California Association of Mental Health Peer-Run Organizations
333 Hegenberger Road, Suite 250, Oakland, CA 94621
(510) 832-7337 fax (510) 452-1645 www.camhpro.org

Date April 20, 2015
Honorable Mark Stone,
Assembly Judiciary Committee, Chair
Legislative Office Building,
1020 N Street, Room 104
Sacramento CA 95814

AB 59 (Waldron) Mental Health Services: Assisted Patient Treatment Strongly Oppose

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 strongly opposes AB 59 (Waldron) because it strengthens a law that has not been proven to be effective and is a violation of rights.

AB 59 would make involuntary outpatient commitment permanent by removing sunsetting provisions. AB 59 would also remove from the law the provision that "the county board of supervisors, --- makes a finding that no voluntary mental health program serving adults, and no children's mental health program, may be reduced as a result of the implementation of this article." These measures strengthen the existing law.

Involuntary Outpatient Treatment has *not* proven itself as a successful approach to justify denying individual rights, and should not be strengthened in any way.

Particularly troublesome in the bill is deleting the finding that implementation of involuntary outpatient treatment cannot reduce voluntary programs serving adults. This opens the door toward involuntary services replacing voluntary services and reversing the movement toward a voluntary system of care of the last 40 years. Proponents of involuntary outpatient treatment describe it as offering an *additional* tool for a small group of people who will not engage in voluntary services. AB 59's amendment to the law has the potential of *replacing* the voluntary tools in the toolbox. It also is contrary to a guiding principle of the LPS to promote voluntary services. "The client should be fully informed and volunteer for all treatment provided, unless danger to self and others or grave disability requires temporary involuntary treatment."[i]

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

More accessible voluntary services are the answer to the unmet needs of people with mental and emotional problems and the suffering that results, not outpatient commitment. 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".[ii] 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". [iii] 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.[iv]

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." [v].

"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." [vi]

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." [vii] 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. [viii]

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."[ix]

More recently, in March 2013, The Lancet reported on a randomized controlled study in Britain 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."[x]

Why strengthen a law that has not been proven to be successful in every randomized study that has been conducted.

Clearly it is the services that make the difference and produce positive results. Through the MHSA (Prop 63), California has put its money into a voluntary network of community services that are person centered and holistic and based on the recovery model. The results of a 2012 UCLA study of MHSA 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.[xi] 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.[xii] AB 34 and 2034, the pilot programs that the full service partnerships are modeled on, produced the same kind of 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.

Involuntary outpatient treatment lowers the bar for abridging civil rights and self-determination. It allows for commitment based on the pessimistic 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. AB 1193 adds to this long list of people who can initiate a petition. 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'.

IOT may violate non-discrimination laws because it only mandates treatment for people with mental health disabilities for being non-compliant with their doctor's orders. No competent person with a physical health condition, even those "non-compliant" with their doctors' orders, would be subjected to court-ordered treatment and forced hospitalization. In addition, IOT has historically discriminated against people based on their race. For example, under Kendra's Law in New York, African American clients were found to be nearly five times as likely as whites, and Latinos twice as likely as whites, to be the subject of court-ordered treatment.[xiii]

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 advancement of involuntary outpatient commitment throughout the State, especially if involuntary outpatient treatment can replace voluntary services as proposed in AB 59, 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. Forced treatment in the community is not a "compassionate" alternative to forced treatment in a hospital. It is the same old answer of force.

Please oppose AB 59. Do not hesitate to contact me for any additional information at 510-681-6165 or szinman@camhpro.org

Sincerely,

Sally Zinman
Executive Director, California Association of Mental health Peer Run Organizations (CAMHPRO)

Cc: Honorable Members, Assembly Judiciary Committee
The Honorable Marie Waldron, Member, California State Assembly

[i] Welfare and Institutions Code section 5801(b)(5), as added by SB 659 in 1996

[ii] 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.

[iii] Little Hoover Commission, Being There Making a Commitment to Mental Health, November, 2000.

[iv] Campbell, Jean, Schraiber, Ron. The Well-Being Project: Mental Health Clients Speak for Themselves. California Network of Mental Heath Clients, California Department of Mental Health, 1989.

[v] 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

[vi] 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

[vii] MacArthur Treatment Competence Study. http.www.sys.virginia.edu.macarthur

[viii] Steadman, H., Gounis, K., Dennis, D., Hopper, K., Roche, B., Swartz, M., andRobbins, 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.

[ix] 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.

[x] 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.

[xi] 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

[xii] 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

[xiii] NY Lawyers for the Public Interest, 2005