Assisted Outpatient Treatment Comes to California—or Does It?

Paul B. Herbert, MD, JD, Laura L. Downs, MD, and Kathryn A. Young, JD

J Am Acad Psychiatry Law 31:249–54, 2003

After five years of legislative tussling, California has passed a law, written by Assemblywoman Helen Thomson (a former psychiatric nurse), that purports to provide for court-ordered (involuntary) outpatient treatment for certain persons with mental illness. The law, which went into effect January 1, 2003, is alternatively titled Laura's Law and The Assisted Outpatient Treatment Demonstration Project Act of 2002.[1]

Laura Wilcox, a 19-year-old county mental health worker in California, was shot to death by a chronically mentally ill man who had refused treatment.[2] The California law is modeled on New York's Kendra's Law,[3] enacted in 1999 out of the furor over the nationally publicized tragedy of 32-year-old Kendra Webdale, who was pushed in front of a subway train and killed by a psychotic individual who had been chronically noncompliant with treatment in the intervals between his numerous involuntary hospitalizations.

Assisted Outpatient Treatment

Deinstitutionalization in the 1960s and 1970s traded secure state hospital confinement for much less restrictive community-based treatment for hundreds of thousands of mentally ill persons nationwide. In California alone, the population of the state psychiatric hospitals plummeted from over 30,000 to today's level of approximately 800 (plus roughly 3,000 forensic patients: insanity acquittees and persons found not competent to stand trial).[4]

Insufficient community resources, however, have made it difficult for individuals to receive needed psychiatric care and ancillary services. The problem is compounded by the inability, or unwillingness, of many chronically ill patients to engage in the treatments that are available. Although these individuals may do well in a hospital, they relapse rapidly after discharge, leading to the revolving door of repeated brief hospitalizations (see Ref. 5, for example). This combination of factors has been responsible for the growing population of chronically ill patients who are particularly visible in large urban centers.

Assisted outpatient treatment (AOT), also known as mandated outpatient treatment or outpatient commitment, programs are designed to reach those persons with serious mental illness who are in need of mental health treatment, but are not quite committable. AOT provides an individualized treatment plan for each patient, usually with an intensive case manager as its centerpiece, and procedures to monitor compliance. A hearing is held before a judge who ultimately determines, based on the evidence presented, whether court-ordered treatment is warranted. The goal is to prevent patients from deteriorating to the point of meeting involuntary inpatient commitment standards and thereby to cut down on both hospitalizations and potentially dangerous acts by a noncompliant individual.

With the recent addition of California, 41 states and the District of Columbia now have statutes authorizing AOT,[6] although actual implementation varies widely. (The nine states without AOT laws are Connecticut, Florida, Maine, Maryland, Massachusetts, Nevada, New Jersey, New Mexico, and Tennessee.[6])

Dr. Herbert is Assistant Professor of Clinical Psychiatry, University of Southern California, Los Angeles, CA. Dr. Downs is Assistant Clinical Professor of Psychiatry, Columbia University, and an attending psychiatrist in the Kendra's Law Clinic for Kings and Richmond Counties (Brooklyn and Staten Island), New York, NY. Ms. Young is an attorney in Los Angeles, CA. Address correspondence to: Paul B. Herbert, MD, JD, Department of Psychiatry and the Behavioral Sciences, Keck USC School of Medicine, 2020 Zonal Avenue, Los Angeles, CA 90033. E-mail: paul@mfire.com

Lanterman-Petris-Short Act

Involuntary psychiatric admission under California's Lanterman-Petris-Short Act, passed in 1967, requires a police or licensed mental health worker's affidavit detailing why the patient is deemed, in the formulation familiar across most of the country, to suffer from a mental disorder that renders him or her currently an imminent danger to self or others, or gravely disabled ("unable to provide for his or her basic personal needs for food, clothing and shelter").[7]

Hospitalization against the patient's will beyond the initial 72-hour detention for evaluation and treatment requires a showing in court that the criteria justifying admission continue to be met. If so, the court will certify the patient for intensive treatment for an additional 14 days.[8]

If the court finds that the person is suicidal (dangerous to self) at the end of the 14-day certification, the certification can be renewed once, for a total of 31 days (the 72-hour detention plus the two 14-day certifications).[9] If the court finds that the person is homicidal (dangerous to others) at the end of the 14-day certification, based on evidence of recent threats or attempted or actual infliction of harm, an additional (renewable) 180-day confinement may be imposed.[10] If the person is gravely disabled (but not dangerous to self or others) at the end of the initial 14-day certification, and "remains unwilling or unable to accept treatment voluntarily," he or she may be certified for an "additional. . .30 days of intensive treatment."[11] Further hospitalization for persisting grave disability is pursuant to conservatorship[12]: first, a temporary 30-day order,[13] which is ordinarily sought during the 14-day certification,[14] and then, if justified, renewable one-year orders.[15]

California's framework for involuntary hospitalization is echoed in general terms in most jurisdictions, largely by dint of *O'Connor v. Donaldson*,[16] in which the U.S. Supreme Court for the first time applied Due Process principles to involuntary hospitalization. There are important variations. For example, in some states, such as Connecticut, the judicial standard for extension of the initial 72-hour detention is the legalistic inquiry of whether the criteria were met "at the time of the admission and at the time of the hearing"[17] rather than California's more practical standard of whether the criteria are met simply at the time of the hearing.[18]

What all involuntary hospitalization schemes lack is a mechanism for involuntary outpatient treatment, essentially for those with chronic psychiatric disorders who, due to a pattern of noncompliance with available care, either hover persistently around the threshold for commitment or repeatedly plunge below it. This problem seemingly was overlooked when the architects of deinstitutionalization imagined abundant and readily accessible outpatient psychiatric and ancillary services, with severely mentally ill persons nonetheless universally eager and possessed of the savvy to navigate the patchwork of delivery systems.

A recent Rand Corporation study revealed that, although no precise totals are available, there are probably over 200,000 adult involuntary psychiatric admissions in California each year[19]—about 600 per day. Of a large sample studied, well over one-third had at least one previous such admission within the past 12 months (Ref. 19, p 93) and at least 38 percent "had no outpatient service use in the 12 months prior to their commitment" (Ref. 19, p 94).

Plainly, such a mental health system is unkind as well as grossly inefficient. Many who are shuffled through the revolving door of repeated psychiatric admissions lead needlessly bleak and often dangerous existences. Others in need of finite public health resources suffer too by virtue of the fiscal waste inherent in overuse of costly inpatient admissions and underuse of outpatient care.

Indeed, there is a sinister feedback loop. Hospital stays are often too short to achieve real stabilization, because of shrinking resources and the pressure of increasing numbers of admissions. Yet the truncated stays themselves elevate the rehospitalization rate, further stretching resources and militating even shorter (hence more frequent) stays.

Individual Autonomy and the Social Contract

Compulsory outpatient treatment laws are designed to fill a manifest need, but the element of coercion is hotly controversial: "[i]nvoluntary treatment. . .has been the most consistently debated issue in mental health law for the last thirty years" (Ref. 19, p xiv). This leads to compromise that satisfies hardly anyone.

The euphemism "assisted" outpatient treatment is not inapposite, since these laws tend not to be truly compulsory, as enforcement is ultimately largely

toothless, and the court order assists more than compels, in that it gives strong imprimatur, in many cases, to the treatment team's outreach to a recalcitrant patient but does not, and cannot, directly compel compliance with outpatient care.

The experience of many who work in the AOT field has been that judicial orders do not so much override nonconsent as coax consent, and that realization was clearly an animating idea behind the California legislation. The committee report[20] cites a recent law review article positing that the intercession of a judge, as a neutral authority figure, often catalyzes long-overdue compliance with treatment, as, "[l]ike most Americans, most persons with mental disorders are law-abiding."[21]

In an AOT order, the judge not only directs the patient to comply with care but also mandates that the mental health agency provide it. The close monitoring thus incumbent on the provider agency is perhaps the best chance a patient has of building on the modest and tenuous progress a typically brief hospitalization produces. Further, a court order generates more intensive efforts to draw a wayward patient back into care, especially through better communication among providers and more assertive attempts to arrange family meetings. AOT patients thus do not so easily drift away. Indeed, New York's Kendra's Law even stipulates that missing patients be sought after by a sheriff's team. Finally, deterioration can be detected earlier, so that a restabilizing hospitalization (voluntary or, if the criteria are met, involuntary) is likely to be shorter, which is better for the patient and more rational fiscally.

AOT laws constitute one of the many intersections of law and psychiatry where the gears do not mesh smoothly because fundamentally conflicting visions of human welfare, both as a matter of social policy and in any actual case, are papered over by legislative compromise. What is free will, and are we nearer the community we should be when rights are tempered by compassion or, rather, when the collective conscience (and convenience) yields to individual liberty?

The psychiatrist sees a patient whose life is a dangerous and undignified shambles, wasted human potential, and needless suffering, that probably could be dramatically improved, simply and painlessly, with medication, counseling, and assistance with housing, socialization and job skills. However, the patient's very illness—and its complications of despair, impaired insight, paranoia, a psychotogenic social matrix, and often the profound neuropsychiatric derangement wrought by chronic substance abuse—incapacitates him or her from making a rational and stable choice to accept available help. Common sense and professional imperative command that help be given, if necessary by cajoling "voluntary" acceptance of a treatment plan in lieu of going to court. Many times, this works.

However, the patient's lawyer—all AOT laws provide for appointed counsel—has a different imperative: the zealous defense of the patient's legal rights. It would be entirely proper—some lawyers would say obligatory—to advise the patient that there will be no consequences if he or she fails to show up in court and flouts any court order: there can be no contempt finding based on an AOT order and the patient can be hospitalized only if the standard commitment criteria are met of dangerousness to self or others or grave disability.[22] In some cases the lawyer explains exactly this. Usually, no AOT care ensues for any patient so advised.

This unresolved philosophical chasm is illustrated by the sides taken by some of the over 1,200 lobbyists (professional and *ad hoc*) weighing in on the California legislation. The American Civil Liberties Union (ACLU) was against the law, but ACLU Members for LPS Reform was for it. The California Medical Association and the California Psychiatric Association were for, the California Psychological Association against; The California Association of Marriage and Family Therapists for, the California Chapter of the National Association of Social Workers against; the National Alliance for the Mentally Ill (NAMI) for, the California Association of Mental Health Patients' Rights Advocates against; numerous police organizations for, the California Judicial Council (the judges' lobby) against; the Mayor of San Francisco for, the Bar Association of San Francisco against; and several church organizations for (rendering unto God), but the State Department of Finance against (rendering unto Caesar).

The fundamental conflict over rights versus welfare resulted, in New York, in Kendra's Law being gradually diluted during the legislative process so that, as finally enacted, treatment orders are substantially precatory rather than mandatory. As such, it does considerable good for many patients who are clearly severely ill (and in some cases dangerous), but certainly not as much good as it could.

California went New York one better. Laura's Law not only lacks coercive enforceability (like Kendra's Law), but is unfunded as well, more a statement of good intentions than positive law—a "compromise" necessary to win support of those "in the Legislature [who], siding with some patients' rights activists, had blocked its passage until this year."[4]

The new law is not statewide law at all, but rather an invitation to individual California counties to enact and fund AOT programs themselves if they choose. In the abstract, this would be a wishful proposition. In context, it is far more tenuous than that. Every state except Vermont must by law balance its budget.[23] In this time of protracted fiscal crisis, California, like many other states, is managing to do so only by siphoning large sums away from municipal and county governments, forcing them to cut services.[24]

Counties all over California are slashing already woefully inadequate mental health budgets. Hospitals have closed, personnel have been cut, and services are contracting. The situation continues to worsen, with years of retrenchment ahead.[25–27] The invitation to add a complex and costly new program surely will have limited appeal to already reeling local officials.

The California Approach

In any California county that chooses to establish an AOT program, an adult family member, housemate, licensed mental health worker, or police officer may request of the county mental health department that a petition be filed for any person.[28] The request will then be investigated, including an examination of the person named if he or she cooperates, and a decision made whether to file a petition:

> If the person. . .does not consent [to a psychiatric examination] and the court finds reasonable cause to believe that the allegations in the petition are true, the court may order [the person to be] take[n] into custody [and]. . .transport[ed]. . .to a hospital for examination by a licensed mental health treatment provider as soon as is practicable. Detention. . .may not exceed 72 hours.[29]

The court must conduct a hearing within 5 days (whether or not the person named shows up). The person named has a right to appointed counsel at all stages and a right to appeal any court decision or order.[30] If the person does not attend the court hearing, he or she "may immediately petition the court for a writ of *habeas corpus*." Treatment then "may not commence until the resolution of that petition."[31]

The court may order AOT, for an initial period of six months, if nine separate factors can be proven by clear and convincing evidence, including that:

> The person is suffering from a mental illness. . .the person is unlikely to survive safely in the community without supervision. . .the person's condition is substantially deteriorating [and]. . .[i]n view of the person's treatment history and current behavior, the person is in need of assisted outpatient treatment to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others, as defined in [the involuntary hospitalization statute,] Section 5150.[32]

In addition, the court must find, by clear and convincing evidence, "a history of lack of compliance with treatment" by either: (a) at least two hospitalizations or incarcerations due to mental illness in the past 36 months, "not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition"; or (b) "one or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm toward himself or herself or another within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition."[32]

The original order may be renewed for successive six-month periods upon a showing that the qualifying conditions still obtain.[33] (In New York, the renewal periods are up to one year, following the initial six-month order.) Every 60 days, the treating agency must file an affidavit in court, attesting that the patient "continues to meet the criteria for assisted outpatient treatment," which the patient may challenge, with "[t]he burden of proof . . .on the treating agency."[34] At any time, the patient may file a petition for a writ of *habeas corpus*, requiring the treating agency to justify further mandated treatment.[35]

The act provides that the person named in a petition may waive the hearing and enter into a "settlement agreement,"[36] for up to six months, which has "the same force and effect as an order" following a hearing. "Either party may request that the court modify the treatment plan at any time. . . ."[37] (New York, too, provides for "voluntary compliance agreements" in lieu of contested hearings.)

In California, "[i]nvoluntary medication shall not be allowed absent a separate order"[38] pursuant to a so-called *Riese* hearing.[39] (In New York, the court

may order medication, either self-administered or administered by a named facility, in the AOT order itself.[40]) The problem, a logical and practical as well as legal one, is that medication—the core element of treatment for most patients who meet criteria for AOT—cannot truly be compelled, because parenteral medication will not be administered forcibly absent a psychiatric emergency, and a psychiatric emergency by definition vitiates eligibility for ongoing AOT, which presupposes psychiatric stability.

California's Legislative Ambivalence

As if to deter any county from seriously contemplating an AOT program, Laura's Law mandates, among myriad other complex and virtually punitive requirements, that the program include:

> . . .community-based, mobile, multidisciplinary highly trained mental health teams that use high staff-to-client ratios of no more than 10 clients per team. . . , staff with the cultural background and linguistic skills necessary to remove barriers to mental health services as a result of having limited-English-speaking ability and cultural differences. . . , [p]rovisions for services to meet the needs of persons who are physically disabled [and] to meet the special needs of older adults. . . , [p]rovision for family support and. . .parenting support. . . , [p]rovision for services specifically directed to seriously mentally ill young adults 25 years of age or younger. . . , [s]ervices reflecting the special needs of women from diverse cultural backgrounds. . .and vocational rehabilitation programs that offer job training programs free of gender bias and sensitive to the needs of women. . . , [p]rovision of housing for clients that is immediate, transitional, permanent, or all of these. . . , [and] individual personal services plan[s] [that] ensure that persons subject to assisted outpatient treatment programs receive age, gender, and culturally appropriate services.[41]

"Counties that elect to implement" AOT programs must develop and self-fund, "in consultation with. . .client and family advocacy organizations. . .and other stakeholders," an elaborate "training and education program" for "mental health treatment providers contracting with the participating counties and. . .other individuals, including, but not limited to, mental health professionals, law enforcement officials, and certification hearing officers involved in making treatment and involuntary commitment decisions."[42]

Finally, any participating county must collect and report to the state "on or before May 1 of each year" no less than fourteen categories of "data," including "[t]he days of hospitalization of persons in the program that have been reduced or avoided. . .[and] [s]ubstance abuse by persons in the program."[43]

After all, the law is only a "demonstration project," expiring on January 1, 2008, "unless a later enacted statute. . .deletes or extends that date,"[44] notwithstanding whatever capital investments and personnel commitments in AOT a cash-strapped county may have made in the meantime.

In case all this may sound too inviting to any interested county, the enactment concludes by repealing the laws of economics:

> Any county that provides assisted outpatient treatment services. . .[s]hall offer the same services on a voluntary basis. . . . [T]he county board of supervisors [must make]. . .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 [law]. Compliance with this section shall be monitored by the State. . . .[45]

Lawyers will not be slow to file suits asserting non-AOT patients' equal rights under this provision to "high staff-to-client ratios of no more than 10 clients per team member," "parenting support," "job training programs free of gender bias and sensitive to the needs of women," "housing that is immediate" (currently available for the indigent virtually nowhere in California), and "age, gender, and culturally appropriate services."

The Promise of AOT

In the end, AOT may prove not to be a discrete third alternative, between involuntary confinement and fully elective outpatient care, as it is currently conceptualized. Instead, it may turn out to be an experiment and a draft template for fortifying and honing elective community care.

After all, AOT schemes such as California's and New York's do not permit rehospitalization based solely on noncompliance. For an involuntary evaluation to be ordered, there must be noncompliance plus substantial deterioration. Hospitalization against the patient's will can then occur only if the decompensation has reached the point that the usual criteria of dangerousness or grave disability apply. At bottom, AOT is a good-hearted, and often very helpful, bluff.

It was learned some time ago that, in chemical dependency treatment, an abrupt transition from hospitalization (or residential treatment) to low-intensity outpatient follow-up paves the way for early relapse. Day treatment (partial hospitalization) programs were developed for the purpose of building on the work only begun in the controlled setting.

Patients with chronic mental illness often do not perceive that treatment noncompliance directly produces decompensation. A successful hospitalization can awaken some insight, but it is usually too fragile to survive traditional follow-up. AOT can and often does preserve and build on the small but significant steps made during inpatient treatment, perhaps because it softens the disjunction between inpatient and purely outpatient care.

The Rand study reports:

> We were surprised to find a trend. . .to use outpatient commitment as a discharge-planning mechanism rather than as a community-initiated alternative to hospitalization. Rather than creating a new class of patients for whom the community is the staging ground for commitment, [some] states are using involuntary outpatient treatment at the time of discharge to extend close supervision and monitoring into the community [Ref. 19, p xix].

Laura's Law, like Kendra's Law, could be a halting step in the right direction—if it proves to be a step at all. Or it could prove to be a false salve, prolonging the misery of patients with chronic mental illness and their families—a hollow gesture that, far from introducing real change, freezes the intolerable status quo.

References

1. Cal. Wel. & Inst. C. § 5345(a) (West 2002)
2. Bender E: Law gives Calif. counties commitment authority. Psychiatric News. November 15, 2002, p 12
3. N.Y. Mental Hygiene Law § 9.60 (McKinney 2002)
4. Morain G, Ingram C: Davis signs bill on forced mental care. Los Angeles Times. September 29, 2002, p B8
5. Selzer v. Hogue, 594 N.Y.S.2d 781 (N.Y. App. Div. 1993) (civil commitment of Larry Hogue, "The Wild Man of 96th Street")
6. Treatment Advocacy Center: Standards for assisted treatment: state by state summary. http://www.psychlaws.org/LegalResources/statechart.htm. (accessed May 8, 2003)
7. Cal. Wel. & Inst. C. § 5150 (West 2002)
8. Cal. Wel. & Inst. C. § 5250 (West 2002)
9. Cal. Wel. & Inst. C. § 5260 (West 2002)
10. Cal. Wel. & Inst. C. § 5300 (West 2002)
11. Cal. Wel. & Inst. C. § 5270.15 (West 2002)
12. Cal. Wel. & Inst. C. §§ 5270.35, 5358 (West 2002)
13. Cal. Wel. & Inst. C. § 5352.1 (West 2002)
14. Cal. Wel. & Inst. C. § 5270.55 (West 2002)
15. Cal. Wel. & Inst. C. § 5361 (West 2002)
16. O'Connor v. Donaldson, 422 U.S. 563 (1975)
17. Conn. Gen. Stat. § 17-502(d) (2002) (". . .considering the condition of the respondent at the time of the admission and at the time of the hearing. . .")
18. Cal. Wel. & Inst. C. § 5250 (West 2002) (". . .is. . .")
19. Ridgely MS, Borum R, Petrila J: The effectiveness of involuntary outpatient treatment: empirical evidence and the experience of eight states. Rand Corp, 2001, pp 85 n. 230, 86–7
20. Cal. Sen. Rules Comm. Analysis, Assembly Bill 1421, August 28, 2002
21. Kress K: An argument for assisted outpatient treatment for persons with serious mental illness illustrated with reference to a proposed statute for Iowa. Iowa Law Rev 85:1269,1364, 2000
22. Cal. Wel. & Inst. C. § 5346(f) (West 2002)
23. Brownstein R: State budget crises mount. Los Angeles Times. November 26, 2002, p A1
24. Greenblatt A: Enemies of the state. Governing Magazine. June 2002, pp 26–8 (http://www.governing.com/archive/2002/jun/intergov.text)
25. Bustillo M, Halper E, Helfand D, *et al*: Wrenching changes likely with budget cuts. Los Angeles Times. December 15, 2002, p A1
26. Bernstein S, Halper E: State budget outlook darkens as deficit nears $30 billion. Los Angeles Times. December 18, 2002, p A1
27. Jones G: Davis says tax hikes likely as shortfall soars. Los Angeles Times. December 19, 2002, p A1
28. Cal. Wel. & Inst. C. § 5346(b) (West 2002)
29. Cal. Wel. & Inst. C. § 5346(d)(3) (West 2002)
30. Cal. Wel. & Inst. C. § 5346(c), (d)(4) (West 2002)
31. Cal. Wel. & Inst. C. § 5346(j) (West 2002)
32. Cal. Wel. & Inst. C. § 5346(a) (West 2002)
33. Cal. Wel. & Inst. C. § 5346(g) (West 2002)
34. Cal. Wel. & Inst. C. § 5346(h) (West 2002)
35. Cal. Wel. & Inst. C. § 5346(i) (West 2002)
36. Cal. Wel. & Inst. C. § 5347 (West 2002)
37. Cal. Wel. & Inst. C. § 5347(b)(3) (West 2002)
38. Cal. Wel. & Inst. C. § 5348(c) (West 2002)
39. Riese v. St. Mary's Hosp. and Med. Ctr., 271 Cal. Rptr. 199 (Cal. Ct. App. 1987)
40. N.Y. Mental Hygiene Law § 9.60(j)(4) (McKinney 2002)
41. Cal. Wel. & Inst. C. § 5348 (West 2002)
42. Cal. Wel. & Inst. C. § 5349.1 (West 2002)
43. Cal. Wel. & Inst. C. § 5348(d) (West 2002)
44. Cal. Wel. & Inst. C. § 5349.5 (West 2002)
45. Cal. Wel. & Inst. C. §§ 5348(b), 5349 (West 2002)