LATE

TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
TWENTY-EIGHTH LEGISLATURE, 2016

ON THE FOLLOWING MEASURE:
H.B. NO. 2559, H.D. 1, RELATING TO MENTAL HEALTH.

BEFORE THE:

SENATE COMMITTEE ON COMMERCE, CONSUMER PROTECTION, AND HEALTH

DATE: Thursday, March 17, 2016 **TIME:** 9:45 a.m.

LOCATION: State Capitol, Room 229

TESTIFIER(S): Douglas S. Chin, Attorney General, or
Julio C. Herrera, Deputy Atorney General

Chair Baker and Members of the Committee:

The Department of the Attorney General appreciates the intent of this bill, but does not support this bill as it is currently written. However, we offer suggestions to address the concerns regarding the perceived lack of implementation of assisted community treatment.

This bill amends chapter 334, Hawaii Revised Statutes (HRS), relating to involuntary psychiatric hospitalization and assisted community treatment. Specifically, this bill requires the family court to consider assisted community treatment as an alternative to commitment to a psychiatric facility for a person subject to a petition for involuntary hospitalization.

Section 1 of this bill inserts a requirement that a petitioner for involuntary hospitalization also request assisted community treatment, pursuant to part VIII of this chapter, as alternative relief, on page 1, starting on line 6. Section 2 of this bill inserts a requirement that the notice in a petition for involuntary hospitalization include a statement that the family court could order assisted community treatment, in lieu of involuntary hospitalization, on page 4, starting on line 16. Section 3 of this bill inserts a requirement that if the family court finds that a person does not meet criteria for involuntary hospitalization, it assess whether the person meets criteria for assisted community treatment and, if so, order that treatment to commence, on page 5, starting on line 14. Section 4 of this bill inserts an explanation that a petition for assisted community treatment can be initiated independently or as a request for alternative relief in a petition for involuntary hospitalization, on page 6, starting on line 3. Finally, sections 5, 6, and 7 strike the repeal provisions, set for July 1, 2020, from pertinent session laws.

We have concerns regarding the practical implications of this bill. First, involuntary hospitalization proceedings and assisted community treatment proceedings are different matters, with different criteria, and require separate petitions. Second, the parties requesting these matters to be heard by the court are different.

The criteria for involuntary hospitalization are laid out in section 334-60.2, HRS, stating that a person may be committed to psychiatric facility, if a court finds that:

(1) The person is mentally ill or suffering from substance abuse;

(2) The person is imminently dangerous to self or others; and

(3) The person is in need of care or treatment, or both, and there is no suitable alternative available through existing facilities and programs which would be less restrictive than hospitalization.

The criteria for assisted community treatment are laid out in section 334-121, HRS, stating that a person may be ordered to obtain assisted community treatment, if a court finds that:

(1) The person is mentally ill or suffering from substance abuse; and

(2) The person is unlikely to live safely in the community without available supervision based upon the professional opinion of a psychiatrist; and

(3) The person, at some time in the past: (A) has received inpatient hospital treatment for mental illness or substance abuse or (B) has been found to be imminently dangerous to self or others, as a result of mental illness or substance abuse; and

(4) The person, based on the person's treatment history and current condition, is now in need of treatment in order to prevent a relapse or deterioration which would predictably result in the person becoming imminently dangerous to self or others; and

(5) The person has a history of a lack of adherence to treatment for mental illness or substance abuse, and the person's current mental status or the nature of the person's disorder limits or negates the person's ability to make an informed decision to voluntarily seek or comply with recommended treatment; and

(6) The assisted community treatment is medically appropriate, and in the person's medical interests; and

(7) Considering less intrusive alternatives, assisted community treatment is essential to prevent the danger posed by the person.

Aside from the first criteria, requiring that an individual be mentally ill or suffering from substance abuse, these proceedings require very different findings. Combining these two complex proceedings into one petition would have the effect of inserting uncertainty and confusion into the implementation of this law.

Adding further to the confusion, the parties requesting the respective petitions are different. Our Department assists the various psychiatric hospitals in the filing of petitions for involuntary hospitalization. Their requests ask the court to order an individual to remain in the hospital to receive treatment for up to ninety days. Contrast that with a petition for assisted community treatment, which asks the court to order an individual to receive treatment in the community. Combining the two processes would require the psychiatric hospitals to follow the individual's treatment in the community, in the event that they do not meet criteria for involuntary hospitalization. However, the statutory scheme for assisted community treatment is designed so that an individual's treatment in the community is followed not by a hospital, but by an aftercare provider.

Currently, section 334-60.7(b), HRS, already allows a psychiatric hospital contemplating discharge of an involuntary patient to assess whether an assisted community treatment plan is indicated. If so indicated, that hospital can coordinate with an aftercare provider as part of discharge planning. The aftercare provider, in turn, would file the petition for assisted community treatment, if appropriate. This section demonstrates that these are two different proceedings, requiring separate petitions, requested by different entities.

Therefore, we recommend removing sections 1 through 4 from this bill and replacing them with the following additions to address the concerns regarding the implementation of assisted community treatment.

Adding a definition to section 334-1, HRS:

A finding of dangerousness is required to civilly commit an individual to a psychiatric facility, however, deference is given to state legislatures to define that term. In re: Doe, 102 Hawai'i 528, 548-49, 78 P.3d 341, 361-62 (App. 2003) (citations omitted). The Ninth Circuit Court of Appeals requires that the danger be imminent. Suzuki v. Yuen, 617 F.2d 173, 178 (9th Cir. 1980). However, the term imminent is not defined in chapter 334, HRS. Different people can disagree as to the meaning of the term "imminent." A strict interpretation of the term would

make it difficult to fulfill the law's original purpose of protecting communities and providing necessary treatment to mentally ill individuals posing a danger to themselves or others. Therefore, to establish a clearer standard, we suggest the Legislature look to chapter 587A, HRS, also known as the Child Protective Act, for guidance. Under section 587A-4, "imminent harm means that without intervention within the next *ninety days*, there is reasonable cause to believe that harm to the child will occur or reoccur." (Emphasis added.) Thus, we recommend the following definition be added to section 334-1:

> "Imminently dangerous to self or others" means that, without intervention, the person will likely become dangerous within the next ninety days.

By including a definition for "imminently dangerous," the law would provide a clearer standard that strikes the appropriate balance between protecting the community and protecting personal liberty interests. In addition, this will allow for better discharge planning of patients.

Changes to section 334-59(a)(1), HRS:

Generally, under section 334-59(a)(1), HRS, when law enforcement is called because an individual may be a danger to him or herself or to others, they must first confirm that with an on-call psychologist before taking that person into custody and transporting them to an emergency department. No judicial review is undertaken of this process. The following changes to this subsection are suggested:

> If a law enforcement officer has reason to believe that a person is imminently dangerous to self or others, the officer shall call for assistance from the mental health emergency workers designated by the director. Upon determination by the mental health emergency workers that the person is imminently dangerous to self or others, the person shall be transported by ambulance or other suitable means, to a licensed psychiatric facility for further evaluation and possible emergency hospitalization. A law enforcement officer may also take into custody and transport to any facility designated by the director any person threatening or attempting suicide[~~, or may take into custody and transport to any designated mental health program, any person subject to an assisted community treatment order, issued pursuant to part VIII of this chapter, for further evaluation and possible emergency hospitalization~~]. The officer shall make application for the examination, observation, and diagnosis of the person in custody. The application shall state or shall be accompanied by a statement of the circumstances under which the person was taken into custody and the reasons therefore which shall be transmitted with the person to a physician, advanced practice registered nurse, or psychologist at the facility[~~, or to a licensed psychiatrist at a designated mental health program~~].

Removing transportation to a designated mental health program from this subsection restores this procedure to what it was prior to the enactment of assisted community treatment.

Changes to section 334-59(a)(2), HRS:

Generally, under section 334-59(a)(2), HRS, an ex parte order is issued by the family court, when facts are presented to it that an individual may be mentally ill or suffering from substance abuse, imminently dangerous to self or others, and in need of care or treatment, or both. The order directs transport of that individual to an emergency department for examination and treatment. The following changes to this subsection are suggested:

> Upon written or oral application of any licensed physician, advanced practice registered nurse, psychologist, attorney, member of the clergy, health or social service professional, or any state or county employee in the course of employment, a judge may issue an ex parte order orally, but shall reduce the order to writing by the close of the next court day following the application, stating that there is probable cause to believe the person is mentally ill or suffering from substance abuse[~~-or~~], is imminently dangerous to self or others, and in need of care or treatment, or both, giving the findings upon which the conclusion is based[~~, and directing~~]. The order shall direct that a law enforcement officer or other suitable individual take the person into custody and deliver the person to a designated mental health program, if subject to an assisted community treatment order issued pursuant to part VIII of this chapter, or to the nearest facility designated by the director for emergency examination and treatment[~~,~~], or both. The ex parte order shall be made a part of the patient's clinical record. If the application is oral, the person making the application shall reduce the application to writing and shall submit the same by noon of the next court day to the judge who issue the oral ex parte order. The written application shall be executed subject to the penalties of perjury but need not be sworn to before a notary public.

By inserting transportation to a designated mental health program into this procedure, it allows for court oversight in authorizing the transport of an individual to a mental health program and/or to a psychiatric facility for examination and treatment. Our understanding is that law enforcement is more comfortable with the wording being inserted into this section than in the previous section.

Changes to section 334-129, HRS:

Currently, under section 334-129, HRS, an individual under an order for assisted community treatment, may be subject to the involuntary administration of medication only upon being civilly committed. The following changes to this section are suggested:

§334-129 Failure to comply with assisted community treatment. (a) A treating psychiatrist may prescribe or administer to the subject of the order reasonable and appropriate medication or medications, if specifically authorized by the court order, and treatment which is consistent with accepted medical standards and the family court order, including the written treatment plan submitted pursuant to section 334-126(h).

(b) No subject of the order shall be physically forced to take medication under a family court order for assisted community treatment[~~, except in accordance with section 334-60.5, relating to admission to a psychiatric facility,~~] unless the subject is within an emergency department or admitted to a hospital, subsequent to the date of the current assisted community treatment order.

(c) A subject may be transported to a designated mental health program, or a hospital emergency department, for failure to comply with an order for assisted community treatment via the following methods:

(1) By an interested party with the consent of the subject of the order; or

(2) In accordance with section 334-59.

(d) The designated mental health program's treating psychiatrist or psychiatrist's designee shall make all reasonable efforts to solicit the subject's compliance with the prescribed treatment. If the subject fails or refuses to comply after the efforts to solicit compliance, the treating psychiatrist shall assess whether the subject of the order meets criteria for admission to a psychiatric facility under part IV of this chapter, and proceed with the admission[~~:~~] pursuant to section 334-59(a)(2) or (3); provided that the refusal of treatment shall not, by itself, constitute a basis for involuntary hospitalization.

The standard for obtaining an order to treat, for the purpose of involuntarily medicating a "custodial" patient is prescribed by State v. Kotis, 91 Hawai'i 319, 974 P.2d 78 (1999) (requiring that a criminal defendant actually pose a danger of physical harm to self or others; that treatment with antipsychotic medication is medically appropriate and in the defendant's medical interests; and that considering less intrusive alternatives, the treatment is essential to forestall the danger posed by the defendant, before he may constitutionally be involuntarily medicated with antipsychotic drugs). However, that case did not necessarily contemplate the potentially more serious danger posed by a mentally ill homeless person on the streets. For example, someone who is a direct threat to the public-at-large, including children and other vulnerable members of society is different from an institutionalized person who is only a threat to a limited number of staff, and which staff are presumably aware of the person's dangerousness, and thus can take precautions. A strict application of Kotis to a person under an assisted community treatment order has the potential to frustrate the very purpose for which assisted community treatment was enacted, which is to treat mentally ill individuals in the community, and not to have to

incarcerate or civilly commit them. Thus, there exists a genuine question as to whether forcibly medicating someone in the community, given new advances in medicine and psychiatric treatment, is less restrictive or intrusive than having that person in custody. Therefore, expanding where and when the medication can be administered, such as in an emergency department, where it can be safely administered may be more preferable to lengthy detainment in a psychiatric or correctional facility. This recommendation does not go so far as to say that an individual may be forcibly medicated on the streets, as such a proposal would not only go too far, but also not be safe for everyone involved.

Changes to sections 334-127(b) and 334-130(b), HRS:

The following changes are suggested to bring the duration of an assisted community treatment order in conformity with that of an order to treat, which is currently for one year.

Section 334-127(b), HRS, relating to disposition:

> (b) If after hearing all relevant evidence, including the results of any diagnostic examination ordered by the family court, the family court finds that the criteria for assisted community treatment under section 334-121(1) [~~[~~]have[~~]~~] been met beyond a reasonable doubt and that the criteria under [~~[~~]section[~~]~~]s 334-121(2) to 334-121(7) have been met by clear and convincing evidence, the family court shall order the subject to obtain assisted community treatment for a period of not more than [~~one hundred eighty days.~~] one year. The written treatment plan submitted pursuant to section 334-126(h) shall be attached to the order and made a part of the order.
>
> If the family court finds by clear and convincing evidence that the beneficial mental and physical effects of recommended medication outweigh the detrimental mental and physical effects, if any, the order may authorize types or classes of medication to be included in treatment at the discretion of the treating psychiatrist.
>
> The court order shall also state who should receive notice of intent to discharge early in the event that the treating psychiatrist determines, prior to the end of the court ordered period of treatment, that the subject should be discharged early from assisted community treatment.

Section 334-130(b), HRS, relating to period of assisted community treatment:

> (b) A subject of assisted community treatment is automatically and fully discharged at the end of the family court ordered period of treatment, a period of not more than [~~one hundred eighty days,~~] one year, unless a new family court order has been obtained as provided hereinbelow.

Finally, we take no position on the sections of this bill striking the repeal provisions.

We urge this Committee not to combine these two different proceedings, and to incorporate the suggested changes to this bill.