



CONSOLIDATED PLANNING ADVISORY WORKGROUP (CPAW)

Background

The Mental Health Services Act (MHSA) provides additional funding to community public mental health with the mandate that these MHSA funded services and supports promote wellness, recovery and resilience, be consumer and family driven, culturally competent, provide an integrated service experience, and provide a process by which mental health clients, their families, and other community members and organizations work together to share information and resources to fulfill shared goals. The community public mental health system includes services provided by community-based organizations and those provided by the county. Contra Costa Mental Health (CCMH) has established the Consolidated Planning Advisory Workgroup (CPAW) in order to ensure that local stakeholders are an integral part of all planning and evaluation of MHSA funded services and supports.

Purpose

CPAW members are appointed by the Mental Health Director, and represent stakeholders who receive or provide services, or who are otherwise involved in public mental health services in Contra Costa County. CPAW 1) assists in the ongoing development and evaluation of the programs and plan elements that comprise the MHSA Three Year Program and Expenditure Plan, and subsequent yearly Plan Updates, 2) advises on the integration of the values and principles inherent in MHSA into the larger public mental health system, and 3) promotes transparency of effort by sharing information with the stakeholder community.

CPAW Committees

CPAW meets the first Thursday of every month to discuss and advise on areas of topical interest, and to receive reports from the following CPAW sponsored sub-committees:

- Steering. Develops the CPAW Committee meeting agenda, and represents CPAW on selected issues.
- Membership. Recommends prospective applicants to the CCMH Director for membership.
- Innovation. Recommends new Innovation Projects and monitors and evaluates existing projects.
- Social Inclusion. Oversees mental health stigma and discrimination reduction initiatives.
- Housing. Plans and advises on new and existing housing and homeless services.
- Age-related Committees. Children's, Transition Age Youth, Adult, and Aging/Older Adult sub-committees advise on planning and evaluation of services and supports specific to the age groups served by CCMH.

CPAW AGENDA ITEM

READINESS WORKSHEET

CPAW Meeting Date: August 7, 2014

Name of Committee: Membership

1. **Agenda Item Name:** Membership Committee Report
2. **Desired Outcome:** Inform CPAW of membership application status
3. **Brief Summary:** The Membership Committee met on Monday, July 21 to review applicants, applications and develop a strategy to assist membership become fully representative of the stakeholder community. The Membership Committee interviewed Matt Wilson, and recommended to the Director his appointment to CPAW. Four applications remain, and will be considered in upcoming meetings.
4. **Background:** The Membership Committee has analyzed the characteristics and affiliations of current membership and prioritized those characteristics and affiliations that will guide recruiting efforts and consideration of new applications for membership.

First priority is current consumers of public community mental health, and family members of children and transition age youth who are currently receiving services from public community mental health.

Second priority is individuals who represent stakeholder groups who are not represented on CPAW; i.e., persons identifying as Latino/a, a representative of law enforcement, a representative of faith based organizations, a representative of social services.

Third priority is individuals who represent stakeholder groups who are under-represented on CPAW; i.e., persons identifying as African American, persons identifying with the eastern or western regions of the county; persons representing the current issues of military service members.

5. **Specific Recommendation:** CPAW members are encouraged to assist in recruiting applications from individuals who can enable CPAW to be fully representative of the stakeholder community; especially those individuals who can well represent the interests of stakeholder groups in the above priorities.
6. **Anticipated Time Needed on Agenda:** 5 minutes (during committee reports)
7. **Who will report on this item?** Mariana Moore, Kathi McLaughlin

Position Statement on Involuntary Commitment

Inpatient Commitment

The United States Supreme Court has termed involuntary civil commitment to a psychiatric hospital "a massive curtailment of liberty."¹ The court has also emphasized that "involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law."² Moreover, the court has found "no Constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom."³ "[T]he mere presence of mental illness," the court held, "does not disqualify a person from preferring his home to the comforts of an institution."⁴

Opposing unnecessary coercion is a key focus of the Bazelon Center's work to protect the rights of people with mental illnesses. We believe that the vast majority of individuals with mental illnesses are better served by access to appropriate voluntary services in the community.

The Bazelon Center opposes involuntary inpatient civil commitment except in response to an emergency, and then only when based on a standard of imminent danger of significant physical harm to self or others and when there is no less restrictive alternative. Civil commitment requires a meaningful judicial process to protect the individual's rights.

Outpatient Commitment

The Bazelon Center also opposes all involuntary *outpatient* commitment⁵ as an infringement of an individual's constitutional rights. Outpatient commitment is especially problematic when based on:

- a prediction that an individual may become violent at an indefinite time in the future;
- supposed "lack of insight" on the part of the individual, which is often no more than disagreement with the treating professional;
- the potential for deterioration in the individual's condition or mental status without treatment;
- an assessment that the individual is "gravely disabled."

The above criteria are not meaningful. They cannot be accurately assessed on an individual basis, and are improperly rooted in speculation. Neither do they constitute imminent, significant physical harm to self or others—the only standard found constitutional by the Supreme Court. As a consequence, these are not legally permissible measures of the need for involuntary civil commitment—whether inpatient or outpatient—of any individual.

The Bazelon Center supports the right of each individual to fully participate in, and approve, a treatment plan and to decide which services to accept. The Bazelon Center encourages the articulation of treatment preferences in advance through the use of advance directives and/or a legally recognized health care agent.

Outpatient commitment is a dangerous formalization of coercion within the community mental health system. Such coercion undermines consumer confidence and causes many consumers to avoid contact with the mental health system altogether. Furthermore:

- Outpatient commitment is a simplistic response that cannot compensate for a lack of appropriate and effective services in the community. In fact, the enforcement demands of outpatient commitment will divert resources away from treatment.
- Data on outpatient commitment show it confers no additional benefit above access to effective community services. (In one of only two controlled studies, individuals given the option of

enhanced community services did just as well as those under commitment orders who had access to the same services.)⁶

- There are enormous practical problems in implementation of outpatient commitment, and potentially high costs for law enforcement.
- The threat of forced treatment, with medication that has harmful side effects, often deters individuals from voluntarily seeking treatment. At best, outpatient commitment undermines the therapeutic alliance between the provider and consumer of mental health services. Greater sensitivity is needed on the part of mental health professionals in working with consumers to find the most effective and acceptable treatment.

In short, outpatient commitment penalizes the individual for what is essentially a systems problem. Lack of appropriate and acceptable community mental health services is the issue.

1999, updated 4/2000

Notes

¹ *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

² *Specht v. Patterson*, 386 U.S. 605, 608 (1967).

³ *O'Connor v. Donaldson*, 422 U.S. 563, 574 (1975).

⁴ *Id.*

⁵ The term "outpatient commitment" when used in this document refers to procedures for (a) involuntary commitment to outpatient treatment and (2) hospital release conditioned on treatment compliance.

⁶ For more information on this study, conducted by the Bellevue program in New York City, contact **Policy Research Associates**, online. The findings of a North Carolina study confirmed the New York study in finding that overall outpatient commitment conferred no additional benefits for individuals receiving enhanced services. This study did, however, find that a small group of patients who were under commitment orders for six months or longer, and who also actually received more services, did better than those not under outpatient commitment.



MHASF POSITION STATEMENT INVOLUNTARY MENTAL HEALTH TREATMENT

- *The Mental Health Association of San Francisco (MHASF) believes effective protection of human rights and the best hope for recovery from mental illnesses comes from access to voluntary mental health treatment and services that are accessible, comprehensive, community based, recovery oriented, and culturally and linguistically competent.*
- *Moreover, the rights of persons with mental illnesses to make decisions concerning their treatment must be respected and protected.*
- *MHASF urges governmental entities to adopt laws, which reflect a commitment to maximizing the dignity, autonomy and self-determination of persons affected by mental illnesses.*
- *Voluntary admissions to treatments and services should be truly voluntary, and the use of advance directives should be implemented.*
- *The MHASF is opposed to outpatient commitment (Laura's Law).*

BACKGROUND INFORMATION:

People with mental illnesses deserve the same degree of personal autonomy as other citizens with disabilities in regard to receiving treatment and services. For years, individuals with mental illnesses have been combating the centuries old stereotype they are not competent to make their own decisions, or to be in charge of their own mental health care. Today, we know otherwise. People with behavioral disabilities are capable of making their own decisions in respect to care and treatment, and more importantly, treatment can only be effective when the person embraces it, not when it is coercive and involuntary. Involuntary mental health treatment, be it inpatient or outpatient, is a serious curtailment of liberty.

Involuntary mental health treatment occurs in a variety of contexts. The most common type is court ordered to an inpatient facility. However, involuntary treatment also includes involuntary medication or other treatments such as electroconvulsive therapy (ECT), whether court ordered or imposed by mental health professionals, treatment imposed upon persons with mental

illnesses in prisons or jails as a condition of probation, supervision or parole, outpatient commitment, and the use of guardianship or conservatorship laws.

In addition, people facing involuntary confinement have a right to substantial procedural protections, including but not limited to the following:

- A judicial hearing and a right to jury trial at which at least one mental health professional is required to testify;
- The right to be represented by competent counsel, including appointed counsel if needed;
- An independent mental health evaluation;
- The right to appeal an adverse decision, including the appointment of appellate counsel and waiver of appellate costs if needed;
- Short time limits on any commitment or procedures for regular review of continued confinement, which are either automatic or readily accessible to persons with serious mental illnesses confined in a hospital; and
- Involuntary commitment to a psychiatric facility should only be imposed if supported by clear and convincing evidence.

Advance directives have proven to be useful instruments for maintaining and increasing the autonomy of persons with mental illnesses. These documents, prepared when the individuals with mental illnesses are not impaired, designate in writing the treatment they want when their decisional capacity may be impaired at a later date. Unfortunately, these are unknown to many people and not promoted by many programs/services. A model for use in California is available through the California Protection and Advocacy program. Advance Directives should be mandated as a component of each person's treatment plan.

AB 1421 ("Laura's Law"), enacted in 2002 and effective January 1, 2003, mandated Assisted Outpatient Treatment (AOT) for people "gravely" disabled as a result of their mental illnesses. The law stipulated each county had to approve implementation before it could be utilized in that county. To date, only one out of 58 counties (Nevada County mandated it in 2008) have approved AOT. Controversy continues regarding implementation of AOT. In San Francisco a modified approach to Laura's Law was developed in 2010, known as the Community Independent Pilot Project (CIPP) which provides clients with both conservatorship and required medication therapy. CIPP is a voluntary program with collaboration between the Office of Conservatorship Services, The Department of Public Health Placement Team, the Offices of the Public Defender and the District Attorney. This program places individuals, who are found to be gravely disabled, in community programs (least restrictive environment) rather than in locked facilities for treatment and stabilization. As of January 2013, seven people have participated in the pilot program.



FOR IMMEDIATE RELEASE

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Mental Health Consumers, Advocates, and Providers Speak out Against Laura's Law

San Francisco, CA – Mental Health consumers, advocates, and providers across San Francisco and beyond expressed disappointment and concern over a press conference held by San Francisco Mayor Edwin Lee and Board of Supervisors Member Mark Farrell on May 20th, 2014 at 9:15 AM at San Francisco General Hospital. At the press conference, Mayor Lee, Supervisor Farrell, and others promoted AB 1421, known as "Laura's Law" as an effective approach for individuals with mental health challenges.

This is the fourth time that AB 1421 has been pushed in the City and County of San Francisco, and each previous time, it has been soundly defeated at the Board of Supervisors with strong opposition from mental health consumers, mental health providers, legal organizations, and advocates from underserved and marginalized communities.

"AB 1421 lowers the bar for abridging civil rights and self-determination. Instead of a helping hand it extends a fist to vulnerable people. It creates a bureaucratic process based on courts, police and threats for coercing disabled individuals into the same services that have failed them in the past. Court orders do not help people experiencing homelessness-- rather than providing new options people will want to use like employment, education, and housing, it threatens to burden our police force and courts as well as people who are already facing enormous challenges," said Eduardo Vega, Executive Director of the Mental Health Association of San Francisco.

AB 1421 is supported by a small minority of individuals and some family advocates in California and to date has only been implemented fully in two counties in California. Implementation of AB 1421 in San Francisco would undermine our unique shared values of hope, equality, and civil liberty that the city of Harvey Milk and other champions of freedom, has long held dear.

"Individuals with mental health conditions who would be affected by AB 1421 will not be silent on this issue," Vega continued. "Those of us who have spent decades working with people with serious mental health conditions know that treatment works when it is based in trusting relationships--1421 completely undermines that process and fosters racial profiling. That is why it has not been used in most parts of California for twelve years and adopted only in conservative communities with little diversity. It will fail to produce results for a ethnically diverse urban area like San Francisco, divide our communities and decrease resources that could be used to make a difference."



MHASF Position Statement – AB 1421

The AB1421 model has proven ineffective and destructive to the long-term health of people with mental health conditions, including those with serious mental illnesses. Among the many problems created by this legislation include:

1. In the 10 years since it was passed, less than five people in one of California's smallest counties have been court-ordered to a program in the AB1421 model;
2. The ultimate burden of these programs falls on law enforcement and threatens people who are disabled with incarceration and indignity when what they really need is treatment and support;
3. Involuntary services under the AB1421 model have not been shown locally or in the international research literature to have ANY benefits above and beyond those same services provided on a voluntary basis. Indeed, coercive responses to mental health challenges promote stigma, fear of service providers and loss of personal rights. Such practices deter people who need services from mental health treatment, resulting in worse illnesses and long-term outcomes for our communities;
4. The unfunded and conjectural AB1421 programs, which involve complicated interagency projects, have been superseded by now-proven and well-funded Full-Service Partnership programs under Proposition 63 statewide. Every individual who would qualify for a coercive AB1421 program can be served without prejudice by these programs, which are designed to serve the people most disabled by serious mental health conditions and to prevent homelessness and incarceration.
5. Forced treatments push people away from services and diminish human dignity, reducing hope and personal resources needed for the recovery of people with mental health conditions.

Arguments in favor of AB 1421 exploit and perpetuate the most negative, demeaning and inaccurate stereotypes of people with mental health conditions. To one extreme, individuals with mental health conditions are painted as violent and out-of-control. On the other hand, such individuals are portrayed as totally incapable of making their own decisions and so must be unworthy of the rights others enjoy and their choices must be unworthy of respect. What we know is that individuals with the most *serious mental illnesses* can and do recover with treatment and support in a community-based setting.

In summary, an unsuccessful pet project promoted by a very small minority of advocates, the AB1421 model has demonstrated its lack of effectiveness and relevance to California communities. The needs it hoped to serve have been far better served by Mental Health Services Act programs.

Opposition to AB 1421

Homelessness and Violence

- AB1421 does not address the homelessness issue in San Francisco. In fact, the bill does not address homelessness, but instead involves law enforcement to remove people from their home without their consent. It gives a family member, friends, and neighbors the power to have a person removed by law enforcement and forced into the judicial system.
- AB1421 puts an increased burden on law enforcement, emergency rooms and the court system with no additional funding to address this burden.
- The law does not decrease violent behavior or prevent mass shootings, there is no methodology that predicts violent behavior.
- According to the MacArthur Violence Assessment Risk Study, the prevalence of violence among people who have been discharged from a hospital and who do not have symptoms of substance abuse is about the same as the prevalence of violence among other people living in their communities who do not have symptoms of substance abuse. In fact, people with mental health conditions are more likely to be the victims of violence.

Violation of Civil Rights

- Forced treatment is a violation of our civil rights. People with mental health conditions deserve the same protections under the law as everyone else.
- The right of a person to determine his or her course of medical treatment has long been recognized as a fundamental right by the courts in this country.
- It takes away control over all treatment decisions -- including what medication regimes a person follows, what therapy sessions he or she attends, and what other mental health programs he or she participates in.
- Allows incarceration without a crime having ever been committed.
- All research on court-ordered mental health treatment demonstrates that the two most salient factors in reducing recidivism and problematic behavior among people with severe mental illness is access to enhanced services and access to enhanced case management/monitoring services.
- There are no empirical data that shows the policy tradeoffs between involuntary outpatient treatment and alternatives such as assisted outpatient treatment. However, the question can be asked: "Does adding

a court order to the provision of intensive treatment significantly improve outcomes over and above the intensive treatment itself?"

- African Americans are almost five times as likely as White people to be the recipients of forced treatment orders. Hispanic people are two and a half times as likely as non-Hispanic White people to be the recipients of forced treatment. People with multiple psychiatric hospitalizations, but no histories of hurting others, are the primary recipients of IOC orders.

Costs

- Based on Nevada County's pilot of AB 1421 in 2008, a total of four clients have been under court-ordered treatment; 15 others who met eligibility criteria voluntarily engaged in treatment. There is no evidence that similar results would not have been achieved absent court order or threat of court order. Cost estimate per person: \$40,000.
 - Results since the 2008 implementation: Only 2 of 4 maintained housing
 - Only 2 of 4 maintained contact with treatment system
 - Social functioning remained poor
 - One hospitalized for 10 months following court order (despite intensive case management and County motive to avoid hospitalization)
 - None engaged in employment services or competitive employment
 - Clients dissatisfied with services

Benefits of Voluntary Treatment

- Arrests dropped by 45%, and the use of emergency services were reduced by 67% and employment increased by 25% as compared to those receiving usual care. (Nicholas C. Pretris Center, "Evidence on the Effectiveness of Full Services Partnership Programs in California's Public Mental Health System" (May 2010).)
- People with psychiatric disabilities are competent to make decisions about their treatment, and often make full recoveries when they have control over the choices in their recovery.

Why California Communities Don't Want "Laura's Law"

By Eduardo Vega, MA

Mr. Vega is Executive Director of the Mental Health Association of San Francisco and Director of the International Center for Dignity, Recovery and Empowerment.ⁱ

Created and passed by the California state legislature as AB1421 over ten years ago, "Laura's Law" has been a subject of significant attention in communities across California in recent years, as its proponents have sought to create support for its implementation at the county level. The controversial AB1421 process for involuntary outpatient commitment (IOC) has not been widely supported by mental health providers, professionals or advocates; and after ten years, in spite of pressure from a small group of advocates and even significant editorial support in local news media, only one very small, politically conservative county has fully implemented it.

Our democracy is based on communities coming together to decide on difficult issues together. As in this case, communities' mental health systems and issues, often need to be served by an open discursive process. Whatever transpires in local discussions and decision-making the controversial issues of involuntary outpatient commitment in California need to be informed by educated and balanced public discourse.

Almost nowhere, however, has there been a thorough discussion of the problems with the AB1421 program that would clarify for the general public why so many of those Californians who usually only advocate in support of new mental health services are so steadfastly opposed to AB1421. This article is an attempt to rectify that, to provide an overview of those area of concern so that Californians can make good decisions, to create balance against the Laura's Law (1421) and other forced treatment advocates, and to provide essential content understanding so that those who seek solutions based for people in their community living with mental health conditions are able to serve their cause well.

AB1421 has some strong supporters among some individual family members, some but not all local California NAMI chapters, and the right-wing national Treatment Advocacy Center (TAC), which focuses its advocacy on promotion of coercive approaches to people with mental illness generally and forced treatment in particular. On the national level, Mental Health America, the Bazelon Center for Mental Health Law, and the National Disability Rights Network, are among those are strongly opposed to institution of involuntary outpatient programs on effectiveness, ethical and human rights grounds.

Less known is that the Mental Health Association of California, Disability Rights California, the California Council for Community Mental Health Agencies (CCCMHA), the California Psychological Association, California Association of Mental Health Peer-Run Organizations (CAMHPRO), California Association of Social Rehabilitation Agencies (CASRA), California Association of Patient Rights Advocates (CAMHPRA) and related stakeholder organizations in local communities have opposed the advancement of AB1421 "Laura's Law" programs, including positions against the 2012

AB1569 bill which extended its initial sunset period. Taken together this group represents a significant majority of all of the California's mental health service providers, mental health and human rights advocates.

The California public remains confused about this issue, because there has not been comprehensive or balanced coverage or an understanding of its implications outside the mental health community. Given California is a generally liberal and progressive state in regards to mental health, Californians have supported legislative and ballot initiatives such as Proposition 63, the Mental Health Services Act (the MHSA) to provide more mental health resources, with some consistency over the years.ⁱⁱ When local professionals, MHA organizations, consumer groups and other mental health stakeholders, come together to counter a push for 1421, community members are often very surprised — as these communities would usually only ever advocate *for* rather than against mental health services.

California's public officials, troubled family members, individuals and lawmakers have also been disserved by advocates of 1421, as the issue has been represented to them as a common-sense community service option, a 'no-brainer' that should be an easy sell at the local Board of Supervisors which is required by statute to authorize implementation in a given county. In some communities, major local news media has been suborned, by TAC and others, into the same agenda, and pushed with strong editorial stances, sustained attacks on public officials and distinctively unbalancing framing of the content and focus in their coverage as well. In one disturbing turn, the brutal beating death of a mental health client in Orange County by police, was used as an argument for this forced treatment approach—notwithstanding the fact, that, as someone already engaged with OC services, he would not have qualified for a 1421 court order.

Despite all this, Laura's Law has not been fully implemented in California, it has not proved value for California, and it has not created results that merit its extension. What has resulted instead is tension, anger, struggles between those who should be allies, stigmatization, personal and political attacks on consumer advocates and progressive mental health service organizations, divisiveness and destructive wrangling at the level of local government. In turn, this has led to conflict between mental health providers and advocates, public mental health agencies and county administrations, and, worst of all, the deepening of mistrust between people with mental health conditions, mental health consumer and patient advocates and service providers, and those family advocates convinced by the forced treatment lobby that passage of 1421 in their county is a laudable end in itself, that will provide a 'magic bullet' that will make a difference for their disabled, difficult and unengaged family members.

The reasons for the controversy over 1421, the same reasons that drive resistance to its broad implementation, are not well understood. Under-informed, biased and unbalanced treatment of the issue, in particular, lack of legal analysis of its provisions, has had the result that the arguments against 1421 are not being well examined until the requisite deliberative process at local boards of supervisors is underway. This is unfair to both the members of the public and supervisors and other public officials who need good

information in their deliberations. In particular there is little understanding of why the majority of mental health services advocates and providers across the state have opposed rather than supported this program, and why, a decade later, it is still not viewed as good for the treatment or well-being of communities and people affected by serious mental illnesses.

“Laura’s Law” History and Context

Devised after the death of a mental health worker in Nevada County, Laura Wilcox, and based on New York State’s Kendra’s Law, California’s AB1421 statutory language cleared the way in 2002 for involuntary outpatient civil commitment of people with mental illnesses in our state, under a ten year sunset provision. Programs designed under the term of ‘assisted outpatient treatment’ (AOT) could, under the new code, utilize a court order process to compel individuals referred by providers, family members or neighbors to accept the terms of an outpatient treatment plan and comply with its provisions. Failure to comply with the AOT treatment plan, would constitute violation of the Involuntary Outpatient Commitment (IOC) court order, triggering an enforcement protocol requiring individuals to be transported to an appropriate facility for psychiatric evaluation for short-term involuntary commitment to an inpatient ward under California WIC statute known as the Lanterman-Petrus-Short (LPS) Act, sections 5150ⁱⁱⁱ. AB1421 did not provide or mandate funding for either the services of the process involved in these programs and stipulated that, approval for implementation of the program necessitates budgetary findings that it would not reduce or replace funding for voluntary services.

It is important to note that AB1421 statutory language contains two distinct elements: 1) an intensive service treatment plan for Assisted Outpatient Treatment (AOT) based on mental health programs historically called Assertive Community Treatment Teams, and substantially the same as what in California has become known as the Full Service Partnership (FSP) model,^{iv} and 2) a court order process for civil commitment on an outpatient basis (Involuntary Outpatient Commitment or IOC) requiring an individual to comply with that treatment plan or face enforcement actions.

Some family advocates, but not all, anguished and reasonably frustrated by the seeming inability of public health systems to serve their family members, have been convinced by proponents of “forced treatment” that implementation of 1421 is the fix that systems need in order to get people ‘into services’. For these individuals, approval at the local level for 1421 is the goal in itself-- if not a magic bullet, at least some added value by bringing the power of the courts and services/treatment together.

Ten years later, in 2012, only one California county, Nevada County, a community of just under 100,000 people in which the tragedy associated with Laura Wilcox occurred, had implemented “Laura’s Law”.^v The report on Laura’s Law required by the California Department of Mental Health was finally released that year as well and showed a mixture of outcomes for the six (6) people treated under the Nevada county 1421 program.

Despite this exceptionally poor showing for a controversial program, the legislature in 2012 voted, through passage of AB1569, to extend the sunset until 2017. In 2013, Yolo county, through expansion of contracts with the mental health provider serving 1421 clients in Nevada County, became the second county in California to implement 1421.

To clarify then, after twelve years ‘on the books’ in the state with largest population in the nation, over 38 million people, the only county to have implemented the program to the point it could show is Nevada County, with a population of 98,200.^{vi} By accounts in the DMH 2012 report on that program and personal testimony of the mental health director of Nevada County, Michael Haggerty, in fact very few of those individuals ‘threatened’ with Laura’s Law court orders have received them to date.^{vii}

The reasons that emerge against 1421 can be summarized broadly into the following:

- Lack of evidence of efficacy
- Undermining of the treatment relationship/retraumatization
- Processes, not services/ Public agency costs
- Civil Rights and Due Process concerns
- Police/public safety costs, and enforcement concerns
- Racial disparities, discrimination and racial profiling
- Underfunding/replacement of proven community services

Evidence gap/lack of efficacy proofs for Involuntary Outpatient Commitment

To date there has been no substantive evidence that IOC in California has produced significant findings for the court order process provided in Laura’s Law. Outcomes that have been produced by Nevada County, for example, demonstrated only what was already known—that intensive services based on the Full Service Partnership model do work for people. Nevada county and others have represented outcomes from the entirety of their contract FSP programs as evidence of efficacy for clients under the court order -- substantial reductions in hospitalization and incarceration were found for the entire cohort of clients and then disaggregated for AOT clients based on prior years hospitalization etc. However no comparison group condition that would substantiate value for AOT process as opposed to those in the voluntary condition was shown—i.e. no proof was presented that would meet standards of research evidence to support the notion that AOT/IOC committed clients showed better outcomes than those who were not under the court order.^{viii}

Proponents of Laura’s Law point to the extensive Duke University study of Kendra’s law for good quantitative outcomes for reduction of hospitalization and incarceration. The outcomes mislead people however since because what they show is significant benefit for people getting services, which were funded and provided after Kendra’s law was passed,

versus not getting services before, at a time when New York's mental health budget and systems were grossly under-resourced.

Put another way, the Duke study compares apples and oranges, or perhaps apples and apple pie. It does not compare people receiving the same services on voluntary versus an involuntary basis. In fact no evidence has been found in any case that a court order creates values for service outcomes beyond the treatment in and of itself.

As a Rand corporation meta-analysis of outcomes in eight states and existing services research concluded, **"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 corporation, 2001)^{ix}

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."^x

Undermining of the treatment relationship/re-traumatization

Treatment works when it is grounded in trusting relationships. Over decades mental health service recipients and providers' personal experience and the vast preponderance of all treatment services research point to the relationship between the provider and the client 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, personal hope and motivation for recovery are diminished, engagement with services fails and 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.

Perhaps this is the reason that the director of the only agency that provides treatment to Laura's Law clients in Nevada County said definitively that he did not support the expansion of involuntary approach.^{xi}

People in extreme states, including psychosis and acute psychological distress may not appear rational in many ways. But one of the things that is often noted by providers, police, medical staff etc. is how so many collect themselves at a hearing or on evaluation in such way as to avoid involuntary inpatient commitment. The thing we service providers know well is that even people experiencing those states, like most of us, are very aware when their freedom is threatened.

Similarly the use of a threat of 5150 and inpatient hospitalization as the enforcement mechanism for non-compliance with a court order carries with it the disturbing connotation that mental health services are a form of punishment. For far too long inpatient hospitalization has been experienced as such by some, and the stigma of this

association diminishes the value that mental health service providers, psychiatrists and others bring to their communities.

When evaluation and treatment are tied to enforcement as the mechanism of coercion, the productive engagement and collaboration that are core to therapeutic alliance is critically undermined. Those of us who have been on either or both sides of psychiatric treatment are deeply aware of how trauma and fear of punishment in the treatment milieu pushes clients away from help and deters many of those in need from connecting to it in any case.

This most significant impact for people exposed to trauma and historically disenfranchised communities such as people of color or gender or sexual minorities is hard to underestimate. For people who have experienced force and trauma in institutional settings, child or domestic abuse, or through interaction with street violence, law enforcement or others, and those exposed to the impacts historical trauma including racism and genocide, including many people with psychiatric disabilities, the recapitulation of such trauma can breach the possibility of any positive engagement with mental health services forever, leading to long-term despair, homelessness and incarceration. That is the *very real possibility exists that coercion in the context of mental health treatment in fact, by virtue fostering fear and augmenting trauma, leads to more of the precise problems AB1421 and IOC in general would propose to reduce.*

Processes, not services; public agency costs

Like most Californians, mental health advocates and providers do not believe that new bureaucratic processes are the same as new solutions. Certainly few providers or advocates believe that simply putting someone before judge represents treatment for people with serious mental health conditions.

AB1421 mandates a process that compels the court system to work with the mental health system to get people into services against their will, in the hopes that this process in itself will make a difference. 1421 language in statute identifies a range of intensive mental health services to be provided as “assisted outpatient treatment” (AOT). These services for this same population already exist throughout California, principally funded by the Mental Health Services Act (MHSA). 1421 does not provide for or identify new funding or new structures for funding the services it mandates. What it does create is a new process for compelling people to receive them, *even if those are same services have not worked for them before.*

Mental health services funding, including MHSA dollars, cannot pay for the court order process, attorney/patient rights advocate or the police, sheriff or marshals involved in due process, detainment, transportation, or other costs incurred through enforcement of 1421 when individuals do not comply. In addition the actual process for outpatient civil commitment, the many new processes and procedures across an integral array of agencies

represent significant time and resources lost to red tape. The actual costs of developing and maintaining a new complex internal process in a large county, for example, including new government positions or redirection of staff from other county agencies, has not been adequately accounted or projected for.

In related system costs, enforcement of the court order requires public safety/police or ambulance transportation to designated facilities when clients of Laura's Law program are found in violation. In rural communities transportation time can be hours in itself. These facilities, often impacted by urgent evaluation needs, need to expand psychiatry, nursing and other high cost services to respond to increased demands for evaluation. Pressures on hospital emergency departments and costs increases there are to be expected as well, as these serve in most California jurisdictions as the principle access point for 5150 evaluation.

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.

1421 lowers the bar for abridging civil rights and self-determination, 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', as happens with frightening frequency in jurisdictions across the country.

All Americans with psychiatric disabilities are entitled to protections of their civil rights under the Americans with Disabilities Act and the federal 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.

Police/public safety costs, and enforcement concerns

AB1421 civil commitment is a court ordered process, meaning that law enforcement must serve individuals with summons, warrants and other due process notifications. Public safety must be involved then, at the outset of the process and as enforcers. Additionally new due process protections and the need for expansion of patient advocates, public defenders etc. to effect the commitment orders would substantially expand.

Ultimately law enforcement may be required, as in the Nevada county program, to 'bring people in' to LPS designated facilities for psychiatric evaluation if they fail to comply

with the IOC court order. The real burden on the judicial and public safety systems in municipalities is potentially extreme in any community with limited resources there.

Adding detail to public safety officials' workload is a significant concern on the public administration side. Much more concerning however, is the need for police or sheriffs to go to people's residences to arrest and transport them to an LPS designated facility for evaluation for a 5150 involuntary hold and inpatient admission. This enforcement action is the central recourse and presumed compliance mechanism under 1421, *whether or not there is presenting urgency or any reason to suspect the individual is a danger to themselves or others*.

The enforcement action is required if the client does not show up for an appointment, for instance, or misses days at a program. By mandate officers are sent to "bring an individual in" for evaluation, a process that create public shame for the person and their family as well as many hours or required process between public safety, hospital emergency rooms etc. Communities in states where IOC is used have had significant problems with this as well where for instance the police are sent to detain and transport a person who was scheduled, by the service provider itself for an appointment outside a court-ordered time window. (i.e. the enforcement mechanism was triggered and police detailed to enforce it, based on provider errors rather than actual non-compliance).

In high population areas, as well as smaller communities with limited public safety officers, the real costs associated with police or sheriffs serving as transportation could be substantial-- not just in terms of wage hours but in the 'opportunity cost' of loss of time on real public safety issues. As illustrated here- **"The RAND team's research could not provide an answer to the question of whether an involuntary treatment system in California is worth the additional costs to mental health... the courts and law enforcement. Nor are there cost effectiveness studies that compare the relative return on investment ..."**^{xii}

Any incident in which law enforcement are expected to remove people from their locations without their consent involves the possibility of real harm, to the individuals as well as the officers. Although it is feasible that AB1421 'clients' throughout California would always go willingly along with these enforcement actions, it is not reasonable to presume such interactions. Most particularly this is problematic for communities that have been affected by histories of violence, racial profiling or abuse and other concerns related to law enforcement excessive force.

When recently questioned by an Alameda County Supervisor as to whether the enforcement actions that had taken place in Nevada county when a client was removed from his home had resulted in peaceful interactions with the dispatched officers, the Nevada county mental health director could only say "I do not know... I do not know if he went quietly".

Racial disparities, discrimination and racial profiling

In the United States the history of discriminatory practices and disparities in mental health services associated with race is sadly well-documented. People of color have less access to, and poorer quality of care in many health domains. In mental health the impacts of these disparities can be extreme in services as well, where, for instance, African-Americans receive statistically poorer prognosis, diagnosis of more severe conditions, lower quality and more sedating drug prescriptions, and higher levels of long-term institutionalization than Anglo peers. California data reveals similar findings where cultural and ethnic communities are under-served in most mental health settings.

Review of studies on AOT programs have revealed that court orders are placed in discriminatory patterns on people of color. In particular the Duke university survey of Kendra's law showed disturbing disparities relating the use of court order to race and ethnicity, where significantly more African-American and Latino clients received court orders than the prevailing demographics and much more than Anglo-Caucasians in general.

“Outpatient commitment indices for six New York counties and the state show that when considered for the total population, outpatient commitment affects African Americans three to eight times more frequently than it affects whites, about five times more frequently, on average, statewide... Put simply, a black New Yorker chosen at random from the community would have about a five times greater chance of being placed in outpatient commitment than a white New Yorker chosen at random.”^{xiii}

While small homogenous communities may not be affected by such concerns, urban areas that have histories of discrimination, racial tension or historical trauma due to these should be concerned with the subjective nature of AOT commitment. In particular, implicit racism has been shown definitively to result in disparately harsh and lower quality treatment of people of color in both mental health services and the criminal justice system. People of color may perceived as more justifiable targets of court ordered ‘hard’ approaches while others are referred to voluntary approaches. The cultural competence of AOT has never been reviewed.

Underfunded services and supports / Conclusion

Treatment success and recovery for people with serious psychiatric conditions is not easy, it is not simple. What has been shown to work is genuine compassion, trusting relationships that support personal dignity and patient persistent engagement to make those happen. AB1421 programs prescribe an involuntary process that undermines the critical ingredients to treatment success.

In an attempt to shortcut the process “AOT” programs expect law enforcement and court orders to replace the effective engagement that trained mental health specialists provide. Rather than build or create new service programs focused on housing or other need areas that ‘meet people where they are’, ie. ‘carrots’ that are seen as valuable to people with psychiatric conditions, involuntary outpatient commitment brings a stick to bear against people who have been failed by our limited systems and underfunded services.

As mental health professionals across the world will attest, treatment succeeds when it is thoughtfully designed, adequately funded and based on supportive human relationships grounded in trust. This truth is no different for people with the most severe kinds of mental illnesses than any others. The difference we've seen in communities across America over dozens of years of community services is not in the lack of a judge or the legal authority to threaten or mandate treatment, the difference is in the determination, the resources and effort made to positively connect with people in support of their dignity.

California communities know that 'black robes' aren't good public policy and don't constitute good programs— we should do what works and what is shown to help. From the perspective of the many communities, providers and advocates who oppose Laura's Law and AOT in general, what is needed is not more processes— it is more modern services, better community supports and adequate funding. A genuine public will to do what it takes to eradicate disparities that unduly impact underserved minorities, reduce social determinants of mental illness such as trauma, develop and resource truly effective outreach and housing programs, and to finally address the systematic and historic underfunding of mental health services, will make a difference for people with mental illness and their families. Laura's Law will not.

- ⁱ A former CA Mental Health Services Oversight and Accountability Commissioner, Mr. Vega has worked in mental health community, inpatient, crisis, residential, homeless psychiatric outreach, intensive outpatient services, research and county mental health programs in five states over 25 years. He has been recognized by the United States Senate, the federal Substance Abuse and Mental Health Services Administration, the State of California and others for work in service of underserved communities, mental health disparities reduction and suicide prevention.
- ⁱⁱ Prior to passage of the MHSA, however, per capita public mental health spending was low in California.
- ⁱⁱⁱ Important to note that the LPS Act was established as one of the nation's first procedural codes for involuntary commitment to ensure due process, rights protections for individuals and eradication of the misuse of psychiatric commitment.
- ^{iv} As implemented in Nevada county, the only county to implement AB1421, FSP is the service model for "Laura's Law" patients who are treated through the same FSP provider of to non-committed clients. This provider (Turning Point) has shown equivalent outcomes and does not support the involuntary commitment process as effective prevention strategy. (MHSOAC, November 2013, Testimony of John Buck, Executive Director of Turning Point)
- ^v By contrast, implementation of California's AB34 and 2034 programs, focused on people with homelessness and mental health conditions, were adopted by dozens of counties within four years of their creation, and set new standards for successful mental health services nationally.
- ^{vi} http://www.california-demographics.com/counties_by_population (US Census Bureau statistics 2010)
- ^{vii} Data presented at Alameda County also confirmed that positive outcomes recently presented in association with the 1421 program there, in several jurisdictions across the state, are in fact aggregated with the entire cohort of the clients of that counties' Full-Service Partnership Program. That is, the involuntary AB1421 'clients' number only a small portion of the pool of recipients of the services -- positive outcome findings as a result can only be attributed to the FSP treatment program, based on a voluntary model, rather than the IOC court order process. This lack of evidence for IOC in itself recapitulates research later herein.
- ^{viii} *Laura's Law in Nevada County A Model for Action Saving Money and Lives; 2011-2012 Nevada County Grand Jury*
downloaded from <http://www.nevadacountycourts.com/documents/gjreports/1112-HEV-AB1421LaurasLaw.pdf>
- ^{ix} *The Effectiveness of Involuntary Outpatient Treatment*, 2001, RAND corporation. Downloaded from http://www.rand.org/content/dam/rand/pubs/monograph_reports/2007/MR1340.pdf
- ^x Burns T, Rugkåsa J, Molodynski A, et. al, *Community treatment orders for patients with psychosis (OCTET): a randomized controlled trial, Lancet* 381:1627-33, 2013.
- ^{xi} MHSOAC, November 2013. Op cit.
- ^{xii} Rand, 2001
- ^{xiii} *Racial Disparities In Involuntary Outpatient Commitment: Are They Real?* Jeffrey Swanson, Marvin Swartz, Richard A. Van Dorn, John Monahan, Thomas G. McGuire, Henry J. Steadman and Pamela Clark Robbins . *Health Aff* May/June 2009 vol. 28 no. 3 816-826



CAMHPRO Public Policy Statement on Involuntary Outpatient Commitment

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".ⁱ 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".ⁱⁱ 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.ⁱⁱⁱ

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.^{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 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

The greatly expanded role for the judicial and criminal justice systems to implement outpatient commitment entails excessive costs that cannot be covered by MHSF 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.”^{xi}

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 MHSF 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.^{xii} 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.^{xiii} 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.”

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.

ⁱ 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.

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

ⁱⁱⁱ 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.

^{iv} 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.”

^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., 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.

^{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} From paper by Harvey Rosenthal, Executive Director, NYAPRS .

^{xii} 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

^{xiii} 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

CPAW Meeting Calendar

August 2014

Sun	Mon	Tue	Wed	Thu	Fri	Sat
3	4	5	6	7 CPAW: 3-6pm 2425 Bisso Ln, 1st Flr Conference Room, Concord	1	2
10	11	12 Social Inclusion: 10am-12pm 2425 Bisso Ln, Concord <i>0XL</i>	13	14 Children's: 12-1:30pm— 1340 Arnold Dr, Ste 200, Martinez	15	16
17	18 Membership: 3-5pm 1340 Arnold Dr, Ste 200, Martinez	19	20 Housing: 9-10:30am 1340 Arnold Dr, Ste 112, Martinez	21 Steering: 3-5pm 2425 Bisso Ln, 1st Flr, Conference Room, Concord	22	23
24	25 Innovation: 2-4pm 1350 Arnold Dr Ste 103, Martinez	26	27 Aging and Older Adult 2-3:30pm 2425 Bisso Ln, Ste 100, Concord	28	29	30
31						