



# CAMHPRO Public Policy Statement on Involuntary Outpatient Commitment

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The California Association of Mental Health Peer-Run Organizations (CAMHPRO) is a nonprofit statewide organization consisting of consumer-run organizations and programs.

CAMHPRO's mission is to transform communities and the mental health system throughout California to empower, support, and ensure the rights of consumers, eliminate stigma, and advance self-determination for all those affected by mental health issues by championing the work of consumer-run organizations.

## **CAMHPRO joins a multitude of stakeholder organizations in strongly opposing the implementation of involuntary outpatient commitment in California's counties.**

Involuntary outpatient commitment (also called assisted outpatient treatment, AB 1421, "Laura's Law") expands criteria for involuntary treatment to pessimistic preemption, unlike California commitment law that is based on current behavior that is dangerous or gravely disabled. It has two components: an intensive service treatment plan based on what is generally called Assertive Community Treatment and substantially the same as what in California is known as the Full Service Partnership (FSP) model; a court order process for civil commitment on an outpatient basis requiring an individual to comply with that treatment plan or face enforcement actions. Enforcement actions include being taken into custody by the police and held for 72 hour detention in a hospital. Essentially, involuntary outpatient commitment is civil commitment in the community as opposed to in the hospital.

Our reasons for opposing involuntary outpatient commitment are many and not easily conveyed in sound bites that play to the fear of the public.

**Voluntary enhanced services are the answer to the mental suffering that surrounds us, not the expansion of involuntary treatment.** Deinstitutionalization did not fail; it was never completed. The problem isn't that there isn't enough involuntary treatment; the problem is that there are not enough person centered, recovery based services. Outpatient commitment proponents advocate for more involuntary treatment as an answer to the lack of accessible services, and the suffering that results from this lack.

CAMHPRO agrees with leading authorities who argue that the mental health system should provide more accessible voluntary services in response to the mental health need. The Mental



Health: A Report of the Surgeon General states, “One point is clear: the *need* for coercion should be reduced significantly when adequate services are readily accessible to individuals with severe mental disorders who pose a threat of danger to themselves or others. The Surgeon General’s Report further states, “Almost all agree that coercion should not be a substitute for effective care that is sought voluntarily”.<sup>i</sup> The Little Hoover Commission, 2000, Being There: Making a Commitment to Mental Health researched the issue of mental health at the time that outpatient commitment was being debated in the California legislature. The Commission came to the conclusion that “Inadequate access to voluntary care should not warrant the use of involuntary care”.<sup>ii</sup> The Little Hoover Commission urged the State to assess how improved access to voluntary treatment could diminish the need for involuntary treatment.

**Coercive treatment is ultimately ineffective.** The expansion of involuntary treatment will not stop “treatment noncompliance,” which is viewed as a problem that more forced treatment will solve. In fact, researchers have found that forced treatment may cause noncompliance. The Well Being Project, a research project supported by the California Department of Mental Health, found that 55 % of clients interviewed who had experienced forced treatment reported that fear of forced treatment caused them to avoid all treatment for psychological and emotional problems.<sup>iii</sup>

**Coercion seriously undermines the therapeutic relationship between a client and his/her therapist.** Over dozens of years, providers’ personal expertise and all the evidence of mental health treatment research point to the relationship as the crucial element for treatment success. All other things aside, when the relationship between the client and therapist is grounded in trust between them, progress can occur that can have powerful positive effects. When poor therapeutic relationships exist, there little chance for success. Involuntary commitment works directly against the therapeutic relationship, magnifies power differentials and reduces the sense of personal dignity and self-efficacy that is so important to recovery.

This adverse effect of force on the therapeutic relationship may contribute to the minimal use of outpatient commitment even when it is law: mental health providers don’t like it.

Although California law since 2002, outpatient commitment has only been fully implemented in Nevada County, a small County of 100,000 people. Also, although 44 States have outpatient commitment, only a minority have used it regularly. Even in New York State where outpatient commitment is used, 75 % of court orders are done in NYC (for reasons later described.) Upstate New York usually use voluntary agreements instead of court ordered treatment.<sup>iv</sup>



**Stigma drives the perceived need for involuntary treatment.**

CAMHPRO is deeply concerned about the false stereotypes of people diagnosed with mental illness that are fueling the recent movement for more forced treatment. These myths – stigma – are the foundation for the perceived need for forced treatment. They are deeply ingrained in the American psyche.

The myth that people diagnosed with mental illness are more violent than the general population is contradicted by researchers and government statistics.

“Violent crimes committed by psychiatric patients become big headlines and reinforce the social stigma and rejection felt by many individuals who suffer from mental illness. But our findings suggest that serious violence is the rare exception among all people with psychiatric disorders. The public perception that people who are mentally ill are typically violent is unfounded.”<sup>v</sup>

“The vast majority of Americans with a mental health condition are not violent. In fact, just 3% to 5% of violent crimes are committed by individuals who suffer from a serious mental illness.”<sup>vi</sup>

Secondly, the myth that people diagnosed with mental illness are not competent to make their own decisions and are incapable of insight into their illness is discredited by researchers. The statistic that 40 – 50 % of people with mental illness are incapable of making decisions is pulled from thin air.

Most people with mental disabilities are competent to make decisions about their treatment. According to the MacArthur Treatment Competence Study, “Most patients hospitalized with serious mental illness have abilities similar to persons without mental illness for making treatment decisions. Taken by itself, mental illness does not invariably impair decision making capacities.”<sup>vii</sup> In the Surgeon General’s words, “Typically, people retain their personality and, in most cases, their ability to take responsibility for themselves.”

**Major Research Indicates that Enhanced Community Services Produce Positive Results, while there is no Evidence that Court Ordered Care is Responsible for Improved Results.**

Major comparative research studies conducted on outpatient commitment have concluded that it is the services, not the court order, that produces the positive results.

The Final Report, Research Study of NYC Involuntary Outpatient Commitment Pilot Project.

1998, Bellevue Study, a comparative study of outpatient commitment in New York City found that, when comparing a control group to persons court ordered to outpatient commitment, there was no difference in any qualitative or quantitative outcomes. The positive element with both the court ordered and non- court ordered groups was the enhanced community services offered to both.<sup>viii</sup>



In 2000, a study was commissioned by the California Senate Committee on Rules in the middle of the outpatient commitment battle in California. The Report found that “There is no evidence that a court order is necessary to achieve compliance and good outcomes, or that a court order, in and of itself, has any independent effect on outcomes.” Rand additionally reported that the literature provides clear evidence that “alternative community based mental health treatments can produce good outcomes for people with severe mental illness.”<sup>ix</sup>

More recently, in March 2013, The Lancet reported on a randomized controlled study that found, “In well- coordinated mental health services the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients. We found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients’ personal liberty.”<sup>x</sup>

The greatly expanded role for the judicial and criminal justice systems to implement outpatient commitment entails excessive costs that cannot be covered by MHSAs funds. Why expend these funds as well as divert them from needed services for a process that significantly curtails personal liberty and that has not been proven to be effective?

**Under the Mental Health Services Act, California has developed a system of voluntary community services and supported it with a funding stream. California’s experience is different from New York.**

Proponents of outpatient commitment point to New York and Kendra’s Law as a model for California. New York followed Kendra’s Law with a massive infusion of funds and services to support it. In NYC where court orders are predominantly used, they can be seen as “efforts to ensure priority access to available community case management and housing.” Court ordered individuals are given priority access to scarce resources.”<sup>xi</sup>

Unlike New York, California has put its money into a voluntary network of community services that are person centered and holistic and based on the recovery model. California doesn’t need forced treatment, with all of its negative consequences, to access coordinated services. California is marching toward “effective care that is sought voluntarily”.

The results of a 2012 UCLA study of MHSAs Full Service Partnerships found that every dollar spent on mental health services in California saved roughly \$0.88 in costs to the criminal justice and health and housing services by reducing the number of arrests, incarcerations, ER visits, and hospitalizations.<sup>xii</sup> These same kinds of results were found in the Petris Center Evaluation, May 2010; a large reduction in homelessness, a rise in the proportion of consumers living independently, less use of mental health related emergency services, less incarcerations, and a



rise in employment.<sup>xiii</sup> AB 34 and 2034, the pilot programs that the full service partnerships are modeled on, produced the same kind of positive results. It is the services that make the difference and produce positive results.

### **Civil Rights and Due Process**

In America we take freedom, autonomy and civil rights seriously. Any process that limits those, or prevents an individual from exercising them, rightly requires significant debate and, where implemented, effective due process to ensure it is not abused. California like all states has an established process for holding and evaluating people whose psychiatric condition is such that they represent a danger to themselves or others, or who are gravely disabled.

AB 1421 lowers the bar for abridging civil rights and self-determination. It allows for commitment based on the prediction of danger to self or others or grave disability in the future, not observable current behavior. It allows for a family member, neighbor or anyone living with an individual to initiate that process, rather than a public safety official or licensed mental health practitioner. It does not provide protections against potential abuse of this process, where for instance, a partner in a domestic squabble might have someone forcibly removed for 'evaluation'.

All Americans with psychiatric disabilities are entitled to protections of their civil rights under the Americans with Disabilities Act and the Protection and Advocacy Act. Involuntary outpatient commitment has not been challenged on constitutional rights grounds in California as yet. Complaints have been filed and investigations are under way, however, in many states that do utilize similar processes nationwide.

### **The Hope of Mental Health Services Act (MHSA)**

CAMHPRO members had and still have great hope that the MHSA will create a true culture shift in the manner that people with mental illness diagnosis are treated. We believe that the MHSA will transform the mental health system from one that is based on force to one that is based on the recovery vision, as described in the MHSA Section 7.,5813.5(d):

*(d) Planning for services shall be consistent with the philosophy, principles and practices of the Recovery Vision for mental health consumers.*

*(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.*

*(2) To promote consumer-operated services as a way to support recovery.*

*(3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.*

*(4) To plan for each consumer's individual needs.*



However, the option of involuntary outpatient commitment for “non-compliant” individuals could seriously undermine the need for and practice of in depth outreach, meeting people where they are at, so necessary to the success of the MHSA. Why do intensive outreach, which is a hard and ongoing effort, when a person can be forced to receive the same services?

The advancement of involuntary outpatient commitment throughout the State threatens to only transform *where* people are forced to, the hospital or the community. Instead of 37,000 people being forced into the big state hospitals of yesterday (1957 statistics), an equal number of people could be forced in the community - the future’s new version of mental hospitals. This is not transformation. Forced treatment in the community is not a “compassionate” alternative to forced treatment in a hospital. It is the same old answer of force.

AB 1421 has divided the mental health community. It has pitted family members against consumers, and family members against each other. Providers have been compelled to take “sides.” We are at our best when we work together for change, such as when the mental health community united to support and advocate for Proposition 63. This debate has taken our collective eyes off of the real prize – securing “effective care that is sought voluntarily.”

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*This position paper represents the collective wisdom and shared information of the consumer movement and allies of over a decade, with acknowledgement to the California Network of Mental Health Clients position papers on Involuntary Outpatient Commitment, Eduardo Vega, and Sally Zinman.*

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<sup>i</sup> U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

<sup>ii</sup> Little Hoover Commission, Being There Making a Commitment to Mental Health, November, 2000.

<sup>iii</sup> Campbell, Jean, Schraiber, Ron. The Well-Being Project: Mental Health Clients Speak for Themselves. California Network of Mental Health Clients, California Department of Mental Health, 1989.

<sup>iv</sup> Harvey Rosenthal, NYAPRS 2005 Assembly Hearing “Once you take out New York City’s 3,000+ court orders (which represent over ¾ of all court orders statewide), most counties have been far more successful in engaging individuals with serious psychiatric conditions without the use of forced treatment. For example, 13 counties have not produced even 1 court order; 12 counties have produced 2 or less forced treatment orders: Also, NYC has sought court orders for 3 out of every 5 investigations; in contrast, Onondaga Co. (Syracuse), has only sought court order for 1 out of every 12.”

<sup>v</sup> Jeffrey Swanson, Ph. D., referring to the study, “Three Risk factors Cited in Violent Behavior Among People With Severe Mental Illness”, American Journal of Public Health, September 2002



<sup>vi</sup> U.S. Secretary of Health and Human Services Kathleen Sebelius remarks during the opening plenary of the National Health Policy Conference organized by The Academy Health February 4, 2013 in Washington, DC

<sup>vii</sup> MacArthur Treatment Competence Study. <http://www.sys.virginia.edu/macarthur>

<sup>viii</sup> Steadman, H., Gounis, K., Dennis, D., Hopper, K., Roche, B., Swartz, M., and Robbins, P. 2001. Assessing the New York City Involuntary Outpatient Commitment Pilot Program. *Psychiatric Services*. 52(3): 330-336. Outcome measures included re-hospitalization, arrest, quality of life, symptomatology, treatment compliance, and perceived level of coercion.

<sup>ix</sup> Ridgely, M., Borum, R., and Petrila, J. 2001. The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States. RAND Institute for Civil Justice.

<sup>x</sup> Burns T, Rugkåsa J, Molodynski A, et. al, Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial, *Lancet* 381:1627-33, 2013.

<sup>xi</sup> From paper by Harvey Rosenthal, Executive Director, NYAPRS .

<sup>xii</sup> UCLA Center for Healthier Children, Families and Communities and EMT Associates, Inc. "Full Service Partnerships: California's Investment to Support Children and Transition-Age Youth with Serious Emotional Disturbance and Adults and Older Adults with Severe Mental Illness", October 2012. Link To Study:  
[http://www.mhsoac.ca.gov/Evaluations/docs/Eval\\_FSP\\_CostOffsetReport\\_UCLA\\_103112.pdf](http://www.mhsoac.ca.gov/Evaluations/docs/Eval_FSP_CostOffsetReport_UCLA_103112.pdf)

<sup>xiii</sup> Nicholas C. Petris Center at the University of Berkeley, "Evidence on the Effectiveness of Full Service Partnership Programs in California's Public Mental Health System," may 2010