regularly certified E&T facility. The court stayed the issuance of its mandate until December 26, 2014. In response DSHS enacted emergency rule changes in August, September, and December. Washington Administrative Code now allows DSHS to grant a single bed certification if the single bed certification is to a facility that is willing and able to provide timely and appropriate mental health treatment, either directly or by arrangement with other agencies. Examples of facilities that may be approved for single bed certifications include community facilities, residential treatment facilities, hospitals with psychiatric units, psychiatric hospitals, and hospitals that are willing and able to provide timely and appropriate mental health treatment. Also in response, DSHS collaborated with the Governor's Office and others to make 145 additional regularly certified E&T beds available for detention in King, Pierce, and Snohomish counties by the end of 2014, with additional expansion of beds planned in 2015.

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 commitment order. In that case, the court may enter a new commitment 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 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 Engrossed Second Substitute Bill**: Regional support networks (RSNs) must provide for an adequate network of E&T services to ensure access to treatment for persons who meet ITA detention criteria. DSHS must collaborate with the RSNs and the Washington State Institute for Public Policy to estimate the capacity needed for E&T services within each regional service area, including consideration of average occupancy rates needed to ensure access to treatment. Each RSN must develop and maintain an adequate plan to provide for E&T service needs.

A DMHP must submit a report to DSHS within 24 hours if the DMHP determines that an adult or minor meets ITA detention criteria but there are not any E&T beds available to admit the person within the time available for evaluation, and the person cannot be served through a single bed certification or LRA. Submission of such a report is prima facie evidence that the responsible RSN is in breach of its duty to provide an adequate network of E&T services. DSHS must develop a standardized form for the DMHP to use to submit this report, including a list of facilities which refused to admit the person. 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. DSHS must track and analyze these reports and initiate corrective actions, including but not limited to enforcement of contract remedies and requiring expenditure of reserve funds, to ensure that each RSN has implemented an adequate plan to provide for E&T services. An adequate plan may include development of LRAs to involuntary commitment such as crisis triage, crisis diversion, voluntary treatment, or prevention programs reasonably calculated to reduce the demand for E&T services. DSHS must publish quarterly reports on its website summarizing information submitted by DMHPs and the number of single bed certifications granted by category.

DSHS may approve the single bed certification of E&T beds to be used for detention under the ITA, if the bed is located in a facility that is willing and able to provide timely and appropriate treatment to the person, either directly or by arrangement with other public or private agencies. 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 at a facility that is willing and able to provide timely and appropriate treatment may presume that

the application will be approved for the purpose of completing the detention process and responding to other emergency calls.

The six-hour time limit for a DMHP to complete an evaluation of a person held in an emergency room or triage facility, or 12-hour time limit to complete the evaluation if the person was placed in the facility by a peace officer, must start upon notification to the DMHP of the need for evaluation and must not begin until there is medical clearance. Medical clearance means a physician or other health care provider has determined that the person is medically stable and ready for referral to the DMHP. Dismissal of the commitment petition is not an appropriate remedy for violation of these timeliness requirements except in the few cases where the facility staff or DMHP has totally disregarded statutory requirements.

The intent of the ITA is updated to include protecting the health and safety of persons suffering from mental disorders and protecting public safety through use of the parens patriae and police powers of the state. When construing ITA requirements, courts must focus on the merits of the petition, except where requirements have been totally disregarded.

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
- 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.

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.

The provisions relating to assisted outpatient treatment are contingent upon specific funding being provided in the omnibus budget appropriations act.

**Appropriation**: None.

**Fiscal Note**: Available.

**Committee/Commission/Task Force Created**: No.

**Effective Date**: The bill contains various effective dates, including sections which are subject to an emergency clause and take effect immediately.

**Staff Summary of Public Testimony on Original Bill (Human Services, Mental Health & Housing)**: 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 (Human Services, Mental Health & Housing)**: 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.

**Staff Summary of Public Testimony on Substitute (Ways & Means)**: PRO: This bill is one of our priorities for the session. The fiscal note addresses part of the cost offset, but a more dynamic fiscal note would delve into more offsets for assisted outpatient treatment. In other states, psychiatric inpatient admissions were more than enough to offset the costs for this.

**Persons Testifying (Ways & Means)**: PRO: Seth Dawson, The National Alliance on Mental Illness (NAMI), NAMI WA.

**House Amendment(s)**: Provisions relating to assisted outpatient treatment are removed. DSHS may designate appropriate settings for single bed certifications by rule. Language is removed stating that an inability to detain a person who meets ITA detention criteria for lack of an E&T bed or appropriate single bed certification is evidence that an RSN or BHO is in breach of its duty to provide adequate involuntary commitment services. Subject to appropriations, the Washington State Institute for Public Policy must study aspects of the involuntary commitment process relating to nonemergency detentions and less restrictive alternative treatment. Court records relating to involuntary commitment proceedings must be shared with DSHS, state hospitals, service providers, and the detained person.