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2003 SENATE JUDICIARY

SB 2296

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2296

Senate Judiciary Committee

☐ Conference Committee

Hearing Date 02/05/03

Tape Number	Side A	Side B	Meter #
4	X		0.0 - End
2		X	0.0 - 25.1

Committee Clerk Signature Mona L Solberg

Minutes: **Senator John T. Traynor, Chairman,** called the meeting to order. Roll call was taken and all committee members present. Sen. Traynor requested meeting starts with testimony on the bill:

Testimony Support of SB 2296

Sen. Tim Mathern - Introduced Bill (meter .4) Read Testimony - Attachment #1, Handed out Amendment Attachment # 1b.

Senator John T. Traynor, Chairman asked if loss of control over ones thoughts defined in this bill? No.

Sheree Spear - Mother of a 22 year old delusional, paranoid and suicidal son. (meter 2.8) Read Testimony Attachment #2a. Evaluation and treatment process flow chart, Attachment #2b.

Randy Petermann - Paranoid disorder patient, (meter 13.9) Read Testimony Attachment #3.

Deb Mathern Read Judy Knutson's Testimony (meter 17.6) Attachment #4.

Watched Video (meter 23) - Attached Testimony #5, Mary T. Zdanowicz, JD Executive Director

and Rosanna M. Esposito, JD Arlington VA.

Janet Sabol - Minot, ND - Nation's Voice on Mental Illness (NAMI) (meter 26.1) Read

Testimony - Attachment #6.

Testimony in opposition of SB 2296

Sharon Gallegher - Mental Health association in ND - MHAND, Non profit volunteer citizens organization affiliated with the National Mental Health Association. (meter 32) Read Testimony Attachment # 7.

Mental and Physical Illness stature - Attachment 7b

Proposed amendment prepared by Mental Health Association in ND - Attachment 7c

Senator Thomas L. Trenbeath stated it unusual that the Supreme Court could tell someone to make a decision in comparison to "a driver who is to sleepy" to pull over. (meter 48)

Discussion in the manor if accepting both sets of amendments what of the bill is left?

Gregory Runge - Attorney of two citizens who had been accused of being mentally ill. (Tape 2, side 2, meter 1.9) Read Testimony - Attachment #8

Corinne Hofmann - Director of Policy and Operations for the Protection and Advocacy Project (P & A) (meter 14.7) Read Testimony Attachment #9a. and Study of chapter 25-03.1 Attachment 9b.

Discussion on study (meter 24.9)

Testimony Neutral to SB 2296

None

Senator John T. Traynor, Chairman closed the hearing.

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2296

Senate Judiciary Committee

☐ Conference Committee

Hearing Date 02/12/03

Tape Number	Side A	Side B	Meter #
3	X		8.0 - 14.0

Committee Clerk Signature Mona L Solberg

Minutes: **Senator Stanley W. Lyson, Vice Chairman** , called the meeting to order. Roll call was taken and not all committee members present. Sen. Lyson requested meeting starts with committee on the bill:

Senator Stanley W. Lyson, Vice Chairman discussed amendment. Senator Carolyn Nelson reviewed amendments with committee (meter 8.5) Attached #1. Senator Carolyn Nelson stated that this was an example of two people who had different opinions and being able to work it out with this bill.

Sheree Spear submitted a letter from Ronald S. Honberg J.D. M.Ed - National Director for Policy and Legal Affairs, The Nation's Voice on Mental Illness - Attachment #2. Karen Romig Larsen after stating her neutral stance sited her concerns on the bill. Several bills are making minor changes on our commitment law and we are concerned that all these small changes may contradict each other or be problematic. It is critical to have all the different groups around the

table. in the decision making process, and it is being done with this one. Discussed making the bill a study (meter 12.9) Senator Carolyn Nelson reviewed the simple changes.

Motion Made to DO PASS Amendments 30427.0103 on SB 2296 by Senator Carolyn Nelson and seconded by Senator Thomas L. Trenbeath

Roll Call Vote: 1 Yes. 0 No. 1 Absent

Motion Passed

Motion Made to DO PASS SB 2296 with Amendments by Senator Carolyn Nelson and seconded by Senator Dennis Bercier.

Roll Call Vote: 5 Yes. 0 No. 1 Absent

Motion Passed

Floor Assignment: Senator Carolyn Nelson

Senator Stanley W. Lyson, Vice Chairman closed the hearing

30427.0103
Title.0200

Prepared by the Legislative Council staff for
Senator Mathern
February 11, 2003

2-12-03

PROPOSED AMENDMENTS TO SENATE BILL NO. 2296

Page 1, line 1, replace the comma with "and"

Page 1, line 2, remove ", and subsection 1 of section 25-03.1-25"

Page 1, line 9, replace "includes" with "may include"

Page 1, line 10, remove "pursuant to section 25-03.1-18.1"

Page 3, line 15, remove the overstrike over "~~a serious risk of harm to that person, others, or property. "Serious risk~~"

Page 3, line 16, remove the overstrike over "~~of harm" means~~"

Page 3, line 20, remove ", Direct"

Page 3, remove line 21

Page 3, line 22, remove "required"

Page 3, line 27, remove "risk of loss"

Page 3, line 28, remove "of the person's ability to function independently in the community or the"

Page 4, line 1, replace "person's inability to make a" with "effect of the person's mental condition on the person's ability to consent"

Page 4, line 2, remove "rational decision about the need for treatment"

Page 5, remove lines 22 through 31

Page 6, remove lines 1 through 8

Renumber accordingly

Date: February 12, 2003
Roll Call Vote #: 1

2003 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2296

Senate **JUDICIARY** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Amendment 0103

Motion Made By Senator Carolyn Nelson Seconded By Sen. Trenbeath

Senators	Yes	No	Senators	Yes	No
Sen. John T. Traynor - Chairman	A	A	Sen. Dennis Bercier	X	
Sen. Stanley. Lyson - Vice Chair	X		Sen. Carolyn Nelson	X	
Sen. Dick Dever	X				
Sen. Thomas L. Trenbeath	X				

Total (Yes) FIVE (5) No ZERO (O)

Absent ONE

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: February 12, 2003
Roll Call Vote #: 2

2003 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2296

Senate **JUDICIARY** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number **30427.0103**

Action Taken DO PASS as Amended

Motion Made By Senator Carolyn Nelson Seconded By Sen. Bercier

Senators	Yes	No	Senators	Yes	No
Sen. John T. Traynor - Chairman	A	A	Sen. Dennis Bercier	X	
Sen. Stanley. Lyson - Vice Chair	X		Sen. Carolyn Nelson	X	
Sen. Dick Dever	X				
Sen. Thomas L. Trenbeath	X				

Total (Yes) FIVE (5) No ZERO (0)

Absent ONE

Floor Assignment Senator Carolyn Nelson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
February 13, 2003 8:26 a.m.

Module No: SR-28-2515
Carrier: Nelson
Insert LC: 30427.0103 Title: .0200

REPORT OF STANDING COMMITTEE

SB 2296: Judiciary Committee (Sen. Traynor, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). SB 2296 was placed on the Sixth order on the calendar.

Page 1, line 1, replace the comma with "and"

Page 1, line 2, remove ", and subsection 1 of section 25-03.1-25"

Page 1, line 9, replace "includes" with "may include"

Page 1, line 10, remove "pursuant to section 25-03.1-18.1"

Page 3, line 15, remove the overstrike over "~~a serious risk of harm to that person, others, or property. "Serious risk~~"

Page 3, line 16, remove the overstrike over "~~of harm" means~~"

Page 3, line 20, remove ". Direct"

Page 3, remove line 21

Page 3, line 22, remove "required"

Page 3, line 27, remove "risk of loss"

Page 3, line 28, remove "of the person's ability to function independently in the community or the"

Page 4, line 1, replace "person's inability to make a" with "effect of the person's mental condition on the person's ability to consent"

Page 4, line 2, remove "rational decision about the need for treatment"

Page 5, remove lines 22 through 31

Page 6, remove lines 1 through 8

Renumber accordingly

2003 HOUSE JUDICIARY

SB 2296

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2296

House Judiciary Committee

☐ Conference Committee

Hearing Date 3-5-03

Tape Number	Side A	Side B	Meter #
1	xx		0-end
1		xx	0-end
2	xx		0-12.1
Committee Clerk Signature	APenrose		

Minutes: 12 members present, 1 member absent (Rep. Wrangham

Chairman DeKrey: We will open the hearing on SB 2296.

Sen. Lyson: Introduced SB 2296 (see attached e-mail messages from two sheriffs who couldn't make it). This is a proactive approach and I recommend a do pass.

Chairman DeKrey: Thank you.

Sen. Mathern: Introduced SB 2296 (see attached testimony) (see attached testimony of Sen. Carolyn Nelson who couldn't attend).

Sheree Spear: Support (see attached testimony, showed a video clip).

Chairman DeKrey: Thank you.

Randy Peterman: Support (see attached testimony).

Vice Chair Maragos: Thank you.

Deb Mathern: Support (read attached testimony of Judy Knutson and testimony of Janet Sabol).

I ask the committee to Do Pass SB 2296.

Chairman DeKrey: Thank you.

Dr. Albert Samuelson, Psychiatrist, practice in Bismarck for 40+ years: I have served as a contract physician for mental health centers and for the prison. I wanted to talk briefly about the bill, focus on the bill, and give you some idea of my perspective as a professional who has to make some decisions about someone's mental health. Commitment is a chaotic and very difficult time for families. I can't tell you how difficult it might be. It usually occurs in the midst of a family crisis. It is not an easy procedure to go into. I have had a difficult time encouraging families to take the initiative and go to the courts and initiate commitment proceedings. Families are very reluctant to do this, even though they might be suffering very much. The problem I've experienced in commitment proceedings, relates to 12D. When you're being cross-examined in the court, which is only appropriate by the counsel of the individual who is being committed, that is sometimes a very difficult issue, it is imprisonment. It is a difficult decision to address. We're talking about substantial deterioration of mental health which would predictably result in danger to that person, others or property. That is a difficult call to make. The psychiatric literature, of course, has not been very helpful in identifying accurately people who are indeed dangerous. Usually it is a judgment call. It seems to me, from my own perspective, and the perspective of my colleagues in the psychiatric association, that the language adds some depth, some broadness to this. A lot of people are going to say, well there are going to be more people committed, infringe upon civil rights. I frankly am concerned about civil rights, too. Though I often have differences with attorneys and such who cross-examine me in court on these issues. I feel good about that and I am happy to experience the fact that the people are being represented. It seems, that as it is written, it is very, very difficult, when a family is trying to have an alcohol/drug

addicted individual committed, or an individual is seriously mentally ill, but has not attempted suicide, and has not exhibited dangerousness to other people. The language as I see it, broadens that and it helps us define better the type of individual who may need treatment. The language addition says it is based upon the loss of cognitive or volitional control over the person's thoughts or actions, based on.... We are talking about the individual's ability to make decisions, a serious compromise, or when there cognitive abilities are compromised. When we are talking about cognitive, we are talking about an individual's ability to make decisions, resources of the brain and whether working intact, can he make decisions. That helps me as a physician address this need a little better. I would support SB 2296. There has been an excellent case made for this, and it was initiated in the grass roots, and I looked at this not knowing if I should go along with it or not, but as I looked at it and thought about it and talked about it with my colleagues, we felt that is something we should go for. I would be happy to answer any questions.

Rep. Klemin: 12D, the focus I think is on the word dangerousness. When you examine a person to determine whether the standard is met or not, is there a methodology that you use that's recognized as valid in the psychiatric community for doing this?

Dr. Samuelson: There is no nice, simple test that you can do. I wish we had one. You usually depend on your examination of the patient, the history of the patient, the appearance of the patient, and the mental status examination. This is akin to a physical examination that we do with psychiatric patients, and part of that is the cognitive. The cognitive aspects of the thinking are those impaired or not, you look at an issue called "insight". Insight into an illness problem, with many individuals who are seriously mentally ill, have manic depressive illness, chronic schizophrenia or whatever and people who are severely addicted to meth or alcohol, they have no

insight into the fact that they are dysfunctional. So they aren't going to acknowledge very often that anything is wrong with them, even though they might be voicing some very bizarre delusional beliefs. That's an easy call. The kinds of calls that you are talking about here, more uncertain ones, I usually see at the back end of the situation. I see them in prison and these are individuals who have been committed of assault, they have been terrorizing individuals, these are very common things. They, of course, have no insight or appreciation of what they are doing. As I observe these individuals, I have a better perspective of how dangerous they might be, and put that together with the observations that have been made by the prison staff. That's the difficulty. We don't have that information when we're here in a treatment hearing. These are facts, these are observations that develop as we get to know the family and the individual. There are other bills that would like to shorten the time between the treatment hearing and the preliminary hearing. There's a two week period (14 days) there, which is very good. I wouldn't recommend you ever shortening that time period, because it does give us an opportunity in the hospital to work with severely mentally ill patients, probably get them on medications, and after a period of a couple of weeks, they are looking a lot better and we don't really have to go through the treatment hearing, or if the treatment hearing is held, the individual waives, says they are feeling better, I am ready to go on with the treatment, and the judge can then place them in an alternative treatment program, etc.

Rep. Klemin: This bill is trying to make a determination that there is a person requiring treatment before you get to the situation where you are reviewing them in the prison, because at that point, it's past the point in time that this bill is intending to address. The new definition of alternative treatment in this bill, when you're looking this up, the term is not actually used in this

bill, it's actually in another section that's not being amended. I think what we're focusing on here is an effort to arrive at a point where you would be able to interview this person, determine that they meet the requirements of 12D and hopefully is able to be treated with an alternative treatment order rather than commitment to an institution.

Dr. Samuelson: That is an alternative that is used more and more, as our mental health resources develop. Many judges will admit someone to an alternative treatment program, with the idea that if they do not adhere to the treatment, not taking their medications, they're not following the prescribed treatment patterns, they will return to court and sometimes the court will place them in an institution.

Rep. Klemin: When you are trying to make a determination of dangerous, are you also able to interview other people, like others in the family and so on.

Dr. Samuelson: It is not possible to make a decision like that without the ancillary information, from family members and in many cases employers and in some cases law enforcement is involved too, to establish their behavior as being different than normal behavior.

Rep. Kretschmar: Are you aware of the statistics as to people who have mental illness and then aren't cured, goes into remission, is there recidivism.

Dr. Samuelson: I think the statistics have already been made, 1% of the people right across the world would have schizophrenia. I suspect around 2 million people in United States have it. These individuals are chronically ill. This isn't something you can cure. It's like heart disease. If you have coronary heart disease, the doctor helps the individual with medication, exercise, with other programs that diminish the risk. That is what you do with the chronic schizophrenic. They function well in situations where there is a supportive network of services including

medications, regular counseling with a psychiatrist; more importantly, involvement with the case manager, who actually walks them through some of the cognitive decisions that have to be made in their life. Individuals with schizophrenia have difficulty making decisions about common, ordinary things that you and have don't have difficulty with. They have trouble managing their money, they are very, very vulnerable to just minor stressors. It is just unreal. I can't say how many people are in North Dakota. I've worked in this city now for the past 40 years, and I've worked with the mental health center here, I would suspect that we have anywhere from 300-500 people with schizophrenia or are actively being treated in our human service center. This does not include many individuals who have a severe bipolar illness, who have alcohol or drug problems, and so on. Services are in place, and I think they are working by and large. It is very important that the legislature fund those, make sure they are working well. It's an illness that is very formidable, and it detracts greatly from our economic health dollars.

Rep. Klemin: A couple of the letters that were submitted by Sen. Lyson, were from sheriffs who were concerned that this bill might result in people being confined in county jails, because there is no room for them in the state hospital and other facilities. As I understand the goal of this bill, is to try and get treatment for people early on so they don't end up in the county jail.

Dr. Samuelson: That's right.

Rep. Klemin: I think I understood you to say that, and for these letters that we received from the sheriffs who are concerned about that, you think that's a valid concern.

Dr. Samuelson: I would disagree with what those letters say. Because the commitment procedures requires that within 24 hours after a petitioner enters the court, this individual has to be examined by a mental health professional. For rural areas, that is a problem. I think these

individuals might have to be transported to State Hospital for their evaluation. In larger cities like our own, we have psychiatric units in our general hospitals that serve this purpose. I would hope that these individuals aren't in jail for extended periods of time, because if they are, that would be breaking the spirit of the commitment proceedings.

Acting Chair Kretschmar: Thank you.

Mary Zdanowics, JD, Executive Director, Treatment Advocacy Center: Support (see attached testimony).

Rep. Delmore: As I looked over the decision that you passed around, one of the questions addressed something about the "substantial probability". You feel that is covered in this bill?

Ms. Zdanowics: Yes, the ...

Rep. Delmore: On page 3, under 12, it looks like it is probably where you are going, but I'm not sure.

Ms. Zdanowics: Actually the bill does say "substantial deterioration" which would predictably result in .... There is one last thing that I will close with, a quote from somebody that sums up my testimony than I could, he was a man who defended civil liberties as a member of the board of directors of the British Columbia Civil Liberties Union, but he also has a child with schizophrenia, "How can so much degradation and death, so much inhumanity be justified in the name of civil liberties. It cannot. The opposition to involuntary committal and treatment betrays a profound misunderstanding of the principles of civil liberties. Medication can free victims from their illness, free them the bad feel of psychosis and restore their dignity, their freedom and the meaningful of their liberties."

Chairman DeKrey: Thank you. Further testimony in support of SB 2296.

Sheree Spear: We had a videotape of a testimony from Ron Honberg, who is Legal Counsel, for the National Alliance on Mental Illness, we can either see the video or I can hand out a letter from him (see attached letter).

Chairman DeKrey: Submit the letter, that will be fine.

Sheree Spear: I would also like to hand out a letter from Police Chief Chris Magnus in Fargo (see attached letter).

Chairman DeKrey: Thank you. Further testimony in support. Opposition to SB 2296.

Corinne Hofmann, Director of Policy and Operations for the Protection and Advocacy Project: Opposed (see attached testimony).

Rep. Delmore: I guess I had many reservations about this bill when I read it over last night, so I am not totally surprised that you come before us speaking on the other side. However, I think people have made a very powerful case today that this is a problem in our state. There are many people falling through the cracks. As a legislature which meets only every other year, we're under time constraints. If we take time to study this bill for an entire interim, it means another two years before we can enact legislation. What I would like to know is if you have some idea of some possible amendments that we could do to this bill, that would put us more in compliance with what you are looking at. I would like to see something done, because I think the need is there.

Ms. Hofmann: I would be happy to work with the committee on drafting an amendment. I do think there is at least one change that would improve the language, and that is a very simple change, to change "or" in the new language to "and", so that if you are going to look at "the loss

of cognitive and volitional control over the person's thoughts or actions "and" based upon acts, threats, or patterns in the person's treatment history.....

Rep. Delmore: I have a comment I would like to make in light of what we have seen and heard this morning, I certainly agree that many of them have not been treated, but I don't think that's a valid reason for us not to pass legislation like this to help people with mental illness who are out there and are in need of help. We make policy, and if say it will be that way, it will; and I hope that we can make sure that we can improve the plight of the mentally ill.

Ms. Hofmann: I appreciate that thought, and I guess my concern is the concern of our agencies, if you are going to do something like this, that you ensure that you are able to provide the services that will be necessary. With the cuts that are being done within the Dept. of Human Services, we are very concerned about what the effect will be on the people that are currently receiving services, if additional people come into the system and the services aren't there. I think there will be a cost to this bill, I don't think that's been looked at, I think it should be looked at, and I think that should be taken into account in the appropriations process.

Rep. Klemin: Looking at the points you addressed of the five points starting on page 2 and continuing on page 3 of your testimony, I am trying to look at this statute as you proposed to be amended to see if it contains the things or not. Other than in line 17 of page 3, there are a number of interrelated definitions, a person requiring treatment who is mentally ill, which is also a defined term, that there must be a serious risk of harm, which then serious of harm is defined within subsection 12 as meaning a substantial likelihood of the four factors. You have focused on the Wisconsin law, and the decision of the Wisconsin Supreme Court on the words

"substantial probability". Do you contend there is a difference between the terms "substantial probability" used in Wisconsin and the term "substantial likelihood" that's used in North Dakota.

Ms. Hofmann: No, I don't see a substantial difference in definitions. I think how they are incorporated into the statute is slightly different, if you look at the Wisconsin statute, it says dangerousness is and lists the five standards; whereas, ours talks about it in a slightly different way, I think.

Rep. Klemin: The next question I have is on page 3, line 24, the word "or", if we did change that to "and" then in order for a court to find that there is a person requiring treatment, you'd have to meet all four of these requirements; in other words, a mental health professional or a psychiatrist, or expert examiner, would not be able to say well there is dangerousness because of 12d, but I don't see any substantial likelihood of this person killing somebody else, if we change that word "or" to "and", then the psychiatrist would have to find that there is a substantial likelihood of somebody who might meet all of the other three standards, but because they don't meet "b" for example of killing or inflicting serious bodily harm on another person, then they're not a person requiring treatment and that's the way I would interpret that if you put the word "and" in there, do you disagree with that.

Ms. Hofmann: Yes, I do. If I understand correctly, to determine whether a person poses a substantial risk of harm and is dangerous, there are four sections within our current law that should be looked at. Subsection d is only one of those. You don't need to meet all four of them. What I am proposing is that within subsection d, the language that's been added "based upon the loss of cognitive or volitional control over the person's thoughts or actions **and** based upon acts, threats, or patterns, etc.....so you are looking at the full range of factors to determine whether the

criteria within that subsection is met and that you do not solely look at the loss of cognitive or volitional control. I think that's a dangerous road to go on, it's overly broad, it's vague, it's going to bring too many people into a very intrusive process that don't need to be there.

Rep. Klemin: So you are suggesting then that the "or" on line 27, "or based upon acts,..." that should be changed to "and".

Ms. Hofmann: Yes. I think that would improve the language considerably.

Rep. Klemin: Then if we did that, what other amendment do you suggest. That's a fairly simple one to do.

Ms. Hofmann: I am very concerned about the language regarding a person's ability to consent, because it does conflict with another statute within the code, and because this is a process that will be used for emergency commitments, as well as involuntary commitments, you're giving the decision making authority about whether someone has the capacity to consent to people who may not be able to make that decision properly. I'm not saying that there couldn't be a better way to include some language like that, but I am uncomfortable with the language as it is. I would be willing to give that some thought. I think we should put some protection in there, by requiring that someone sat down with the person and explained to them the disadvantages and advantages, and they were then determined unable to make an informed choice. At least there is someone sitting down with the person, you know that's occurring and that they are being given the information to make the decision. As it stands now, with the current wording, I would have real serious concerns about it.

Rep. Klemin: Section 33 deals with legal incompetence, which is not necessarily the same as inability to consent based on the person's mental condition.

Ms. Hofmann: I agree, but I think that by putting that language in subsection d that you are incorporating the issue of the ability to consent into that definition and I think that's improper.

Rep. Klemin: This is the second time this bill has been heard. It was heard over in the Senate. Now you are suggesting that there should be some amendments. Did you propose those amendments over in the Senate.

Ms. Hofmann: We did not propose amendments, because we were opposed in general. We are opposed to this bill. I can't state that strongly enough. If you are intending to pass this, I guess I am willing to make concessions that these changes would improve it. I think our current statute can address adequately the needs of the people in our communities if there is adequate training and implementation of the law. If there are changes that need to be made, I strongly believe that we do need to study this and the effect on the system. I know there have been some concerns expressed about the meth. problem, whether this statute can adequately address that, they are downsizing the hospital, the system is changing, and we probably need to do that anyway. Will this change, address the problems that have been expressed. I don't think so. I don't think this is going to solve the problems that are out there.

Rep. Klemin: What will solve these problems.

Ms. Hofmann: I think a very good look at the commitment statute and probably some significant changes in the whole scene that we put together. I cant say without having that study and having input from all the parties and what that would mean. Because there are people out there that have additional information that know how things are operating, how they need to operate them, things that I don't have; but I know there are concerns from a wide variety of persons that it's not working the way it should and there are changes needed. I agree with the

proponents of this bill in terms of outcome. I want the same things they do, but I don't think this will achieve that.

Chairman DeKrey: If we don't do anything, there will be no outcome.

Rep. Klemin: An observation, if we do pass this bill, whether it gets further amendments or not, and do the study, wouldn't both acts be something that we could try to work on resolving this.

Ms. Hofmann: Yes, I suggest that we would be willing to live with this bill if there are to be the amendments made that I suggested. We do support the study in addition, if you pass this with the amendments.

Rep. Delmore: I guess that's where its at. I still come back to my point. Can we afford for people to fall through the cracks for the next two years. Maybe this isn't perfect, but I think it addresses some of the issues of mental health and the people who need help.

Ms. Hofmann: That's obviously a decision you need to make. I'm here to give you information and another point of view, and I hope that is going to be helpful in your decision-making process.

Chairman DeKrey: Thank you. Further testimony in opposition to SB 2269.

Ed Dyer, Attorney: Opposed (see attached testimony).

Rep. Delmore: I think the constitutionality, whether it passes, will be decided by a higher authority than either you or I will. My question to you is can we always successfully define based on serious risk to yourself or others.

Mr. Dyer: I haven't studied this thoroughly constitutionally, but I am familiar with the Wisconsin case that has been discussed, but I haven't studied it. I think the problem is it's a balancing between the needs of the individual in society vs. the individual's liberty being deprived. What I have a problem with more, is that it's just a matter of a psychiatrist saying this

person could become dangerous. The psychiatrist could say, this person if not treated is dangerous, incites specific actions in the individual. My experience is that the court's generally rely on the opinion of the expert examiner in mental illness case, generally the psychiatrist. It still has to be something facts based opinion.

Rep. Klemin: As I understood your testimony, you're primarily raising the concern that this is possibly unconstitutional, but yet I hear you say in response to Rep. Delmore that you have not actually studied the issue of the constitutionality of this; however, you can't point out anything to us that's definitive as to why is might actually be unconstitutional, is that right.

Mr. Dyer: Well, I haven't had the time to do study, but the basic principle at the Supreme Court has pointed out, there has to be a serious risk of harm before you can deprive the liberty of these people and put them in a hospital situation. Whether you can do that without facts, I think that is problematic.

Rep. Klemin: The issue about the requirement that there must be some facts to support the expert examiner's opinion. You have, I'm sure, cross-examined many psychiatrists in civil commitment proceedings on their opinion. Do the courts not require as part of that opinion, when it is given by the expert examiner in court, that it be based on some relevant facts.

Mr. Dyer: I think the distinction is if you look at the example of the individual who is substance committed, schizophrenic and psychotic. Under current law, assuming they are not suicidal, or going to harm somebody, if they are delusional, my experience would be the psychiatrist would say it fits under subsection 12c of the definition, to carry it further and say, these are the things that this individual is capable of, that harm is likely to occur. Because a person has delusions about certain people out to get them, etc. The proposed amendment short circuits the process,

you just have to show the person, in the mental process, is that you loss some volition control without showing because of that they pose a harm to themselves or others.

Rep. Klemin: That's a kind of different jump than what you were just saying about facts. Certainly isn't loss of cognitive and volitional control over the person's thoughts have to be shown by some facts.

Mr. Dyer: Yes, it still does, but the facts that someone showing that there is a serious potential seriousness of harm, not just that the individual will, but because of their illness they pose a threat to themselves or others.

Rep. Klemin: The statute says that it still requires a substantial deterioration in mental health which would predictably result in dangerousness to that person, others or property. That's still required. Is that what you just said, you've got to have that?

Mr. Dyer: Yes.

Chairman DeKrey: Thank you. Further testimony in opposition to SB 2296.

Dr. Joseph Belanger, Licensed Clinical Psychologist, State Hospital: Opposed (see attached testimony).

Rep. Klemin: It seems to me that the thrust of your testimony here is that we don't want to hospitalize people who don't really need it, or against their wishes or that type of thing and that we need to look at alternatives to hospitalization. But I guess I don't see that this bill really changes anything on that aspect because we still have section 25-03.1-21, which deals with the involuntary treatment order which specifically requires the State Hospital or treatment facility, to provide a report to the court assessing the availability and appropriateness of treatment programs

other than hospitalization, and the courts have to consider that before requiring hospitalization.

How does this bill change any of that.

Dr. Belanger: It changes it by sliding the standard to a more mentalistic point. What it does is it sets up the psychologist and the psychiatrist to be able to really know what is really going on inside the mind of another person and allows this with less behavioral evidence. For example, I do about 100 night call a year at the State Hospital and we get meth. people coming in quite regularly because of the widespread nature of its usage and its extremely deleterious effects. I have never had difficulty in establishing behaviorally based evidence that warrants the commitment. That's my concern, is that the risk from behaviorally based evidence to a more mentalistic approach, particularly when we have an explosion of information based on more competing power to create better databases and find out what are the actual risk factors to a finer degree of specificity.

Rep. Klemin: You're the psychologist, and you're examining these people to see, to make a determination as an expert examiner, whether a person does require treatment under the statutes. I don't see anything in this amendment that requires you to weigh one factor more than another factor. Aren't you still able to make your determination the way that you would regardless of what the statute says, it doesn't say that if they find this or don't find that, that you can't reach the same conclusions you do now, based on the same evidence you use now. How does this change that?

Dr. Belanger: What you want me to be able to do here is to know whether that person over there, no longer has volitional control over their thoughts. Now, if you ask me to do that, I will adhere to the standard that says that I must see some evidence of this. Example of this, a patient

tore up the room, tearing up the room because they were looking for the electronic listening devices. That's good behavioral evidence that something is going on there, but if someone says to me, for example, so and so, my brother is really out to lunch, he believes in ET's. The brother is brought in and is managing his affairs in life, he's running his business and all the rest of it, so what if he believes in ET's. So what if he has some very deeply irrational beliefs.

Rep. Klemin: Looking at this bill and the language that we're using, you're saying that this bill requires you to determine loss of cognitive or volitional control based on evidence, but I think if we made the amendment proposed by Ms. Hofmann, that bill would then require that you must see evidence of loss of volitional control; whereas the bill right now as it presently reads, uses the word "or" which then wouldn't make that requirement. I think if we put the word "and" in, as is suggested here, then that's the precise problem you've got. Whereas if we continue with the word "or", it does allow you the latitude to look at other things.

Dr. Belanger: But it also allows other people the latitude to look just at the thoughts; this is what JCHL, the Joint Committee for Declaratation of Health Care organizations would suggest that we should be doing. The loss of cognitive or volitional control over the person's thoughts as evidenced by, and then you have to be able to show where is the evidence, is it in the vegetative signs of the patient, is it in the loss of sleep, is it in the disturbance of thought, is it in the social functioning, are they no longer able to hold a job, were they ever able to hold a job, etc.

Rep. Onstad: Isn't that the reason to have a hearing processes, if the claims aren't substantiated, they are let go.

Dr. Belanger: Yes, what I am hoping to be able to persuade you to do, is to consider that we can improve the accuracy with which we do the whole thing if we still down and study it. We've

been asked, for example, to accept numbers in New York and other states. Those numbers are very valid, maybe they are very good; on the other hand what would the numbers be in a rural state like North Dakota.

Rep. Onstad: Those numbers that happen in other states, it doesn't involve a hearing process.

Dr. Belanger: Absolutely true.

Rep. Onstad: So if you just throw all that out, that's why the hearing process is in the bill to establish that, and if you can't establish the facts, I don't think they would be there.

Dr. Belanger: It is a lot harder to do to the professional or scientific certainty if people are allowed to say, well the patient lacks insight. How do you know a patient lacks insight. Because I examined him and therefore he lacks insight. He lacks insight as evidenced by what? The only thing that should really pass is that he lacks insight, as evidenced by the fact it was January 14, it was 5 degrees below zero, he walked outside without his shoes on, because he thought that he had magical power. That will work. But that's what I'm still arguing for, is that the language from my point of view doesn't provide enough protection against somebody winging it on the basis of the argument of authority. I know the person's mental state because I am a professional.

Rep. Onstad: It just seems like you are cutting down the credibility of your professional.

Dr. Belanger: No I am not. What I am attacking is the sense of being able to do this on the basis of guesstamation about another person's mental state. I assure you, the profession and myself, are more than adequate to come up with a behavioral test and other evidence that justifies this, and to swing that to a place where people can introduce standard on the basis of what they think the other person thinks, gets to be a bit too vague.

Rep. Klemin: Just to follow up on this point again, based upon the loss of cognitive or volitional control over the person's thoughts or actions. That's the new language that's being proposed, and what you're saying is, as I understand you, that should be evidenced by some objective facts.

Dr. Belanger: Exactly.

Rep. Klemin: If you don't have objective facts, then all you have...

Dr. Belanger: All you have is opinion, if you don't have facts, you don't have an expert opinion anymore.

Rep. Klemin: What kind of objective facts then would we be looking at, say if we were to put some additional language into this, to require evidence of objective factors, what kind of objective factors are we talking about.

Dr. Belanger: Disturbance in vegetative signs is a clear objective fact that's highly predicted. That's disturbance in sleep, disturbance in appetite, change in level of functioning. For example, you start out in school, you're doing fairly well, all of a sudden you throw out all the furniture of your room, one presumes you're no longer attending class, your grades have plummeted, you have adopted a most unusual diet that's not established to be good for your health. All of these things are out there as behaviors to be observed.

Rep. Delmore: I think they did talk about it when they talk about being based on facts or actions, threats, history, etc. I don't think you have to construe it in the least possible manner. As a trained professional, obviously, you make these calls all the time.

Dr. Belanger: Going the other way around, can some other professional construe it on the basis of thoughts alone.

Rep. Delmore: You think there are that many in your profession that would take it in the least restrictive way in order to take someone's rights away and incarcerate them.

Dr. Belanger: I took no position on the relative incidence within the profession. The position that I took was that it is entirely possible.

Chairman DeKrey: Thank you for appearing. Further testimony in opposition to SB 2296.

Marilyn Schoenberg, Advocate for Holistic Health Care and former mental patient: I am not a member of any organization, I am advocating for these principles against the course of psychiatry. I have a lot of ideas for reform and for health care in a holistic way. The bad news is that the problem that we are here to talk about are not that we can't get people into the system, but the system itself is the problem. I, too, care very deeply about people with problems and who are troubled. The trouble is with the mental health care system, most people are not really mentally ill; they are spiritually and emotionally ill. They are called mentally ill and treated with drugs. Now I know that everybody here cares, and that you are frustrated as I am frustrated, because we have a lot of people who are not getting help. Right now, the only help really available is the mental health care. If we have somebody who we are worried about, we're not given alternatives to mental health care. For myself, a critic of the system, helped get a friend just a year ago, into a psychiatric unit because I was afraid for his life. Right now that is all that is available. But there are growing concerns with the system, this may be the first time that many of you may hear this, but it won't be the last. I am a supporter of all the other people that testified before me. I came alone. I didn't know that they would be here. I am in support of psychology and psychologists. It is in the area of psychiatry where the problems are occurring. I know you want to do something to help people. We want to prevent suicide, and you don't like

to see people troubled. I feel very much for Sheree, here, and her son. So to talk about what else could be done. The trouble is that somebody is in trouble, and all we can do is try to get them into the hospital. What would be better to have support groups available for parents to call, such as Tough Love, etc. That is not being done right now, but that is something that could be strengthened. So many problems in mental health care, for instance, misdiagnosis. As the psychiatrist testified, 1% of the population is schizophrenic usually. Most people in mental health care are not schizophrenic, and even for them recovery is limited, restricted, because it is not holistic, mental health care is not holistic. I would just compare it to a baseball diamond. You start out here at the plate getting help, we may either ask for help or we may be committed to get help by family members, another problem is that a lot of families are dysfunctional. You have a person who is vulnerable because of their family situation, perhaps they are going to exaggerate the trouble in the family to stand out as the worst one, and the families are not typically treated in mental health care. So what mental health care does is combines intervention with drugs and hospitalization. But usually the help stops there at first base. I've been in treatment myself, addiction treatment, abuse therapy and mental health. If you keep going, second base would be education and reeducation therapy, third base would be support groups, and reentry into the community would be a home run. I haven't made a home run yet because I'm not acceptable, with a label of major mental illness. We have a lot of good things going on in human services, but we just need to keep going and the answers are not in mental health. They're not there, we have to look elsewhere, we have to build other services and community help and support. There is a great stigma with the label, because as the psychiatrist testified, as the lady from the East testified about the label; people with mental illness are seen as not able to

take care of themselves, not able to make decisions, their minds don't work, dependent forever, we are considered static, not able to grow and change. Addiction treatment is for certain process, abuse therapy is a certain process, you are given tools to use, you may not choose to use them, it's not a guarantee, people have their own will, but you are given tools. In mental health care, you are not even given the tools you need to recover to become independent. They do not believe that is possible, and there is too much dependence on drugs. They think drugs are the answer to everything. I don't really expect very much here today. I wanted to speak my peace, speak my truth and appreciate the opportunity to do that. It is still a partially free country for me, I'm here. I'm able to speak. I don't expect you to understand what I'm trying to tell you, because it may be the first time you've heard such things.

Chairman DeKrey: Thank you. Further testimony in opposition. We will close the hearing.

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2296

House Judiciary Committee

☐ Conference Committee

Hearing Date 3-18-03

Tape Number	Side A	Side B	Meter #
1		xx	2.9-9.6
Committee Clerk Signature	A Penrose		

Minutes: 10 members present, 3 members absent (Rep. Grande, Wrangham, Eckre).

Chairman DeKrey: What are the committee's wishes in regard to SB 2296.

Rep. Klemin: Explained the amendments. I move the amendments.

Rep. Maragos: Seconded.

Voice Vote: Carried.

Rep. Klemin: I move a Do Pass as Amended.

Rep. Delmore: Seconded.

10 YES 0 NO 3 ABSENT DO PASS AS AMENDED CARRIER: Rep. Klemin

30427.0201
Title.0300

Prepared by the Legislative Council staff for
Representative Klemin
March 5, 2003

House Amendments to Engrossed SB 2296 - Judiciary Committee 03/05/2003

Page 3, line 26, after "upon" insert "evidence of objective facts to establish"

Renumber accordingly

Date: 3/18/03
Roll Call Vote #: 1

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2296

House Judiciary Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 30427.0201 . 0300

Action Taken Do Pass As Amended

Motion Made By Rep. Klemin Seconded By Rep. Delmore

Representatives	Yes	No	Representatives	Yes	No
Chairman DeKrey	✓		Rep. Delmore	✓	
Vice Chairman Maragos	✓		Rep. Eckre	AB	
Rep. Bernstein	✓		Rep. Onstad		
Rep. Boehning	✓				
Rep. Galvin	✓				
Rep. Grande	AB				
Rep. Kingsbury	✓				
Rep. Klemin	✓				
Rep. Kretschmar	✓				
Rep. Wrangham	AB				

Total (Yes) 10 No 0

Absent 3

Floor Assignment Rep. Klemin

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
March 18, 2003 2:01 p.m.

Module No: HR-48-5074
Carrier: Klemin
Insert LC: 30427.0201 Title: .0300

REPORT OF STANDING COMMITTEE

SB 2296, as engrossed: Judiciary Committee (Rep. DeKrey, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (10 YEAS, 0 NAYS, 3 ABSENT AND NOT VOTING). Engrossed SB 2296 was placed on the Sixth order on the calendar.

Page 3, line 26, after "upon" insert "evidence of objective facts to establish"

Renumber accordingly

2003 TESTIMONY

SB 2296

AH #1

Senate Judiciary Committee Testimony
Senator Tim Mathern
Senate Bill 2296

Chairman Traynor and members of the Senate Judiciary Committee. My name is Tim Mathern, Senator from District 11 in Fargo. I sponsored Senate Bill 2296 because I believe there are persons who suffer from mental illness who do not receive treatment early enough.

Amendments are being offered to make this bill as narrow as possible to meet the objectives but not violate people's rights to refuse treatment when they are not in need of treatment.

Members of the Committee I believe this bill is urgent. From my experience working in a large parish in Fargo I know people wander the streets needing treatment but not getting it. Some individuals get better using medication and then go off the medication when they feel better but then need to be hospitalized to reestablish the medication pattern and its benefit. Far better that the medication use continue without interruption. Also from my experience in the Appropriations Committee I have learned that there are far too many people in prison who have committed crimes when they were in need of mental health services. With this bill we're just trying to make it possible to get people who are clearly in desperate need of help (delusions, psychotic) and the care they need before they become dangerous to themselves or others. This bill adds language to the Century Code to allow courts to use the loss of control over ones thoughts as a basis for predicting dangerousness to self or others. Otherwise, with no expanded definition, the assumption by some courts has been that a violent or suicidal act is required to prove or predict dangerousness. Again, I believe this bill is urgent. We must stop needless incarcerations, suicidal deaths, and personal suffering as soon as possible

Mr. Chairman and members of the Committee there are others who wish to testify and I ask that you permit Ms. Sheree Spear to testify next so that you get a full description of the need for this bill and orderly introduction of proponents to respect the time constraints you are under.

I ask for your support of SB 2296 with amendments. Thank you for your consideration.

1b. New

30427.0102
Title.

Prepared by the Legislative Council staff for
Senator Mathern
February 5, 2003

PROPOSED AMENDMENTS TO SENATE BILL NO. 2296

Page 1, line 9, replace "Includes" with "may include"

Page 1, line 10, remove "pursuant to section 25-03.1-18.1"

Page 3, line 27, remove "risk of loss"

Page 3, line 28, remove "of the person's ability to function independently in the community or the"

Page 4, line 1, replace "person's inability to make a" with "effect of the person's mental condition on the person's ability to consent"

Page 4, line 2, remove "rational decision about the need for treatment"

Page 5, line 1, after "medication" insert "on an inpatient or outpatient basis"

Renumber accordingly

AH #2a 2/5

Senate Judiciary Committee Testimony
Sheree Spear
Senate Bill 2296

My name is Sheree Spear. It is not easy to commit someone. And it shouldn't be. But it shouldn't be impossible when everyone can see that a person is delusional, paranoid, or psychotic and clearly in need of help. But that is exactly the situation that I and many family members in ND have found themselves in when trying to get help for a severly ill loved one.

Our objective with this bill is not to make it less difficult to get people across the board into the hospital for an evaluation. Instead this bill has been honed to focus very specifically on getting treatment for those who are too sick to help themselves.

18 months ago my 22 yr old son became delusional and paranoid and seemed suicidal. I wanted to get him into the hospital involuntarily because he wasn't willing to go on his own. His paranoia was too strong for him to overcome and he believed the nurses would try to poison him. So a few months later he busted the glass on a gun cabinet, loaded a gun to kill himself. Only by a miracle did a family member come in at exactly the right moment and interrupted his suicide plan.

My son almost died because this law requires family to not only PREDICT but PROVE what an unpredictable, unstable person will do. Once they have a history of violent acts and so on it becomes much easier. But when it's a first time psychotic break you have no prior act or event to point to substantiate a claim of potential dangerousness. That's where there's a little gap in the law. Getting first time help for people before they become dangerous.

I've heard it said that we shouldn't piece meal changes to this law. But this law doesn't need wholesale revision. It is one of the most well-crafted laws in the country. Legislators did their job well when they passed this law. The 5 attorneys who drafted or reviewed this bill, two of which are in ND, believe this is good legislation – and needed. How any other aspect of the law may be affected by the proposed changes has been thoroughly considered.

In the course of discussion, I explained to an individual, "Look all I'm trying to do is prevent tragedies, prevent some deaths." This person replied, "I don't know of anyone who's DIED!" (meaning of mental illness) This coming from someone who lives in ND which has the highest suicide rate in the nation – not just for children ages 10-14, but also for adolescents ages 15-19! In the nation! Could there be a correlation between those statistics and the fact that there hasn't been a movement in this state toward assisted treatment for those too sick to realize they need help? A movement toward getting people help before they become dangerous – or toward keeping them stable?

I wish I lived in a world where people didn't die or hurt someone because of untreated mental illness. If that was the world I lived in mentally I would probably be proposing we just "study" this for a couple years. Two years, three, 5 years – no rush. But I live in this world. And I know that if this bill isn't passed this session it will be a death sentence for someone.

In this state people die. Like Jerome Emo from Jamestown who hung himself last October after his wife spent the summer trying to get him help to no avail. She was willing to come here and speak but I'm speaking on her behalf today.

In this state PREVENTABLE tragedies occur. Jeffrey Scott of Fargo was just

sentenced this past Dec. to 20 years in the Bismarck prison. He shot his mom's fiancée in the neck, leaving him a quadriplegic and on a vent for life. His mom told me he had paranoid schizophrenia and they tried for years to get him help but he's gone all this time with no medicine. People say you have to wait until they do something.

The people of ND will pay about $500,000 or more over the next 20 years to house Jeffrey Scott. We will all pay for the medical care and disability payments for the person he shot. There is a HUGE cost to society for untreated mental illness. Elaine Little, Dir. Of Corrections for ND said that she, personally, believes this bill will make a difference (as do most in law enforcement, and other areas as well). She said, "With all the people we see coming through our doors every year with untreated mental illness, we can't help but wonder if maybe they wouldn't have committed that crime had they gotten help."

The final point I'd like to make before quickly running through a couple changes, and touching on the process map attached is this. What about the issue of Civil Rights? Some say you are taking away people's right if you require them to take medicine when they say they don't want to.

First, we have to distinguish between those who are able to act out of their own feel will and those who cannot. A delusional person is not acting out of their own will.

Secondly, I think some people have been waving the Civil Rights flag for so long they've forgotten what it means. Life, Liberty and the Pursuit of Happiness. Jeffrey Scott lost his liberty for 20 years because he didn't get proper care for his medical problem. The man he shot almost lost his life. And someone lingering in a state of delusion is unable to exercise his/her civils rights and certainly is being denied the right

to pursue happiness, like they would be able to with the better meds available today. No, the civil rights of these people are being denied when they are denied care for their disability.

Comments on language.

Amendment adds "on an in-patient or out-patient basis" to the end of sentence in first line of section on Court ordered treatment with prescribed medication.

This section became effective in 1993, after the shift from hospitalization to community based care. It is the legislative intent that this apply to in-patient or out-patient. The legislative intent of this Chapter is that the least restrictive treatment plan be used. Clearly out-patient, independent living is much less restrictive than hospitalization. In fact, these out-patient court orders are what make it possible for people to live outside the hospital and have a shot at some of the good stuff you and I enjoy in life.

Under "Person Requiring Treatment" we are providing clarity. We are saying if a person has clearly lost control of his or her thoughts or actions, that can be used as a basis for determining potential dangerousness. While some jurisdictions may already do this, out of tradition, this is not interpreted consistently through-out the State. The best way to ensure that it is done is by providing clarification, because judges can only work with what is in front of them.

MAP:

- Safeguards are in place to protect against "railroading".
- HMOs pressure to hospitals to not keep people for treatment.
- In the 4 versus 7 day situation, the petition wasn't filed by the hospital, so the current process wasn't followed.

Attachment to Testimony for Sheree Spear
Senate Bill 2296

CONTACTS MADE

Numerous Consumers and Family Members
Legislators
Karen Larson, Dir. Mental Health & Substance Abuse
Jeff Stenseth, SE Human Service Center
Jerry Kemmet, Dir. Bureau of Criminal Investigation
Sheriff Busching, Pres. Sheriff's Assoc., Williston
Sheriff Rudnick, Fargo
Sheriff Thomas, Grafton
Police Chief Bruce Kemmet, Devils Lake
Police Chief Chris Magnus, Fargo
Sheriff Kim Murphy, Wahpeton
Burch Burdick, St. Attorney, Cass Cnty
Fritz Fremgen, St. Attorney, Jamestown
Thomas Mayer, Asst. Atty. Gen.
Elaine Little, Dir. Dept. of Corrections
Dr. Samuelson, Psychiatry
Dr. Glenn Johnson, Jamestown
Dick Weber, MHA
Mike Kaspari, First Step Recovery, MHA
Allen Stenehjem, MHA
Susan Helgeland, MHA
Barb Berghart, Pres. Bismarck National Alliance for Mental Illness (NAMI)
Janet Sabol, NW ND NAMI
Theresa Larson, Dir. Protection & Advocacy (P&A)
Corrine Hoffman, P&A

Evaluation and Treatment Process

4 Methods to 24 Hour Evaluation

1	Voluntary
2	Peace Officer
3	Non-Emergency Petition

- Notice Sent
- Visit w/ Psychiatrist scheduled

4	Emergency Petition	Person requiring treatment

Petition filed → State's Attorney → Human Service Center investigates → Judge's Order

Hospital Admission for 24 hrs. evaluation by Psychiatric Team

Phase I – 24 hour evaluation

Released. Follow-up might include counseling/medication	Released w/day program follow-up.	Hospital files petition for treatment	Hearing within 7 days with person under evaluation. Then repeats at 14 days...90

AH#3 3/5

Senate Judiciary Committee Testimony
Randy Petermann
Senate Bill 2296

Chairman Traynor and Senators,

My name is Randy Petermann. I've had paranoid disorder for over 25 years. I support this bill because it will save lives. I know this because of my own experience.

When I was younger, I knew my thoughts were messed up. I was beating myself up inside all the time and I didn't want to live. When you're suicidal you are so emotional that you want to go on, yet it's so painful to go on. Killing yourself is the only ticket out. You want it over. And when you're like that you're not figuring things out. You're just going on impulse. Things are happening so fast when you're suicidal. I was doing things like endangering people by driving wrecklessly. I was in terrible shape inside.

Without medication I also couldn't keep other people out of my head. Their ideas and thoughts became mine. I needed people to help me rationalize things out. They helped me with this in the hospital. But, if no one had taken the first step to get me help I'd be dead now, because I didn't know how to help myself.

Some people fight going to the hospital because they think they're right. They think they <u>should</u> die. Most people are too afraid to admit they need help. Once they get that sick – anything is hard. When you get that sick you think the doctors are against you, too. And there is the stigma. It's still hard for me to admit I was in the hospital because of the stigma.

I fought medication at first, like a lot of people do. But I realize now that my life started to take positive steps, to get better, when I had to start taking antipsychotic medicine and got professional guidance and support. I just wish I'd gotten help sooner

because after my second break I lost some of my memory abilities.

When you have an episode it is like an electrical storm occurs in your brain. It does cause damage to the nerves and can cause lesions, or scars to form on the brain tissue. The longer a person goes without the medicine they need the more cognitive skills they lose and the harder it is for them to recover.

Mental illness is a problem with the connections in the brain. It's a medical problem. It is not kind to let someone with a problem like this go without help.

My son inherited this neurological problem. When he got sick we could all see it. But we couldn't get him in the hospital because people didn't think he was dangerous. But he was a danger to himself and he almost committed suicide. Why does someone have to become dangerous before they can get help? It isn't asking a lot to be able to get someone help when they are that sick.

This bill will save lives. People that are against it think it is wrong to put someone in the hospital if they don't want to go. But when someone is that sick they aren't thinking clearly. They can't help themselves. At that time they might not think they want to go to the hospital. But no one wants to kill themselves either.

Thank you.

AH #4 2/5

Senate Judiciary Committee Testimony
Judy Knutson
Senate Bill 2296

My name is Judy Knutson. My brother was diagnosed with a schizophrenic break-down over 20 years ago. I can't even begin to describe the nightmare we've been through over the past 20 some years trying to get him help. There are many things that need to change in the system so our family members can get decent treatment. This includes access to information about medical care, supportive and structured living arrangements, and more inclusion of family in team planning for after care.

But this bill is so important because it all starts right here. It starts with getting and keeping them on their medicine. People who are opposed to that concept should ask: "Why would a doctor prescribe medication if it wasn't needed?" They need to look at what does the medicine do and to care deeply about what happens to the person if they aren't getting proper medicine and care.

My brother has lived as a homeless person for years. He's been beaten and left for dead on more than one occasion. He's scared to live on the street. He doesn't want to live on the street because he said, "It's worse now – a lot of them are on drugs out there." He has frozen his feet. He was suspended from the homeless shelter for violent behavior so he was freezing out on the streets, trying to warm up by going into businesses.

Without medication people with paranoia think people are against them, people with schizophrenia hear voices telling them scarey, terrible things about themselves and others. The voices can be very loud and many at the same time. Because of all this they may become violent at times just in an effort to try to defend themselves. But they are very vulnerable and easily preyed upon out on the streets.

The truth is that the Humane Society does a better job of protecting animals than our society does of protecting people with mental illness! If a pet was out getting cold and unfed, the owners could be brought up on charges. More value is placed on animals than on our family members! All these organizations that say they protect people with mental illness – why aren't they protecting them? They sit behind their desks with no intimate knowledge of the reality that people are actually living every day. Do any of them have a family member who is suffering like this with mental illness?

Some groups claim to be protecting people by saying you can't make someone take medicine if they don't want to. Is it more important to leave people alone than to get them help and keep them alive?

This lack of compassion and negligence has gone on far too long. My brother himself said, "At least YOU know people like me need help and we shouldn't be treated like animals." People who do not act responsibly in helping those with severe mental illness get proper medical care may start seeing themselves facing wrongful death lawsuits from family members. This sort of thing hasn't been done historically. But I think you'll find that as family members have become more educated about the true medical basis for their family member's illness, the more outraged we've become when our loved ones are denied treatment.

And treatment goes beyond a hospital evaluation. It means continuing care because serious mental illness is chronic and on-going. A major problem currently is how difficult it is to get a long-term court order for medication. This means they are required to take their medication as an out-patient so they can stay stable. Even if you manage by some miracle to get a 1 year court-order requiring them to take medication, then after a

year – then what? Wait until something bad happens again? This bill is good because it allows loss of control of one's thought or actions to be considered when determining if the person qualifies for treatment.

If people can't get medication for their illness they just get worse and worse. My brother cycled in and out of treatment so many times that is has taken it's toll on him. His case worker said, "He just doesn't get as well as he used to."

Please pass bill 2296. It will help some people who are too sick to help themselves, get decent care and maybe even a decent life. A person shouldn't be subjected to a life unfit for an animal just because they were unlucky enough to inherit a mental illness. Anyone who opposes this because they think it's wrong to make someone take medicine doesn't truly understand paranoia, they don't understand that delusional people don't make the same choices that they would if they were on medication. Please vote 'do pass' on bill 2296. Thank you.

AH #5

Senate Judiciary Committee
Chairman: Senator John T. Traynor
February 5, 2003

Testimony by Mary T. Zdanowicz, JD, Executive Director
and
Rosanna M. Esposito, JD
Treatment Advocacy Center

Senate Bill 2296
Position: Support

The Treatment Advocacy Center is a national non-profit organization, located in Arlington, Virginia. We provide technical support to states nationwide that are updating their mental health treatment laws to reflect the advances that have been made in our understanding of the nature and treatment of severe mental illnesses.

North Dakota's current mental health law is one of the most well-crafted in the nation. Senate Bill 2296 makes relatively minor but functionally important changes to the current law. There are three changes that merely clarify the existing current law, and one substantive change.

I will briefly describe the three points of clarification and then Rosanna Esposito will address the one substantive change. First, SB 2296 amends the definition of "person requiring treatment," by removing the additional defined term "serious harm to self, others or property." The statute's definition within a definition is confusing. The superfluous language can be removed without changing the meaning of the defined term "person requiring treatment" while simultaneously making it clear that four specific criteria are operative in determining whether a person requires treatment. Removing this unnecessary language will remove the confusion that now exists in determining when treatment intervention is allowed.

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Second, the term "alternative treatment order" which is in the existing statute is defined. It is clear from the context in the statute that an "alternative treatment order" is court ordered outpatient treatment and that the medication procedure applies. The definition makes this clear.

Finally, the North Dakota Supreme Court has held that direct evidence of overt violence or an expressed intent to commit violence is not required in determining the likelihood of serious bodily harm. The Court's ruling is incorporated in the statute for clarity.

The one substantive change incorporated in SB 2296 updates the "substantial deterioration in mental health" standard to make it consistent with the most progressive standards in the country. The language for this substantive amendment is drawn from Wisconsin's progressive "Fifth Standard," which was unanimously upheld as constitutional by the Wisconsin State Supreme Court in July, 2002. Specifically, the amendment incorporates what medical research in the last decade has revealed – that is, nearly half of people with schizophrenia and manic-depression have impaired awareness of the illness. This affects a person's ability to recognize that they are ill and appreciate the need for treatment. Research shows that the majority of people with mental illness are not being treated because they don't think they need it. These individuals cannot make an informed decision about treatment. SB 2296 recognizes this by allowing treatment before a person deteriorates to the point where they lose control or the ability to function because they cannot make a reasoned decision about treatment. In upholding a similar standard, the Wisconsin Supreme Court recognized that it was necessary to break the cycle of hospitalization, incarceration and homelessness. SB 2296 maintains the current procedural and substantive due process safeguards contained in the Century Code, while ensuring that the revised standards reach only those individuals who are unable to make a rational decision concerning their need for treatment.

For these and other reasons, we recommend a favorable report on Senate Bill 2296. Thank you for your consideration of this important measure.

Att #6

Senate Bill 2296 Testimony
February 5, 2003

Mr. Chairman and members of the Judiciary Committee, my name is Janet Sabol from Minot. I'm in favor Senate Bill 2296 because it will allow people with mental illnesses or brain disorders to get treatment **before** they do something dangerous to themselves or to others.

The most substantial change in the law is under the definition #12. "Person requiring treatment." Letter d. identifies that if there is substantial deterioration in mental health "based upon the loss of cognitive or volitional control over the person's thoughts or actions" and other relevant factors "including the person's inability to consent to care", that person would fit the definition. These words are crucial in determining if a person needs to be committed involuntarily. A number of people with schizophrenia, bipolar disorder and other mental illnesses have a neurological syndrome that is part of their illness and caused by brain damage. Basically a person does not believe he or she is ill and will explain any contradictions that would indicate that they are ill. Having poor insight into your own illness makes it difficult to seek out treatment and also to remain on a treatment course.

In my volunteer capacity of a state coordinator for NAMI: The Nation's Voice on Mental Illness, I have talked to many families who have had to suffer along with their loved one as they see their physical and mental condition deteriorate before they are able to be committed to inpatient or outpatient treatment. One mother watched her daughter resort to going only a few feet from her apartment to get vending machine

items to eat because her schizophrenia and social phobia was so bad that she couldn't go into a grocery store, pick up items and go to the checkout. Yet when she was seen at the Human Service Center, she appeared fine. Another parent was called when his son had resorted to moving all the furniture and other items out of his college room, was eating raw meat and making sounds before his illness received treatment through involuntary commitment. Another parent feared for her life as her son was yelling and threatening her. He talked of 'getting rid of' someone. She had to testify in court that the verbal remarks were evidence of schizophrenia even as her son's lawyer questioned her knowledge of the illness. Her son had already lived with the effects of the illness for 20 years. Seeking treatment for someone with a serious mental illness, even though it is court-ordered, is the most humane thing to do so that they can again exercise their civil rights without hallucinations, voices and delusions guiding their thoughts.

As a consumer myself, there were a couple of times where a pastor drove me to the hospital or to the doctor's office and then to the hospital because I could not stop the thoughts of wanting to end the pain of mental illness. I was angry for a number of days even when I knew it was the only way I could get help in stopping the overdoses. I have depression and know when the illness is getting worse; and also at what point I have to intervene by reaching out to a professional before I can no longer make good decisions about coping with the depression. Considering those whose illnesses prevent them from seeing they're ill, this change in the law is absolutely essential.

AH #7

Testimony of Mental Health Association in North Dakota
Re: Senate Bill No. 2296
Senate Judiciary Committee
February 5, 2003

Mr. Chairman, members of the committee, my name is Sharon Gallagher. I am a volunteer representing the Mental Health Association in North Dakota. The MHAND is a non-profit volunteer citizens organization affiliated with the National Mental Health Association. We recently celebrated our 50th Anniversary as advocates for persons suffering from mental illnesses and their families.

I appear today to oppose any efforts to weaken the standard for commitment of persons suffering from mental illnesses and to offer some amendments to the bill, which we hope will protect the law from constitutional challenge and still allow for some additional clarity.

I have spent over 20 years as a volunteer with the MHAND and a large part of my work has been focused on the commitment law. As you may remember, in the mid '70's the United States Supreme Court ruled that the state could not deprive a mentally ill person of his or her liberty unless that person was a danger to himself or others. I was the staff person assigned by the Legislative Council to draft an entirely new chapter relating to commitment procedures in 1977. Most if not all of the states went a little further than the restrictions set out by the US Supreme Court and adopted language allowing an order for treatment when there was evidence of a "substantial deterioration in physical health, or substantial injury, disease, or death, based upon poor self-control or judgment in providing one's shelter, nutrition, or personal care." To date this standard for commitment has not been successfully challenged.

Since 1977, I have chaired numerous multi-disciplinary committees in fulfilling our promise to the legislature that the MHAND would continue to monitor the implementation of the law. In all those years, the most difficult task for us as well as for the legislature has been to responsibly balance the rights of the individual and the compassionate concerns of the family members. Under our constitution, all of us enjoy the right of freedom of choice and liberty. The courts have recognized that a person suffering from a mental illness, may as a result of that illness, pose a danger to himself or others, and that in those instances, the state may intervene to force treatment. However, the courts have also held, that while a person suffering from mental illness may be hospitalized, that person still retains the right to refuse medication, when the side effects of the medication may pose greater health risks than suffering through the illness.

It is our concern that SB 2296 as drafted would create numerous opportunities for constitutional attack. To protect the integrity of the current process we ask that you not delete the standard which is represented the phrase "serious risk of harm to that person, others or property". This language was actually proposed by a district court judge who not

only had served on our committees by who presided over commitment proceedings. This language represents a more objective standard to guide the judges and is one that with which they are very familiar. To remove the standard in an attempt to make it easier to commit someone could have system wide unintended consequences. I am concerned about the potential for constitutional challenges that may result in not having a law we can enforce.

We did take a bold step in the 80's by adding as a criteria for whether a person is one requiring treatment the language of subsection 12 d to allow the system to respond with court ordered treatment when: in the opinion of the mental health professional the substantial deterioration in mental was reasonably predictable. This provision is not used often but was intended to allow the system to intervene when the mental health professional has historical knowledge of the persons illness and can reasonably predict its course. The new language being proposed is appropriate and certainly does clarify our original intent.

I am deeply troubled by the new language on page 3 which amends subsection 12 b of 25-03.1-02. The United States Supreme Court in its landmark decision in the '70's and in subsequent cases was very clear that the state's desire to deprive someone of their liberty albeit for an humanitarian purpose of "providing treatment" must be based on real, not illusory or anticipatory conduct. In other words, there must be direct evidence of violent acts or threats of violence before the state can order the person detained for treatment. It is not enough to present evidence that someone is scarred, or concerned for the welfare of the respondent.

It is my understanding that this bill is before you at the urging of a family member who was unsuccessful in an attempt to seek a treatment order for a loved one. I am sympathetic to these concerns, but am fearful of attempts to change the law, based on one anecdotal instance. It is my opinion that many of the concerns could be more appropriately addressed through the provision of training for our judges, states' attorneys, law enforcement personnel and mental health professionals. I would urge you to ensure that adequate funding for such training is appropriated by the legislature.

Thank you for your consideration of our concerns. I would be willing to answer any and all of your questions.

25-03.1-18.1. Court-authorized involuntary treatment with prescribed medication.

1. a. Upon notice and hearing, a treating psychiatrist may request authorization from the court to treat a person under a mental health treatment order with prescribed medication. The request may be considered by the court in an involuntary treatment hearing. As a part of the request, the treating psychiatrist and another licensed physician or psychiatrist not involved in the current diagnosis or treatment of the patient shall certify:
   (1) That the proposed prescribed medication is clinically appropriate and necessary to effectively treat the patient and there is a reasonable expectation that if the person is not treated as proposed there exists a serious risk of harm to that person, other persons, or property;
   (2) That the patient was offered that treatment and refused it or that the patient lacks the capacity to make or communicate a responsible decision about that treatment;
   (3) That prescribed medication is the least restrictive form of intervention necessary to meet the treatment needs of the patient; and
   (4) That the benefits of the treatment outweigh the known risks to the patient.

   b. The court shall inquire whether the patient has had a sufficient opportunity to adequately prepare to meet the issue of involuntary treatment with prescribed medication and, at the request of the patient, the court may continue the involuntary treatment hearing for a period not exceeding seven days or may appoint an independent expert examiner as provided in subsection 4.

2. a. Evidence of the factors certified under subsection 1 may be presented to the court at an involuntary treatment hearing held pursuant to sections 25-03.1-19 and 25-03.1-22, or at a separate hearing after motion and notice. The court in ruling on the requested authorization for involuntary treatment with prescribed medication shall consider all relevant evidence presented at the hearing, including:
   (1) The danger the patient presents to self or others;
   (2) The patient's current condition;
   (3) The patient's treatment history;
   (4) The results of previous medication trials;
   (5) The efficacy of current or past treatment modalities concerning the patient;
   (6) The patient's prognosis; and
   (7) The effect of the patient's mental condition on the patient's capacity to consent.

   b. Involuntary treatment with prescribed medication may not be authorized by the court solely for the convenience of facility staff or for the purpose of punishment.

3. If the factors certified under subsection 1 have been demonstrated by clear and convincing evidence, the court may include in its involuntary treatment order a provision, or it may issue a separate order after notice and hearing, authorizing the treating psychiatrist to involuntarily treat the patient with prescribed medication on such terms and conditions as are appropriate. The order for involuntary treatment with prescribed medication, however, may not be in effect for more than ninety days.
4. If a patient has requested an examination by an independent expert examiner under this chapter, and if the treating psychiatrist has requested authorization for involuntary treatment with prescribed medication, only a psychiatrist may independently examine the patient as to the issue of involuntary treatment with prescribed medication.

Source: S.L. 1991, ch. 292, § 3; 1993, ch. 279, § 10.

Applicability to Criminal and Civil Commitments.

The very specific protections afforded by this section are applicable to all persons committed for treatment. There is no language under N.D.C.C. ch. 12.1-04.1 that manifests a legislative intent to avoid application of this section to persons who have been committed for treatment under N.D.C.C. ch. 12.1-04.1. State v. Nording, 485 N.W.2d 781 (N.D. 1992).

This section applies to insanity detainees who are committed to treatment facilities under N.D.C.C. ch. 12.1-04.1. The court has authority to commit and order treatment under N.D.C.C. ch. 12.1-04.1 but, when the treatment is to include forced medication, the procedural requirements of this section must be met. State v. Nording, 485 N.W.2d 781 (N.D. 1992).

Authorization.

Involuntary treatment may not be authorized solely for the convenience of facility staff or for punishment. Arevalo v. J.S., 528 N.W.2d 367 (N.D. 1995).

Benefits of Medication.

The county court did not err in determining that the evidence was clear and convincing that the benefits of forced medication outweighed its risks to the patient where, except for evidence of stiffness, there was no evidence that the patient had suffered side effects when taking the medication in the past. In re B.D., 510 N.W.2d 629 (N.D. 1994).

Expert Testimony.

District court's acceptance of uncontroverted expert testimony was not clearly erroneous where counsel for patient presented no testimony in opposition to expert's conclusion; if counsel wished to attack the expert opinion of the state's psychiatrist, he should have requested an independent expert examiner for his client. Arevalo v. J.S., 528 N.W.2d 367 (N.D. 1995).

Least Restrictive Form of Treatment.

When the choice is between involuntarily treating a patient with drugs which could stabilize the patient and allow an early release from hospitalization, and not medicating the patient at all which could cause a deterioration in condition and lead to indefinite hospitalization, forced medication is the least restrictive form of treatment. Waters v. C.W., 552 N.W.2d 382 (N.D. 1996).

Multiple Combinations of Medicines.

The potential differences in the length of hospitalizing patient for treatment, the relative brevity of 90-days forced medication, and the need for judicial economy, made it sensible to authorize more than one combination of medicines, depending on later refusals. Shannon J. v. R.A.J., 554 N.W.2d 809 (N.D. 1996).

Proof Required.

To support involuntary treatment, each of the factors listed in this section must be proven by clear and convincing evidence. Arevalo v. J.S., 528 N.W.2d 367 (N.D. 1995).

Purpose.

By enacting this section, the legislature has recognized the complexity of the question of administering psychotic drugs forcefully. This new legislation is designed to safeguard a patient's right to be free of forced medication unless the prescribed medication is necessary to effectively treat the patient, unless the medication is the least restrictive form of intervention available for the patient's treat-

9c

Proposed Amendments to Senate Bill No. 2296
Prepared by Mental Health Association in ND
February 5, 2003

Page 1, line 9, replace "includes" with "may include"

Page 3, line 15, remove the overstrike over "~~a serious risk of harm to that person, others, or property. "Serious risk~~"

Page 3, line 16, remove the overstrike over "~~of harm" means~~"

Page 3, line 20, remove "Direct"

Page 3, line 21, remove "evidence of overt violence or an expressed intent to commit violence is not"

Page 3, line 22, remove "required."

Page 5, line 26, remove the overstrike over "~~and there exists a serious risk of harm to that person, other~~"

Page 5, line 26, remove the overstrike over "~~persons, or property~~" and remove "and"

AH #8

Senate Bill 2296

Mr. Chairman, Members of the Senate Judiciary Committee:

My name is Gregory Runge. I am one of two attorneys who represent those individuals who have been alleged to be mentally ill and/or chemically dependant and requiring treatment here in Burleigh and Morton Counties. I have been representing respondents since 1989. After reviewing this bill, in great detail, I come before this committee to ask that you vote a DO NOT PASS on these amendments.

Let me start on page 1 lines 8-10, "Alternative Treatment Order (ATO)." Under the new definition of Alternative Treatment Order inclusion of a medication order under section 25-03.1-18.1 NDCC is nonsensical. Under this amendment, an order for forced medication must be made by the court even where prescribed medication is not sought. If the concern is ordering that medication be taken in conjunction with an ATO with non-compliance resulting in hospitalization, that is already being done. As I stated above, since medication is not generally ordered in chemically dependant cases and it is not always required in mental illness cases it should not be required in <u>all</u> ATO's.

Next, on page 3, lines 20 through 22 is language that is superfluous and redundant. The North Dakota Supreme Court has already ruled that "overt violence or an expressed intent to commit violence" need not be shown.

Again on page 3, lines 27 through 29 are unconstitutional, violating due process. The language is vague. For example, who is to determine what it means to "function independently in the community" or what it means to lose "cognitive or volitional control." Clearly, in view of the lack

of definitive clarity, the respondent could not defend him or herself because they would not know what to defend, thereby violating their due process, in that, they would not have proper notice of the deed they were purported to have committed. Even if the terms were spelled out, these terms would be redundant because they are already defined under section 25-03.1-02 §§10.

On page 4, lines 1 through 2, this language also violates due process due to vagueness. Who is to say when a person is requiring treatment and when a person would merely benefit from treatment? See *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975); *In the Interest of R.N.*, 450 N.W.2d 278 (N.D. 1990).

The biggest problem with this bill is the deliberate attempt to water down the requirements for depriving persons of their liberty by removing the requirement for showing a serious risk of harm from not only the definition of a "person requiring treatment," but from the emergency committal process and forced medication provisions. Again, this will raise issues of constitutionality if these changes take effect.

As a final point, I would ask that this matter be deferred to further study to give an opportunity to all participants of the mental health process to give input in the form of a study resolution or the like. I would also add that the real problem to be address is to update the statute to take into account the greater use of non-hospital treatment in both the mentally ill and chemically dependant cases. The statute is still too focussed on the North Dakota State Hospital as the primary provider.

Thank you for your attention. I would be happy to answer any questions you may have.

Gregory Ian Runge
Respondents' Attorney

AH #9a

SENATE BILL 2296
SENATE JUDICIARY COMMITTEE
February 5, 2003

CORINNE HOFMANN
PROTECTION AND ADVOCACY PROJECT

Chairman Traynor and Members of the Committee, my name is Corinne Hofmann. I am Director of Policy and Operations for the Protection and Advocacy Project [P&A]. We are aware of the concerns that led to the submission of this bill for the legislature's consideration. We have great compassion for the frustration that families sometimes endure in navigating the mental health system in North Dakota. We believe that in some cases the system fails to provide the needed intervention and assistance. In other cases, we believe the system works as it should, but simply yields a result unacceptable to some of those involved.

The state has an obligation to provide for the welfare of its citizens. Adequately addressing the needs of persons with mental illness is a challenge. The state must walk a fine line between safeguarding the health of this vulnerable population and safeguarding individuals' right to self-determination. Errors will sometimes be made. Ultimately, the system relies on fallible human beings to implement our statutes. Human error can be minimized with education and training, but never wholly eliminated.

Our current commitment law was conceived and outlined with much thought and input. We believe the changes outlined in Senate Bill 2296 jeopardize the delicate balance achieved in our current law. We do not believe that the changes proposed in SB 2296 will clarify or assist those implementing the law.

The bill defines "alternative treatment order". We believe this is unnecessary. Under section 25-03.1-21 the plain and clear meaning

of "alternative treatment order" is an order for a treatment program other than hospitalization. That section also outlines the process for using alternative treatment orders.

Section 25-03.1-21 does not reference 25-03.1-18.1, the section in the commitment chapter which outlines the process for involuntary treatment of individuals with medication in an inpatient setting. We believe it would be inappropriate to include the language referencing section 25-03.1-18.1 in the definition of an alternative treatment order.

If treatment were visualized on a continuum from least intrusive to most intrusive, voluntary treatment in the community would lie at one end, alternative treatment orders would be in the middle, and involuntary inpatient hospitalization would be near the other end of the continuum. The most intrusive treatment on the continuum would be involuntary inpatient hospitalization with a forced medication order obtained under 25-03.1-18.1. With each step across the continuum, individual choice and liberty become increasingly limited.

We believe that involuntary treatment with medication, as conceptualized in 25-03.1-18.1, is inconsistent with the philosophy underlying the use of alternative treatment orders. Taking prescribed medication and medication monitoring may be, and often is, part of the alternative treatment program and order, but forcible administration of medication is not. Apart from philosophical and constitutional concerns, as a practical matter it is unlikely that the manpower and resources exist to forcibly administer medication in an outpatient setting.

Should the Committee believe it would be beneficial to add a definition for "alternative treatment order" to section 25-03.1-02, we

support adopting the definition currently used in 25-03.1-21, as outlined in the second paragraph of my testimony.

Senate Bill 2296 removes "serious risk of harm" from the definition of a person requiring treatment in section 25-03.1-2. It also replaces "serious risk of harm" with a "person requiring treatment" in section 25-03.1-18.1, pertaining to involuntary inpatient medication and in section 25-03.1-25 pertaining to emergency procedures.

In discussing this bill with someone who participated in the 1989 task force responsible for developing chapter 25-03.1, I was told that this language was deliberate and has important conceptual relevance and utility. It was intended to keep those implementing the statute focused on the critical issue to be considered in the commitment process. Eliminating this language weakens this focus and increases the likelihood that people will be inappropriately committed. Involuntary treatment was not intended to be imposed, and should not be imposed, on those who would merely benefit from treatment, but only on those who pose a serious risk of harm to themselves and others.

The remaining change proposed in Senate Bill 2296 is a change to section 25-03.1-2 (11) (d). The proposed language invites a more subjective and expansive interpretation that is inconsistent with the well established requirement for clear and convincing evidence prior to imposing involuntary treatment. It seems certain to result in an increased number of inappropriate involuntary commitments.

We understand that amendments to this portion of the bill may be offered that would include the person's capacity to consent or make an informed choice as an element to be considered in determining "dangerousness". Incorporating this standard is inconsistent with section 25-03.1-33, which states that a determination that a person

requires treatment, a court order for hospitalization or for alternative treatment, or an admission to a hospital is not a finding that the person is legally incompetent or unable to give or withhold consent.

If the person's capacity to consent or make an informed choice is at issue, guardianship or other less intrusive interventions can be put in place to address the needs of the person at risk. Lack of capacity to consent and legal incompetence do not predict "dangerousness". Many people with guardianships function quite well in the community.

While P&A does not support the changes in Senate Bill 2296, we believe that the state would benefit from a study of chapter 25-03.1. Addressing the needs of people with mental illness is a complex undertaking, particularly at a time when the state hospital is downsizing and human service centers are experiencing cuts in funding. Any change to the state's commitment law should be done thoughtfully after careful study and input from all relevant parties involved in the process - including consumers and family members. P&A intends to support House Concurrent Resolution 3034, which proposes such a study.

This concludes my testimony. I would be happy to answer any questions from the committee. Thank you.

25-03.1-2

AH # 96

9. "Mental health professional" means:

   a. A psychologist with at least a master's degree who has been either licensed or approved for exemption by the North Dakota board of psychology examiners.

   b. A social worker with a master's degree in social work from an accredited program.

   c. A registered nurse with a master's degree in psychiatric and mental health nursing from an accredited program.

   d. A registered nurse with a minimum of two years of psychiatric clinical experience under the supervision of a registered nurse as defined by subdivision c or of an expert examiner.

   e. A licensed addiction counselor.

   f. A licensed professional counselor with a master's degree in counseling from an accredited program who has either successfully completed the advanced training beyond the master's degree as required by the national academy of mental health counselors or a minimum of two years of clinical experience in a mental health agency or setting under the supervision of a psychiatrist or psychologist.

10. "Mentally ill person" means an individual with an organic, mental, or emotional disorder which substantially impairs the capacity to use self-control, judgment, and discretion in the conduct of personal affairs and social relations. "Mentally ill person" does not include a mentally retarded person of significantly subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior, although a person who is mentally retarded may also suffer from a mental illness. Chemical dependency does not per se constitute mental illness, although persons suffering from that condition may also be suffering from mental illness.

11. "Person requiring treatment" means a person who is mentally ill or chemically dependent, and there is a reasonable expectation that if the person is not treated there exists a serious risk of harm to that person, others, or property. "Serious risk of harm" means a substantial likelihood of:

   a. Suicide, as manifested by suicidal threats, attempts, or significant depression relevant to suicidal potential;

   b. Killing or inflicting serious bodily harm on another person or inflicting significant property damage, as manifested by acts or threats;

   c. Substantial deterioration in physical health, or substantial injury, disease, or death, based upon recent poor self-control or judgment in providing one's shelter, nutrition, or personal care; or

   d. Substantial deterioration in mental health which would predictably result in dangerousness to that person, others, or property, based upon acts, threats, or patterns in the person's treatment history, current condition, and other relevant factors.

12. "Private treatment facility" means any facility established under chapter 10-19.1 or 10-33 and licensed under chapter 23-16 or 23-17.1.

13. "Psychiatrist" means a licensed physician who has completed a residency program in psychiatry.

medication and other forms of treatment before the preliminary or treatment hearing. However, a physician may prescribe medication or a less restrictive alternative if it is necessary to prevent bodily harm to the respondent or others or to prevent imminent deterioration of the respondent's physical or mental condition. The patient has the right to be free of the effects of medication at the preliminary or treatment hearing by discontinuance of medication no later than twenty-four hours before the hearing unless, in the opinion of the prescribing physician, the need for the medication still exists or discontinuation would hamper the respondent's preparation for and participation in the proceedings.

25-03.1-17. Involuntary treatment - Right to preliminary hearing. A respondent who is in custody under section 25-03.1-25 and who is alleged to be mentally ill or to be suffering from a combination of chemical dependency and mental illness is entitled to a preliminary hearing. At the preliminary hearing the magistrate shall review the medical report. During the hearing the petitioner and the respondent must be afforded an opportunity to testify and to present and cross-examine witnesses, and the court may receive the testimony of any other interested person. The magistrate may receive evidence that would otherwise be inadmissible at a treatment hearing. At the conclusion of the hearing, if the court does not find probable cause to believe that the individual is a person requiring treatment, the petition must be dismissed. The person must be ordered discharged from the treatment facility if that person has been detained before the hearing. If the court finds probable cause to believe that the respondent is a person requiring treatment, it shall consider less restrictive alternatives to involuntary detention and treatment. The court may then order the respondent to undergo up to fourteen days' treatment under a less restrictive alternative or, if it finds that alternative treatment is not in the best interests of the respondent or others, it shall order the respondent detained for up to fourteen days for involuntary treatment in a treatment facility.

The court shall specifically state to the respondent and give written notice that if involuntary treatment beyond the fourteen-day period is to be sought, the respondent will have the right to a treatment hearing as required by this chapter.

25-03.1-18. Involuntary treatment - Release. The superintendent or the director may release a patient subject to a fourteen-day evaluation and treatment order or a seven-day emergency order if, in the superintendent's or director's opinion, the respondent does not meet the criteria of a person requiring treatment or, before the expiration of the fourteen-day order, the respondent no longer requires inpatient treatment. The court must be notified of the release and the reasons therefor. If the respondent is released because the respondent does not meet the criteria of a person requiring treatment, the court shall dismiss the petition.

25-03.1-18.1. Court-authorized involuntary treatment with prescribed medication.

1. a. Upon notice and hearing, a treating psychiatrist may request authorization from the court to treat a person under a mental health treatment order with prescribed medication. The request may be considered by the court in an involuntary treatment hearing. As a part of the request, the treating psychiatrist and another licensed physician or psychiatrist not involved in the current diagnosis or treatment of the patient shall certify:

   (1) That the proposed prescribed medication is clinically appropriate and necessary to effectively treat the patient and there is a reasonable expectation that if the person is not treated as proposed there exists a serious risk of harm to that person, other persons, or property;

   (2) That the patient was offered that treatment and refused it or that the patient lacks the capacity to make or communicate a responsible decision about that treatment;

   (3) That prescribed medication is the least restrictive form of intervention necessary to meet the treatment needs of the patient; and

(4) That the benefits of the treatment outweigh the known risks to the patient.

b. The court shall inquire whether the patient has had a sufficient opportunity to adequately prepare to meet the issue of involuntary treatment with prescribed medication and, at the request of the patient, the court may continue the involuntary treatment hearing for a period not exceeding seven days or may appoint an independent expert examiner as provided in subsection 4.

2. a. Evidence of the factors certified under subsection 1 may be presented to the court at an involuntary treatment hearing held pursuant to sections 25-03.1-19 and 25-03.1-22, or at a separate hearing after motion and notice. The court in ruling on the requested authorization for involuntary treatment with prescribed medication shall consider all relevant evidence presented at the hearing, including:

(1) The danger the patient presents to self or others;

(2) The patient's current condition;

(3) The patient's treatment history;

(4) The results of previous medication trials;

(5) The efficacy of current or past treatment modalities concerning the patient;

(6) The patient's prognosis; and

(7) The effect of the patient's mental condition on the patient's capacity to consent.

b. Involuntary treatment with prescribed medication may not be authorized by the court solely for the convenience of facility staff or for the purpose of punishment.

3. If the factors certified under subsection 1 have been demonstrated by clear and convincing evidence, the court may include in its involuntary treatment order a provision, or it may issue a separate order after notice and hearing, authorizing the treating psychiatrist to involuntarily treat the patient with prescribed medication on such terms and conditions as are appropriate. The order for involuntary treatment with prescribed medication, however, may not be in effect for more than ninety days.

4. If a patient has requested an examination by an independent expert examiner under this chapter, and if the treating psychiatrist has requested authorization for involuntary treatment with prescribed medication, only a psychiatrist may independently examine the patient as to the issue of involuntary treatment with prescribed medication.

25-03.1-19. Involuntary treatment hearing. The involuntary treatment hearing, unless waived by the respondent or the respondent has been released as a person not requiring treatment, must be held within fourteen days of the preliminary hearing. If the preliminary hearing is not required, the involuntary treatment hearing must be held within seven days of the date the court received the expert examiner's report, not to exceed fourteen days from the time the petition was served. The court may extend the time for hearing for good cause. The respondent has the right to an examination by an independent expert examiner if so requested. If the respondent is indigent, the county of residence of the respondent shall pay for the cost of the examination and the respondent may choose an independent expert examiner.

The hearing must be held in the county of the respondent's residence or location or the county where the state hospital or treatment facility treating the respondent is located. At the hearing, evidence in support of the petition must be presented by the state's attorney, private counsel, or counsel designated by the court. During the hearing, the petitioner and the respondent must be afforded an opportunity to testify and to present and cross-examine witnesses. The court may receive the testimony of any other interested person. All persons not necessary for the conduct of the proceeding must be excluded, except that the court may admit persons having a legitimate interest in the proceeding. The hearing must be conducted in as informal a manner as practical, but the issue must be tried as a civil matter. Discovery and the power of subpoena permitted under the North Dakota Rules of Civil Procedure are available to the respondent. The court shall receive all relevant and material evidence which may be offered as governed by the North Dakota Rules of Evidence. There is a presumption in favor of the respondent, and the burden of proof in support of the petition is upon the petitioner.

If, upon completion of the hearing, the court finds that the petition has not been sustained by clear and convincing evidence, it shall deny the petition, terminate the proceeding, and order that the respondent be discharged if the respondent has been hospitalized before the hearing.

25-03.1-20. Involuntary treatment hearing - Findings and dispositions. If an individual is found at the involuntary treatment hearing to be a person requiring treatment, the findings and conclusions must be entered in the record of the proceedings and the court may:

1. Order the individual to undergo a program of treatment other than hospitalization;

2. Order the individual hospitalized in a public institution; or

3. Order the individual hospitalized in any other private hospital if the attending physician agrees. The reason supporting the court's particular treatment order must be entered in the record.

25-03.1-21. Involuntary treatment order - Alternatives to hospitalization - Noncompliance with alternative treatment order - Emergency detention by certain professionals - Application for continuing treatment order.

1. Before making its decision in an involuntary treatment hearing, the court shall review a report assessing the availability and appropriateness for the respondent of treatment programs other than hospitalization which has been prepared and submitted by the state hospital or treatment facility. If the court finds that a treatment program other than hospitalization is adequate to meet the respondent's treatment needs and is sufficient to prevent harm or injuries which the individual may inflict upon the individual or others, the court shall order the respondent to receive whatever treatment other than hospitalization is appropriate for a period of ninety days.

2. If the respondent is not complying with the alternative treatment order or the alternative treatment has not been sufficient to prevent harm or injuries that the individual may be inflicting upon the individual or others, the department, a representative of the treatment program involved in the alternative treatment order, the petitioner's retained attorney, or the state's attorney may apply to the court or to the district court of a different judicial district in which the respondent is located to modify the alternative treatment order. The court shall hold a hearing within seven days after the application is filed. Based upon the evidence presented at hearing and other available information, the court may:

   a. Continue the alternative treatment order;

   b. Consider other alternatives to hospitalization, modify the court's original order, and direct the individual to undergo another program of alternative treatment for the remainder of the ninety-day period; or

5. If, upon the discharge of a hospitalized patient or the termination of alternative treatment of an individual under this chapter, the individual would benefit from further treatment, the hospital or provider of alternative treatment shall offer appropriate treatment on a voluntary basis or shall aid the individual to obtain treatment from another source on a voluntary basis. With the individual's consent, the superintendent or director shall notify the appropriate community agencies or persons of the release and of the suggested release plan. Community agencies include regional mental health centers, state and local counseling services, public and private associations whose function is to assist mentally ill or chemically dependent persons, and the individual's physician. The agencies and persons notified of the individual's release shall report to the facility that initial contact with the individual has been accomplished.

6. If, before expiration of an initial treatment order, the superintendent or director determines that a less restrictive form of treatment would be more appropriate for a patient hospitalized by court order, the superintendent or director may petition the court which last ordered the patient's hospitalization to modify its order. The petition must contain statements setting forth the reasons for the determination that the patient continues to require treatment, the reasons for the determination that a less restrictive form of treatment would be more appropriate for the patient, and describing the recommended treatment program. If the patient consents, the court may, without a hearing, modify its treatment order by directing the patient to undergo the agreed treatment program for the remainder of the treatment order. The patient must be given an opportunity to protest the discharge and modification of treatment order and to receive a hearing on the merits of the protest.

25-03.1-31. Procedure to extend continuing treatment orders - Respondent's right to petition for discharge.

1. If the director or superintendent believes that a respondent continues to be a person requiring treatment, the director or superintendent, not less than thirty days before expiration of the order, shall petition the court where the facility is located for another continuing treatment order in the manner prescribed by section 25-03.1-23. The petition must also contain a notice to the respondent that, unless the respondent waives a hearing on the petition within fifteen days after service of the petition upon the respondent, a hearing will be held by the court. The court shall appoint counsel for the respondent upon receipt of the petition, unless retained counsel has appeared on behalf of the respondent. If retained counsel has appeared, the court shall provide notice of the petition to the attorney. If the hearing is not waived, it must be held within thirty days after the petition was filed, unless extended for good cause shown. The burden of proof is the same as in an involuntary treatment hearing.

2. Every individual subject to an order of continuing treatment has the right to petition the court for discharge once annually. The petition may be presented to the court or a representative of the facility who shall transmit it to the court forthwith. If the patient is indigent or is unable for reasons satisfactory to the court to obtain an independent expert examiner, the court shall appoint an independent expert examiner to examine the patient and to furnish a report to the court. The court shall set a hearing date which must be within fourteen days of receipt of the examiner's report. At the hearing, the burden of proof is the same as in an involuntary treatment hearing.

25-03.1-32. Periodic hearing and petition for discharge - Continuing hospitalization. Repealed by S.L. 1979, ch. 334, § 33.

25-03.1-33. Legal incompetence - Presumption - Finding - Adjudication negated.

1. No determination that a person requires treatment, no court order authorizing hospitalization or alternative treatment, nor any form of admission to a hospital gives rise to a presumption of, constitutes a finding of, or operates as an adjudication of legal incompetence, or of the inability to give or withhold consent.

2. No order of commitment under any previous statute of this state, in the absence of a concomitant appointment of a guardian, constitutes a finding of or operates as an adjudication of legal incompetence, or of the inability to give or withhold consent.

25-03.1-34. Transfer of patients.

1. The superintendent or director of a treatment facility may transfer, or authorize the transfer of, an involuntary patient from a hospital to another facility if the superintendent or director determines that it would be consistent with the medical needs of the patient to do so. Due consideration must be given to the relationship of the patient to family, legal guardian, or friends, so as to maintain relationships and encourage visits beneficial to the patient. Whenever any treatment facility licensed by any state for the care and treatment of mentally ill or chemically dependent persons agrees with a parent, a spouse, a brother, a sister, a child of legal age, or guardian of any patient to accept the patient for treatment, the superintendent or director of the treatment facility shall release the patient to the other facility.

2. Upon receipt of notice from an agency of the United States that facilities are available for the care or treatment of any individual ordered hospitalized who is eligible for care or treatment in a treatment facility of that agency, the superintendent or director of the treatment facility may cause the individual's transfer to that agency of the United States for treatment. No person may be transferred to any agency of the United States if the person is confined pursuant to conviction of any felony or misdemeanor or the person has been acquitted of the charge solely on the ground of mental illness unless the court originally ordering confinement of the person enters an order for transfer after appropriate motion and hearing. Any person transferred under this section to an agency of the United States is deemed committed to that agency under the original order of treatment.

3. No facility may transfer a patient to another hospital or agency without first notifying the patient and the patient's legal guardian, spouse, or next of kin, if known, or a chosen friend of the patient and the court that ordered treatment. The patient must be given an opportunity to protest the transfer and to receive a hearing on the protest. The patient's objection to the transfer must be presented to the court where the facility is located or to a representative of the facility within seven days after the notice of transfer was received. If the objection is presented to a representative of the facility, the representative shall transmit it to the court forthwith. The court shall set a hearing date which must be within fourteen days of the date of receipt of the objection. If an objection has not been filed or the patient consents to a transfer, the court may enter an ex parte order authorizing transfer.

25-03.1-34.1. Exchange of chemically dependent patient or prisoner. The director of the department of human services, a county, a city, or a local law enforcement agency may enter into reciprocal agreements with the appropriate authorities of any other state regarding the mutual exchange, return, and transportation of chemically dependent or mentally ill patients or prisoners who are treated or confined in hospitals of one state for treatment of chemical dependency or mental illness but who have legal residence in another state.

25-03.1-35. Treatment by an agency of the United States.

1. If a respondent under this chapter is eligible for treatment by any agency of the United States, the court, upon receipt of notice from that agency showing that facilities are available and that the individual is eligible for care or treatment therein, may order the respondent placed in the custody of the agency for treatment. Any

INCORPORATIONS FROM CASE LAW ND

- The district court must find by clear and convincing evidence that alternative treatment is not adequate or hospitalization is the least restrictive alternative. In the Interest of J.A.D., 492 N.W.2d 82, 86 (N.D. 1992).

- [C]onclusive reports, particularly ones with preprinted conclusions checked or underlined without satisfactory explanations, are unacceptable. Such forms do not carry out the intent of Ch. 25-03.1 and are not appropriate for findings of fact or an order. In the Interest of J.K., 599 N.W.2d 337, 342 (N.D. 1999) (*citing* numerous cases).

- Although D.Z. has not yet exhibited overt violent action, such conduct is not a prerequisite to finding that a person poses a serious risk of harm to himself or others. Direct evidence of overt violence or an expressed intent to commit violence are not required to find a person poses a serious risk of harm. In re D.Z., 649 N.W.2d 231, 235 (N.D. 2002) (*citing* In re D.P., 636 N.W.2d 921.)

- Significantly, § 25-03.1-02(11)(d), N.D.C.C., specifically allows patterns in the person's treatment history to be used as a basis for finding a serious risk of harm and we have further held, a court can use what has happened in the past as prognostic evidence to help predict future conduct. In the Interest of R.M., 555 N.W.2d 798, 799 (N.D. 1996) (*citing* In the Interest of C.W., 552 N.W.2d 382, 384 (N.D. 1996).

- When the choice is b/w involuntarily treating a patient with drugs (which could stabilize the patient and allow an early release from hospitalization), and not medicating the patient at all (which could cause a deterioration in condition and lead to indefinite hospitalization), forced medication is the "least restrictive form of treatment." In the Interest of C.W., 552 N.W.2d 382, 385 (N.D. 1996) (*citing* In the Interest of B.D., 510 N.W.2d 629, 633 (N.D. 1994).

NATIONAL SHERIFFS' ASSOCIATION

Resolution

NATIONAL SHERIFFS' ASSOCIATION SUPPORTS THE MISSION OF THE TREATMENT ADVOCACY CENTER

WHEREAS, the National Sheriffs' Association (NSA) and the Accreditation, Detention & Corrections Committee of NSA have reviewed and considered the mission of the Treatment Advocacy Center, a non-profit organization in Arlington, Virginia; and

WHEREAS, the mission of the Treatment Advocacy Center is to eliminate barriers to treatment for Americans who suffer from, but are not being treated for, severe mental illnesses such as schizophrenia and manic-depressive illness; and

WHEREAS, 40% of individuals who suffer from severe mental illnesses are not being treated at any given time, primarily because the illness affects their ability to recognize that they are ill and they therefore refuse treatment; and

WHEREAS, one of the most serious consequences of failing to treat severe mental illnesses is that there are now more than twice as many mentally ill individuals in jails and prisons than there are in state psychiatric hospitals, and more than one million individuals with severe mental illnesses admitted each year to jails, and that these individuals comprise as much as 15% of the population of jails; and

WHEREAS, the most significant barrier to treatment for the most severely mentally ill are laws that prevent the treatment of individuals who refuse treatment until they are a danger to themselves or others and laws that prevent a court from ordering individuals to take medication while living in the community; and

WHEREAS, the consequences of non-treatment, including incarceration, suicide, homelessness, worsening symptoms, victimization and violence, can be prevented by having laws that require treatment based on a "need for treatment" rather than just "dangerousness" for those who refuse it; and

WHEREAS, the consequences of non-treatment can also be prevented by having laws that allow a court to order treatment in the community for individuals who are in need of treatment but refuse it (also known as Assisted Outpatient Treatment);

THEREFORE, BE IT RESOLVED that the National Sheriffs' Association and the Accreditation, Detention & Corrections Committee of NSA hereby share and approve of the mission of the Treatment Advocacy Center and support laws that require treatment based on a "need for treatment" rather than just "dangerousness" for those who refuse it and laws that allow a court to order treatment in the community for individuals who are in need of treatment but refuse it (also known as Assisted Outpatient Treatment).

Adopted at a meeting of the
General Assembly on June 30,
1999, in Columbus, Ohio

Briefing Paper

THE EFFECTS OF INVOLUNTARY MEDICATION ON INDIVIDUALS WITH SCHIZOPHRENIA AND MANIC-DEPRESSIVE ILLNESS

SUMMARY: Patients with psychiatric disorders refuse medications for a variety of reasons, including experience with, or fear of, side effects. In other cases, the refusal is based on lack of awareness of illness or on delusional beliefs. Many such patients must ultimately be medicated involuntarily. Studies suggest that the long-term effects of involuntary medication on individuals with schizophrenia and manic-depressive illness (bipolar disorder) are more positive than is commonly thought. In most studies, the majority of patients retrospectively agreed that involuntary medication had been in their best interest. Anecdotal claims by opponents of involuntary medication that involuntary treatment has widespread, devastating, and lasting effects are not supported by these studies.

* * *

- Nine patients, seven with schizophrenia and two with bipolar disorder, refused medication when admitted to a psychiatric unit. All nine were given a single injection of long-acting fluphenazine decanoate. At the end of two weeks, their symptoms were markedly improved (BPRS improved from 10.4 to 4.1), and all were accepting medication voluntarily.

  Keisling R. Characteristics and outcome of patients who refuse medication. *Hospital and Community Psychiatry* 34:847–848, 1983.

- Twelve patients refused medication when admitted to a psychiatric unit. Three-quarters of them were diagnosed with schizophrenia or bipolar disorder. Compared to a control group that accepted medication, the refusers had less insight into their illness, were more psychotic, had higher mood elevation, and were more grandiose. After two weeks of medication, six of the patients (50 percent) no longer wished to refuse medication. "They were more likely to view medications as important for their illness and were less likely to believe in alternative treatments." The other six patients "still preferred to refuse treatment despite considerable improvement in their clinical condition."

  Marder SR et al. A study of medication refusal by involuntary psychiatric patients. *Hospital and Community Psychiatry* 35:724–726, 1984.

- Twenty-four patients who had been involuntarily medicated with antipsychotic medication were interviewed at the time of discharge from the hospital. Sixteen (67 percent) were diagnosed with schizophrenia or bipolar disorder, and 5 more (21 percent) with atypical psychosis. Thirty-three percent of the patients said they had refused medication because they believed they had no need for it, 29 percent said they had refused medication because of "severe confusion or psychotic ideation," and 17 percent "stated that they did not know why they [had] refused medication." At discharge, 17 patients (71 percent) agreed that the decision to involuntarily medicate them had been correct and agreed with the statement: "If I become ill again and require medication, I believe it should be given to me even if I don't want it at the time." The 7 patients (29 percent) who disagreed scored high on measures of grandiosity, hostility, and suspiciousness; 6 of them had a diagnosis of bipolar disorder. The authors concluded that "it is impossible to avoid the conclusion that the treatment refusal of every patient in our sample was influenced by psychosis."

  Schwartz HI et al. Autonomy and the right to refuse treatment: patients' attitudes after involuntary medication. *Hospital and Community Psychiatry* 39:1049–1054, 1988.

- Eleven patients who had been forcibly medicated during their psychiatric hospitalization were retrospectively interviewed. Seven strongly agreed and two somewhat agreed (thus 82 percent total) that their involuntary treatment had been useful.

  Selde M et al. The reluctant psychiatric patient: ethics and efficacy around the issue of forced medication (Session 2219). American Public Health Association 117th Annual Meeting, Chicago, October 24, 1989.

- Seventy-nine patients who had been placed under guardianship, 75 (95 percent) of whom had been involuntarily medicated, were asked to retrospectively fill out a questionnaire. Eighty-seven percent of the patients had been diagnosed with schizophrenia or bipolar disorder. The results were as follows:

Do you have a mental illness?

definitely/probably not - 47%
don't know - 9%
definitely/probably do - 44%

How helpful was your guardianship?

very/fairly helpful - 45%
neutral - 21%
very/fairly unhelpful - 34%

There was a high correlation between patients who believed they had a mental illness and those who found the guardianship helpful ($p < .01$). The authors concluded that "although a majority of the patients were against enforced treatment in principle, often because they thought it conflicted with their civil rights, most found the actual experience, including medication, to be helpful."

Adams NHS and Hafner RJ. Attitudes of psychiatric patients and their relatives to involuntary treatment. *Australian and New Zealand Journal of Psychiatry* 25:231–237, 1991.

- Fifty-one state hospital involuntary inpatients who refused to accept medication and were therefore involuntarily medicated were compared with 51 matched involuntary inpatients who were similar except that they voluntarily accepted medications. Seventy-nine percent of the study group and 66 percent of the matched controls had diagnoses of schizophrenia or affective disorder. The patients who were involuntarily mediated had improved symptoms and were discharged more quickly than the matched controls, suggesting that their refusal to take medication had prolonged their hospital stay. At one year follow-up, there was no difference between the two groups in their rate of rehospitalization or compliance with follow-up outpatient medication, which was relatively poor for both groups. This is not surprising since both study patients and controls had been involuntarily hospitalized and had been assigned to long-stay wards for chronic patients. In addition, none of the patients were placed on outpatient commitment or other form of assisted treatment at discharge. The authors conclude that "those in need of continued care could be considered for an expanded use of outpatient commitment."

  Cournos F et al. Outcome of involuntary medication in a state hospital system. *American Journal of* Psychiatry 148:489–494, 1991.

- In a forensic psychiatric hospital in which 97 percent of all patients were in involuntary treatment, an anonymous questionnaire was used to assess the attitudes of 203 patients to various forms of treatment. Two-thirds of the patients felt that medication was helpful, and only 10 percent considered medication to be harmful.

  Vartiainen H et al. The patients' opinions about curative factors in involuntary treatment. *Acta Psychiatrica Scandinavica* 91:163–166, 1995.

- Twenty-eight outpatients who "had felt pressured or forced to take psychiatric medications within the past year" were administered a questionnaire by their peers. Diagnostically, they were part of a larger group of users of psychosocial rehabilitation centers in which 52 percent of those with known diagnoses had schizophrenia or bipolar disorder. Only 2 of the 28 had actually been physically forced to take medication. In reply to questions about how they felt about having been pressured to take medications, 9 (32 percent) were positive, 9 (32 percent) expressed mixed views, 6 (21 percent) reported no effect, and 3 (11 percent) reported a negative effect. In addition, 12 patients (43 percent) said that "the experience gave them a sense that people were looking out for their best interest." The authors also noted that "only a few respondents said that past experiences of pressured or forced medication had had any effect on their subsequent willingness to take medication."

  Lucksted A and Coursey RD. Consumer perceptions of pressure and force in psychiatric treatments. *Psychiatric Services* 46:146–152, 1995.

- Thirty patients who had been forcibly medicated during their psychiatric hospitalization were interviewed by telephone one to two weeks later by individuals who had not been involved in their treatment. Eighty-seven percent of the patients had been diagnosed with schizophrenia or bipolar disorder. Among the refusers, 30 percent recalled having refused the medication because they had believed there was nothing wrong with them, and 20 percent said they had refused because they had believed the medication was poison.

  Retrospectively, 18 patients (60 percent) said that having medication forced was a good idea, 9 (30 percent) disagreed, and 3 (10 percent) were unsure. Most of those who disagreed had either paranoid schizophrenia or bipolar disorder with grandiosity. The authors concluded that "forced medication frequently restores the capacity to make competent decisions and often results in a more rapid return of freedom to be discharged from involuntary hospitalization."

Greenberg WM et al. Patients' attitudes toward having been forcibly medicated. *Bulletin of the American Academy of Psychiatry and the Law* 24:513–524, 1996.

Treatment Advocacy Center

Briefing Paper

Updated January 2003

VIOLENCE AND UNTREATED SEVERE MENTAL ILLNESS

SUMMARY: It is well known that the two major demographic predictors of violent behavior are male sex and younger age. It is also known that the two major clinical predictors of violent behavior are past history of violence and substance abuse (alcohol and/or drug). Recent studies have established that being severely mentally ill and not taking medication is a third major clinical predictor of violent behavior.

* * *

1. Severely mentally ill individuals who *ARE* taking their medication are *NOT* more dangerous than the general population.

- The three-site MacArthur Foundation Study of violence and mental illness reported that discharged psychiatric patients without substance abuse had approximately the same incidence of violent behavior as other individuals living in the same neighborhoods. These patients were being followed closely for a year and most were taking their medications. The reported results were weakened by the fact that the patients with the most violent past histories were excluded from the study and the fact that the Pittsburgh neighborhoods used as controls were "disproportionately impoverished and had higher violent crime rates through the city as a whole."

  Steadman HJ, Mulvey EP, Monahan J, et. al. Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry 55:393-401, 1998.*

2. Severely mentally ill individuals who are *NOT* taking their medication *ARE* more dangerous than the general population.

- Several early studies in the 1970s suggested this fact but were not well controlled. For example, a 6-year follow-up of 301 patients discharged between 1972 and 1975 from a California state hospital reported that their arrest rate for "violent crimes" was 10 times the rate for the general population.

  Sosowsky, L. Explaining the increased arrest rate among mental patients: A cautionary note. *American Journal of Psychiatry* 137:1602-1605, 1980.

- In reviewing these earlier studies on discharged psychiatric patients, Dr. Judith Rabkin concluded: "Arrest and conviction rates for the subcategory of violent crimes were found to exceed general population rates in every study in which they were measured."

  Rabkin J. Criminal behavior of discharged mental patients: A critical appraisal of the research. *Psychological Bulletin* 86:1-27, 1979.

- The Epidemiological Catchment Area (ECA) surveys carried out in 1980-1983 reported much higher rates of violent behavior among individuals with severe mental illness living in the community compared to other community residents. For example, individuals with schizophrenia were 21 times more likely to have used a weapon in a fight.

  Swanson JW, Hozer CD, Ganju VK, et. al. Violence and psychiatric disorder in the community: Evidence from the Epidemiologic Catchment Area surveys. *Hospital and Community Psychiatry* 41:761-770, 1990.

- In a more recent analysis of data from the ECA study the authors noted that "mentally ill individuals with no treatment contact in the past 6 months had significantly higher odds of violence in the long term...moderate levels of agitation and psychoticism increase the risk of violence." They then conclude: "This would seem to provide a strong argument for providing more interventions targeted specifically to persons with combined mental illness and addictive disorders who are likely not to comply voluntarily with conventional outpatient therapies."

  Swanson J, Estroff S, Swartz M, et. al. Violence and severe mental disorder in clinical and community populations: The effects of psychotic symptoms, comorbidity, and lack of treatment. *Psychiatry* 60:1-22, 1997.

- A study of inpatients diagnosed with schizophrenia reported an inverse correlation between their propensity to violence and their blood level of antipsychotic medication.

  Yesavage, J.A. Inpatient violence and the schizophrenic patient: An inverse correlation between danger-related events and neuroleptic levels. *Biological Psychiatry* 17:1331-1337, 1982.

- A study of severely mentally ill patients in a state forensic hospital found a highly significant correlation ($p < 0.001$) between failure to take medication and a history of violent acts in the community.

  Smith LD. Medication refusal and the rehospitalized mentally ill inmate. *Hospital and Community Psychiatry* 40:491-496, 1989.

- A study in a forensic hospital in England reported an association between violent behavior and untreated psychotic symptoms. According to the authors "over 80 percent of the offenses of the psychotic [men] were probably attributable to their illness....Within the psychotic group those driven to offend by their delusions were most likely to have been seriously violent, and psychotic symptoms probably accounted directly for most of the very violent behavior."

  Taylor P. Motives for offending amongst violent and psychotic men. *British Journal of Psychiatry* 147:491-498, 1985.

- A 1990 study investigated violent behavior among severely mentally ill individuals in 1401 randomly selected families who were members of the National Alliance for the Mentally Ill (NAMI). In the preceding year 11 percent of these individuals were reported to have physically harmed another person.

  Steinwachs DM, Kasper JD, Skinner EA. Family perspectives on meeting the needs for care of severely mentally ill relatives: A national survey. Arlington, VA: National Alliance for the Mentally Ill, 1992.

- A 9 to 12 year follow-up of 192 men with schizophrenia who had been detained by the Secret Service when they had presented themselves at the White House with delusional demands found that they had a subsequent arrest rate for violent crimes 1.6 times (no past history of violence) to 4.8 times (with a past history of violence) the general population.

  Shore D, Filson CR, Rae DS. Violent crime arrest rates of White House case subjects and matched control subjects. *American Journal of Psychiatry* 147:746-750, 1990.

- A study of 133 outpatients with schizophrenia showed that "13 percent of the study group were characteristically violent." Having inadequately treated symptoms of delusions and hallucinations was one of the predictions of violent behavior. Specifically, "71 percent of the violent patients...had problems with medication compliance, compared with only 17 percent of those without hostile behaviors," a difference which was statistically highly significant ($p < 0.001$).

  Bartels J, Drake RE, Wallach MA, et. al. Characteristic hostility in schizophrenic outpatients. *Schizophrenia Bulletin* 17:163-171, 1991.

- A Swedish study of 644 individuals with schizophrenia followed for 15 years reported that they committed violent offenses at a rate four times greater than the general population.

  Lindqvist P, Allebeck P. Schizophrenia and crime: A longitudinal follow-up of 644 schizophrenics in Stockholm. *British Journal of Psychiatry* 157:345-350, 1990.

- Another Swedish study, using case registers, examined the criminal records of all individuals born in Stockholm in 1953 and still living there 30 years later. Men and women with a severe mental illness were 4.2 times (men) and 27.5 times (women) more likely to have been convicted of a violent crime compared to individuals with no psychiatric diagnosis.

  Hodgins, S. Mental disorder, intellectual deficiency, and crime. *Archives of General Psychiatry 49:476-483, 1992.*

- In a follow-up of patients released from a psychiatric hospital, Dr Henry Steadman et. al. reported that "27 percent of released male and female patients report at least one violent act within a means of four months after discharge."

  Monahan J. Mental disorder and violent behavior. *American Psychologist* 47:511-521, 1992.

- Among 20 individuals who pushed or tried to push another person in front of the subway in New York, all except one was severely mentally ill and offered motives directly related to their untreated psychotic symptoms.

  Martell DA, Dietz PE. Mentally disordered offenders who push or attempt to push victims onto subway tracks in New York City. *Archives of General Psychiatry* 49:472-475, 1992.

- In a carefully controlled study comparing individuals with severe mental illness living in the community in New York with other community residents, the former group was three times more likely to commit violent acts such as weapons use or "hurting someone badly." The sicker the individual, the more likely they were to have been violent.

Link BG, Andrews H, Cullen FT. The violent and illegal behavior of mental patients reconsidered. *American Sociological Review* 57:275-292, 1992.

- A study of 538 individuals with schizophrenia living in London reported that the men had a 3.9 times and women 5.3 times greater risk for conviction for assault and serious violence compared to a control group with other psychiatric diagnoses.

Wessely SC, Castle D, Douglas AJ, et. al. The criminal careers of incident cases of schizophrenia. *Psychological Medicine* 24, 483-502, 1994.

- A study of 348 inpatients in a Virginia state psychiatric hospital found that patients who refused to take medication "were more likely to be assaultive, were more likely to require seclusion and restraint, and had longer hospitalizations."

Kasper JA, Hoge SK, Feucht-Haviar T, et. al. Prospective study of patients' refusal of antipsychotic medication under a physician discretion review procedure. *American Journal of Psychiatry* 154:483-489, 1997.

- A study in Switzerland compared 282 men with schizophrenia with a matched control group in the general population. The patients were five times more likely to have been convicted of violent crimes, mostly "assaults resulting in bodily harm." The more acutely ill the patient was, the more likely he was to have been violent.

Modestin J, Ammann R. Mental disorder and criminality: Male schizophrenia. *Schizophrenia Bulletin* 22: 69-82, 1996.

- A study of homicides in Finland reported that "the risk of committing a homicide was about 10 times greater for schizophrenia patients of both genders than it was for the general population." For men "schizophrenia without alcoholism increased the odds ratio more than 7 times; schizophrenia with coexisting alcoholism more than 17 times."

Eronen M, Tiihonen J, Hakola P. Schizophrenia and homicidal behavior. *Schizophrenia Bulletin* 22:83-89, 1996.

- In another study in Finland an unselected birth cohort of 11,017 individuals was followed for 26 years. Men with schizophrenia without alcoholism were 3.6 times more likely to commit a violent crime than men without a psychiatric diagnosis. Men with both schizophrenia and alcoholism were 25.2 times more likely to commit a violent crime.

Rasanen P, Tiihonen J, Isohanni M, et.al. Schizophrenia, alcohol abuse, and violent behavior: a 26-year follow-up study of an unselected birth cohort. *Schizophrenia Bulletin* 24:437-441, 1998.

- In the three-site MacArthur Foundation Study of violence and mental illness referred to above, 17.4 percent of the patients were violent in the 10-week period prior to hospitalization, during which time they were not being treated, compared to an average of 8.9 percent for the five 10-week periods after hospitalization during which most of them were being treated.

Steadman HJ, Mulvey EP, Monahan J, et. al. Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry* 55:393-401, 1998.

- An English study of 1015 forensic patients with severe mental illness ("functional psychosis") reported that the diagnosis of "schizophrenia was most strongly associated with personal violence" and that "more than 75 percent of those with a psychosis were recorded as being driven to offend by their delusions." The authors concluded that "treatment appears as important for public safety as for personal health."

Taylor PJ, Leese M, Williams D, et. al. Mental disorder and violence. *British Journal of Psychiatry* 172:218-226, 1998.

- A 10-year follow-up of 1056 severely mentally ill patients discharged from mental hospitals in Sweden in 1986 reported that "of those who were 40 years old or younger at the time of discharge, nearly 40 percent had a criminal record as compared to less than 10 percent of the general public." Furthermore, "the most frequently occurring crimes are violent crimes."

Belfrage H. A ten-year follow-up of criminality in Stockholm mental patients. *British Journal of Criminology* 38:145-155, 1998.

- A study of 331 individuals with severe mental illness reported that 17.8 percent "had engaged in serious violent acts that involved weapons or caused injury." It also found that "substance abuse problems, medication noncompliance, and low insight into illness operate together to increase violence risk."

Swartz MS, Swanson JW, Hiday VA, et. al. Violence and severe mental illness: The effects of substance abuse and nonadherence to medication. *American Journal of Psychiatry* 155:226-231, 1998.

- A four-state (NH, CT, MD, and NC) study of 802 adults with severe mental illness (64 percent schizophrenia or schizoaffective disorder, 17 percent bipolar disorder) reported that 13.6 percent had been violent within the previous

year. "Violent" was defined as "any physical fighting or assaultive actions causing bodily injury to another person, any use of lethal weapon to harm or threaten someone, or any sexual assault during that period." Those who had been violent were more likely to have been homeless, to be substance abusers, and to be living in a violent environment. Those who had been violent were also 1.7 times more likely to have been noncompliant with medications. As has been found in other such studies, the women with severe psychiatric disorders were almost as likely to have been violent (11 percent) as were the men (15 percent). Because the data on violent behavior were collected by self-report, the authors suggested "that our findings are probably conservative estimates of the true prevalence of violent behavior for persons with SMI." They concluded "that risk of violence among persons with SMI is a significant problem" and "is substantially higher than estimates of the violence rate for the general population."

Swanson JW, Swartz MS, Essock SM et al. The social-environmental context of violent behavior in persons treated for severe mental illness. *American Journal of Public Health* 92:1523-1531, 2002.

- A study of 63 inpatients with schizophrenia in Spain reported that the best predictors of violent behavior were being sicker (i.e. higher scores on symptom measures) and less insight into their illness. "The single variable that best predicted violence was awareness into psychotic symptoms."

Arango C, Barba AC, Gonzalez-Salvador T, et. al. Violence in schizophrenic inpatients: A prospective study. *Schizophrenia Bulletin*, in press.

- In reviewing many of these studies in 1992 Professor John Monahan concluded: "The data that have recently become available, fairly read, suggest the one conclusion I did not want to reach: Whether the measure is the prevalence of violence among the disordered or the prevalence of disorder among the violent, whether the sample is people who are selected for treatment as inmates or patients in institutions or people randomly chosen from the open community, and no matter how many social and demographic factors are statistically taken into account, there appears to be a relationship between mental disorder and violent behavior."

Monahan J. Mental disorder and violent behavior. *American Psychologist* 47:511-521,1992.

- In a 1996 editorial reviewing such studies Dr. Peter Marzuk added: "In the last decade, however, the evidence showing a link between violence, crime, and mental illness has mounted. It cannot be dismissed; it should not be ignored."

Marzuk PM. Violence, crime, and mental illness. *Archives of General Psychiatry* 53:481-486, 1996.

- A 2001 review article on violence and schizophrenia, authored by researchers at the Institute of Psychiatry in London, concluded: "It is now generally accepted that people with schizophrenia, albeit by virtue of the activity of a small subgroup, are significantly more likely to be violent than members of the general population, but the proportion of societal violence attributable to this group is small." The authors also noted that "comorbid substance abuse considerably increases the risk." They emphasized that the proportion of total violence in society attributable to schizophrenia is small, specifically "below 10 percent."

Walsh E, Buchanan A, Fahy T. Violence and schizophrenia: examining the evidence. *British Journal of Psychiatry* 180: 490-495, 2001.

3. Individuals with severe mental illnesses probably are responsible for no more than 5 percent of violent episodes in the United States.

- Compared to substance abuse, severe mental illness contributes a relatively small percentage to total violence. Professor John Monahan cited a study that estimated "that 3 percent of the variance in violent behavior in the United States is attributable to mental disorder."

Monahan J. Mental illness and violent crime. *National Institute of Justice Research Preview, October 1996.*

- A 1968 Department of Justice study reported that individuals with a history of mental illness (not including drug or alcohol abuse) were responsible for 4.3 percent of the homicides in the United States, or 897 out of 20,860. In instances in which the homicide occurred among family members the percentage was much higher, eg. in 25 percent of cases in which an individual killed his/her parent, that individual was mentally ill. If the 4.3 percentage held in 1993, the total mental illness-related homicides would have been 1,055 (4.3 percent of 24,530). It seems reasonable to assume that most of these would have been preventable if the individual had been receiving psychiatric treatment.

Dawson JM, Langan PA. Murder in families. *U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 1994.*

- In countries such as the United States, where violence is relatively common, the percentage of violent acts attributable to individuals with severe psychiatric disorders is comparatively low, probably no more than 5 percent. In many other countries where violence is less common, the percentage of violent acts attributable to individuals with severe psychiatric disorders may be proportionately greater. Thus, in New Zealand, a study reported that "just over 10 percent of past-year violence committed by these young adults was attributable to schizophrenic spectrum disorders."

Walsh E, Buchanan A, Fahy T. Violence and schizophrenia: examining the evidence. *British Journal of Psychiatry* 180: 490-495, 2001.

4. At least 10 percent of males with severe mental illnesses become violent and a lesser percentage of females. In the United States this would total approximately 200,000 – 250,000 individuals.

- There is very little data which can be used to estimate the percentage of severely mentally ill individuals who become violent. The best study used the Danish psychiatric case register, covering the whole country, and convictions for criminal offenses. Between1978 and 1990 6.7 percent of males and 0.9 percent of females with "major mental disorders" (psychoses) were convicted of a violent crime ("all offenses involving interpersonal aggression or a threat thereof"), compared with 1.5 percent males and 0.1 percent females among individuals with no psychiatric diagnosis. Since these are only convictions, it can be assumed that another unknown percentage committed a violent act for which they were not charged or convicted.

Hodgins S, Mednick SA, Brennan PA, et.al. Mental disorder and crime. *Archives of General Psychiatry* 53:489-496, 1996.

- The incidence of violent behavior among severely mentally ill individuals in the studies discussed under II above includes:
  - 11 percent in the survey of NAMI families
  - 13 percent among outpatients with schizophrenia
  - 8.9 percent in treatment and 17.4 percent not in treatment in the MacArthur Foundation Study
  - 17.8 percent among inpatients with severe mental illness
- In light of the above, it seems reasonable to estimate that at least 10 percent of males with a severe mental illness exhibit violent behavior at some time during their illness and a lesser percentage of females. Since there are at least 4 million individuals in the United States with schizophrenia and manic-depressive disorder, then approximately 200,000 – 250,000 severely mentally ill individuals are or have been violent.

5. Publicized episodes of violence by individuals with severe mental illnesses are a major cause of discrimination and stigma against this group.

- Following highly publicized attacks on prominent German officials by individuals with severe mental illnesses, there was a measurable "marked increase in desired social distance from mentally ill people immediately following [the] violent attacks." The increased social distance and consequent stigma slowly decreased over time but had not returned to baseline two years later.

Angermeyer MC, Matschinger H. The effect of violent attacks by schizophrenic persons on the attitude of the public towards the mentally ill. *Social Science and Medicine* 43:12:1721-1728, 1996.

- A study using university volunteers demonstrated that reading a newspaper article reporting a violent crime committed by a mental patient led to increased "negative attitudes toward people with mental illnesses."

Thorton JA, Wahl OF. Impact of a newspaper article on attitudes toward mental illness. *Journal of Community Psychology* 24:17-25, 1996.

- Such studies suggest that it is futile to try and decrease stigma against individuals with mental illness until the problem of violence is addressed. This was noted as early as 1981 by Dr. Henry Steadman who observed:

"Recent research data on contemporary populations of ex-mental patients supports these public fears [of dangerousness] to an extent rarely acknowledged by mental health professionals. . . .It is [therefore] futile and inappropriate to badger the news and entertainment media with appeals to help destigmatize the mentally ill."

Steadman, HJ. Critically reassessing the accuracy of public perceptions of the dangerousness of the mentally ill. *Journal of Health and Social Behavior* 22. 31—316, 1981.

- In 1992 Dr. John Monahan added:

"The data suggest that public education programs by advocates for the mentally disordered along the lines of 'people with mental illness are no more violent than the rest of us' may be doomed to failure....And they should: the claim, it turns out, may well be untrue."

Monahan J. Mental disorder and violent behavior. *American Psychologist* 47:511-521, 1992.

- The 1999 Surgeon General's Report on Mental Health noted that "the perception of people with psychosis as being dangerous is stronger today than in the past.... People with mental illness, especially those with psychosis, are

Briefing Paper

ASSISTED OUTPATIENT TREATMENT REDUCES HOSPITAL STAYS, VIOLENCE AND ARRESTS AND IMPROVES CHANCE OF RECOVERY FOR PEOPLE WITH SEVERE MENTAL ILLNESSES

Approximately 40 percent of all individuals with severe mental illnesses (i.e. schizophrenia and manic-depressive illness) are not receiving treatment at any given time.[1] Many of these individuals are homeless, in jail on misdemeanor charges, and responsible for increasing episodes of violence.[2] A major reason why so many severely psychiatrically ill individuals are not being treated is that, because of the effects of the illness on their brain, they lack awareness of their illness. Studies have shown that approximately half of all patients with schizophrenia[3] and mania[4] have markedly impaired awareness of their illness as measured by tests of insight; thus, they are similar to some patients with cerebrovascular accidents (strokes) and with Alzheimer's disease. Such individuals consistently refuse to take medication because they do not believe they are sick. In most cases, they will take medication only under some form of assisted treatment.

Forty-one states use a form of assisted treatment commonly referred to as outpatient commitment, also called assisted outpatient treatment.[5] Assisted outpatient treatment involves court ordered treatment (including medication) as a condition of remaining in the community for individuals who have a history of medication non-compliance. Typically, violation of the court ordered conditions can result in the individual being hospitalized for further treatment.

Long-term assisted outpatient treatment (LT-AOT) combined with routine outpatient services (3 or more outpatient visits per month) has been shown to be significantly more effective in reducing violence and improving outcomes for severely mentally ill individuals than routine outpatient care without LT-AOT. Results from a North Carolina study[6] showed a 36% reduction in violence among severely mentally ill individuals in long-term assisted outpatient treatment (LT-AOT - 180 days or more) compared to individuals receiving less than LT-AOT (0 to 179 days). Among a group of individuals characterized as seriously violent (i.e. committed violent acts within the 4 month period prior to the study), 63.3% of those not in LT-AOT repeated violent acts while only 37.5% of those in LT-AOT did so. LT-AOT combined with routine outpatient services reduced the predicted probability of violence by 50%.

Another significant finding of the North Carolina study was that for individuals who had a history of multiple hospital admissions combined with arrest and/or violence in the prior year, LT-AOT reduced the risk of arrest by 74%. The predicted risk of being arrested for individuals with LT-AOT was 12%, compared to 47% for those who had no AOT.[7]

In another report from the North Carolina study,[8] LT-AOT reduced hospital admissions by 57% and length of hospital stay by 20 days compared to individuals without court ordered treatment. The results were even more dramatic for individuals with schizophrenia and other psychotic disorders for whom LT-AOT reduced hospital admissions by 72% and length of hospital stay by 28 days compared to individuals without court ordered treatment.

The effectiveness of assisted outpatient treatment in decreasing hospital admissions has been clearly established in several studies. In Washington, D.C., admissions decreased from 1.81 per year to 0.95 per year before and after outpatient commitment.[9] Similarly, in Ohio the decrease was from 1.5 to 0.4[10] and in Iowa from 1.3 to 0.3.[11] In North Carolina, admissions for patients on outpatient commitment decreased from 3.7 to 0.7 per 1,000 days.[12] Only two studies have failed to definitively find assisted outpatient treatment effective in reducing admissions. One was a Tennessee study in which it was evident that "outpatient clinics are not vigorously enforcing the law" and thus non-adherence had no consequences.[13]

The second was a study in New York in which the authors acknowledged that a "limit on [the study's] ability to draw wide-ranging conclusions is the modest size of [the] study group."[14] Additionally, during the period of the study, there was no procedure in place to transport individuals who did not comply with treatment orders to the hospital for evaluation. As in the Tennessee study, non-adherence to a treatment order had no consequences. Although not statistically significant, the New York study suggests that the court orders did in fact help reduce the need for hospitalization. Patients in the court-ordered group spent a median of 43 days in the hospital during the study year, while patients in the control group spent a median of 101 days in the hospital. The difference in fact just misses statistical significance at the level of $p = 0.05$.

Outpatient commitment has also been shown to be effective as a form of assisted treatment in increasing treatment compliance. In North Carolina only 30 percent of patients on outpatient commitment refused medication during a six-month period compared to 66 percent of patients not on outpatient commitment.[15] In Ohio, outpatient commitment increased patients' compliance with outpatient psychiatric appointments from 5.7 to 13.0 per year and with attendance at day treatment sessions from 23 to 60 per year.[16] In Arizona, among patients who had been outpatient committed "71 percent of the patients voluntarily maintained treatment contacts six months after their orders expired" compared to "almost no patients" who had not been put on outpatient commitment.[17] And in Iowa "it appears as though outpatient commitment promotes treatment compliance in about 80 percent of patients while they are on outpatient commitment. After commitment is terminated about three-quarters of that group remain in treatment on a voluntary basis."[18]

Endnotes

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[3]Amador, X.F., Strauss, D.H., Yale, S.A., and Gorman, J.M. Awareness of illness in schizophrenia. *Schizophrenia Bulletin*, 17:113--132 (1991).

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[14]Research study of the New York City involuntary outpatient commitment pilot program. Policy Research Associates, Inc. (December 1998).

[15]Hiday, V.A. and Scheid-Cook, T.L. The North Carolina experience with outpatient commitment: a critical appraisal. *International Journal of Law and Psychiatry*, 10:215–232 (1987).

[16]Munetz, *supra* note 8.

[17]Van Putten, R.A., Santiago, J.M., Berren, M.R. Involuntary outpatient commitment in Arizona: a retrospective study. *Hospital and Community Psychiatry* 39:953–958 (1988).

Scott gets 20-year tern.

The Forum, Fargo, N.D. Dec. '02

Fargo man pleads guilty to shooting mother's fiancé

By Steven P. Wagner
swagner@forumcomm.com

Moments before closing time at The Nestor, Jeffrey Scott drove his white van to the bar to make good on a threat.

After shopping for groceries and putting them away at his south Fargo apartment, Scott arrived at the bar last Dec. 14 to kill Ralph Bakkila.

Out of the shadows, Scott walked up to Bakkila and fired a bullet into his neck. Bakkila, now 51, was engaged to Jeffrey Scott's mother, Kathy, and the two had lived together for several years.

The shooting came after Kathy Scott told her son that she wouldn't pay his rent, food or car repair bills anymore, Cass County State's Attorney Birch Burdick said Friday.

"He (Scott) relied on his mother to support him," Burdick said moments after the 31-year-old Scott pleaded guilty in Cass County District Court to attempted murder.

"The defendant realized his meal ticket was at an end. ... Clearly, he had talked for a long time about his act."

East Central District Judge Norman Backes sentenced Scott to 20 years in prison, with five years suspended, and five years of probation.

The sentence reflected the longest penalty allowed under state law.

"If the law would have been different, I might have given you more," Backes told Scott after listening to attorneys' arguments and family members.

Scott received credit for 358 days in custody, must undergo a mental health evaluation and have no contact with his mother, a sister, Bakkila or Bakkila's three children.

Derek Bakkila, son of shooting victim Ralph Bakkila, is consoled by his mother, Debbie Bakkila, both of Fargo, during Jeffrey Scott's hearing in Cass County District Court.

Photos by Sandee Gerbers The Forum

Scott tells court he was unloved and neglected

For years, Scott told family members he had been molested by Bakkila.

The claim wasn't supported by testimony prosecutors would have submitted had the trial started Tuesday as planned, Burdick said.

SCOTT: Back Page

By Steven P. Wagner
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Jeffrey Scott stood weeping in a Cass County courtroom as he recalled a childhood of drug use, alcohol abuse and neglect.

"A lot of things that have been said weren't really true," Scott said while delivering a rambling 20-minute statement Friday.

"There's a lot of things that my mom doesn't know. I could never talk to her."

The statement came after Scott pleaded guilty in Cass County District Court to shooting Ralph Bakkila, his mother's fiancé, with a .22-caliber pistol last year.

Scott spoke emotionally in a barely audible voice. His mother, Kathy Scott, Bakkila's children and his ex-wife listened quietly.

He told East Central District Judge Norman Backes that he smoked marijuana with his dad at age 10 and became a "hard-core alcoholic at 11."

By age 21, Scott said he had quit drinking.

"I take responsibility (for the shooting)," he said. "I just have so much hurt inside from all those years of neglect. I have to live with this the rest of my life, too."

As Scott's speech continued, family members cried; a defendant in court for an unrelated case yawned and sighed out loud.

"I know I've hurt a lot of people, and I feel terrible about it," Scott said. "I have to live with knowing I hurt someone and that my parents don't love me and never did."

STATEMENT: Back Page

Jeffrey Scott twists a tissue into a ball while addressing the court before his sentencing Friday morning in Cass County Court. "I know I've hurt a lot of people, and I feel terrible about it," he said.

SCOTT: Shooting victim is quadriplegic

From Page A1

Monday, Burdick said Scott planned to change his earlier innocent plea. The decision followed last week's court ruling allowing the defense to use an "extreme emotional disturbance" argument.

Before sentencing Friday, Burdick told the judge how Scott stalked his mother for years, kept a list of family members' license plate numbers in his van and flashed a gun to family members while making threats.

"He has had a deep rage and anger against Ralph Bakkila and his mother for years," Burdick said. "He told his mother, 'I'll kill you both and feel real good.'"

Burdick also showed the judge a picture of Bakkila and Kathy Scott two years ago and a recent picture with his son. Bakkila will never go dancing with his fiancee, work on his home or repair cars, Burdick said.

Kathy Scott said she contacted Moorhead police about her son's threatening behavior, but officers said they couldn't take action until he acted on it.

"My dad was a good man," Derek Bakkila, 20, told the judge. "He's always been there for me."

Sandee Gerbers / The Forum

Kathy Scott, Fargo, mother of the accused, Jeffrey Scott, told the court "there were years and years of threats."

His father enlisted and served in the Vietnam War before returning home to raise three children, he said.

Fighting tears, Derek Bakkila said the shooting changed all of their lives.

Kathy Scott told the judge that her fiancé never molested her son. On behalf of Bakkila, who couldn't attend the court hearing, she said, "I don' know why you did this to me. never hurt you. I never molest ed you."

Scott's attorney, Mari Beauchene, told the judge tha his client came from a broke home, abused alcohol and suf fers delusions from paranoi schizophrenia.

"This isn't just a case that hi mother cut him off financial ly," Beauchene said. "It goe much deeper."

Scott wrote threatening let ters to his mother and Bakkil before the shooting, bu authorities never charge Scott or asked the court to com mit him for mental help Beauchene said.

"It is an explanation tha there were warning signs o the tragedy that followed," h said.

As a result of the shooting Bakkila is a quadriplegic an remains hooked up to a respi rator.

"He got off scot-free com pared to our life sentence,' Kathy Scott said after the hear ing. "There were years an years of threats. I'll remain afraid of him for the rest of my life whether he's in prison o not."

Readers can reach Forum reporter Shawn R Wagner at (701) 241-5542

STATEMENT: Claims 'miserable life'

From Page A1

"I am sorry, I really am. ... I could go on about my miserable life but I don't think anybody wants to hear about that."

Kathy Scott refuted her son's claims after the hearing.

"I told him I loved him," she said. "I don't think you ever quit loving your children, but I'm pretty numb about it now."

Cass County State's Attorney Birch Burdick said Scott may suffer from a mental health disorder. However, two expert evaluations conclude that Scott is responsible for his actions, he said.

The Scott family has a history of mental illness, Kathy Scott said.

Bakkila's two daughters Aimee and Kayla, said Scott's claims that he was repeatedly molested by Bakkila, are unfounded.

The shooting, they say, ha changed their lives and Scot should face a greater penalty.

"I think he deserved more," Kayla Bakkila said.

Readers can reach Forum reporter Shawn R Wagner at (701) 241-5542

Minnesota Activities

Minnesota statutes | most recent changes in Minnesota law

After one of Jim's rampages at home his parents called the police and asked them to take him to the hospital. But the police refused, since the mentally ill cannot be committed until they pose a threat. "You reach the point," said [Minnesota Rep.] Mindy [Greiling], "where you're actually hoping for something to happen, so he'll be forced to go to a hospital."
'Is there trouble with Jim?' When someone you love hears voices through walls," Newsweek, March 11, 2002

Recent news

CHANGE IN LAW SF179 provides better access to treatment, became effective July 2002.

Governor Jesse Ventura signed SF179 into law on June 30, 2001.

The law allows earlier intervention, removing the requirement that danger be "imminent" for emergency response, and improving the standard for treatment so that a person's deteriorating psychiatric condition may be considered in the standard for care.

The law also allows for lengthened hospital stays to stabilize a person's condition as well as timely intervention with medication.

Our profound admiration and grateful congratulations go to Minnesota Representative Mindy Greiling, the original sponsor of this legislation and the leader of the effort for treatment reform in her state.

NEWS In jailhouse interview, Shoreview mom tells why she killed her son
Minneapolis Star-Tribune, March 11, 2002

No one would think of letting a loved one lie about the house with an untreated fracture, or dismissing a worker grappling with diabetes or shunning a neighbor whose eyesight is failing. Yet with society's blessing, many of us look away when the illness in question involves certain disorders of the brain.
"Still ill: Betraying the sick, time and again?"
Minneapolis Star-Tribune, March 15, 2002

History

ARTICLE Idealism gone awry - Exploring origins of dysfunction in mental health care
by John W. Milton, former State Senator and Co-chair, NAMI-MN Legislative Committee
Catalyst newsletter, May/June 2001

PRESS RELEASE HF 281 helps those who need it most - A benefit for all
Treatment Advocacy Center
March 5, 2001

ARTICLE A lesson from Minnesota and California
by E. Fuller Torrey, president, Treatment Advocacy Center
Catalyst newsletter, January/February 2001

United Press International (UPI)

March 15, 2002

Betting on the right horse to save lives

By E. Fuller Torrey, M.D., and Mary T. Zdanowicz, Esq.

"The reality is that advocates must challenge criminal laws ill equipped to deliver justice for people like Andrea Yates who commit crimes while ravaged by a severe mental illness."

Mental health advocates rallied to save Andrea Yates' life, just as they do every time someone with severe mental illness could be sentenced to death for a heinous crime.

This is the mental health community's equivalent of closing the barn door after the horse has escaped. It is too little too late for the thousands of individuals who each year become violent because of untreated mental illnesses.

While the Yates case has captured the nation's attention, it is hardly an exception. Within days of the death of the Yates children, Kristin Anderson's 15-month-old son died of blunt force trauma injuries and stab wounds. Anderson, diagnosed with bipolar disorder, confessed that she twice jumped from a deck carrying her son in her arms, fatally stabbed him, and then burned his body in the backyard of a friend's home because "voices told me to jump off the balcony and follow the light." One month later, Mee Xiong of Minneapolis stabbed two of her children to death. Xiong had a long history of delusions and hallucinations, at least one suicide attempt, multiple hospitalizations, and a few years before had chased her children with a knife.

And just last month in San Francisco, Donna Marie Anderson killed her son to save him from being kidnapped into a non-existent child porn ring. Her family noted for years that she saw conspiracies everywhere as her condition progressively worsened. She still firmly believes she saved her son by stabbing him 15 times.

Attempting to fight the stigma that stems from such cases, the sacred mantra of mental health advocates is that "people with mental illness are no more violent that the general public." But that is only a half-truth. While people who are being treated are no more violent, non-treatment increases the risk of violence substantially.

Friends and families are lulled into a false sense of security, desperately wanting to believe that loved ones transformed by psychosis won't actually obey the voices in their heads. Only this deception can explain Russell Yates' testimony that "[a]t the time, I didn't think she was dangerous, none of us did," despite the fact that one psychiatrist who examined her concluded she was "one of the sickest patients I had ever seen."

There was ample evidence that Andrea was in desperate need of treatment and that her condition had been worsening for years. She had a long history of mental illness, including multiple suicide attempts. Voices had even instructed her to kill her first child. In the months before the tragedy, she stopped washing her hair and bathing. She barely ate or drank. Her best friend said she was

virtually comatose, answering her questions with a single word. She paced like a "scared animal."

So why didn't she and thousands of others like her get adequate treatment?

An estimated 4.5 million Americans today suffer from the most severe mental illnesses, schizophrenia and manic-depressive illness. The National Advisory Mental Health Council estimates that 40 percent of these individuals, or 1.8 million people, are not receiving adequate treatment on any given day.

In a recent study, individuals with serious mental illnesses were interviewed to ascertain why they were not receiving treatment. The majority - 55 percent - denied having a problem that required treatment.

That is largely because almost half of those with schizophrenia and manic-depressive illness suffer from a neurological deficit called anosognosia, which impairs their awareness of their illness. Such people can truly believe that God is speaking to them, that the CIA is after them, or that they must kill their children to save them from Satan. They refuse treatment because they don't think there is anything wrong with them, or worse that agents are trying to poison them with the medicine. And in some states, if you refuse treatment - even if that refusal is because of the disease itself -courts cannot intervene unless you are an immediate danger to yourself or others.

If Andrea Yates was so sick, why did it matter if she was dangerous or not? If she was so obviously deteriorating, wasn't there a way to get her some help?

The horse that escaped from the barn is still running. Families have been misled again - they are told that nothing can be done for a loved one who refuses treatment for psychosis until they become dangerous. In most states this is not true - laws have been changed to allow for early treatment intervention, before someone becomes dangerous. The laws in the remaining states can and must be reformed.

The reality is that advocates must challenge criminal laws ill equipped to deliver justice for people like Andrea Yates who commit crimes while ravaged by a severe mental illness. Yet improving the criminal justice system will be a hollow victory if the untreated mentally ill are still condemned to it because advocates avoid the harsh realities of untreated mental illness. We must get the horse back in the barn by ensuring timely and effective treatment for individuals who refuse it because they don't think they are ill.

READ MORE
TAC's statement on the Andrea Yates sentencing | anosognosia | criminalization

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TREATMENT ADVOCACY CENTER

Minot Daily News

REGION

Sunday, January 5, 2003 • Section B

CHALLENGING THE SYSTEM

Kim Montgomery, left, who is looking into changing the state's medical confidentiality law, and **Janet Sabol** of the northwest North Dakota affiliate of the National Alliance for the Mentally Ill, review information that Montgomery has collected over the years about advocating for people with mental illness.

...Jill Schramm/Staff Writer

Getting more say

Families want laws changed in mental health system

By JILL SCHRAMM
Staff Writer
jschramm@ndweb.com

For 7-1/2 years, Kim Montgomery of Minot has sought closure on her father's suicide.

Her efforts to bring justice to what she calls a preventable death have resulted only in additional frustration with a mental health system that she believes failed her father. If she can't get healing for her grief, Montgomery hopes she can at least loosen medical confidentiality laws to spare another family what she's gone through.

"I don't want a tragedy like this to happen to anyone else," she said.

Meanwhile, Sheree Spears of Des Moines, Iowa, also is talking to N.D. legislators about easing the legal requirements for involuntary hospital commitments because of the near-suicide of her son in Fargo.

Consumer advocacy groups get nervous about proposed law changes that appear to whittle away at patient protections such as confidentiality and self determination. However, some advocates are saying the time is right to look at whether current laws are helping or hindering consumers in getting appropriate care.

"The big question is how many tragedies do we have to have before people with mental illnesses get good care," said Janet Sabol of Minot, coordinator for the Northwest North Dakota affiliate of the National Alliance for the Mentally Ill.

"We have to get the discussion going," she said. "We need to inform the public what's happening in the mental-health area."

Allan Stenehjem, executive director for the Mental Health Association of North Dakota in Bismarck, said his group is open to reviewing the law but feels strongly about safeguarding patients' rights. If there's to be a break in confidentiality or an involuntary commitment, there needs to be substantiation for it, he said.

Montgomery believes substantiation existed in her father's case. He committed suicide three days after his release from the hospital that now is Trinity-St. Joseph's.

After hiring an attorney to obtain her father's medical records, Montgomery learned her father hadn't been taking medicine, talked about suicide and had a difficult time throughout his 3-1/2 weeks of hospitalization. Nowhere in the records did it indicate that her father was doing well, which is what the doctor told the family upon his release, she said.

"They took precautions in the hospital," she said, "but they took no precautions to protect us or my father when he was released."

Trinity officials declined to comment on the case because of patient confidentiality.

A forensic expert's report based on a review the medical records was that Montgomery's father's death "was preventable with aggressive psychiatric treatment, adequate communication with fam-

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See next page

MENTAL HEALTH

Montana family finds gap in system

By JILL SCHRAMM
Staff Writer
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Micheal Kemp of Minot isn't happy that he had to go to the emergency room with a stab wound before his brother could qualify for hospital care for his mental illness.

He's just as upset that others in his family had to be endangered because his brother was released only days later.

"It's got to be darn near illegal," he said of the hospital's release of his brother. "If not, it should be."

Officials at Trinity-St. Joseph's were unable to comment about the case but denied that they erred in releasing Kemp's brother.

Kemp said his brother, 20, had become lax about taking his medicine in the months before coming from Montana to Minot for the Christmas holiday. Although his brother's condition had deteriorated, he hadn't ...ally proved himself a threat to himself or ...ers so that he could be hospitalized, Kemp said.

Kemp recalled that his brother was acting delusional on Christmas Eve. He had stepped outside briefly, and no one saw him take a steak knife from the kitchen when he came in. He stabbed Kemp in the chest, sending him to the hospital for stitches.

Kemp's brother was hospitalized in Trinity-St. Joseph's. Kemp's parents, who also were visiting in Minot, began a series of phone conversations with medical staff, social workers and law enforcement agencies to ensure that their son remained hospitalized until a commitment hearing could be held in Minot Dec. 31.

Doctors advised long-term hospitalization at the State Hospital in Jamestown and told the family that treatment would continue in St. Joseph's until the hearing and transfer could occur, Kemp said.

Ron Kemp, Micheal's father, said he and his wife stopped by the hospital to deliver personal items to their son Dec. 27 when they learned he was to be immediately released. Ron Kemp said the doctor told him that Montana Medicaid no longer would pay for the hospital care. The hospital waived the court hearing and issued papers saying their son was in stable condition, he said.

But Ron Kemp added the doctor also said, "He's a very sick boy, and you need to get him some help."

The Kemps returned with their son to Montana, where he again experienced another violent episode in attempting to physically harm family members. He was jailed overnight before getting into a hospital. He now is receiving long-term care through the Montana State Hospital.

Ron Meier, director of mental health services at St. Joseph's, said the hospital doesn't release patients unless they are stable or are to be transported to another center for care. If patients are dangerous to themselves or others, he said, "We don't just let them out."

That policy holds regardless of the person's residency or insurance status, Meier said. Montana Medicaid will cover a Montana resident hospitalized in another state as long as the hospitalization can be medically justified, he said. A patient who is stable, although not fully recovered, can be discharged into outpatient care, he said. Coverage of outpatient care requires a medical referral from a network provider in Montana.

Michael Kemp and his family say the system failed them. His brother continued to be delusional and potentially a threat to himself or others when he was released, he said.

"The money runs out, so he's out," Kemp said. "That's the shame of the system."

☐ Mental

Continued from Page B1

ily members and intensive outpatient followup care and treatment."

Despite that finding, the State Board of Medical Examiners determined the physician didn't commit gross negligence as defined by state law. The board declined to initiate disciplinary action. Nor could Montgomery's family find an attorney willing to take their case.

Montgomery said her family also had difficulty getting assistance through the State Protection and Advocacy Office.

The law says a doctor can be held responsible for breaking confidentiality – but not for failing to break confidentiality to protect the patient, Montgomery said. She's concluded that law needs to be changed.

"We need laws in North Dakota to protect the patient," she said. "Keeping the illness confidential from the family is not protecting the patient. ... Something has to be done to get the family involved or there are going to be more suicides, more tragedies."

Sabol said advocacy agencies don't object to breaking confidentiality to protect people.

"If you are advocating for the consumer, you want the consumer to live. You want them to be well enough to participate in the community at whatever level they are able," she said.

Sabol said a common characteristic of many mental illnesses is that the patient doesn't realize he or she is ill. Because of their mental conditions, some patients won't sign a medical release form to enable a family member to be part of their care, she said. That might keep a patient from getting the best care, she said.

"What NAMI is trying to get across is that family members really are an important part of the treatment team," Sabol said.

Another problem, she said, is that families don't often know about availability of the release form.

Trinity-St. Joseph's officials say that all patients receive a release form upon discharge so medical information can be transferred to follow-up caregivers. That form also lets patients designate any others to receive that information.

Tom Bennett, director of Trinity Health's outpatient behavioral health, and Ron Meier, director of Trinity-St. Joseph's mental health services, said families are included in treatment plans and receive hospital discharge information.

"Most doctors are fairly liberal with that information if they think there's a safety issue," Bennett said.

Meier said it's good to review the laws affecting mental-health services once in a while. However, he added, it's difficult to support changes that take away from consumer rights.

"It's a complex issue," he said. "The patient is the one we are dealing with and we have to respect his wishes and his rights."

Spear said most consumers want someone to look out for their best interests when they aren't well enough to make decisions for themselves.

She faced a dilemma about two years ago when her son's condition deteriorated after he quit taking his medicine. She wasn't able to commit him to a hospital because she couldn't prove he was dangerous to himself or others.

"The laws really barred us from getting him help," she said. "The window where you can commit somebody is so small. They have to have the gun in their hand so you can prove intent, but not yet pull the trigger. What has happened is a lot of people have actually died. These are preventable deaths."

Her family was lucky. In June 2001, her son broke into his grandparents' gun cabinet but a family member walked in and intervened before he could shoot himself.

Spear now is lobbying for legislation to permit a court committal when there's a substantial deterioration in mental health that is detrimental to that person and others, regardless of whether they might be dangerous.

Meier said families do have the option of pursuing court-ordered outpatient care or partial hospitalization, which is easier to obtain than a hospital commitment. Once outpatient care is obtained, there's a better opportunity for getting any necessary hospitalization, he said.

Spear also would like greater use of court orders to force non-compliant patients to take their medicine.

"When you get them to the point where they are safe and stable, why not keep them there?" Spear said. "Anyone who says you can take away somebody's rights by forcing them to take medicine – the medicine that's required for their illness – they have a lack of human compassion."

2/10 from Shari

AH #2

NAMI

February 10, 2003

The Honorable John T. Traynor
Chairman, Standing Committee on the Judiciary
North Dakota Senate
P.O. Box 838
Devils Lake, ND 58301-0838

Dear Senator Traynor:

I am writing in behalf of the National Alliance for the Mentally Ill (NAMI) in support of Senate Bill Number 2296 (SB 2296), an Act to amend certain sections of the North Dakota Century Code relating to civil commitment procedures for individuals with mental illnesses. With more than 220,000 members and 1,200 state and local affiliates, NAMI is the nation's leading grassroots organization dedicated to improving the lives of people with severe mental illnesses.

NAMI strongly believes that decisions to involuntarily commit individuals to treatment should not be made lightly. Involuntary interventions should occur only as a last resort and laws governing involuntary commitment and involuntary treatment must ensure that individuals subject to these interventions are afforded a full range of due process rights and protections, including right to counsel, right to present testimony in one's own half, and others.

However, NAMI also recognizes that laws requiring proof of imminent dangerousness before involuntary treatment interventions occur can cause unnecessary suffering and impede treatment and recovery for certain individuals whose symptoms preclude them from recognizing their need for treatment or making informed treatment decisions. And, scientific evidence establishes that it is very difficult for psychiatrists or other mental health professionals to accurately predict imminent dangerousness to self or others.

SB 2296 would establish a more balanced approach by allowing treatment interventions to occur based on lack of capacity to make informed, rational treatment decisions that create a substantial risk of substantial deterioration in physical or mental health or a substantial risk of injury, disease or death. The burden of proving that the individual requires treatment would remain with the party seeking the involuntary treatment order, while enhancing the ability to intercede in a humane fashion before needless suffering occurs.

Thank you for affording me the opportunity to comment on this important legislation. Please contact me (phone: 301-424-5847; email: RonH@nami.org) with any questions.

Sincerely,

Ronald S. Honberg

Ronald S. Honberg, J.D., M.Ed
National Director for Policy and Legal Affairs

Cc. The Honorable Stanley W. Lyson

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2002 WI 104

SUPREME COURT OF WISCONSIN

CASE NO.: 01-0374

COMPLETE TITLE:

In re the Commitment of Dennis H.,

State of Wisconsin,
Petitioner-Respondent,
v.
Dennis H.,
Respondent-Appellant.

ON CERTIFICATION FROM THE COURT OF APPEALS

OPINION FILED: July 12, 2002
SUBMITTED ON BRIEFS:
ORAL ARGUMENT: May 1, 2002

SOURCE OF APPEAL:
COURT: Circuit
COUNTY: Milwaukee
JUDGE: Victor Manian

JUSTICES:
CONCURRED: ABRAHAMSON, C.J., concurs (opinion filed). BABLITCH and BRADLEY, JJ., join concurrence.
DISSENTED:
NOT PARTICIPATING:

ATTORNEYS:

For the respondent-appellant there were briefs by *Ellen Henak*, assistant state public defender, and *Thomas K. Zander*, Milwaukee, and oral argument by *Ellen Henak*.

For the petitioner-respondent the cause was argued by *Thomas J. Balistreri*, assistant attorney general, with whom on the brief was *James E. Doyle*, attorney general.

An amicus curiae brief was filed by *Theresa M. Hottenroth* and *Whyte Hirschboeck Dudek S.C.*, Madison, on behalf of the Treatment Advocacy Center, and there was oral argument by *Mary Zdanowicz*.

An amicus curiae brief was filed by *Mary Dianne Greenley*, Madison, on behalf of the Wisconsin Coalition for Advocacy, Inc.

An amicus curiae brief was filed by *Robert Theine Piedl* and *Schott, Bublitz & Engel, S.C.*, Brookfield, on behalf of the American Civil Liberties Union of Wisconsin Foundation.

An amicus curiae brief was filed by *Michael J. Bachhuber*, Milwaukee, on behalf of the Grassroots Empowerment Project, Inc.

An amicus curiae brief was filed by *Richard G. Niess* and *Coyne, Niess, Schultz, Becker & Bauer, S.C.*, Madison, and *Kenneth J. Kress*, Iowa City, Iowa, on behalf of Kenneth J. Kress.

An amicus curiae brief was filed by *Herbert S. Bratt*, Milwaukee, and *Mark L. Adams* and *Melanie E. Cohen*, Madison, on behalf of the Wisconsin Psychiatric Association, Inc., and the State Medical Society of Wisconsin.

An amicus curiae brief was filed by *Mary Dianne Greenley*, Madison, on behalf of the Wisconsin Coalition for Advocacy, Inc., and the Judge David L. Bazelon Center for Mental Health Law.

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NOTICE

This opinion is subject to further editing and modification. The final version will appear in the bound volume of the official reports.

No. 01-0374
(L.C. No. 00 ME 1299)

STATE OF WISCONSIN : IN SUPREME COURT

In re the Commitment of Dennis H.,

State of Wisconsin,

Petitioner-Respondent,

v.

Dennis H.,

Respondent-Appellant.

FILED

JUL 12, 2002

Cornelia G. Clark
Clerk of Supreme Court

APPEAL from an order of the Circuit Court for Milwaukee County, Victor Manian, Circuit Court Judge. *Affirmed.*

¶1 DIANE S. SYKES, J. This case is before the court on certification from the court of appeals, which we accepted to resolve a single issue of law: whether the fifth standard of dangerousness in the involuntary civil commitment statute, Wis. Stat. § 51.20(1)(a)2.e. (1999-2000), is constitutional. We hold that it is.

¶2 Dennis H. is the subject of this mental health commitment, and he has schizophrenia. His father, his psychiatrist, and his case manager filed a three-party petition

in Milwaukee County Circuit Court seeking to commit him pursuant to Wis. Stat. § 51.20(1)(a) (1999-2000)[1], because he was exhibiting behavior that had previously led to his hospitalization in critical condition for kidney failure.

¶3 Dennis H. moved to dismiss, arguing that the fifth standard of dangerousness, Wis. Stat. § 51.20(1)(a)2.e., is unconstitutional.[2] The circuit court denied the motion, a jury found Dennis H. dangerous under the fifth standard, and he was committed. He appealed, and the court of appeals certified the case to this court.

¶4 Dennis H. contends that the fifth standard is facially unconstitutional because it violates the due process and equal protection guarantees of the federal and state constitutions and is also vague and overbroad.[3] More specifically, he argues that

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[1] All references to the Wisconsin Statutes are to the 1999-2000 version unless otherwise noted.

[2] It was determined at the probable cause hearing that none of the first four definitions of dangerousness sufficient for commitment under Wis. Stat. § 51.20(1)(a)2.a.-d. applied.

[3] The Fourteenth Amendment to the United States Constitution states: "No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

Article I, Section I of the Wisconsin Constitution states: "All people are born equally free and independent, and have certain inherent rights; among these are life, liberty and the pursuit of happiness; to secure these rights, governments are instituted, deriving their just powers from the consent of the governed."

the statute is constitutionally infirm because it lacks a requirement of imminent dangerousness to self or others, and because it allows commitment upon a finding of a substantial probability of something less than physical harm, to wit, mental or emotional harm.

¶5 A facial constitutional challenge to a statute is an uphill endeavor. The state has a well-established, legitimate interest under its parens patriae power in providing care to persons unable to care for themselves, and also has authority under its police power to protect the community from mentally ill persons determined to be dangerous. Heller v. Doe, 509 U.S. 312, 332 (1993) (citing Addington v. Texas, 441 U.S. 418, 426 (1979)). The general rule, of course, is that any legislative enactment carries a presumption of constitutionality. State v. Carpenter, 197 Wis. 2d 252, 263-64, 541 N.W.2d 105 (1995).

¶6 Furthermore, "[w]e deal here with issues of unusual delicacy, in an area where professional judgments regarding desirable procedures are constantly and rapidly changing." Heller, 509 U.S. at 333 (discussing mental health commitments) (quoting Smith v. Organization of Foster Families for Equality & Reform, 431 U.S. 816, 855-856 (1977)). "In such a context, restraint is appropriate on the part of courts called upon to adjudicate whether a particular procedural scheme is adequate

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"[T]he due process and equal protection clauses of the Wisconsin Constitution are the substantial equivalents of their respective clauses in the federal constitution." State v. McManus, 152 Wis. 2d 113, 130, 447 N.W.2d 654 (1989).

under the Constitution." Id. We conclude that the fifth standard is not unconstitutionally vague or overbroad, and does not violate due process or equal protection.

I

¶7 On June 23, 2000, Dennis H.'s father, psychiatrist, and case manager filed a petition in Milwaukee County Circuit Court to have him involuntarily committed for treatment under Wis. Stat. § 51.20(1)(a). Dennis H. suffers from schizophrenia and, due to medication noncompliance, had previously been hospitalized in acute renal failure and electrolyte imbalance brought on by extreme and rapid weight loss and dehydration.

¶8 Dennis H. sought to have the petition dismissed, arguing that the fifth standard of dangerousness as grounds for involuntary commitment, Wis. Stat. § 51.20(1)(a)2.e., violates the federal and state constitutions. The circuit court, the Honorable Michael J. Dwyer, rejected Dennis H.'s constitutional challenge and denied the motion to dismiss.

¶9 Noting that the state has a legitimate interest under its police and parens patriae powers in protecting society and the mentally ill, the circuit court concluded that the fifth standard constituted a "new description of dangerousness" sufficient to justify commitment. The circuit court viewed the fifth standard's new definition as encompassing a requirement of present dangerousness, albeit "in a little different vocabulary"

than the other four. Because the fifth standard did not dispense with dangerousness as a pre-condition of commitment, but merely defined it in a different way, the circuit court found it "constitutionally appropriate."[4]

¶10 A probable cause hearing was held. Following the testimony of two doctors, the first four standards of dangerousness were determined to be inapplicable, and the case proceeded to trial on the fifth standard only.

¶11 A jury trial was held on July 24-25, 2000, before the Honorable Victor Manian. The jury was instructed on the statutory elements of the fifth standard, and returned a verdict finding Dennis H. dangerous. The circuit court ordered Dennis H. committed for a period of six months. Pursuant to stipulation, this was later extended for another six months. Dennis H. appealed the order of commitment, and the court of appeals certified the case to this court.

II

¶12 The constitutionality of a statute is a question of law which this court reviews de novo. State v. Janssen, 219 Wis. 2d 362, 370, 580 N.W.2d 260 (1998). The party challenging

[4] Dennis H. asserts that Judge Dwyer recast the statute to require evidence of "imminent physical dangerousness." The Honorable Victor Manian presided at trial, however, and instructed the jury precisely according to the text of the statute.

a statute must establish its unconstitutionality beyond a reasonable doubt. State v. McManus, 152 Wis. 2d 113, 129, 447 N.W.2d 654 (1989). "Every presumption must be indulged to sustain the law if at all possible and, wherever doubt exists as to a legislative enactment's constitutionality, it must be resolved in favor of constitutionality." Carpenter, 197 Wis. 2d at 263-64 (citing McManus, 152 Wis. 2d at 129 (citations and quotation marks omitted in original)). A court does not evaluate the merits of the legislature's economic, social, or political policy choices, but is limited to considering whether the statute violates some specific constitutional provision. State ex rel. Hammermill Paper Co. v. La Plante, 58 Wis. 2d 32, 46-47, 205 N.W.2d 784 (1973).

¶13 We have previously noted that the United States Supreme Court has declined to prescribe "strict boundaries for legislative determinations of what degree of dangerousness is necessary for involuntary commitment," because "[s]ubstantive as well as procedural limitations on a state's traditional power to commit the dangerously mentally ill vary widely from jurisdiction to jurisdiction." State v. Post, 197 Wis. 2d 279, 312, 541 N.W.2d 115 (1995), cert. denied, 521 U.S. 1118 (1997) (footnote omitted) (citing Jackson v. Indiana, 406 U.S. 715, 736-37 (1972)). Because of "the uncertainty endemic to the field of psychiatry . . . particular deference must be shown to

legislative decisions in that arena." Id. (citing Jones v. United States, 463 U.S. 354, 364 n.13 (1983)). Accordingly, courts generally proceed with restraint in this complex, delicate, and policy-sensitive area, deferring to the procedural scheme the legislature has chosen. See Heller, 509 U.S. at 332; Smith, 431 U.S. at 855-856; Post, 197 Wis. 2d at 312.

III

¶14 We start with the text of the statute at issue. Section 51.20 of the Wisconsin Statutes governs involuntary civil commitments for mental health treatment and contains five different definitions or standards of dangerousness for purposes of involuntary commitment. The so-called "fifth standard," Wis. Stat. § 51.20(1)(a)2.e., was enacted in 1995, see 1995 Wis. Act 292, and provides that "an individual, other than an individual who is alleged to be drug dependent or developmentally disabled," is considered "dangerous" if:

> [A]fter the advantages and disadvantages of and alternatives to accepting a particular medication or treatment have been explained to him or her and because of mental illness, evidences either incapability of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives, or substantial incapability of applying an understanding of the advantages, disadvantages, and alternatives to his or her mental illness in order to make an informed choice as to whether to accept or refuse medication or treatment; and evidences a substantial probability, as demonstrated by both the individual's treatment history and his or her recent acts or omissions, that

> the individual needs care or treatment to prevent further disability or deterioration and a substantial probability that he or she will, if left untreated, lack services necessary for his or her health or safety and suffer severe mental, emotional or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions. The probability of suffering severe mental, emotional or physical harm is not substantial under this subd.2.e. if reasonable provision for the individual's care or treatment is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services or if the individual is appropriate for protective placement under § 55.06. Food, shelter or other care that is provided to an individual who is substantially incapable of obtaining food, shelter or other care for himself or herself by any person other than a treatment facility does not constitute reasonable provision for the individual's care or treatment in the community under this subd.2.e. The individual's status as a minor does not automatically establish a substantial probability of suffering severe mental, emotional, or physical harm under this subd.2.e.

Wis. Stat. § 51.20(1)(a)2.e.

¶15 Dennis H. argues that the fifth standard: (1) is unconstitutionally vague and overbroad; (2) violates his right to equal protection of the law by allowing for commitment under circumstances different than those existing under any of the four other standards; and (3) violates his right to substantive due process by allowing commitment without requiring evidence of a risk of imminent physical harm to himself or others. We disagree, and uphold the statute against his vagueness, overbreadth, equal protection, and due process challenges.

Vagueness

¶16 The statute is long and complex. Neither attribute makes it unconstitutional, however, for neither is the proper measure of a statute's constitutionality. We have previously explained that:

> The principles underlying the void for vagueness doctrine . . . stem from concepts of procedural due process. Due process requires that the law set forth fair notice of the conduct prohibited or required and proper standards for enforcement of the law and adjudication. Based upon these concepts of due process, a statute is void for vagueness if it fails to give notice to those wishing to obey the law that their conduct falls within the proscribed area, or if it fails to provide those who must enforce and apply the law objective standards with which to do so.

In re Commitment of Curiel, 227 Wis. 2d 389, 414-15, 597 N.W.2d 697 (1999) (quoting State v. Popanz, 112 Wis. 2d 166, 172-73, 332 N.W.2d 750 (1983)) (citations and internal quotation marks omitted).

¶17 Our task, then, is to determine whether the statute provides objectively discernible standards by which commitment decisions can be made. In other words, "we must determine whether the statute fails to be sufficiently definite to allow judges, juries and expert witnesses to apply (its) terms . . . objectively to the question before them in order to determine whether to commit the defendant without having to create or apply their own standards." Curiel, 227 Wis. 2d at 415 (citing Popanz, 112 Wis. 2d at 173); see also State v. Courtney, 74 Wis. 2d 705, 711, 247 N.W.2d 714 (1976).

¶18 The statute identifies five elements, each of which must be satisfied before a person may be civilly committed. It

precisely, though perhaps clumsily, identifies those to whom it applies. That the statute attempted to do all of this in one paragraph, rather than through separate, discrete subparts, does not make it constitutionally infirm. We measure the statute for its constitutionality, not its technique of draftsmanship.

¶19 First, a person who is the subject of a commitment petition must be mentally ill. See Wis. Stat. § 51.20(1)(a)1.[5] and § 51.20(1)(a)2.e.[6] Whether a person is mentally ill is a medical judgment, see Humphrey v. Cady, 405 U.S. 504, 509 (1972), made by applying the definition of mental illness in Wis. Stat. § 51.01(13)(b), which is applicable to all involuntary commitments under Wis. Stat. § 51.20. A determination of mental illness requires a finding of "a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life." Wis. Stat. § 51.01(13)(b).

¶20 Dennis H. argues that the fifth standard's definition of dangerousness is essentially no more than a reiteration of the definition of mental illness, although in slightly different terms, and therefore allows involuntary commitment upon a finding of mental illness alone. This is not true. The fifth

[5] "The individual is mentally ill . . . drug dependent or developmentally disabled and is a proper subject for treatment." Wis. Stat. § 51.20(1)(a)1.

[6] The fifth standard removes those "alleged to be drug dependent or developmentally disabled" from its scope. Wis. Stat. § 51.20(1)(a)2.e.

standard's definition of dangerousness requires proof of a substantial probability of something more than impairment; section 51.20(1)(a)2.e. requires proof of a substantial probability of a "loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions." In this regard, the fifth standard spells out a heightened standard of impairment—beyond the threshold definition of mental illness—for purposes of the dangerousness determination. Accordingly, a finding of mental illness alone does not equate to a finding of dangerousness under the fifth standard.

¶21 Second, the person who is the subject of the commitment petition must be incompetent to make medication or treatment decisions, or, more specifically, must be unable, "because of mental illness," to make "an informed choice as to whether to accept or refuse medication or treatment." Wis. Stat. § 51.20(1)(a)2.e. This must be evidenced either by an "incapability of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives," or by a "substantial incapability of applying an understanding of the advantages, disadvantages, and alternatives to his or her mental illness." Id. This must occur "after the advantages and disadvantages of and alternatives to accepting a particular medication or treatment have been explained to him or her." Id.

¶22 Third, the person must show a "substantial probability" that he or she "needs care or treatment to prevent

further disability or deterioration." Id. This must be "demonstrated by both the individual's treatment history and his or her recent acts or omissions." Id.

¶23 Fourth, the person must evidence a "substantial probability that he or she will, if left untreated, lack services necessary for his or her health or safety." Id.

¶24 Fifth, the person must evidence "a substantial probability that he or she will, if left untreated, . . . suffer severe mental, emotional, or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions." Id.

¶25 Only after each of these elements is proven may the person be considered "dangerous" under the fifth standard. The statute also contains an explicit limitation on its reach: "if reasonable provision for the individual's care or treatment is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services," then a substantial probability of suffering severe mental, emotional, or physical harm does not exist. Id. However, the simple provision of food and shelter by a non-treatment facility does not satisfy the requirement of "reasonable provision for the individual's care or treatment." Id. The statute also specifies that an "individual's status as a minor does not automatically establish a substantial probability of suffering severe mental, emotional, or physical harm. . . ." Id.

¶26 It is important to note that the fifth standard requires that these conditions be evident to a "substantial probability." Id. The "substantial probability" degree of proof provides a proper standard of adjudication. See Curiel, 227 Wis. 2d at 414-15. The statute "is not so obscure that men of common intelligence must necessarily guess at its meaning and differ as to its applicability." Curiel, 227 Wis. 2d at 415 (citing Peissig v. Wisconsin Gas Co., 155 Wis. 2d 686, 699, 456 N.W.2d 348 (1990)). Accordingly, we reject Dennis H.'s contention that the fifth standard is unconstitutionally vague.

Overbreadth

¶27 Invalidation of a statute on overbreadth grounds is "strong medicine" that is "employed by the Court sparingly and only as a last resort." Janssen, 219 Wis. 2d at 373 (quoting Broadrick v. Oklahoma, 413 U.S. 601, 613 (1973)). "A statute is overbroad when its language, given its normal meaning, is so sweeping that its sanctions may be applied to constitutionally protected conduct which the state is not permitted to regulate." Id. (quoting Bachowski v. Salamone, 139 Wis. 2d 397, 411, 407 N.W.2d 533 (1987)). "A statute must be narrowly enough drawn that its terms can be given a reasonably precise content and those persons it encompasses can be identified with reasonable accuracy." Post, 197 Wis. 2d at 303 (citing O'Connor v. Donaldson, 422 U.S. 563, 575 (1975)).

¶28 When the legislature "undertakes to act in areas fraught with medical and scientific uncertainties," however, "legislative options must be especially broad." Post, 197 Wis.

2d at 304 (quoting Jones, 463 U.S. at 370, and Marshall v. United States, 414 U.S. 417, 427 (1974)). A mental commitment provision is overly broad only if by its terms it could reasonably be applied to commit mentally ill persons who are not in any way dangerous to themselves or others. See id. The fifth standard's focus is on dangerousness to self—dangerousness of a particularly insidious nature because it is chronic and cyclical (measured by treatment history and recent acts or omissions), and brought on by mental illness that produces an incapacity to make medication or treatment decisions as well as a substantial probability of an incapacity to care for oneself. The fifth standard does not apply to mentally ill people who are not dangerous to themselves. Accordingly, the statute is not unconstitutionally overbroad.

Equal Protection

¶29 Dennis H. also argues that the fifth standard violates equal protection by allowing for commitment and involuntary medication under circumstances different than those existing under any of the other four standards. See Wis. Stat. § 51.20(1)(a)2.a.-e. and (13)(dm). The focus of his argument is on the fifth standard's use of the phrase "mental, emotional, or physical harm," see Wis. Stat. § 51.20(1)(a)2.e., in contrast to the requirement in each of the first four standards of some form of "physical" harm. See Wis. Stat. § 51.20(1)(a)2.a.-d.[7]

[7] The first four standards define dangerousness as follows:

> Evidences a substantial probability of physical harm to himself or herself as manifested by evidence

Specifically, Dennis H. contends that the statute impermissibly dispenses with a requirement of physical harm, allowing involuntary commitment and forcible medication upon a finding of mere mental or emotional harm.

¶30 Dennis H. reads the statute too narrowly. The fifth standard requires proof of a substantial probability that "if left untreated," the individual will "lack services necessary for his or her *health or safety* and suffer *severe* mental, emotional or physical harm *that will result in the loss of the individual's ability to function independently in the community*

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of recent threats of or attempts at suicide or serious bodily harm. Wis. Stat. § 51.20(1)(a)2.a.

Evidences a substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other violent behavior, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do serious physical harm . . . ." Wis. Stat. § 51.20(1)(a)2.b.

Evidences such impaired judgment, manifested by evidence of a pattern of recent acts or omissions, that there is a substantial probability of physical impairment or injury to himself or herself. Wis. Stat. § 51.20(1)(a)2.c.

Evidences behavior manifested by recent acts or omissions that, due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness. Wis. Stat. § 51.20(1)(a)2.d.

or the loss of cognitive or volitional control over his or her thoughts or actions." Wis. Stat. § 51.20(1)(a)2.e. (emphasis added). The legislature has thus defined dangerousness in the fifth standard by reference to a threat to the individual's fundamental health or safety *and* a loss of the ability to function independently or control thoughts or actions. Mere emotional or mental harm is insufficient for commitment.

¶31 In any event, to the extent that the differences between the fifth standard and the first four result in a classification for purposes of equal protection analysis, it is not a constitutionally impermissible one. Whether a legislative distinction between otherwise similarly situated persons violates equal protection depends upon whether there is a reasonable basis to support it. State ex rel. Jones v. Gerhardstein, 141 Wis. 2d 710, 733, 416 N.W.2d 883 (1987); see also Post, 197 Wis. 2d at 319-20 (noting that the Supreme Court has not explicitly required strict or intermediate scrutiny of involuntary commitment statutes challenged on equal protection grounds). "Where the classification does not involve a suspect class, equal protection is denied only if the legislature has made an irrational or arbitrary classification." Jones, 141 Wis. 2d at 733.

¶32 "[T]he state retains broad discretion to create classifications so long as the classifications have a reasonable basis." McManus, 152 Wis. 2d at 131 (citing Graham v. Richardson, 403 U.S. 365, 371 (1971)). Under the rational basis test, a statutory classification is presumed to be proper.

State v. Hart, 89 Wis. 2d 58, 65, 277 N.W.2d 843 (1979). It will be sustained if the reviewing court can identify any reasonable basis to support it. Matter of Care and Maintenance of K.C., 142 Wis. 2d 906, 916, 420 N.W.2d 37 (1988). Any doubt must be resolved in favor of the reasonableness of the classification and the constitutionality of the statute in which it is made. Racine Steel Castings v. Hardy, 144 Wis. 2d 553, 560, 426 N.W.2d 33 (1988). A "legislative enactment must be sustained unless it is 'patently arbitrary' and bears no rational relationship to a legitimate government interest." McManus, 152 Wis. 2d at 131 (citing Frontiero v. Richardson, 411 U.S. 677, 683 (1973)).[8]

¶33 The fifth standard applies to mentally ill persons whose mental illness renders them incapable of making informed medication decisions and makes it substantially probable that, without treatment, disability or deterioration will result, bringing on a loss of ability to provide self-care or control thoughts or actions. It allows the state to intervene with care and treatment before the deterioration reaches an acute stage,

[8] Accord Milner v. Apfel, 148 F.3d 812, 815-16 (7th Cir. 1998). The Seventh Circuit noted that "the uniform view of the courts of appeals" is that "rational basis is the proper standard for deciding equal protection cases" involving the mentally ill. The court also noted that several Supreme Court cases imply or suggest the same. See id. (citing Heller v. Doe by Doe, 509 U.S. 312, 321 (1993)("We have applied rational-basis review in previous cases involving the mentally retarded and the mentally ill."); City of Cleburne v. Cleburne Living Center, 473 U.S. 432, 466 (1985); Jones v. United States, 463 U.S. 354, 363 (1983); Jackson v. Indiana, 406 U.S. 715, 736-37 (1972); Baxstrom v. Herold, 383 U.S. 107, 111-15 (1966)).

thereby preventing the otherwise substantially probable and harmful loss of ability to function independently or loss of cognitive or volitional control. There is a rational basis for distinguishing between a mentally ill person who retains the capacity to make an informed decision about medication or treatment and one who lacks such capacity. The latter is helpless, by virtue of an inability to choose medication or treatment, to avoid the harm associated with the deteriorating condition.

¶34 Mentally ill persons who meet the fifth standard's definition are clearly dangerous to themselves because their incapacity to make informed medication or treatment decisions makes them more vulnerable to severely harmful deterioration than those who are competent to make such decisions. The state has a strong interest in providing care and treatment before that incapacity results in a loss of ability to function. We conclude that any distinctions between the fifth standard and the first four are rationally-based. The fifth standard does not violate equal protection.

Substantive Due Process

¶35 Finally, Dennis H. argues that the fifth standard violates substantive due process by allowing involuntary commitment without evidence of a risk of imminent physical dangerousness to self or others.

¶36 "The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable to care for themselves." Addington v. Texas, 441 U.S. 418, 426

(1979). The state also has "authority under its police power to protect the community" from any dangerous mentally ill persons. Heller, 509 U.S. at 332 (citing Addington, 441 U.S. at 426). The state's legitimate interest ceases to exist, however, if those sought to be confined "are not mentally ill or if they do not pose *some* danger to themselves or others."[9] Addington, 441 U.S. at 426 (emphasis added).

¶37 "[E]ven if there is no foreseeable risk of self-injury or suicide, a person is literally 'dangerous to himself' if for physical *or other reasons* he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends." O'Connor v. Donaldson, 422 U.S. 563, 574, n.9 (1975) (emphasis added). Substantive due process has not been held to require proof of imminent physical dangerousness to self or others as a necessary prerequisite to involuntary commitment.[10]

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[9] Addington also held that due process requires that the middle "clear and convincing" burden of proof apply to involuntary commitment proceedings. Addington v. Texas, 441 U.S. 418, 433 (1979); see also Foucha v. Louisiana, 504 U.S. 71, 75-76 (1992).

[10] O'Connor held that "[a] finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in *simple* custodial confinement." O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) (emphasis added). As we have noted, the fifth standard does not allow involuntary civil commitment upon a finding of mental illness alone. Nor does it place the mentally ill person in simple custodial confinement. See, e.g., Wis. Stat. § 51.20(10)(cm) (requiring the formulation of a treatment plan prior to commitment); Wis. Stat. § 51.20(13)(g)2d.a. (limiting the time a person committed under the fifth standard can spend in inpatient treatment to 30 days).

¶38 It is well-established that the state "cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." Id. at 576; see also Foucha v. Louisiana, 504 U.S. 71, 78 (1992) (involuntary mental health commitment is improper absent a determination of current mental illness and dangerousness). This does not mean, however, that substantive due process requires the state to restrict the scope of its mental health commitment statutes to only those individuals who are imminently physically dangerous. There is no "single definition that must be used as the mental condition sufficient for involuntary mental commitments." Post, 197 Wis. 2d at 304. In this complicated and difficult area, the Supreme Court "has wisely left the job of creating statutory definitions to the legislators who draft state laws." Id.

¶39 The fifth standard permits commitment only when a mentally ill person needs care or treatment to prevent deterioration but is unable to make an informed choice to accept it. This must be "demonstrated by both the individual's treatment history" and by the person's "recent acts or omissions." Wis. Stat. § 51.20(1)(a)2.e. It must also be *substantially probable* that if left untreated, the person "will suffer severe mental, emotional or physical harm" resulting in the loss of the "ability to function independently in the community" or in the loss of "cognitive or volitional control."

Id. Only then may the individual be found "dangerous" under the fifth standard.

¶40 The fifth standard thus fits easily within the O'Connor formulation: even absent a requirement of obvious physical harm such as self-injury or suicide, a person may still be "dangerous to himself" if "he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends." O'Connor, 422 U.S. at 574, n.9.

¶41 Moreover, by requiring dangerousness to be evidenced by a person's treatment history along with his or her recent acts or omissions, the fifth standard focuses on those who have been in treatment before and yet remain at risk of severe harm, *i.e.*, those who are chronically mentally ill and drop out of therapy or discontinue medication, giving rise to a substantial probability of a deterioration in condition to the point of inability to function independently or control thoughts or actions. See Darold A. Treffert, The MacArthur Coercion Studies: A Wisconsin Perspective, 82 Marq. L. Rev. 759, 780 (1999). The statute represents the fruition of the efforts of the Wisconsin State Medical Society and the Alliance for the Mentally Ill, professional organizations which recognized a need for a law that could be applied to those victims of mental illness who fell through the cracks under the old statutory scheme. See id.

¶42 "As with all enactments, we presume good faith on the part of the legislature." Post, 197 Wis. 2d at 308 (citing State ex rel. Thomson v. Zimmerman, 264 Wis. 644, 652, 60 N.W.2d

416 (1953)). By permitting intervention before a mentally ill person's condition becomes critical, the legislature has enabled the mental health treatment community to break the cycle associated with incapacity to choose medication or treatment, restore the person to a relatively even keel, prevent serious and potentially catastrophic harm, and ultimately reduce the amount of time spent in an institutional setting.[11] This type of "prophylactic intervention" does not violate substantive due process.

¶43 A number of amicus curiae briefs have been filed by professional and advocacy organizations, both in support of and opposition to the fifth standard, and they cite academic research on both sides of the policy choice that the statute embodies. "The fact that studies reaching opposite conclusions can be cited on both sides of this issue does not preclude the legislature from acting, nor does it compel a finding of unconstitutionality." Post, 197 Wis. 2d at 311.

¶44 The Supreme Court has cautioned against judicial second-guessing of legislative judgments in the area of mental health commitments:

> We do not agree with the suggestion that Congress' power to legislate in this area depends on the research conducted by the psychiatric community. We have recognized repeatedly the "uncertainty of diagnosis in this field and the tentativeness of professional judgment. The only certain thing that

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[11] As we have noted, those committed under the fifth standard are initially limited to 30 days of inpatient treatment. See supra, note 10.

> can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment . . . . " The lesson we have drawn is not that government may not act in the face of this uncertainty, but rather that courts should pay particular deference to reasonable legislative judgments.

Id. (citing Jones, 463 U.S. at 364 n.13 (citations omitted in original)). We defer, therefore, to the legislature's resolution of the conflicting positions of mental health advocates and psychiatric professionals.

¶45 In summary, the fifth standard does not allow involuntary commitment upon a finding of mental illness alone, and contains an ascertainable standard of commitment, and is therefore not unconstitutionally vague or overbroad. Furthermore, the fifth standard does not create a class of persons who can be involuntarily committed upon a finding of mere mental or emotional harm, and therefore does not violate equal protection. Finally, the fifth standard does not violate substantive due process, because the constitution does not require proof of imminent physical harm prior to commitment for treatment. Accordingly, the fifth standard of dangerousness for involuntary civil commitment, Wis. Stat. § 51.20(1)(a)2.e., is constitutional.

By the Court.—The order of the Milwaukee County Circuit Court is affirmed.

¶46 SHIRLEY S. ABRAHAMSON, CHIEF JUSTICE *(concurring)*. Both mental illness and dangerousness are necessary to satisfy the requirements of substantive due process for involuntary civil commitment in Wisconsin.

¶47 The so-called fifth standard was enacted to allow for the hospitalization and treatment of individuals with a history of mental health treatment who become incapable of making rational treatment decisions and refuse treatment. For such individuals, refusing timely treatment could lead to substantial mental deterioration. For family members and friends, a loved one's refusal of timely treatment can result in an agonizing and helpless vigil as that individual's mental, emotional, and physical condition deteriorates.

¶48 A court must balance the desires of mental health professionals, friends, and family members who believe that care and treatment are in the best interests of a person who is mentally ill, and the constitutional liberty interests of individuals to be free from unwanted and unnecessary restraints. In recent decades, this balance has been struck by requiring proof of mental illness and imminent dangerousness to self or others before permitting involuntary civil commitment.[1]

¶49 The fifth standard comes perilously close to upsetting this balance. It passes constitutional muster for me only so

[1] See O'Connor v. Donaldson, 422 U.S. 563, 573-76 (1975) (state cannot confine nondangerous person without more); Lessard v. Schmidt, 379 F.Supp. 1376, 1381 (E.D. Wis. 1974), vacated and remanded on other grounds, 421 U.S. 957 (1975), reinstated 413 F.Supp. 1318 (E.D. Wis. 1976) (mandating dangerousness as a constitutional prerequisite to involuntary hospitalization).

long as courts require significant evidence of the statutory elements, and treatment is in fact provided. For the reasons set forth, I write separately.

¶50 I am authorized to state that Justices WILLIAM A. BABLITCH and ANN WALSH BRADLEY join this opinion.

NAMI

February 27, 2003

Representative Duane DeKrey
Chairman, House Committee on the Judiciary
4323 – 27th Street, SE
Pettibone, ND 58475-9357

Dear Chairman DeKrey and Members of the Judiciary Committee:

I am writing in behalf of the National Alliance for the Mentally Ill (NAMI) in support of Senate Bill Number 2296 (SB 2296), an Act to amend certain sections of the North Dakota Century Code relating to civil commitment procedures for individuals with mental illnesses. With more than 220,000 members and 1,200 state and local affiliates, NAMI is the nation's leading grassroots organization dedicated to improving the lives of people with severe mental illnesses.

NAMI strongly believes that decisions to involuntarily commit individuals to treatment should not be made lightly. Involuntary interventions should occur only as a last resort and laws governing involuntary commitment and involuntary treatment must ensure that individuals subject to these interventions are afforded a full range of due process rights and protections, including right to counsel, right to present testimony in one's own half, and others.

However, NAMI also recognizes that laws requiring proof of imminent dangerousness before involuntary treatment interventions occur can cause unnecessary suffering and impede treatment and recovery for certain individuals whose symptoms preclude them from recognizing their need for treatment or making informed treatment decisions. And, scientific evidence establishes that it is very difficult for psychiatrists or other mental health professionals to accurately predict imminent dangerousness to self or others.

SB 2296 would establish a more balanced approach by allowing treatment interventions to occur based on lack of capacity to make informed, rational treatment decisions that create a substantial risk of substantial deterioration in physical or mental health or a substantial risk of injury, disease or death. The burden of proving that the individual requires treatment would remain with the party seeking the involuntary treatment order, while enhancing the ability to intercede in a humane fashion before needless suffering occurs.

Thank you for affording me the opportunity to comment on this important legislation. Please contact me (phone: 301-424-5847; email: RonH@nami.org) with any questions.

Sincerely,

Ronald S. Honberg, J.D., M.Ed
National Director for Policy and Legal Affairs

NAMI | The Nation's Voice on Mental Illness
Colonial Place Three • 2107 Wilson Blvd., Suite 300 • Arlington, VA 22201-3042
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Sen. C. Nelson

NORTH DAKOTA SENATE

STATE CAPITOL
600 EAST BOULEVARD
BISMARCK, ND 58505-0360

Senator Carolyn Nelson
District 21
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COMMITTEES:
Judiciary
Government and Veterans Affairs

Testimony in favor of SB 2296

Can you identify a mentally ill person? Is it that man you passed on the street yesterday? Is it the woman you talked to in the grocery store? Is it the young man in the advanced economics class of the university's MBA program? Is it the young mother you saw at the daycare center? Is it a family member? It could be any of these people. Mental illness is a neurological brain disorder, requiring medical care the same as any other disease. This bill deals with civil commitment of mentally ill persons to a place deemed to be the least restrictive environment for the situation. In the past we have viewed this place to be residential or institutional. Now we see "out-patient" as an alternative. The last revision of this section of the code was 1993.

This bill adds one definition. "Alternative treatment" order means an involuntary outpatient order for a treatment program, other than hospitalization, which may include treatment with a prescribed medication. Involuntary commitment should occur only as a last resort. The bill is written to protect the rights of citizens with mental illness with the full range of safeguards and due process.

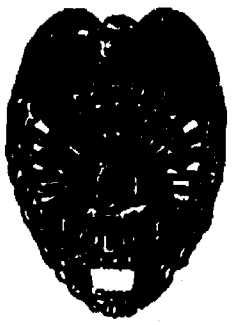
The second revision of a definition is in subsection 12, "person requiring treatment". Subsection d. "Serious risk of harm" will include (along with subsections a-c) the substantial deterioration in mental health which would predictably result in dangerousness to that person, others or property based upon acts, threats, or patterns in the person's treatment history, current condition, and other relevant factors, including the effect of the person's mental condition on the person's ability to consent.

Section 2 allows upon notice and hearing, a treating psychiatrist and another licensed physician (or a psychiatrist not involved in the current diagnosis or treatment) may request authorization of the court to treat a person with a prescribed medication that is clinically appropriate and necessary to effectively treat the patient. The only change here is the deletion of "there is a reasonable expectation that if the person is not treated as proposed there exists a serious risk of harm to that person, other person, or property." Suicide, murder, preventable crime, irreversible brain damage, drug addiction... can we not only predict these tragedies but prove that they will happen? The Senate judiciary committee preferred the language "patient is a person requiring treatment".

This bill is a balanced approach to allow treatment interventions to occur based on lack of capacity to make informed, rational decisions.

I encourage a "Do Pass" on SB 2296

FAX TRANSMISSION



City of Fargo
Police Department
P.O. Box 150, Fargo, North Dakota 58107

February 26, 2003

Dear Representative Timm:

I am writing to express my support for SB2296 when it comes before you next week. This bill would make it easier to get help for people with mental illnesses through the commitment process. Rather than waiting until someone commits suicide, seriously hurts themselves, or harms other people, this bill would allow family, friends, and others who interact with persons with serious untreated mental illnesses to get them the care they need—when it can still make a difference.

As someone involved in law enforcement for the past twenty years, I have seen many situations where individuals with various mental illnesses were allowed to "fall through the cracks," often resulting in tragic outcomes. A fellow police officer I worked with for several years, Officer Julie Englehardt, was shot and killed by an older man with untreated mental problems when she approached him in his backyard about a sled he had taken from some neighborhood children. We learned later that his family and others had tried for years to get him help, but he had refused all intervention efforts.

Many of us have recognized for a long time that the commitment process throughout this country needs to be improved. By passing SB2296, North Dakota has a chance to be a leader in this area. I hope you will carefully review this important piece of legislation and give it the support it deserves.

Sincerely yours,

Chris Magnus

Fargo Chief of Police

(701)241-1400

cjmagnus@ci.fargo.nd.us

"Jerry Hjelmstad" <hjelmstad@ndlo.org>

03/03/2003 03:25 PM

To: <ddekrey@state.nd.us>
cc:
Subject: Senate Bill 2192

Representative DeKrey:
I see that Senate Bill 2192 has been referred to the House Judiciary Committee. The bill was introduced at the request of the Fire Chief from Minot. He will not be available during the week of March 10-14, so I am writing to request that the hearing on that bill be delayed until after March 17th, if at all possible. Thank you for your consideration.

Jerry Hjelmstad
ND League of Cities

"Kim D. Murphy" <kmurphy@state.nd.us>

03/03/2003 05:02 PM

To: <slyson@state.nd.us>, <tmathern@state.nd.us>
cc: <scottb@co.williams.nd.us>, <rthane@state.nd.us>, <jheitkam@state.nd.us>, <beckre@state.nd.us>, <cdwilliams@state.nd.us>
Subject: SB 2296

Senator Stan Lyson –

I understand you will be testifying Wednesday at 0900hrs in committee hearing on Mental Health SB 2296. I also know that you support this bill and that Sheree Spear has had communications with you. I too support this bill, but with some reservations. I have been in contact with Sheree Spear over the past few weeks on a somewhat regular basis. I also am aware that she has had contact with Chief Kemmet of Devils Lake, Chief Magnus of Fargo, and Sheriff Scott Busching of Williams County. Both Chief Kemmet and Chief Magnus fully support this bill. I cannot speak for Sheriff Busching but, I think he too supports this bill but this some reservations.

This bill would make it easier to help people with suspected mental illnesses. It would allow law enforcement to act earlier in the mental illness committal process, i.e. act more on a "gut feeling" or "sixth sense" approach. I believe that the current mental illness committal process is a good one and I do not want the current tools we have to become more restricting in anyway for law enforcement or families. However, I hope that SB 2296 will only help facilitate family, friends, law enforcement, and others who interact with people with suspected untreated mental illnesses. Getting people with untreated mental illnesses into treatment or at least into the evaluation process as soon as possible so care and treatment can be started is key and I can see benefits this Bill in that regard. However…

This Bill may create much more work for Sheriff's Departments across the State, much more so than Police Departments. Currently police departments do not transport mental health committals to Jamestown that is almost solely a County law enforcement function. I am concerned (as is Sheriff Busching) that it will cause sheriff departments to expend more labor hours in transports, mental health hearings, and interventions for both juvenile and adults. Therefore, we will need to increase our department budgets to adequately cope with this. I also have a concern with the current limited number of mental health facilities around the State. If we currently deal with any mental health intervention, we are required to transport immediately. If the person has insurance they may be admitted to a local hospital, otherwise, we will be required to transport to Fargo or Jamestown right away. Most of the time it will be a transport to Jamestown (as you remember I am sure). Furthermore, if law enforcement is able to act on a more discretionary opinion for suspected mental illnesses under SB 2296 will there be a "Hold Harmless Clause" for law enforcement agencies and officers? If we act in good faith on what we believe, at the time, to be someone suffering from an untreated mental illness and it later turns out not to be, but now that person claims that they suffer from the "stigma of mental illness" will there be protection?

Again, I do support this bill, but with some reservations. I do believe we need to improve the mental health laws for the benefit of the patients, family, friends, and community. However, there are the looming issues of disappearing funding, facilities, and mental health professional staff. Everyone is feeling these funding cuts on the State and County levels. We are all endeavoring to do more with less and there is no real relief for all these issues. Therefore, I hope we all can have a careful review of this Bill so it will be truly a benefit for all those that need assistance and not let anyone fall through the mental health treatment/evaluation cracks. The second balanced issue to this will be not create a funding or staffing burden on any one or two entities.

Thank you, Sir for taking the time to review my input. If at anytime, you have any questions or concerns please do not hesitate to ask.

Respectfully,

Kim D. Murphy, Sheriff (Kim)

Kim D. Murphy, Sheriff

Richland County Sheriff's Department

413 3rd Ave No., L.E.C.

Wahpeton, No. Dak., 58075

Office: 701-642-7711

Fax: 701-642-7720

"Uniting Richland County by

Investing in the Strengths of each other."

"Scott Busching" <ScottB@co.williams.nd.us>
03/04/2003 10:54 AM

To: <slyson@state.nd.us>
cc: <kmurphy@state.nd.us>
Subject: SB 2296

Dear Senator Lyson,

I am writing concerning SB 2296, the Mental Health Commitment Bill. On its face, we as ND Sheriff's & Deputies support this bill. We do, however, have some concerns.
With the downsizing of the State Hospital and the requirements that patients have insurance for the private facilities, we wonder what effect this bill will have on our ability to house and treat these folks. We certainly see the need to be able to provide services for those people who require intervention but do not necessarily meet the "danger to themselves or others" requirement as it is now written. We are afraid, however, that our jails may see an increase in use by those who are not criminals, but are suffering from mental illness and for lack of any where to house them, are placed with us. We strongly agree that Jail is not a place for those who are mentally ill.

We are also aware that this bill would benefit those who need help but do not qualify under current regulations but as law enforcement officers are sometimes stuck between feuding spouses, or other family members who, at times, tell us stories in order to "get back" at their partners. This, at times, make for some very difficult decisions to be made by us, who are not mental health professionals.

Having said all this, we want to do what's right for those individuals who may fall through the cracks of the current system and will have to place our trust in the mental health people who support this bill.

Sincerely,

Scott W. Busching
Williams County Sheriff

SENATE BILL 2296
HOUSE JUDICIARY COMMITTEE
March 5, 2003

CORINNE HOFMANN
PROTECTION AND ADVOCACY PROJECT

Chairman DeKrey and Members of the Committee, my name is Corinne Hofmann. I am Director of Policy and Operations for the Protection and Advocacy Project [P&A]. We are aware of the concerns that led to the submission of this bill for the legislature's consideration. We agree with proponents of this bill that the system sometimes fails to provide the needed intervention and assistance to people with mental illness. We have heard concerns expressed by those in law enforcement and corrections about too many people with mental illness ending up in the criminal justice system for lack of adequate services. We do not agree that the changes proposed in this bill will address these problems and are opposed to Senate Bill 2296.

The bill defines "alternative treatment order". Section 25-03.1-21 establishes the meaning of "alternative treatment order". It is an order for a treatment program other than hospitalization. That section also describes the process for obtaining alternative treatment orders. Currently, alternative treatment orders often include prescribed medication and medication monitoring. The proposed definition is unnecessary

Senate Bill 2296 proposes to delete "serious risk of harm" and replace it with a "person requiring treatment" in section 25-03.1-18.1.

"Serious risk of harm" was chosen by the task force that drafted this section specifically to emphasize the critical issue in the commitment process. Eliminating this language makes the process less focused and this increases the likelihood that people will be inappropriately committed. Involuntary treatment is supposed to be

imposed only on those who pose a serious risk of harm to themselves and others. The process is too intrusive to be available just because someone might benefit from treatment.

The remaining change proposed in Senate Bill 2296 is a change to section 25-03.1-2 (11) (d). The proposed language is problematic.

Similar language can be found in Wisconsin's mental health commitment statute. The language is part of Wisconsin's "Fifth Standard" for involuntary commitment. The Wisconsin standard has been challenged and upheld as constitutional by Wisconsin's Supreme Court.

The Wisconsin court decision is not helpful in the legal or constitutional analysis of the language in Senate Bill 2296. Wisconsin's Fifth Standard is substantially different from the language in SB 2296. The standard is quite lengthy. I have attached a copy to my testimony. The Wisconsin Supreme court explained its Fifth Standard as requiring each of five elements:

1. The person must be mentally ill; and
2. The person must be unable, because of mental illness to make an informed choice as to whether to accept or refuse medication. This must be evidenced by an inability to express an understanding, or an inability to apply an understanding of the advantages and disadvantages of accepting treatment and the alternatives after this has been explained to him or her; and
3. There must be a substantial probability that the person needs care or treatment to prevent further deterioration. This must be demonstrated by both the individual's treatment history and his recent acts or omissions; and

4. There must be a substantial probability that the person will, if left untreated, lack services necessary for his or her health or safety; and
5. There must be a substantial probability that if left untreated, the person will suffer severe mental, emotional, or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions.

This standard does not apply in emergency commitments.

In contrast, the language proposed in Senate Bill 2296 is overly broad and vague and would apply to both involuntary and emergency commitments. Unlike the Wisconsin statute, it allows a determination of "dangerousness" based solely upon a "loss of cognitive or volitional control over a person's thoughts or actions". The meaning of this language is unclear and interpretation will, of necessity, be highly subjective.

Because "or" is used to connect the new language to the rest of subsection d, acts, threats, or patterns in the person's history, current condition, and other relevant factors would not need to be considered. This is inconsistent with the well established constitutional requirement for clear and convincing evidence prior to imposing involuntary treatment.

Also, inclusion of the person's capacity to consent or make an informed choice should not be an element in determining "dangerousness". Incorporating this standard is inconsistent with section 25-03.1-33, which states that a determination that a person requires treatment, a court order for hospitalization or for alternative treatment, or an admission to a hospital is not a finding that the person is legally incompetent or unable to give or withhold consent.

If the person's capacity to consent or make an informed choice is at issue, a guardianship proceeding adequately addresses the needs of the person. Lack of capacity to consent and legal incompetence do not predict "dangerousness".

The cases presented in support of SB 2296 point to failures in implementation of the law, not a problem with the law itself. Human error can be minimized with education and training. Adequate training and dialogue between the various parties responsible for interpreting and implementing the law will help ensure consistency in implementation. This is not occurring. This needs to happen.

The state has an obligation to provide for the welfare of its citizens. Adequately addressing the needs of persons with mental illness is a challenge. The state must walk a fine line between safeguarding the health of this vulnerable population and safeguarding individuals' right to liberty. Our current commitment law was designed in a deliberate process that allowed adequate time for research, input, and study. The changes proposed in Senate Bill 2296 jeopardize the delicate balance achieved in our current law.

There are other more practical problems. The Department of Human Services funds are being cut rather than increased. The state hospital is downsizing and human service centers are cutting services and staff. If the system must serve more people, will resources be adequate for those currently in the system? Will additional money be given to the delivery system to meet the needs of people brought into the system? How and where will these people be served? Can we ensure that people are served in the least restrict setting possible? If the language proposed in Senate Bill 2296 leads to more commitments, will this create an unmanageable burden for the court

system? The affect of the proposed language needs to be carefully considered.

Any change to the state's commitment law should be done thoughtfully after careful study and input from all relevant parties involved in the process - including people with mental illness and family members. P&A supports House Concurrent Resolution 3034, which proposes such a study and asks you to vote against Senate Bill 2296.

This concludes my testimony. I would be happy to answer any questions from the committee. Thank you.

who is confined in a jail, if the individual consents to the evaluation, diagnosis or treatment.

(11m) TRAINING. Law enforcement agencies shall designate at least one officer authorized to take an individual into custody under this section who shall attend the in–service training on emergency detention and emergency protective placement procedures offered by a county department of community programs under s. 51.42 (3) (ar) 4. d., if the county department of community programs serving the law enforcement agency's jurisdiction offers an in–service training program.

(12) PENALTY. Whoever signs a statement under sub. (4), (5) or (10) knowing the information contained therein to be false is guilty of a Class H felony.

NOTE: Sub. (12) is shown as amended eff. 2–1–03 by 2001 Wis. Act 109. Prior to 2–1–03 it reads:

(12) PENALTY. Whoever signs a statement under sub. (4), (5) or (10) knowing the information contained therein to be false may be fined not more than $5,000 or imprisoned for not more than 7 years and 6 months or both.

History: 1975 c. 430; 1977 c. 29, 428; 1979 c. 175, 300, 336, 355; 1985 a. 176; 1987 a. 366, 394; 1989 a. 56 s. 259; 1993 a. 451; 1995 a. 77, 175, 292; 1997 a. 35, 283; 2001 a. 16 ss. 1966d to 1966h, 4034zb to 4034zd, 4041d to 4041g; 2001 a 109.

A mental health worker did not have immunity under sub. (11) for actions regarding a person already in custody and not taken into custody under an emergency detention. Keil v. Raemisch, 190 Wis. 2d 754, 528 N.W.2d 13 (Ct. App. 1994).

The time limits established by this section are triggered when a person taken into custody under this section is transported to any of the facilities designated by sub. (2), irrespective of whether the facility is one specifically chosen by the county for the receipt of persons taken into custody under this section. Milwaukee County v. Delores M. 217 Wis. 2d 69, 577 N.W.2d 371 (Ct. App. 1998).

The community caretaker exception that allows police officers to make a warrantless entry into a home when engaging in an activity that is unrelated to criminal activity and is for the public good applies to police activity undertaken pursuant to this section. State v. Horngren, 2000 WI App 177, 238 Wis. 2d 347, 617 N.W.2d 508.

It is inadvisable to treat individuals transported across state lines for emergency medical care differently than other individuals when determining whether emergency detention proceedings should be initiated pursuant to this section. 78 Atty. Gen. 59.

While sub. (7) does not authorize contractual agreements with counties outside of Wisconsin, ss. 51.75 (11), 51.87 (3), and 66.30 (5) [now 66.0303] each contain legal mechanisms through which financial or other responsibility for care and treatment of individuals from such counties may be shared under certain specified circumstances. 78 Atty. Gen. 59.

A law enforcement officer who places an individual under emergency detention is obligated to transport the individual to one of the four categories of facilities listed under sub. (2) until custody of the individual is transferred to the facility. 81 Atty. Gen. 110.

51.20 Involuntary commitment for treatment. (1) PETITION FOR EXAMINATION. (a) Except as provided in pars. (ab), (am), (ar) and (av), every written petition for examination shall allege that all of the following apply to the subject individual to be examined:

1. The individual is mentally ill or, except as provided under subd. 2. e., drug dependent or developmentally disabled and is a proper subject for treatment.

2. The individual is dangerous because he or she does any of the following:

a. Evidences a substantial probability of physical harm to himself or herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm.

b. Evidences a substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other violent behavior, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do serious physical harm. In this subd. 2. b., if the petition is filed under a court order under s. 938.30 (5) (c) 1. or (d) 1., a finding by the court exercising jurisdiction under chs. 48 and 938 that the juvenile committed the act or acts alleged in the petition under s. 938.12 or 938.13 (12) may be used to prove that the juvenile exhibited recent homicidal or other violent behavior or committed a recent overt act, attempt or threat to do serious physical harm.

c. Evidences such impaired judgment, manifested by evidence of a pattern of recent acts or omissions, that there is a substantial probability of physical impairment or injury to himself or herself. The probability of physical impairment or injury is not substantial under this subd. 2. c. if reasonable provision for the subject individual's protection is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services. If the individual is appropriate for protective placement under s. 55.06 or, in the case of a minor, if the individual is appropriate for services or placement under s. 48.13 (4) or (11) or 938.13 (4). The subject individual's status as a minor does not automatically establish a substantial probability of physical impairment or injury under this subd. 2. c. Food, shelter or other care provided to an individual who is substantially incapable of obtaining the care for himself or herself, by a person other than a treatment facility, does not constitute reasonable provision for the subject individual's protection available in the community under this subd. 2. c.

d. Evidences behavior manifested by recent acts or omissions that, due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness. No substantial probability of harm under this subd. 2. d. exists if reasonable provision for the individual's treatment and protection is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services, if the individual is appropriate for protective placement under s. 55.06 or, in the case of a minor, if the individual is appropriate for services or placement under s. 48.13 (4) or (11) or 938.13 (4). The individual's status as a minor does not automatically establish a substantial probability of death, serious physical injury, serious physical debilitation or serious disease under this subd. 2. d. Food, shelter or other care provided to an individual who is substantially incapable of obtaining the care for himself or herself, by any person other than a treatment facility, does not constitute reasonable provision for the individual's treatment or protection available in the community under this subd. 2. d.

★ e. For an individual, other than an individual who is alleged to be drug dependent or developmentally disabled, after the advantages and disadvantages of and alternatives to accepting a particular medication or treatment have been explained to him or her and because of mental illness, evidences either incapability of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives, or substantial incapability of applying an understanding of the advantages, disadvantages, and alternatives to his or her mental illness in order to make an informed choice as to whether to accept or refuse medication or treatment; and evidences a substantial probability, as demonstrated by both the individual's treatment history and his or her recent acts or omissions, that the individual needs care or treatment to prevent further disability or deterioration and a substantial probability that he or she will, if left untreated, lack services necessary for his or her health or safety and suffer severe mental, emotional, or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions. The probability of suffering severe mental, emotional, or physical harm is not substantial under this subd. 2. e. if reasonable provision for the individual's care or treatment is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services or if the individual is appropriate for protective placement under s. 55.06. Food, shelter, or other care that is provided to an individual who is substantially incapable of obtaining food, shelter, or other care for himself or herself by any person other than a treatment facility does not constitute reasonable provision for the individual's care or treatment in the community under this subd. 2. e. The individual's status as a minor does not automatically establish a substantial probability of suffering severe mental, emotional, or physical harm under this subd. 2. e.

(ab) If the individual is an inmate of a prison, jail or other criminal detention facility, the fact that the individual receives food, shelter and other care in that facility may not limit the applicability

A Guide to

Kendra's Law

Third Edition

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KENDRA'S LAW

New York's Law for Assisted Outpatient Treatment

Kendra's Law (New York Mental Hygiene Law § 9.60) allows courts to order certain individuals with brain disorders to comply with treatment while living in the community. This court-ordered treatment is called assisted outpatient treatment. The law took effect on November 8, 1999.*

Kendra's Law is an important advance. It allows individuals to be ordered into treatment without ordering them into a hospital. In addition, the criteria to place someone in assisted outpatient treatment are easier to meet than the "imminent dangerousness" standard often required for inpatient commitment in New York. Kendra's Law allows someone to be ordered into treatment "to prevent a relapse which or deterioration which would likely result in serious harm to the patient or others." In other words, there is no need to wait until a deteriorating consumer actually is dangerous to self or others, as in the inpatient standard; under Kendra's Law you can start procedures to "prevent a relapse" that could lead to dangerousness. The law includes strict eligibility criteria and numerous consumer protections.

In enacting Kendra's Law, the legislature found that some people, as a result of mental illness, have great difficulty taking responsibility for their own care, and often reject outpatient treatment offered to them on a voluntary basis. These individuals often commit suicide; become homeless; end up in jail; or, on rare occasions, are involved in acts of violence. Family members and caregivers often must stand by helplessly and watch their loved ones and patients decompensate to actual "dangerousness" before they are allowed to facilitate treatment. Assisted outpatient treatment is a new tool that may help in these situations. But it is not a panacea.

Assisted outpatient treatment is meant to help consumers, not punish them. Kendra's Law makes New York the 41st state to adopt assisted outpatient treatment.

** In addition to provisions for assisted outpatient treatment, Kendra's Law also includes (1) a mechanism to see that individuals with brain disorders who are discharged from hospitals and jails and not yet Medicaid eligible can continue to receive medications while their application is pending; (2) provisions for improved record sharing among hospitals and mental health care providers so that a facility can access a consumer's records, even if the consumer was treated at other facilities; (3) procedures to improve the use of conditional discharge for individuals released from hospitals prior to the expiration of their inpatient commitment period, and (4) extension of the outpatient commitment program at Bellevue Hospital in New York City. However, this summary only explains the provisions related to assisted outpatient treatment.*

OVERVIEW

Arranging for assisted outpatient treatment is technical and somewhat cumbersome. Assisted outpatient treatment is only available to individuals who meet certain defined criteria. Consumers can only be placed in the program by a court, which must first receive a petition from one of a defined group of individuals. The petition must give the reasons why the petitioner believes the consumer meets the criteria and be accompanied by an affidavit from a physician who has examined or tried to examine the consumer within 10 days prior to filing the petition.

Once the court receives the petition and the physician's affidavit it will schedule a hearing within 3 days. Notice of the hearing must be given to the consumer and certain other individuals. The consumer is provided with free legal representation from mental hygiene legal services and extensive due process protections throughout the assisted outpatient treatment process.

In the hearing, the court hears testimony and takes evidence from all the parties, including a doctor who has examined the consumer. If the consumer has refused to be examined and the court believes the individual may meet the criteria for assisted outpatient treatment, the court can order an examination and adjourn the hearing until after it is completed. If the consumer has been examined and the court finds the individual meets all the criteria for placement in assisted outpatient treatment, it will have a treatment plan developed and order the consumer to comply with it.

The time frame for creating the treatment plan varies slightly depending on who the petitioner is. If the petitioner is a government official, the treatment plan will have been prepared by the time of the hearing. If the petitioner is anyone else and the court believes the individual meets the criteria for assisted outpatient treatment, the court will have the state prepare a treatment plan and conduct a second hearing to finalize it within three days. The consumer will be ordered to comply with the treatment plan once the court approves it. The service providers identified in the plan will be required to supply the services ordered in it as well as monitor the patient's condition and treatment compliance.

Consumer compliance with the court's order is monitored through case managers, ACT teams, and other treatment providers. If an individual fails to comply with his or her treatment plan, interventions are triggered which can ultimately result in the individual's rehospitalization for 72 hours for treatment and evaluation to determine if he or she meets the inpatient commitment criteria.

Initial assisted outpatient treatment orders are for up to six months and each renewal can be for up to one year.

QUESTIONS & ANSWERS

The answers to the following questions provide a more detailed explanation of the procedures outlined above.

What services can be included in an assisted outpatient treatment plan?

Assisted outpatient treatment orders have to include case management services or assertive community treatment team services and may also include:

1. medication;
2. blood or urinalysis tests to determine compliance with prescribed medications;
3. individual or group therapy;
4. day or partial day programs;
5. educational and vocational training;
6. supervised living;
7. alcohol or substance abuse treatment;
8. alcohol and/or substance abuse testing for those with a history of alcohol or drug abuse and for whom such testing is necessary to prevent a deterioration of their condition (court orders for drug/alcohol tests are subject to review every six months); and
9. any other services prescribed to treat the person's mental illness and to either assist the person in living and functioning in the community or to help prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization.

What are the eligibility criteria for assisted outpatient treatment?

A patient may be placed in assisted outpatient treatment only if, after a hearing, the court finds that all of the following have been met. The consumer must:

1. be eighteen years of age or older; and
2. suffer from a mental illness; and
3. be unlikely to survive safely in the community without supervision, based on a clinical determination; and
4. have a history of non-compliance with treatment that has:
   i. been a significant factor in his or her being in a hospital, prison or jail at least twice within the last thirty-six months or;
   ii. resulted in one or more acts, attempts or threats of serious violent behavior toward self or others within the last forty-eight months; and
5. be unlikely to voluntarily participate in treatment; and
6. be, in view of his or her treatment history and current behavior, in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in:
   i. a substantial risk of physical harm to the consumer as manifested by threats of or attempts at suicide or serious bodily harm or conduct demonstrating that the consumer is dangerous to himself or herself, or
   ii. a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm; and
7. be likely to benefit from assisted outpatient treatment; and
8. if the consumer has a health care proxy, any directions in it will be taken into account by the court in determining the written treatment plan. However, nothing precludes a person with a health care proxy from being eligible for assisted outpatient treatment.

Any time spent in a hospital or jail immediately prior to the filing of the petition does not count towards either the 36 or 48-month time limits in criterion No. 4 above. In other words, if an individual spent the two months prior to the filing in a hospital, the court can then look back 38 months (36+2=38) to see if he or she meets criterion No. 4(i).

Who can petition the court for assisted outpatient treatment?

Any of the following persons can file a petition with the court for a consumer to be placed in assisted outpatient treatment:

1. any adult person living with the consumer;
2. the parents, spouse, adult sibling, or adult child of the consumer;
3. if the consumer is an inpatient, the hospital director;
4. the director of a program providing mental health services to the consumer in whose institution the consumer resides;
5. a treating or supervising psychiatrist;
6. the director of community services, or his or her designee, or the social services official of the city or county in which the consumer is present or believed to be present; or
7. the consumer's parole or probation officer.

The petition must be filed in the supreme or county court in the county in which the consumer is present or reasonably believed to be present.

What has to be in or included with the petition?

The petition must state (1) the consumer is present, or believed to be present, within the county where the petition is filed; (2) all the criteria for outpatient treatment; and (3) the facts supporting the belief that the consumer meets all the criteria.

The petition has to be accompanied by an affirmation or affidavit of a physician (who can not be the petitioner) which states either:

1. the physician examined the consumer no more than ten days prior to the submission of the petition, the physician recommends assisted outpatient treatment, and the physician is willing to testify at the hearing; or
2. the physician or his or her designee (no more than ten days prior to the filing of the petition) tried to but could not persuade the consumer to be examined, that the physician has reason to suspect the consumer meets the criteria assisted outpatient treatment, and that the physician is willing to examine the consumer and testify at the hearing.

Who has to be notified when you file a petition?

The petitioner has to cause written notice of the petition to be given to the consumer and:

1. the consumer's nearest relative; and
2. the Mental Hygiene Legal Service; and
3. the current health care agent appointed by the consumer, if known; and
4. as many as three additional persons, if designated in writing to receive notice by the consumer; and
5. the Director of assisted outpatient treatment for the county; and
6. the Director of Community Services, if the director is not the petitioner.

The New York State Office of Mental Health will appoint a Director of Assisted Outpatient Treatment who will be responsible for the program in each county. The Director of Community Services is an already existing county official. For the name of these individuals (Nos. 5 and 6), call the NYS Office of Mental Health (518-474-4403) or NAMI-New York (800-950-FACT).

What must the court do before it holds a hearing?

After receiving a petition, the court is required to have a hearing on it within three days (excluding weekends and holidays). It must also notify all the parties of the hearing date.

Continuances will only be allowed for good cause. Before granting one, the court shall consider the need for an examination by a physician or the need to provide assisted outpatient treatment expeditiously.

What happens at the first hearing?

The court will hear testimony and, if advisable, examine the consumer (in or out of court). The testimony need not be limited to the facts included in the petition.

If the consumer fails to appear at the hearing despite appropriate attempts to elicit attendance have failed, the court may conduct the hearing in the consumer's absence.

However, the court is prohibited from ordering assisted outpatient treatment unless a physician, who has personally examined the consumer no more than ten days before the filing of the petition, testifies in person at the hearing. If the consumer refuses to be examined and the court finds reasonable cause to believe the allegations in the petition to be true, it then may order the consumer be taken into custody and transported to a hospital for examination for no longer than 24 hours.

How is the treatment plan developed?

A consumer ordered into assisted outpatient treatment is required to follow a treatment plan approved by the court.

An examining physician appointed by the county's director of outpatient treatment or a director of an approved assisted

outpatient treatment program must develop the treatment plan. A physician must testify and explain it to the court. Unless the petitioner is an employee of one of the state agencies empowered to develop treatment plans, it is unlikely that such a plan will be presented at the initial hearing.

If the court finds that the consumer meets the criteria but a treatment plan has not been developed, the court will order the director of community services to provide one to the court within three days, excluding weekends and holidays. Another hearing will then be held to finalize and approve the plan.

In developing a treatment plan, the physician will provide the consumer; the treating physician; and, upon the request of the patient, one person selected by the consumer with an opportunity to actively participate in its development. Also, if the patient has one, the court will consider any directions included in a health care proxy. However, the existence of a health proxy will not prevent a person with a health care proxy from being ordered into assisted outpatient treatment.

The physician developing the treatment plan will state:

1. which categories of assisted outpatient treatment are recommended and the rationale for each;
2. facts which establish that such treatment is the least restrictive alternative; and,
3. if the proposed treatment plan includes medication, the types or classes recommended, physical and mental effects of such medication (both beneficial and detrimental), and whether such medication should be self-administered or administered by a professional.

The physician should specify the types and dosage ranges of medication most likely to provide "maximum benefit," since the court will consider what will be to the consumer's maximum benefit when ordering treatment.

What kinds of decisions can the court make?

If after hearing all relevant evidence, the court finds that the consumer does not meet the criteria for assisted outpatient treatment, the court will dismiss the petition.

If the court finds by clear and convincing evidence that the consumer meets the criteria for court-ordered outpatient treatment and there is no appropriate, feasible, and less restrictive alternative, the court can order the consumer to receive assisted outpatient treatment for up to six months (renewals can be for up to a year).

The order will include the categories of treatment that the consumer is to receive, but cannot require any unless it was recommended by both the examining physician and included in the written treatment plan. The order may specify whether such medication should be self-administered or administered by an authorized professional as well as delineate the types and dosage ranges of medication most likely to provide maximum benefit.

If the petitioner is the director of a hospital that operates an assisted outpatient treatment program, the court order will direct the hospital director to provide or arrange for all categories of treatment for the assisted outpatient throughout the period of the order.

For all other persons, the order will require the director of community services to make sure that all the categories of services in the treatment order are supplied to the consumer. This is very important, because not only is the consumer being ordered into treatment, the director of community services is being ordered to provide treatment.

How can the treatment plan be changed?

The director of an assisted outpatient treatment program needs court approval to make any material change in a treatment order unless the change was contemplated in the original order. A material change is the addition or deletion of a category of assisted outpatient treatment or any deviation, without the patient's consent, from an existing order relating to the administration of medicines. An assisted outpatient treatment program does not need court approval to institute non-material changes.

How can the assisted outpatient treatment order be renewed?

If the Director of Community Services determines that a consumer requires further assisted outpatient treatment, the director

shall apply prior to the expiration of the assisted outpatient treatment order for a subsequent order for a period that can last up to one year. The procedures for obtaining a renewal for the director and all others are the same as for an initial order except the consumer does not have to meet either the 36 month or 48 month rule regarding previous hospitalizations or acts of violence.

What if a consumer fails to comply with an assisted outpatient treatment order?

If someone placed in assisted outpatient treatment fails or refuses to comply with the treatment order despite efforts made to solicit compliance, a physician may request that the consumer be brought to a hospital if in his or her clinical judgment, the consumer "may" meet a current "inpatient"commitment standard, i.e., "danger to self or others."

A physician may consider if a consumer refuses to take medications as required by the court order, or either refuses to take, or fails a blood test, urinalysis, or alcohol or drug test as required by the court order, when determining whether the consumer is in need of an examination to determine whether he or she meets the standard for placement in inpatient care.

One inpatient standard referenced in Kendra's Law, §9.27, allows committal if the consumer has (1) a mental illness for which care and treatment in a hospital is essential to his or her welfare and (2) the consumer's judgment is so impaired that he or she may need or is unable to understand his or her need for treatment. However, some New York courts have interpreted this very narrowly, sometimes to the point where some form of dangerousness is required. Courts may allow this more flexible inpatient standard to be applied as it is written in the case individuals who have "failed" on assisted outpatient treatment.

If he or she believes that a consumer may meet the current inpatient commitment standard, the physician may request a director of an assisted outpatient treatment program or certain others empowered to direct peace officers, sheriff's deputies, ambulance services, or approved mobile crisis outreach teams to transport such consumers to hospitals.

At the hospital, the consumer may be retained for observation, examination and treatment for up to seventy-two hours in order to determine whether treatment in a hospital pursuant to one of the existing inpatient commitment standards is needed. Thus, if the physician decides that a consumer on assisted outpatient treatment is non-compliant and "may" meet the inpatient commitment criteria, the doctor can order that person hospitalized for up to 72 hours to see if they meet inpatient commitment procedures.

If at any time during this period the person is found not to meet the involuntary inpatient commitment criteria, he or she must be released unless kept on a voluntary basis. However, continued non-compliance can result in subsequent 72-hour evaluations.

What rights and protections do consumers have?

A consumer has the right to:

1. free legal representation by the Mental Hygiene Legal Service (or other counsel, at the expense of the consumer) at all stages of an assisted outpatient treatment proceeding;
2. present evidence, call witnesses and cross-examine adverse witnesses;
3. not be involuntarily committed or held in contempt of court solely for failure to comply with a treatment order;
4. move the court to stay, vacate or modify the assisted outpatient treatment order at any time (along with Mental Hygiene Legal Service or anyone else acting on the consumer's behalf) and;
5. not be deemed legally incapacitated solely on the determination that he or she is in need of assisted outpatient treatment.

Also, a petitioner, physician, or anyone else making a false statement or providing false information in a petition or hearing is subject to criminal prosecution.

Will the mental health system petition for me?

Kendra's Law allows families and others to petition the court to place someone in assisted outpatient treatment. But it is easier and less costly if the mental health system, rather than relatives, files the petition. However, New York's mental health system is notoriously reluctant to file petitions, so you must be persistent. In case it ever becomes necessary, below are some tips on convincing mental health authorities to file a petition for your loved one.

Hospitals: For a relative who is in a hospital, families should try to convince the hospital to file a petition before the person is discharged. Ask the doctor. If he or she refuses, you should appeal to the director of psychiatry and hospital director. The higher up you go, the more likely you are to get what is needed.

Director of Community Services ("DCS"): This individual is the local (not state) official responsible for coordinating local services and for the receipt and investigation of persons alleged to be in need of assisted outpatient treatment in each locality. The law requires the DCS to establish an assisted outpatient treatment program to serve the community. If someone needs assisted treatment, as much information as possible (including why the individual meets each of the required criteria) should be provided to the DCS in order to convince him or her to file a petition for assisted outpatient treatment.

If the person you are seeking treatment for lives in New York City, contact Dr. Michael Lesser, Medical Director of that city's Department of Mental Health, (212) 219-5602. Elsewhere in the state, you can call your local NAMI ((800)950-FACT) or MHA chapter to find out who the DCS in your county is. This information is also available on the Office of Mental Health's Website, www.omh.state.ny.us, and from the head of the Kendra's Law Program, (518) 402-2416.

Assisted Outpatient Treatment Coordinator: Each county is required to have an individual assisted outpatient treatment program and the coordinator of one is virtually certain to be able to file petitions.

The names and phone numbers for the heads of New York City's programs are listed at the end of this guide. To learn who is in charge of a program elsewhere in the state, call your local NAMI or MHA chapter, Director of Community Services, or Mental Health Commissioner.

Regional Program Coordinator: This is the state official charged with overseeing the assisted outpatient treatment programs in whichever of the five designated regions of the state your loved one lives. He or she is responsible for making sure the system is working and that providers are supplying the services that the courts have ordered them to provide. A Regional Program Coordinator is not authorized to file petitions, but can be an important information source when you are seeking an assisted outpatient treatment order for a loved one and even more valuable at making sure your relative actually gets the treatment that the court orders.

The five Regional Coordinators are listed at the end of this guide.

As a Final Attempt: If you cannot convince any of the people described above to file a petition, call the Office of Mental Health's Kendra's Law Project Director, Glen Leibman, (518) 402-2416, and/or Counsel, John Tauriello, (518) 474-1331.

Individual Petitioners: Even if you cannot convince any of these officials to file a petition, you can still do so as long you are in one the categories of people listed in the "*Who can petition the court for assisted outpatient treatment?*" section. Extensive information (including pro-forma petitions) is available on the Office of Mental Health's Website at www.omh.state.ny.us.

Contact Mental Health Officials: Anyone who knows someone in need of assisted outpatient treatment or is displeased with how the program is working should submit written comments to the officials above. If you are having problems with the care of a consumer in assisted outpatient treatment, write to the officials above plus the court that ordered the treatment, the case manager, the treatment providers, and the Commissioner of the Office of Mental Health. By notifying all of them, you will increase the odds that your concerns will be addressed.

KENDRA'S LAW CONTACTS

NEW YORK STATE OFFICE OF MENTAL HEALTH
(www.omh.state.ny.us)

OMH Kendra's Law Project Director
Glen Leibman (518) 402-2416

Regional Kendra's Law Program Coordinators

Central New York Region
Rebecca Briney (315) 472-2097

Hudson River Region
Jan Spalding (845) 454-8229

Long Island Region
Marilyn Sullivan (631) 761-2092

Western New York Region
Patricia Bylewski (716) 885-4219 (x234)

New York City
Susan Shilling (718) 221-7667
(For New York City also see below)

N. Y. C. DEPARTMENT OF MENTAL HEALTH

Kendra's Law Coordinator
Dr. Michael Lesser (212) 219-5602

Assisted Outpatient Treatment Programs in NYC

Bronx - North Central Bronx Hospital
Dr. Rogge (718) 519-2475

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Dr. Trachtenberg (718) 963-5744

Manhattan - Bellevue Hospital
Dr. Berger (212) 562-4219

Queens - Elmhurst Hospital
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This Guide was prepared as a public service by the

TREATMENT ADVOCACY CENTER

This Guide was found at:

www.psychlaws.org/StateActivity/NewYork/GuideKL.htm

The Treatment Advocacy Center is a nonprofit organization dedicated to eliminating barriers to timely and humane treatment for the millions of Americans with severe brain disorders, such as schizophrenia and manic-depression (bipolar disorder). Current federal and state policies hinder treatment for psychiatrically ill individuals who are most at risk for homelessness, arrest, or suicide. As a result, an estimated 1.5 million individuals with severe mental illnesses are not being treated for their illness at any given time. The Center serves as a catalyst to achieve proper balance in judicial, legislative, and policy decisions that affect the lives of people with serious brain disorders.

To learn more about the Center's efforts, contact:

Treatment Advocacy Center
3300 N. Fairfax Dr., Suite 220
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If this has been helpful to you, donations, which are tax-deductible, are appreciated.
The Treatment Advocacy Center is a 501(c)(3) organization and your donation will be deductible to the full extent allowed by the law.

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TREATMENT ADVOCACY CENTER

Corinne Hoffman

A Guide to Laura's Law

California's New Law for Assisted Outpatient Treatment

Second Edition, January 2003

Prepared by

The California Treatment Advocacy Coalition &

The Treatment Advocacy Center

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I – How & Why Assisted Outpatient Treatment Came to California

Randall Hagar, Charles Sosebee & Carla Jacobs
Coordinators, California Treatment Advocacy Coalition

The California Treatment Advocacy Coalition formed in 1999. Bringing us together were lives lost to severe mental illnesses – lives of people in jail or prison, people mired on the streets, people who killed themselves – because of laws that withhold treatment for treatable conditions.

At first we were only a handful. With shared passions and the support of the Treatment Advocacy Center, we soon became an advocacy cadre with hundreds of consumers, family members, and mental health professionals visiting legislators, writing letters to politicians and newspapers, and stomping the halls of the Capitol.

And always in the name of treatment.

The law has been among treatment's worst enemies in California. Passed over 30 years ago, the Lanterman-Petris-Short Act ("LPS") governs interventions of needed care for people overcome by psychiatric disorders. It takes no account of what has since been learned about these illnesses, the vastly different present framework of mental health services, or the diversity of effective medications that are now available.

Under LPS, people in California rendered incapable of making rational decisions - no matter how psychotic or delusional - must be an immediate danger to themselves or others before being placed in treatment. Even when they are permitted, moreover, interventions are essentially limited to short inpatient stays. As a result, LPS has come to champion the "right" to be sick over the right to be well.

The members of CTAC rallied behind the indomitable Assemblywoman Helen Thomson's efforts to reform our state's archaic treatment laws. And after three years, a failed original bill, nine committee votes, four floor votes, and the last quest for a governor's signature – CTAC's crusaders helped bring about the most significant reform of California's treatment law in more than three decades when Governor Gray Davis signed Assemblywoman Thomson's Assembly Bill 1421 into law.

Fashioned after New York's proven Kendra's Law, AB 1421 (also know as "Laura's Law) makes assisted outpatient treatment available in California. Assisted outpatient treatment's sustained and intensive court-mandated care in the community now can help those most overcome by the symptoms of a severe mental illness. The treatment mechanism is used until a person is well enough to again maintain his or her own treatment regimen. And eligibility for assisted outpatient treatment is not predicated solely on dangerousness. A progressive eligibility standard allows programs created

under AB 1421 to help people who are vitally in need of care but who do not meet LPS' restrictive dangerousness threshold for inpatient hospitalization.

As a bridge to recovery, assisted outpatient treatment can stop the "revolving door" of repeated hospitalizations, jailings, and homelessness. Yet while thousands of Californians can now receive essential treatment because AB 1421 is law, this is in no way guaranteed. Assisted outpatient treatment is only available in those counties that establish programs for this new treatment option.

The bulk of this guide describes how assisted outpatient treatment works and how it can be used to bring care for someone overwhelmed by a severe psychiatric disorder. The last section is about how, should it not have this critical treatment mechanism, you can help secure assisted outpatient treatment for your community.

A law unused might as well have never been passed. We urge you to find out if your county has assisted outpatient treatment. If it does not, we ask you to write, call, or visit and make your county mental health director and board of supervisors know that it should.

AB 1421 creates for many, where none existed before, the chance for help and maximum possible recovery. It is up to you to make use of this avenue to treatment and, if need be, help make it available to those in your county who most suffer because of mental illness.

II – Overview

What is assisted outpatient treatment?

Assisted outpatient treatment is sustained and intensive court-ordered treatment in the community for those most overcome by the symptoms of severe mental illness. The treatment mechanism is only used until a person is well enough to maintain his or her own treatment regimen. Serving as a bridge to recovery for those released from inpatient facilities as well as an alternative to hospitalization, assisted outpatient treatment can stop the "revolving door" of repeated hospitalizations, jailings, and homelessness.

Is assisted outpatient treatment for all people with mental illness?

Absolutely not. Assisted outpatient treatment (AOT) is for those who are in a crisis or recovering from a crisis caused by mental illness and for whom voluntary services are not working. California's program is based on that of Kendra's Law, a statewide assisted outpatient treatment program created in New York in 1999 that has proven extraordinarily successful. In New York State, Kendra's Law is used to help approximately one thousand people each year.

Does assisted outpatient treatment work?

Yes, spectacularly so. The best studies of AOT show that it drastically reduces rehospitalizations, length of hospital stays, arrests, victimization, and violent behavior.

The outcome numbers available for Kendra's Law have been equally favorable and dramatic, particularly in the areas of treatment adherence, usage of mental health services, and reducing homelessness.

Where is assisted outpatient treatment available in California?

Assisted outpatient treatment is available in those counties that have a program for the treatment mechanism and in which the county board of supervisors has passed a resolution authorizing its use. Some counties may choose to establish a separate program for AOT, while others may integrate its use into existing ones that already provide intensive services.

Call your county's mental health department to find out if it has an assisted outpatient treatment program. If your county does not have AOT, please pay special attention to the last section of this guide and learn how to secure this vital treatment mechanism for those in your area who most suffer from severe mental illness.

III – How Assisted Outpatient Treatment Works

What are the eligibility criteria for assisted outpatient treatment?

A person may be placed in assisted outpatient treatment only if, after a hearing, a court finds that all of the following have been met. The person must:

1) Be eighteen years of age or older;
2) Be suffering from a mental illness;
3) Be unlikely to survive safely in the community without supervision, based on a clinical determination;
4) Have a history of non-compliance with treatment that has either:
   A. Been a significant factor in his or her being in a hospital, prison or jail at least twice within the last thirty-six months; or
   B. Resulted in one or more acts, attempts or threats of serious violent behavior toward self or others within the last forty-eight months;
5) Have been offered an opportunity to voluntarily participate in a treatment plan by the local mental health department but continue to fail to engage in treatment;
6) Be substantially deteriorating;
7) Be, in view of his or her treatment history and current behavior, in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would likely result in the person meeting California's inpatient commitment standard, which is being:
   A. A serious risk of harm to himself or herself or others; or
   B. Gravely disabled (in immediate physical danger because unable to meet basic needs for food, clothing, or shelter);
8) Be likely to benefit from assisted outpatient treatment; and
9) Participation in the assisted outpatient program is the least restrictive placement necessary to ensure the person's recovery and stability.

Any time spent in a hospital or jail immediately prior to the filing of the petition does not count towards either the 36 or 48-month time limits in criterion No. 4 above. In other words, if an individual spent the two months prior to the filing in a hospital, the court can then look back 38 months (36+2) to see if he or she meets criterion No. 4(A).

Who can petition the court for assisted outpatient treatment?

Only the county mental health director, or his or her designee, may file a petition with the superior court in the county where the person is present or reasonably believed to be present. The following persons, however, may request that the county health department investigate whether to file a petition for the treatment of an individual:

1) Any adult with whom the person resides;
2) An adult parent, spouse, sibling, or child of the person;
3) If the person is an inpatient, the hospital director;
4) The director of a program providing mental health services to the person and in whose institution the person resides;
5) A treating or supervising licensed mental health treatment provider; or
6) The person's parole or probation officer.

On receiving a request from a person in one of the classes above, the county mental health director is required to conduct an investigation. The director, however, shall only file a petition if he or she determines that it is likely that all the necessary elements for an AOT petition can be proven by clear and convincing evidence.

What has to be in or included with the petition?

The petition must state: (1) that the person is present or believed to be present within the county where the petition is filed; (2) all the criteria necessary for placement in AOT; and (3) the facts supporting the belief that the person meets all the criteria.

The petition must be accompanied by an affidavit of a licensed mental health treatment provider stating that either:

1) The licensed mental health treatment provider examined the person no more than ten days prior to the submission of the petition, recommends assisted outpatient treatment, and is willing to testify at the hearing; or
2) The licensed mental health treatment provider, or his or her designee, made appropriate attempts no more than ten days prior to the filing of the petition to examine the person and the person refused as well as that the licensed mental health treatment provider has reason to suspect the person meets the criteria for assisted outpatient treatment and he or she is willing to examine the person and testify at the hearing.

How long after the filing is the hearing on the petition?

The court must fix a date for a hearing on the petition that is no more than five days (excluding weekends and holidays) after it is filed.

Continuances will only be allowed for good cause. Before granting one, the court shall

consider the need for an examination by a physician and the need to provide assisted outpatient treatment expeditiously.

Who has to be notified when you file a petition?

The petitioner must cause a copy of the petition and notice of the hearing to be personally served on the person who is its subject. The petitioner also has to send notice of the hearing and a copy of the petition to:

1) The county office of patient rights; and
2) The current health care provider appointed for the person, if known.

Note: The person subject to a petition may also designate other people to receive adequate notice of the hearings.

Is the person subject to the petition represented by counsel?

The person who is subject to the petition has the right to be represented by counsel at all stages of an AOT court proceeding. If the person elects, the court shall immediately appoint a public defender or other attorney to oppose the petition. If able to afford it, the person is responsible for the cost of the legal representation on his or her behalf.

What is a settlement agreement and how does it affect assisted outpatient treatment?

After an AOT petition is filed but before the conclusion of the hearing on it, the person who is the subject of the petition may waive the right to a hearing and enter into a settlement agreement. If the court approves it, a settlement agreement has the same force and effect as a court order for assisted outpatient treatment, including in the case of non-compliance.

The settlement agreement must be in writing, agreed to by all parties and the court and may not exceed 180 days (note – initial orders by a court after a hearing are for a period of up to six months, which can be a few days longer). The agreement is conditioned upon an examining licensed mental health treatment provider stating that the person can survive safely in the community. It also must include a treatment plan developed by the community-based program that will provide services to the person.

After entering a settlement agreement, a court designates the appropriate county department to monitor the person's treatment under, and compliance with, the settlement agreement. Only the court can modify settlement agreements, but either party may request a modification at any time during the 180-day period.

What happens at the first hearing?

The court will hear testimony and, if advisable, examine the person (in or out of court). The testimony need not be limited to the facts included in the petition.

If the person fails to appear at the hearing and appropriate attempts to elicit attendance have failed, the court may conduct the hearing in the person's absence. However, the court is prohibited from ordering AOT unless a physician who has personally examined

the person no more than ten days before the filing of the petition testifies in person at the hearing.

If the person is present at the hearing but has refused and continues to refuse to be examined and the court finds reasonable cause to believe the allegations in the petition to be true, it may order the person be taken into custody and transported to a hospital for examination by a licensed mental health treatment provider. Absent the use of the inpatient hospitalization provisions of California law, the person may be kept at the hospital for no more than 72 hours.

Any person ordered to undergo assisted outpatient treatment who was not present at the hearing at which the order was issued may immediately petition the court for a writ of habeas corpus, which is a judicial challenge asserting, under these circumstances, that the person does not meet the eligibility criteria for AOT. Treatment under the order may not commence until that petition is resolved in another hearing.

What kinds of decisions can the court make?

If after hearing all relevant evidence, the court finds that the person does not meet the criteria for assisted outpatient treatment, the court will dismiss the petition.

If the court finds, by clear and convincing evidence, that the person meets the criteria for assisted outpatient treatment and there is no appropriate and feasible less restrictive alternative, the court may order the person to receive assisted outpatient treatment for up to six months.

How is the treatment plan developed?

In the assisted outpatient treatment order, the court shall specify the services that the person is to receive. The court may not require any treatment that is not included in the proposed treatment plan submitted by the examining licensed mental health treatment provider. The court, in consultation with the county mental health director, must also find the following:

1) That the ordered services are available from the county or a provider approved by the county for the duration of the court order;
2) That the ordered services have been offered on a voluntary basis to the person by the local director of mental health, or his or her designee, and the person has refused or failed to engage in treatment;
3) That all of the elements of the petition have been met; and
4) That the treatment plan incorporated in the order will be delivered to the county director of mental health, or his or her appropriate designee.

How can the assisted outpatient treatment order be renewed?

If the condition of the person requires an additional period of AOT, the director of the assisted outpatient treatment program may apply to the court prior to the initial order's expiration for an additional period of AOT of no more than 180 days (initial orders are for a period of up to six months, which can be a few days longer). The procedures and

requirements for obtaining a renewal order are the same as for obtaining an initial order.

Can a person be released early from an assisted outpatient treatment order?

There are two methods by which someone under an order can establish that he or she no longer meets the eligibility criteria and should be released from an AOT order:

1) No less than every 60 days the director of the assisted outpatient treatment program is required to file an affidavit with the court stating that the person still meets the criteria for placement in the program. Although not explicitly stated in the statute, this presumably means that anyone who does not meet the criteria must be released from AOT. The person has the right to a hearing to challenge the assessment. If the court finds that the person does not meet the criteria, it will void the AOT order.
2) Also, an assisted outpatient may at any time file a petition for a writ of habeas corpus. At the hearing on this petition the court will determine whether or not the person still meets the initial AOT eligibility requirements. If not, the person shall be released from the AOT order.

In either type of hearing the burden of proving that the AOT criteria are still met is on the director.

What if a person fails to comply with an assisted outpatient treatment order?

A licensed mental health treatment provider can request that one of certain designated classes of persons (peace officers, evaluation facility attending staff, members of mobile crisis teams, and other professional persons designated by the county) take a person under an AOT order to a hospital to be held for an up to 72 hours to determine if he or she meets the criteria for inpatient hospitalization (*i.e.*, that the person is a danger to self/others or gravely disabled because of a mental illness).

The treatment provider may only make such a request on determining that:

1) The person has failed or refused to comply with the court-ordered treatment,
2) Efforts were made to solicit compliance, and
3) The person <u>may</u> need involuntary admission to a hospital for evaluation.

Any continued involuntary retention in the evaluating facility beyond the initial 72 hours must be pursuant to the California Code's provisions for inpatient hospitalization. A person found not to meet the standard for involuntary inpatient hospitalization during the evaluation period and who does not agree to stay in the hospital voluntarily must be released.

Failure to comply with an order of assisted outpatient treatment alone is not sufficient grounds for involuntary civil commitment. Neither may such non-compliance result in a finding of contempt of court.

What rights and protections do persons subject to the petition have?

A person subject to a petition for assisted outpatient treatment has the right to:

1) Retain counsel or utilize the services of a court-appointed public defender;

2) Adequate notice of the hearings;
3) Have notice of hearings sent to parties designated by the person;
4) Receive a copy of the court-ordered evaluation;
5) Present evidence, call witnesses and cross-examine adverse witnesses;
6) Be informed of his or her right to judicial review by habeas corpus;
7) Not be involuntarily committed or held in contempt of court solely for failure to comply with a treatment order;
8) Be present at the hearing, unless he or she waives this right;
9) Appeal decisions and be informed of his or her right to appeal; and
10) Receive the least restrictive treatment deemed appropriate and feasible.

IV – Getting Assisted Outpatient Treatment For Your County

What can I do to help obtain assisted outpatient treatment for my county?

You should strive to persuade the people who determine mental health policy in your county that not only is AOT needed, but that it will work. Since they must pass a resolution adopting AOT, the ultimate decision lies with the members of your county's board of supervisors. We urge you to write, call, and/or meet with them. And the more you coordinate your efforts with others in the pursuit of this treatment-ensuring program, the more your efforts will be amplified.

In order to bring AOT to your county, you should seek out assistance from other individuals and organizations interested in securing care for people with severe psychiatric disorders. Contacts, and especially visits, from representatives of groups like NAMI, police, sheriffs, judges, correctional officials, and mental health professionals should be particularly effective in getting the message out to the members of the board of supervisors of your county.

As the elected leaders of counties rely on them for advice on mental health policy, you should also promote assisted outpatient treatment with the director of your county mental health department and the members of your local mental health board. You will be playing into an interesting dynamic. The director is the expert but the members of the board of supervisors are collectively his or her bosses. And the board members, as elected officials, are accountable to you, the registered voter.

What types of services must a county provide to establish an assisted outpatient treatment program?

Any county that elects to establish an assisted outpatient treatment program must have available for those placed in the program a threshold of services that, among others, includes:

1) Community-based, mobile, multidisciplinary, highly trained mental health teams that have staff-to-client ratios of no more than one team member per ten clients

under AOT orders;

2) A service planning and delivery process that includes provisions to:
   - A. Determine the numbers of persons to be served, and the programs and services that will be provided to meet their needs;
   - B. Plan for outreach to families, psychiatric and psychological services, coordination and access to medications, substance abuse services, housing assistance, vocational rehabilitation, and veterans' services;
   - C. Provide staff who can remove barriers to services resulting from cultural, linguistic, racial, age, and gender differences;
   - D. Offer services to older adults, persons who are physically disabled and seriously mentally ill young adults (25 years of age or younger) who are at risk of becoming homeless; and
   - E. Provide housing that is either immediate, transitional, permanent, or all of these.
3) Personal service coordinators, who may be part of the AOT program team, who are responsible for ensuring, to the extent feasible, that people subject to assisted outpatient treatment receive services which enable them to:
   - A. Live in the least restrictive housing feasible in the local community;
   - B. Engage in the highest level of productive activities appropriate to their abilities and experience;
   - C. Access appropriate education and vocational training;
   - D. Obtain an income;
   - E. Exert as much control over their lives as possible;
   - F. Access physical health care; and
   - G. Reduce antisocial or criminal behavior.

Will these assisted outpatient treatment services be more than my county is willing to provide?

Most, if not all, of the components of the service and delivery process in the second section above should already be part of most county mental health systems and would only have to be used by the AOT team. The personal service coordinators and the objectives outlined in the third section can be integrated into any high-intensity service program, like one for assisted outpatient treatment. Furthermore, the objectives of those coordinators must only be met "to the extent feasible," which makes them far less than absolute requirements.

The primary obstacle to a county establishing an AOT program is that it must have an intensive treatment team with a high staff to client ratio, which is described in the first section above. There are three basic manners in which a county can satisfy this requirement.

1) Create a team dedicated solely to the care of people in AOT. This solution would allow your county to make the greatest use of the AOT program authorized by Assembly Bill 1421.
2) Integrate assisted outpatient treatment into existing programs that meet the

threshold requirements. Many counties already have programs that meet or substantially meet the service requirements, such as programs for assertive community treatment or intensive homeless outreach programs. Even if counties with these in place are not willing to establish specifically dedicated AOT teams, these programs can – often with little modification – meet the requirements for and make use of AB 1421.

3) Designate a team from existing county mental health professionals. AB 1421 does not require that every member of the team must be dedicated full-time to the care of those in assisted outpatient treatment. Any group of county-designated mental health professionals can qualify as an AOT team so long as the staff to client ratio is no more than one to ten (an average of approximately four hours total staff time per client), the team is mobile (at least some of the team members can reach clients in the community), and the team can provide the level and types of services mandated by the statute. Thus a personal services coordinator and a psychiatrist on an AOT team would not have to work together on a daily basis. They would only need to be part of a team that provides the necessary AOT services. Otherwise, the AOT team members could work with other clients and in other programs. Using this approach, even the smallest county can make use of assisted outpatient treatment.

Will my county have to offer increased voluntary services if it offers assisted outpatient treatment?

Provisions of the authorizing legislation, AB 1421, require that any county providing assisted outpatient treatment must also offer the same services on a voluntary basis. This does not require that everyone asking for those services be provided with them.

What it does mean is that intensive services, such as those in an AOT program, cannot be reserved exclusively for those under AOT orders. Rather, voluntary patients must have access – with distribution prioritized on the basis of need – to the same services offered by AOT treatment teams or to equivalent ones offered in programs not dedicated to assisted outpatient treatment. AB 1421 thus guarantees that those with the greatest need can take a place in line for the best available community services regardless of whether or not they are subject to court-ordered treatment.

Can my county create an assisted outpatient treatment program out of its existing mental health budget?

In order to create an AOT program a county's board must make a finding that no voluntary mental health program will be reduced as a result. As it is targeted at helping those prone to multiple hospitalizations, repetitive jailings, suicide, and violence – AOT is more appealing to most elected officials than a typical mental health program. County boards should be interested in funding such a politically attractive program.

An assisted outpatient treatment program can also, however, be justified on the basis of its cost-effectiveness. AOT substantially reduces the single greatest expense to any mental health system, that of inpatient hospital days. Based on those savings alone, a

county board of supervisors could make the finding that voluntary services will not be affected. Moreover, those placed in AOT will, for the most part, be people who are continually – if sporadically – already under the care of the mental health system. The cost of much of their care will thus be a shifting of costs rather than an increase.

What has proven the effectiveness of assisted outpatient treatment?

The Duke Studies are the largest and most respected of the controlled examinations of assisted outpatient treatment. Among the released findings of this one-year randomized trial:

1) **AOT Reduces Hospitalizations**
   Assisted outpatient treatment for 6 months or more combined with routine outpatient services (3 or more outpatient visits per month) decreased hospital admissions by 57% and the average length of hospital stays by 20 days.[1]

2) **AOT Reduces Arrests**
   For a subgroup with a history of multiple hospitalizations as well as prior arrests and/or violent behavior, the re-arrest rate of those in AOT for 6 months or more was one-quarter (12% versus 47%) that of those who were not under treatment orders.[2]

3) **AOT Reduces Violence**
   Assisted outpatient treatment of 6 months or more combined with routine outpatient services reduced the incidence of violence in half (24% versus 48%).[3]

4) **AOT Reduces Victimization**

   Over one year, 42% of those in the control group were victims of crimes, such as rape, theft, mugging, or burglary versus only 24% of those who were in AOT for 6 months or more with routine services: AOT decreased victimization by 43%.[4]

The outcome numbers from the law on which California's assisted outpatient treatment is based are equally conclusive. The first 141 people placed in assisted outpatient treatment in New York pursuant to Kendra's Law experienced:

- 129% increase in medication compliance;
- 194% increase in case management use;
- 107% increase in housing services use;
- 67% increase in medication management services use;
- 50% increase in therapy use;
- 26% decrease in harmful behavior; and

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[1] Swartz, M.S., Swanson, J.W., Wagner, R.H., et al: Can involuntary outpatient commitment reduce hospital recidivism? *American Journal of Psychiatry*, 156:1968-1975 (1999).
[2] Swanson, J.W., Swartz, M.S., Borum, R., et al: Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. *British Journal of Psychiatry*, 176: 224–231 (2000).
[3] Swanson, J.W., Swartz, M.S., Borum, R., et al: Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. *British Journal of Psychiatry*, 176: 224–231 (2000).
[4] Hiday V.A., Swartz. M.S., Swanson J.W. et al: Impact of outpatient commitment on victimization of people with severe mental illness. *American Journal of Psychiatry, 159*: 1403-1411 (2002).

- 100% decrease in homelessness.[5]

What can I do to get more information about getting assisted outpatient treatment for my county?

The Treatment Advocacy Center can answer questions about AOT, supply you with additional materials on the treatment mechanism, as well as help you join the California Treatment Advocacy Coalition, a group of advocates that led the movement for legislation authorizing assisted outpatient treatment in California, and who are now at the forefront of the effort to secure its adoption in the counties.

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[5] New York State Office of Mental Health, Progress Report on New York State's Mental Health System (Jan. 2001), pp. 16-18.

Prepared as a public service by the

TREATMENT ADVOCACY CENTER

This Guide and other materials on AB 1421 can be found at:

http://www.psychlaws.org/StateActivity/California.htm

The Treatment Advocacy Center is a nonprofit organization dedicated to eliminating barriers to timely and humane treatment for the millions of Americans with severe brain disorders, such as schizophrenia and manic-depression (bipolar disorder). Current federal and state policies hinder treatment for psychiatrically ill individuals who are most at risk for homelessness, arrest, or suicide. As a result, an estimated 2.2 million individuals with severe mental illnesses are not being treated for their illness at any given time. The Center serves as a catalyst to achieve proper balance in judicial, legislative, and policy decisions that affect the lives of people with serious brain disorders.

To learn more about the efforts of the Treatment Advocacy Center or the California Treatment Advocacy Coalition, please contact:

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The Treatment Advocacy Center is a 501(c)(3) organization and donations to it are deductible to the full extent allowed by the law. The Treatment Advocacy Center does not, however, accept contributions from pharmaceutical companies.

Jim Jacobson

From: Pam Mack [pmack@pioneer.state.nd.us]
Sent: Tuesday, February 18, 2003 8:59 AM
To: Jim Jacobson ; Lorena Poppe ; Loretta Movchan
Subject: FW: DDCM - adults on regional caseloads

Just passing on some additional information relative to people with DD served in the regions of the state.

Pamela Mack
Disabilities Advocate

-----Original Message-----
From: Victoria M. Pederson [mailto:sopedv@state.nd.us]
Sent: Monday, February 17, 2003 2:54 PM
To: Pamela J. Mack
Cc: Robbin E. Hendrickson; Gene A. Hysjulien
Subject: DDCM - adults on regional caseloads

Hi Pam,
I think the easiest way to give you this information is a report that lists the unduplicated number of individuals over the age of 18 years of age who are receiving DD Case Management at a point in time. The report below was run 1-8-03 and tells you by region, how many folks over the age of 18 that were being served on that date. I know it is not as of today, but caseloads for adults don't change that much. I'm guessing this should work for you.

Undup DDCM 01/01/2002 - 12/31/2002
(Over 18 as of 01/08/2003)

REGION NAME	COUNT Count
I - Northwest	117
II - North Central	330
III - Lake Region	175
IV - Northeast	372
V - Southeast	588
VI - South Central	365
VII - West Central	486
VIII - Badlands	185
	2,618

3-5-03

TESTIMONY OF EDWIN W. F. DYER III ON SB2296

Although this bill was substantially amended in the Senate, it still substantially broadens the reach of the involuntary commitment process beyond those persons who represent a risk of harm to themselves and other and, it is therefore, possibly unconstitutional. I urge that it not be passed.

I was a member of the task force organized by the Mental Health Association which developed major changes in Chapter 25-03.1 which was adopted by the 1989 Legislature. The subpart d. of the definition of "Person requiring treatment" (page 3 of the bill) was added at that time. I opposed its adoption at that time and I testified before this Committee against in during 1989 Session. The intent of this provision was to allow early legal intervention in the case of chronically mentally ill persons who were no longer taking their medications and, based upon past history, would become seriously ill and a danger to themselves or others unless they resumed taking their medication. My problem with this provision was that it went beyond the need for a showing of a serious risk of harm that the courts have required as a constitutional prerequisite for involuntary committal.

At least the current language requires some objective factors such as past treatment history before this provision could be used for commitment purposes. The proposed amendment

adds factors which are purely matters for opinion and speculation. What does "loss of cognitive and volitional control over the person's thoughts or actions" mean? If it means a person who is psychotic, that person will be committed under the current definition, usually under subpart c. by linking the psychotic state with specific dangers. I don't understand what the last sentence is supposed to mean. What is the person lack the ability to consent to? Does it mean that any mentally an ill person who refuses treatment can be committed? Without some requirement that there be some facts to support an expert examiner's opinion that this provision applies there is not assurance that it is fairly applied.

Confinement against ones will is a serious matter. It should be only ordered for mentally ill or chemically dependent persons if there is a serious risk of harm to them or others. The current law is adequate to ~~met~~ meet the public's need to be protected from harm.

Thank you for the opportunity to address the committee on this bill. I would be happy to answer any questions from the Committee, including about my experience with the operation of the current law.

TESTIMONY

SB 2296

HOUSE JUDICIARY COMMITTEE

REPRESENTATIVE DUANE DEKREY, CHAIRMAN

MARCH 5, 2003

Chairman DeKrey and members of the House Judiciary Committee, I am Dr. Joseph Belanger, Licensed Clinical Psychologist at the North Dakota State Hospital. Thank you for allowing me to testify on Senate Bill 2296.

As members of the medical staff, we understand the anxiety of families and appreciate their wish to be helpful. At the same time, we have to uphold the fundamental standard of testimony to a reasonable degree of professional or scientific certainty. The specific wording of the proposed bill makes this hard to do. It is difficult if not impossible for professionals to truly know the mind of another, which is what we are being asked to do in the phrasing "... the loss of cognitive or volitional control over the person's thoughts..." What we can do is assess the risk of behaviors such as suicide and homicide based on the signs and symptoms of the patient.

A deeper level of concern than the specific language is the way this bill will exacerbate the current tensions between concerned family members and the identified patient. While the families have anxious concerns for the well being of their injured member, the patient him-or-herself tends to feel misunderstood and put upon. Reconciliatory family therapy is needed. This work proceeds best as a conversation among equals. The proposed bill will slide the power differential to the side of the concerned family members. When the patient is already paranoid and depressed, to know your family controls your freedom sets in motion alienation difficult-to-impossible to address in psychotherapy.

None of this is meant to imply that we disagree with the intent of this bill. Families wish to prevent injury or worse to their ill member by hospitalizing him

or her when this is needed. At the same time they wish the best for the mentally ill person and that includes freedom – nor hospitalizing when it is not needed. As psychiatrists and psychologists we wish the same. To achieve the goal of balancing freedom and provision of needed care we must increase the degree of accuracy with which we, the allied medical staff members, make three professional decisions.

1.) We testify that some Respondents need commitment as patients.
2.) We testify others do not.
3.) For those who do meet commitment standards, we testify as to the least restrictive alternative. On all of these decisions, we must testify to a reasonable degree of professional or scientific certainty.

At its core this is an assessment task about which we already know a good deal. However, recent developments in actuarial research are improving the accuracy in two ways. We are learning how to identify those at most immediate risk for suicide \ homicide in a way that is more sensitive to the subtle indicators. Simultaneously we are learning how to more specifically identify those individuals who do not need to lose their freedom.

The problem is that the 'how to' studies are scattered across more than a hundred professional journals. We need time to gather the best; time to build a proposal that will achieve the aims of this bill while using wording that allows for professional / scientific testimony. Could we please consider an alternative? It is in the best interests of the mentally ill and their family members that we study this matter scientifically and report our findings to the formers of social policy. All we are asking for is an interim study period so we can suggest reforms that will work well for all our citizens.

I would be pleased to answer any questions from the committee.

[redacted]

House Judiciary Committee
March 5, 2003
Testimony by Mary T. Zdanowicz, JD
Executive Director, Treatment Advocacy Center
Senate Bill 2296 Position: Support

The Treatment Advocacy Center is a national non-profit organization, located in Arlington, Virginia, providing technical support to states that are reforming mental health treatment laws. We support SB 2296 and want to address two areas of concerns that this committee may have: 1) whether the proposal is constitutional and protective of civil liberties; and 2) whether the reform proposal should be studied rather than implemented this year.

In determining whether a statute is constitutional, we must ask both whether the state has the right to restrict an individual's liberty (a substantive question) and whether the statute has sufficient safeguards to protect civil rights (a procedural question).

SB 2296 would make only one substantive change to North Dakota's current law, but it is an important one. The existing law allows for treatment intervention based on a person's "substantial deterioration in mental health." The amendment recognizes the inherent danger when a person with a severe mental illness loses both control of their cognitive processes and their ability to recognize the need for treatment, which is necessary to consent to treatment. These two key features were unanimously upheld as constitutional by the Wisconsin State Supreme Court in July 2002.

In determining whether Wisconsin's law, which is substantially similar to what is being proposed, was constitutional, the court had to determine whether the state had just cause to deprive a person of the liberty to make their own treatment decisions. The court held that neither the State nor the U.S. Constitution (pursuant to the seminal U.S. Supreme Court decision in O'Connor v. Donaldson) require proof of imminent physical danger as a prerequisite to involuntary treatment. The critical finding of the court was that the state is justified in treating "those who are chronically mentally ill and drop out of therapy or discontinue medication, giving rise to a substantial probability of a deterioration in condition to the point of inability to ... control thoughts or actions." That is exactly what SB 2296 will do.

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This bill also recognizes what medical research in the last decade has revealed -- that is, nearly half of people with schizophrenia and manic-depression have impaired awareness of their illness, a condition that affects their ability to consent to treatment because they do not recognize that they are ill. SB 2296 recognizes this by allowing intervention for those who cannot make a reasoned decision about treatment before they deteriorate to the point of imminent dangerousness. In upholding its similar standard, the Wisconsin Supreme Court recognized that it was necessary to break the cycle of hospitalization, incarceration and homelessness. So not only does the state have a legal right to intervene, it has a moral obligation.

The civil liberties of North Dakota's most vulnerable citizens will continue to be protected by the plethora of procedural safeguards contained in the existing law. For example, before someone can be hospitalized on an emergency petition for treatment: the petition must be verified by affidavit, a qualified mental health professional must investigate the facts and details in the petition, the state's attorney must decide there are sufficient grounds for filing, and a magistrate must review the petition for probable cause to believe that the person meets the emergency petition criteria. Attached to my testimony is a list of more than 25 specific safeguards. It is also important to recognize that leaving someone in a state of psychosis is neither civil nor right, and that the majority of those treated against their will retroactively agree with the decision to do so.

I realize that it may be tempting to defer a decision on this bill and study it instead. I urge you not to do that – delay is deadly. New York delayed reform of its law several years ago for a study. When the law was ultimately enacted, the results were stunning. For example, incidents of harm to self or others were cut in half for people who benefited from the new law. There were also significant reductions in hospitalization, homelessness, arrests and jailings. Putting off implementation only caused more people to suffer longer.

My testimony is best summed up by quoting Herschel Hardin, a man who defended civil liberties as a director of the Board of the British Columbia Civil Liberties Union and also has a child with schizophrenia, when he asked,

> *How can so much degradation and death – so much inhumanity – be justified in the name of civil liberties? It cannot. The opposition to involuntary committal and treatment betrays a profound misunderstanding of the principle of civil liberties. Medication can free victims from their illness – free them from the Bastille of their psychoses – and restore their dignity, their free will and the meaningful exercise of their liberties.*

SB 2296 Continues to Safeguard Civil Rights

The intent of the law is to, "Encourage, whenever appropriate, that services be provided in the community" and to, "Provide prompt evaluation and treatment of persons with serious mental disorders..." (Sec. 25-03.1-01) The law contains protections for individual rights at every step in the process:

Emergency Petition – Sec. 25-03.1-08, -09

- Petition must be verified by affidavit
- Qualified mental health professional investigates and evaluates facts alleged by petitioner
- State's attorney must determine that there are sufficient grounds for filing
- Magistrate must review for probable cause
- If probable cause established, notice must be sent informing patient of procedures and the right to a preliminary hearing
- Patient has right to independent examination, paid for if indigent

Psychiatric Examination – Sec. 25-03.1-10, 11

- If taken in under emergency treatment provisions, examination must be conducted within 24 hours

Preliminary Hearing

- If taken in under emergency treatment provisions, patient is entitled to a preliminary hearing (Sec. 25-03.1-17)
- Hearing to take place within 7 days of date taken in under emergency treatment provisions (Sec. 25-03.1-11)
- Entitled to legal counsel, paid for if indigent (Sec. 25-03.1-13)
- Patient (respondent) has right to refuse medication and other treatment before the hearing unless necessary to prevent bodily harm (Sec. 25-03.1-16)
- Patient has right to be free of the effects of medication at hearing (Sec. 25-03.1-16)
- Patient must be afforded opportunity to testify on own behalf at hearing (Sec. 25-03.1-17)
- Patient must also be afforded opportunity to present and cross-examine witnesses
- Court must review petition for probable cause (Sec. 25-03.1-17)
- If probable cause, then court must consider least restrictive alternative for treatment (Sec. 25-03.1-17)

Treatment Hearing - Sec. 25-03.1-19

- Hearing to take place within 14 days from the time petition was served
- Patient has right to independent examination if requested, paid for if indigent
- Hearing must be held in same county of residence, hospital, or treatment facility
- Patient must be afforded opportunity to testify on own behalf
- Patient must be afforded opportunity to present and cross-examine witnesses
- Discovery and power of subpoena per ND Rules of Evidence available to patient
- Presumption is in favor of respondent (patient)
- Burden of proof in support of petition is upon the petitioner
- Court must find petition sustained by clear and convincing evidence
- Before making its decision, the court must review a report assessing the availability and appropriateness of treatment programs other than hospitalization. If adequate to patients treatment needs, court shall order treatment other than hospitalization. (Sec. 25-03.1-21)

Did not appear.
Was sick.
Read by Deb Mathern

House Judiciary Committee
Senate Bill 2296 Testimony
March 5, 2003

Mr. Chairman and members of the House Judiciary Committee, my name is Janet Sabol from Minot. I'm in favor Senate Bill 2296 because it will allow people with mental illnesses or brain disorders to get treatment **before** they do something dangerous to themselves or to others.

A number of people with schizophrenia, bipolar disorder and other severe mental illnesses have a neurological syndrome that is part of their illness and caused by brain damage. Because of this a person does not believe he or she is ill and will explain away anything that would indicate that they are ill. Having poor insight, which is well known and has been researched, into your own illness makes it difficult to seek out treatment and also to remain on a treatment course. If you don't think you're ill, you won't go to a doctor.

In my volunteer capacity of a state coordinator for NAMI: The Nation's Voice on Mental Illness, I have talked to many families who have had to suffer along with their loved one as they see the person's physical and mental condition deteriorate before they are "dangerous" enough to be committed to inpatient or outpatient treatment. One mother watched her daughter resort to going only a few feet from her apartment to get vending machine items to eat because her schizophrenia and social phobia was so bad that she couldn't go into a grocery store, pick up items and go to the checkout. Yet

when she was seen at the Human Service Center, she appeared fine just as consumers can look fine for a short time in court. Another parent was called when his son had resorted to moving all the furniture and other items out of his college room, was eating raw meat and making strange sounds before his illness was recognized and he was committed involuntarily. Another parent feared for her life as her son was yelling and threatening her. He talked of 'getting rid of' someone. She testified in court that the verbal remarks were evidence of schizophrenia untreated. Her son had had the illness for 20 years. Relationships in families suffer, as it's the family members who usually have to bring the commitment suits to court. Seeking treatment for someone with a serious mental illness, even though it is court-ordered, is the most humane thing to do so that they can again exercise their civil rights without hallucinations, voices and delusions guiding their thoughts.

Having depression for over 35 years myself, there were a couple of times when a pastor drove me to the hospital or to the doctor's office and then to the hospital because I could not stop the thoughts or actions of wanting to end the pain of mental illness. I was angry for a number of days when on a secured unit, even when I knew it was the only way I could get help in stopping the overdoses. But I knew that I was ill and that it was necessary to get help. There are many who are not aware of how ill they are. I am more aware of the course of the depression in my life, and also at what point I have to intervene by reaching out to a professional before I can no longer make good decisions about coping with the depression. Decision-making and cognitive skills are

some of the first skills that are compromised when a mental illness is not effectively treated. Although depression is considered to be like the common cold in prevalence, its symptoms can be hard-to-treat. After trying many drugs, I've only been somewhat symptom-free in the last three years.

The change in this law is absolutely essential in preventing some of the suicides and many of the crimes against other people caused by untreated mental illness.

The NAMI affiliates in the state, including the newly formed one in Bismarck/Mandan support this bill because it will help alleviate a lot of suffering of consumers and their family members.

Read by Deb Mathern

House Judiciary Committee Testimony
Testimony for Judy Knutson
Senate Bill 2296
Wednesday, March 5, 2003

Chairman DeKrey and Members of the House Judiciary Committee,

My name is Judy Knutson. My brother was diagnosed with a schizophrenic break-down over 20 years ago. I can't even begin to describe the nightmare we've been through over the past 20 some years trying to get him help. There are many things that need to change in the system so our family members can get decent treatment. This includes access to information about medical care, supportive and structured living arrangements, and more inclusion of family in team planning for after care.

But this bill is so important because it all starts right her. It starts with getting and keeping them on their medicine. People who are opposed to that concept should ask: "Why would a doctor prescribe medication if it wasn't needed?" They need to look at what does the medicine do and to care deeply about what happens to the person if they aren't getting proper medicine and care.

My brother has lived as a homeless person for years. He's been beaten and left for dead on more than one occasion. He's scared to live on the street. He doesn't want to live on the street because he said, "It's worse now – a lot of them are on drugs out there." He has frozen his feet. He was suspended from the homeless shelter for violent behavior so he was freezing out on the streets, trying to warm up by going into businesses.

Without medication people with paranoia think people are against them, people with schizophrenia hear voices telling them scary, terrible things about themselves and others. The voices can be very loud and many at the same time. Because of al this they may become violent at times just in an effort to try to defend themselves. But they are

very vulnerable and easily preyed upon out on the streets.

The truth is that the Humane Society does a better job of protecting animals than our society does of protecting people with mental illness! If a pet was out getting cold and unfed, the owners could be brought up on charges. More value is placed on animals than on our family members! All these organizations that say they protect people with mental illness – why aren't they protecting them? They sit behind their desks with no intimate knowledge of the reality that people are actually living every day. Do any of them have a family member who is suffering like this with mental illness?

Some groups claim to be protecting people by saying you can't make someone take medicine if they don't want to. Is it more important to leave people alone than to get them help and keep them alive?

This lack of compassion and negligence has gone on far too long. My brother himself said, "At least YOU know people like me need help and we shouldn't be treated like animals." People who do not act responsibly in helping those with severe mental illness get proper medical care may start seeing themselves facing wrongful death lawsuits from family members. This sort of thing hasn't been done historically. But I think you'll find that as family members have become more educated about the true medical basis for their family member's illness, the more outraged we've become when our loved ones are denied treatment.

And treatment goes beyond a hospital evaluation. It means continuing care because serious mental illness is chronic and on-going. A major problem currently is how difficult it is to get a long-term court order for medication. This means they are required to take their medication as an out-patient so they can stay stable. Even if you manage by

some miracle to get a 1 year court-order requiring them to take medication, then after a year – then what? Wait until something bad happens again? This bill is good because it allows loss of control of one's thought or actions to be considered when determining if the person qualifies for treatment.

If people can't get medication for their illness they just get worse and worse. My brother cycled in and out of treatment so many times that is has taken it's toll on him. His case worker said, "He just doesn't get as well as he used to."

Please pass bill 2296. It will help some people who are too sick to help themselves, get decent care and maybe even a decent life. A person shouldn't be subjected to a life unfit for an animal just because they were unlucky enough to inherit a mental illness. Anyone who opposes this because they think it's wrong to make someone take medicine doesn't truly understand paranoia, they don't understand that delusional people don't make the same choices that they would if they were on medication. Please vote 'do pass' on bill 2296. Thank you.

House Judiciary Committee Testimony
Randy Petermann
Senate Bill 2296- March 5, 2003

Chairman DeKrey and Members of the House Judiciary Committee,

My name is Randy Petermann. I've had paranoid disorder for over 25 years. I can tell you it's cruel if someone can't get treatment. It's inhumane. If no one had taken the first step to get me help I'd be dead now because I didn't know how to help myself.

I fought treatment at first too. A lot of people do. Some people fight going to the hospital because they think they're right. They think they <u>should</u> die. Most people are too afraid to admit they need help. Once they get that sick – anything is hard. When you get that sick you think the doctors are against you, too. And there is the stigma. It's still hard for me to admit I was in the hospital because of the stigma.

When I was younger, I knew my thoughts were messed up. I was beating myself up inside all the time and I didn't want to live. When you're suicidal you are so emotional that you want to go on, yet it's so painful to go on. Killing yourself is the only ticket out. You want it over.

And when you're like that you're not figuring things out. You're just going on impulse. Things are happening so fast when you're suicidal. I was doing things like endangering people by driving wrecklessly. I was in terrible shape inside.

Without medication I also couldn't keep other people out of my head. Their ideas and thoughts became mine. I needed people to help me rationalize things out. They helped me with this in the hospital.

I fought medication at first like a lot of people do. But I realize now that my life

started to take positive steps, to get better, when I had to start taking antipsychotic medicine and got professional guidance and support.

I just wish I'd gotten help sooner because after my second break I lost some of my memory abilities. And I wouldn't be as fragile as I am today. When you have an episode it does cause damage to the nerves in your brain and it's harder to recover.

My son inherited this neurological condition. When he got sick we could all see it. But we couldn't get him in the hospital because people didn't think he was dangerous. But he was a danger to himself and almost committed suicide.

Why does someone have to become dangerous before they can get help? It isn't asking a lot to be able to get someone help when they are that sick.

This bill will save lives. People that are against it think it's wrong to put someone in the hospital if they don't want to go. But someone who is that sick isn't thinking clearly. They can't help themselves. At that time they might not think they want to go to the hospital. But no one wants to kill themselves either.

Please vote DO PASS on bill 2296.

Thank you.

House Judiciary Committee Hearing
Testimony for Sheree Spear
Senate Bill 2296
Wednesday, March 5, 2003

Chairman DeKrey and Members of the House Judiciary Committee:

I wonder how many bills this session will give you the power to influence whether someone lives or dies? When this hearing is over, if you have any doubt, I hope you'll vote "Do Pass" in favor of a person's right to Live. And live well. "Do Pass" in favor of a person's right to Pursue Happiness.

You see, a person lingering in a state of delusion is unable to exercise their civil rights the way you and I can. Losing control over one's own thoughts is a terrifying experience. No one choses to develop a neurological brain disorder - what medicine has proven in the past 10 years that mental illnesses are.

No one choses to be psychotic, paranoid or delusional. And no one wants to stay that way. The same faulty neuron signaling causing those symptoms also oftens impairs one's ability to think clearly and objectively about their need for treatment. No one really wants to kill themselves, or to be driven by delusions to kill their children or a police officer. No one wants to endure the constant, unrelenting torment of paranoia and psychosis. Which is one reason the suicide rate among people with bipolar and schizophrenia is so high. Another reason is because the delusions seem so real the person cannot separate them from reality. That's why they do sometimes act on them.

You're being asked to vote today on something most of us can't even conceptualize. So I thought it might be helpful to show a brief video clip that gives us an idea of what the experience of hearing auditory hallucinations is like for the person having them. Jim, the

person in the video you'll see, killed himself a month after this interview. He had schizophrenia. For time's sake we'll just show a very brief segment of that interview.

VIDEO CLIP - "I'm still here." by Wheeler Communications

Chairman DeKrey and Members of the House Judiciary Committee:

All we're asking is that the classic symptoms of severe mental illness- lose of control of one's thoughts or actions, be added. Just like the classic symptoms of other diseases are recognized and people get help based upon those symptoms *before* there is a negative outcome, we're asking that the same be permitted when it comes to mental illness.

When my dad was having severe chest pain, shortness of breath and turning gray the hospital said , "Bring him in right away." They recognized the symptoms of an underlying disease. He started crying and saying he didn't want to go to the hospital. He was scared, but I was able to get him medical care anyway and he's alive today because of it.

One the other hand, when my son started walking backwards, was cutting his arms, wanted to get his nose surgically removed, and was crying because he thought he'd never be able to survive the Holocaust - I knew he was in trouble too. He wouldn't voluntarily go in for help either because his paranoia was so strong he was sure the nurses would try to poison him. He was scared. But I couldn't even get him in for a 24 hour evaluation because I couldn't prove he was dangerous. Later he attempted suicide but someone intervene in the moments between him loading the gun and pulling the trigger. He almost died because the law barred me from getting him the medical care he desperately needed.

Do you see the double standard? It exists because mental illness used to be so

mysterious. But the huge medical advances of the past 10 years have brought us proof that mental illnesses are legitimate medical conditions deserving of the same compassion and medical care afforded those with Parkinson's, diabetes, or any other disease. We're asking that the law catch up with the science.

Death and suffering due to untreated mental illness is and has been a problem in North Dakota for hundreds, probably thousands of people. 1% of the population will develop schizophrenia - regardless of geographic location. That percentage is the same in the North Dakota as it is in the back hills of the Himalayas.

A friend of mine, an instructor at the Tech School in Grand Forks, shot and killed himself a year ago last August. He had untreated major depression. A man I used to work with at the Floor to Ceiling Store in Fargo who seemingly had everything to live for stuck a tube in his exhaust and killed himself. He had bipolar disorder. In high school a young man did the same thing. Of the 4 people I personally know who either completed or attempted suicide, 3 were North Dakota residents. There are hundreds or more stories like this across the State. We can never prevent every tragedy. But we can prevent some.

Mary in Minot lost her brother to suicide. He had schizophrenia. Carol in Grand Forks lost her son and daughter-in-law to suicide last fall. They had schizophrenia. Eunice Emo in Jamestown tried all last summer to get help for her husband, Jerome, but couldn't prove he was dangerous. He hung himself last October. Michael in Minot can't understand why he had to go to the emergency room last Christmas with stab wounds before his brother could get help for his mental illness. This Capitol building doesn't contain a room large enough to hold all the people from across

the State that can tell you a personal story about why this bill should be passed.

Suicide isn't the only outcome of untreated mental illness. Drug and alcohol addiction, homelessness and victimization and prison sentences are others

Stakeholders have been brought together on this issue in this state. I presented this bill for feedback to the annual Sheriff's and Police Chief's Association meetings. Before this bill was even drafted Chief Magnus, and Sheriff Rudnick and states attorneys were consulted. A number of attorneys specializing in mental health law have been involved. Many state employees in mental health services, at various levels and law had input. Jerry Kemmet, Dir. of Bureau of Criminal Investigations, personally thinks this is a good bill. Elaine Little, Dir. of Corrections, personally thinks this bill will help. She gave me permission to quote her as saying, "With all the people we see coming through our jail and prison doors every year who have untreated mental illness, we can't help but wonder if maybe they would not have committed the crime if they'd gotten help for their illness."

Associations such as National Alliance for the Mentally Ill and Mental Health Assoc. had input. We made significant concessions to satisfy the requests made by Mental Health Assoc. through their attorney, Sharon Gallagher, necessary to gain their support. Dr. Glenn Johnson, Pres. of MHA board confirmed their position remains that they support the bill as amended in the Senate. And consumers (those with mental illness). Especially consumers had input. The homeless people with untreated mental illness aren't members of any association and aren't even aware there's a hearing today. We're representing them and those too sick to speak at this podium.

The word "commitment" is scary for some. It makes people think of the days when medicines weren't good and people were institutionalized for years. I'm well aware of how things used to

be and can tell you this bill doesn't take us back there. The attached flow chart illustrates some of the processes in place to ensure rights are protected. Attorney Mary Zdanowich will elaborate on that issue.

In conclusion, some have wondered why we would expend so much time and energy to try to make this change. For me the answer is: I'm making an investment in my son's future. And in the futures, if they are to have one, of others who suffer along with him.

Most families invest in their children's future by saving for college and raising them well. I only have one child and at the young age of 22 he's been stuck with a chronic, severe illness. Having done all the other right things, what can I do at this point to invest in his future? I can try to create the best possible environment for him, including the best: medicines, housing options, and law.

I've encountered so many other people in the state who share similar stories, so it's a privilege to be working on their behalf also.

Please vote DO PASS on SB 2296. Thank you.

House Judiciary Committee Testimony
Senator Tim Mathern
Senate Bill 2296
March 5, 2003

Chairman DeKrey and members of the House Judiciary Committee. My name is Tim Mathern, Senator from District 11 in Fargo. I sponsored Senate Bill 2296 because I believe there are persons who suffer from mental illness who do not receive treatment early enough.

Amendments were made by the Senate to make this bill as narrow as possible to meet the objectives but not violate people's rights to refuse treatment when they are not in need of treatment.

Members of the Committee I believe this bill is urgent. From my experience working in a large parish in Fargo I know people wander the streets needing treatment but not getting it. Some individuals get better using medication and then go off the medication when they feel better but then need to be hospitalized to reestablish the medication pattern and its benefit. Far better that the medication use continue without interruption. Also from my experience in the Appropriations Committee I have learned that there are far too many people in prison who have committed crimes when they were in need of mental health services. With this bill we're just trying to make it possible to get people who are clearly in desperate need of help (delusions, psychotic) and care they need before they become dangerous to themselves or others.

Again, I believe this bill is urgent. We must stop needless incarcerations, suicidal deaths, and personal suffering as soon as possible.

Mr. Chairman and members of the Committee there are others who wish to testify and I ask that you permit Ms. Sheree Spear to testify next so that you get a full description of the need for this bill and orderly introduction of proponents to respect the time constraints you are under.

I ask for your support of SB 2296 as amended by the Senate. Thank you for your consideration.