

Assembly Bill 1800: Changing Mental Health Law

Summarized by Thomas T. Thomas

The current law governing treatment of brain disabled people—the Lanterman-Petris-Short Act, passed more than 25 years ago to address issues of involuntary treatment—requires amendment to protect patients, their families, and the community. An act now before the California Legislature, Assembly Bill 1800, provides for these necessary amendments. At our March 22 meeting, two speakers discussed AB 1800: **Randall Hagar**, Legislative Chair of NAMI California, and **Yehuda Sherman, MD**, a psychiatrist who recently retired after 31 years with Alameda County Behavioral Health Care.



RANDALL HAGAR

Randall Hagar began by pointing out that California once had the country's first outpatient committal procedure, in 1939. Dubbed the "hospital without walls," its philosophy was that if mental health patients could survive in the community without trouble, they could stay in the community. Then, after development of the first psychotropic medications, the Kennedy Administration in 1963 began offering community treatment incentives for states to de-institutionalize their mental health delivery systems. The Lanterman-Petris-Short Act in 1967 continued this trend by closing the state mental hospitals and was supposed to provide money to support community treatment. At the time, California was spending 4 percent of its gross domestic product on mental health care; today, California spends only 1 percent.



YEHUDA SHERMAN, MD

Lanterman-Petris-Short was intended to correct the abuses of the system—neglectful treatment, indeterminate commitments, and the possible abuse of commitment procedures. However, the pendulum swung too far, in Hagar's opinion, and set too restrictive a standard for commitment, requiring people to pose a grave danger before they could get treatment. The result was rising homelessness and criminality. We now have 20,000 to 30,000 mentally ill people in prison and up to 50,000 on the streets.

Assembly Bill 1800—authored by Assemblywoman Helen Thompson (D-Solano/Yolo Counties), who is a champion of mental health issues—seeks to change the standards. It addresses the needs of the sickest patients with the least access to services. Under current law, the standard for commitment is that the person must be “gravely disabled” (i.e., unable to provide for his or her own food or shelter) or a danger to self or others. “With this standard,” Hagar said, “a person who can lift a garbage can lid to find food or sleep under a bridge can be dismissed as not ‘gravely disabled.’ Such people end up in a revolving door of repeated hospitalizations and criminalizations. AB 1800 is designed to intervene earlier in the process by expanding the ‘gravely disabled’ standard to give more people access to treatment.”

The legislation in its current form, with proposed amendments, would take into account the patient’s history and his or her risk of physical or mental deterioration without treatment. It would reduce repeated hospitalizations and homelessness by offering outpatient commitment. Before the client is released, the hospital, client, and intended care providers would agree to a treatment plan which serves as a contract ratified by a judge. The plan would include all the elements of housing, prescribed medication, freedom from substance abuse, and promised good behavior that would enable the client to remain stable in the community.

In this respect, AB 1800 adopts the Program for Assertive Community Treatment (PACT) which was pioneered in Madison, Wisconsin, 25 years ago and has been adopted by NAMI as the gold standard for patient services. Under AB 1800, case workers would carry a patient load of 1 to 10 clients—a remarkable departure from current practice. The bill allocates \$350 million to support this level of service.

AB 1800 also streamlines the hearing process for commitment. Currently, the patient is exposed to repeated public hearings to establish the 72-hour hold, the administration of medication, the 14-day hold, and so on—a process that in the past has sometimes led to clients being detained but not getting treatment. The new legislation would mandate a single capacity hearing and combine the two 14-day detentions into one 28-day period during which the client can be released at any time he or she is determined to be stable. AB 1800 changes the evidentiary standard for assigning a conservatorship from the criminally based “beyond a reasonable doubt” to the civil basis of “clear and convincing.”

Yehuda Sherman not only worked as a psychiatrist but was also a reserve officer with the Berkeley Police Department; so he has seen the mental health system from both sides of the commitment process.

“For the past 15 years California’s penal code has had involuntary outpatient treatment for two groups of people,” Sherman said, “those who are found not guilty by reason of insanity and those found too ill to stand trial.” These people can be released under supervision with a contract specifying where they can live—usually in a board-and-care facility—that they will take medication, not abuse alcohol or drugs, not be violent or associate with bad influences. “The approach works,” Sherman said, “but only with administrators who believe hospitalization is good and who are willing to put the person back in the hospital if they violate the contract. Too often, administrators believe hospitalization is bad because it costs money. Any law depends on the people working under it.”

Sherman recalled Judge Lionel Wilson, of Alameda County's mental health court. He ran informal proceedings predicated on serving the best interests of the patient. However, Lanterman-Petris-Short recast the hearing process as a battle between lawyers, and the "best interests of the patient" disappeared.

Under the old law, before Lanterman-Petris-Short, a patient was held three days and then could petition for release or be committed to a state hospital. There was no community treatment. And commitment was without a termination date. With Lanterman-Petris-Short, after the 14-day hold the patient can petition for a conservator to be appointed to look after him or her for a period of one year, with powers appropriate to the patient's needs. "In reality," Sherman said, "the conservator signs a piece of paper that says for the patient 'I want to be in the hospital.'" AB 1800 would provide outpatient treatment that is voluntary to the extent that the patient him- or herself can choose to sign for it but involuntary to the extent that he or she must maintain the terms or be re-hospitalized.

Groups opposed to the new legislation include the California Network of Mental Health Clients and others who automatically oppose any form of involuntary commitment.

After their presentations, the speakers took questions from the audience.

Will \$350 million be enough to support the services mandated by AB 1800? Berkeley Mental Health has already started the Assertive Community Treatment program. The variety of services and the caseload numbers are good, but expensive.

AB 1800 does not dictate to the counties how to spend that money. Clearly, the amount will not support the PACT model for every client, which currently runs about \$18,000 per case load. Our hope is to build momentum for mental health issues and spending in an era when California is running a \$9 billion surplus. The law would require that attention be paid to issues of housing, job skills, and so on, depending on the patient's circumstances. It is also possible that the \$350 million would be leveraged with Federal funding.

When is the earliest we can expect AB 1800 to be made law? What are its chances of passing?

Co-authors of the bill with Assemblywoman Helen Thompson are the chairs of the two Assembly committees that will review and recommend it, so the chances are good. The state Senate will watch how the Assembly votes. If it passes this year, AB 1800 would probably be signed in October and become law as of January 1, 2001.