



Mental Health Commission

INFORMATION CALENDAR

November 28, 2006

To: Honorable Mayor and  
Members of the City Council

From: Mental Health Commission

Submitted by: Carol Patterson, Secretary, Mental Health Commission

Subject: Assisted Outpatient Mental Health Treatment

INTRODUCTION

On September 29, 2006, AB 2357 was chaptered in State law and will extend the Assisted Outpatient Mental Health Treatment Demonstration Project Act of 2002 to January 1, 2013. Assisted Outpatient Mental Health Treatment or Involuntary Outpatient Commitment (IOC) has not been implemented in any California Mental Health system, and has not been proven to be more effective than the provision of voluntary services. Voluntary services, which are the basis of Berkeley Mental Health's evidence-based services, could be undermined by the introduction of Assisted Outpatient Mental Health Treatment.

CURRENT SITUATION AND ITS EFFECTS

The Lanterman-Petris-Short Act provides for involuntary treatment in a hospital setting of persons who are gravely disabled, a danger to themselves or to others. Berkeley residents requiring involuntary treatment are referred by Berkeley Police or Mental Health staff, under Welfare and Institutions Code 5150, to Alameda County Behavioral Health Care Services. Involuntary treatment is a last resort intervention. Rather than relying on involuntary treatment to engage persons with psychiatric disabilities in mental health treatment, the City of Berkeley offers a range of voluntary services including Homeless Outreach, Case Management and Assertive Community Treatment. It is generally held to be true that in the long run, these voluntary services are much more effective in engaging clients in recovery.

BACKGROUND

Past efforts to legislate Assisted Outpatient Mental Health Treatment (AB 1028 and AB 1800), a form of involuntary commitment, have failed. Assisted Outpatient Mental Health Treatment, as defined in AB 1421, was passed by the State Legislature in 2002 but has a sunset clause of January 1, 2008. AB 2357, which will extend the sunset until January 1, 2013, recently passed the State Legislature and has been signed by Governor Schwarzenegger.

According to the Bill Analysis written by Rosielyn Pulmano, Assembly Health Committee, “Laura’s Law [AB 1421], permits counties to provide court-ordered outpatient treatment services for people with serious mental illness when a court finds that a person’s recent history of hospitalizations or violent behavior, coupled with noncompliance with voluntary treatment, indicate the person is likely to become dangerous or gravely disabled without the court-ordered outpatient treatment. AB 1421 allows a request for the filing of a petition for an IOC order to be made to the county mental health department by an adult living with the person who is the subject of the petition, the parent, spouse, sibling, or adult child of that person, or specified mental health and law enforcement personnel.”

To date, no counties have implemented AB 1421. The law requires that the IOC petition be filed only if the same array of services is offered on a voluntary basis as is available under the commitment, and the person declines voluntary services. While Los Angeles County claims to be implementing IOC under AB 1421, it has actually only been used to treat a handful of people with mental disabilities who have been charged with misdemeanors, been found incompetent to stand trial, hospitalized, and are now on their way to restoration of competency.

Voluntary enhanced services are the answer to the mental suffering that troubles many of Berkeley’s residents, not the expansion of forced treatment. Before resorting to the extreme measure of denying the rights of a whole group of persons, we need to first try voluntary services. Deinstitutionalization did not fail; it was never completed. People with mental disabilities were never offered the full array of voluntary community mental health services they were promised, including medications, housing, job and benefits assistance, outreach teams and alternative support for people in crisis, and client-run and self-help services, such as peer counseling.

A recent 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. The increase of people with mental disabilities in our jails and among our homeless on the streets is a failure of a system to provide access to voluntary community services of the kind clients want and need. It is not a failure – a defect – of the individuals.

“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.” California has moved in the direction of making adequate services readily available to people with mental disabilities with AB 34, AB 2034, and the Mental Health Services Act; the City of Berkeley is building on these initiatives to expand services for the highest risk individuals. The Surgeon General’s Report further states, “Almost all agree that coercion should not be a substitute for effective care that is sought voluntarily”.

Expansion of involuntary treatment has been suggested as a remedy for “treatment noncompliance.” In fact, researchers have found that involuntary or forced treatment often causes 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. Moreover, coercion seriously undermines the therapeutic relationship between a client and his/her therapist.

The rationale supporting the expansion of involuntary treatment is flawed because it is based on a set of myths about serious mental disability.

**Myth #1: People with mental disabilities are violent.**

Studies indicate that people diagnosed with major mental illnesses account for a very small percentage of the violence in American society. For example, the MacArthur Violence Risk Assessment Study found that “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.” The Surgeon General’s Report substantiates this. “...to put this all in perspective, the overall contribution of mental disorders to the total level of violence in society is exceptionally small”. Yet proponents of the expansion of involuntary treatment have purposely conducted a campaign to link mental illness with violence, so as to encourage public stereotypes that people with psychiatric disabilities are dangerous, exploiting public fears of crime, and promoting involuntary treatment as a public safety measure.

**Myth #2: People with mental disabilities lack capacity to make decisions and have no insight into their condition.**

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.” In the Surgeon General’s words, “Typically, people retain their personality and, in most cases, their ability to take responsibility for themselves.” Nevertheless, to advance their agenda, proponents of the expansion of involuntary treatment liken mental disabilities to Alzheimer’s or a stroke and assert that persons with mental disabilities are incapable of making decisions and have no insight into their condition. Avoiding treatment because of the experience of a system that is coercive, harmful or/and simply ineffective is not lack of insight.

**Myth #3: There are new wonder drugs that always work and provide safe treatment for people diagnosed with mental illness.**

Studies indicate that, “at best, drug treatment provides significant help in only about 50 % of schizophrenic patients...at least, 30 – 40 % of manic-depressives are not helped sufficiently by lithium or by any of the mood stabilizers ...” (Elliot Valenstein, Ph.D., Blaming the Brain) Psychiatric medications are powerful and can have serious, sometimes life threatening side effects. Adverse effects of anti-psychotic medications, such as extreme weight gain, zombie-like feeling, unending restlessness and tremors are common. Tardive Dyskinesia, irreversible neurological damage including twitches of the face, arms and tongue, is a potential permanent and untreatable side effect of the older, still commonly prescribed anti-psychotic drugs. These effects are well known and a major reason why many consumers choose to avoid them. Moreover, new brain imaging research indicates there are harmful effects to the brain itself from the newer “miracle” and older drugs.

**Fact:** *Choice is Essential for Recovery.* Choice is so important a concept to human kind and human dignity, that medical interventions, with only the exception of psychiatric, are soundly based on choice, including extensive consent policies and procedures. Informed choice about treatment and control over one's own individualized path to health, is necessary for recovery. Treatment and civil rights are not antithetical to each other; in fact, good treatment can only occur in an atmosphere of choice and freedom.

Current law offers significant control over people judged to be a danger to themselves or others or gravely disabled due to a mental disorder. Under the current law, in 1998 in Los Angeles County alone 43,000 people were involuntarily committed to 72 hour holds; 20,000 were held involuntarily for an additional fourteen days. This represents an overall increase in forced treatment over previous years. Civil commitment is not only being done throughout the state, but is steadily increasing. The mental health community, in forums held throughout the state, did identify inconsistent and uneven application of the current law across counties as a major problem.

In a state that avows client empowerment, a client driven system, and client inclusion in decision-making, the fact that clients of the state overwhelmingly oppose increasing forced treatment is in itself a powerful reason to oppose it. The people, for whom this approach intends to help, oppose it.

The City of Berkeley provides cutting edge mental health services that are voluntary and promote client choice. To include the use of IOC could undermine the successful, voluntary engagement of new clients into treatment and their subsequent recovery.

At its October 12, 2006 meeting, the Mental Health Commission approved the following motion:

**M/S/C** (*Wilson, Taggart*) to submit the revised information report to the City Council regarding IOC. **Ayes:** Unanimous; **Absent:** Gresher.

#### POSSIBLE FUTURE ACTION

Should any local efforts to implement IOC under AB 2357 occur, we will recommend that the Berkeley City Council oppose that implementation and continue to support voluntary community based mental health services.

#### FISCAL IMPACTS OF POSSIBLE FUTURE ACTION

None.

#### CONTACT PERSON

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Carol Patterson, Mental Health Commission Secretary, Health and Human Services, 981-5217

Attachments:

1: References

**Attachment 1: References**

- ◇ Final report. Research Study of the New York City Involuntary Outpatient Commitment Pilot Project. Policy Research Associates, Inc. December 4, 1998.
- ◇ 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.
- ◇ 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.
- ◇ Steadman, Henry, et al. Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods. Archives General Psychiatry, 1998; 55:393-401.
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- ◇ The Lancet. Sept.5, 1998 v352n9130p784(1).
- ◇ Gur, Raquel E., et al. Subcortical MRI Volumes in Neuroleptic-Naïve and Treated Patients with Schizophrenia. Am J Psychiatry 155:1711-1717, December 1998.
- ◇ Summary Report on the LPS Dialogue Project Local Forums, prepared by Laura Mancuso, January 2000.
- ◇ Position on Involuntary Outpatient Commitment/ Expanding Forced Treatment, The California Network of Mental Health Clients

