

EXPANDING CALIFORNIA'S COERCED TREATMENT FOR THE MENTALLY ILL: IS THE PROMISE OF CARING TREATMENT IN THE COMMUNITY A LOST HOPE?

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I. INTRODUCTION

A controversy in California's legislature rages over the problem of the mentally ill. Helen Thomson has proposed a bill that promises to streamline the commitment system and bring treatment to those in dire need. The problem of the mentally ill has achieved public attention as the mentally ill's presence on the streets and in prisons has become an increasing concern.¹ Laurie Flynn, executive director of the National Association of the Mentally Ill ("NAMI") notes, "[p]risons and jails have become the mental hospitals of the 1990s."² NAMI reports that at least sixteen percent of all jail and prison inmates suffer from schizophrenia, bipolar disorder, or major depression.³ On any given day, there are roughly 265,000 persons with severe mental illnesses incarcerated in federal and state jails and prisons.⁴ Furthermore, about forty percent of the half-million homeless are mentally ill.⁵

The prevalence of untreated mentally ill on the streets and in prisons has caused clinicians and family members to reevaluate today's mental health policy, which was formulated just over 30 years ago. Today's mental health policy is based on restricting freedom only in the most dire circumstances. Many who seek to reform California's mental health law argue that constraining the government's ability to coerce treatment and

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¹ See, e.g., *New Paths in Mental Care*, L.A. TIMES, Nov. 23, 1999, at B8.

² *Mentally Ill Need More Than Cells: Jails and Prisons Are Ill-Equipped to Help Disturbed Inmates*, THE DAYTON DAILY NEWS, July 18, 1999, at 12B.

³ Nat'l Alliance for the Mentally Ill, *The Criminalization of People with Mental Illness*, at <http://www.nami.org/update/unitedcriminal.html>.

⁴ *Id.*

⁵ Carole Currie, *Mental Health: Who Foots the Bill? North Carolina's Leaders Facing Tough Choices on a System Bordering on Chaos*, ASHEVILLE-CITIZEN TIMES, Apr. 30, 2000, at A11.

involuntarily detain the mentally ill has only forced the mentally ill into the more tragic reality of imprisonment and vagrancy. By nature, mental illness causes the patient to have an aversion to treatment. Thus, these reformers call for expanding California's coerced treatment⁶ of the mentally ill in order to provide for those who lack the capacity to understand their condition and seek help on their own.

A story of violence pervades the public's discussion of the mentally ill and adds fuel to the controversy. Last year, thirty-two-year-old Kendra Webdale was shoved from a New York subway platform into the path of a train.⁷ Andrew Goldstein, the accused murderer, is a man who suffers from paranoid schizophrenia. For many, Goldstein has become a frightening symbol of what can happen when untreated mental illness erupts into random violence. This story of violence prompted the recent passing in New York of a new law. "Kendra's Law," provides for the government's expanded ability to detain the mentally ill and coerce treatment in a hospital facility.⁸

Assemblywoman Helen Thomson has made a proposal in the California legislature that would similarly expand coerced treatment for the mentally ill in California. Thomson's bill⁹ is an amendment to the Lanterman-Petris-Short Act ("LPS")¹⁰ which attempts to address the public's concern about the mentally ill. LPS, the law that governs the involuntary detainment and coerced treatment of the mentally ill, was written 30 years ago when Dorthea Dix's vision of peaceful asylum in hospitals had become tattered.¹¹ LPS was passed because of the deficiencies in the hospitalization-based mental health system.

The passing of LPS was a significant landmark in a process that occurred throughout America known as deinstitutionalization. During deinstitutionalization, psychiatric activists and their allies began to promote new policies designed to provide care and treatment in the community

⁶ "Coerced treatment" is the government provision of mental health services pursuant to or just prior to a court order in a hospital setting. California's involuntary mental health law is embodied in §5000 of the Welfare and Institutions Code.

⁷ Julie Marquis & Dan Morain, *Rights of the Mentally Ill Pitted Against Public, Patient Safety*, L.A. TIMES, Nov. 23, 1999, at A1.

⁸ *Id.*

⁹ A.B. 1800, 1999-2000 S. (Cal. 2000).

¹⁰ CAL. WELF. & INST. CODE § 5008(h) (Deering 2001).

¹¹ 8 L.P.S. REFORM: A NEW VISION FOR MENTAL HEALTH TREATMENT LAWS 22 (Carla Jacobs et al. eds., 1999) [hereinafter LPS REFORM]. Dorthea Dix, noted crusader for the mentally ill, envisioned a system of hospitals that were to be a sanctuary for treatment and recovery. Dix alone was responsible for the founding of thirty-two mental hospitals, and for the enlargement of existing institutions in twenty states. She nearly succeeded in obtaining a federal grant of over twelve million acres of land as a "reservation" for the mentally ill. AM. BAR FOUND., *THE MENTALLY DISABLED AND THE LAW* 8 (2d ed. 1971); John E.B. Meyers, *Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change*, 29 VILL. L. REV. 367, 373 (1984).

rather than in mental asylums. Courts helped the process along by declaring that lenient commitment standards were unconstitutional infringements on the right to liberty. The two tenets of deinstitutionalization were a concern that the mentally ill should not be deprived of their rights and that the community would provide for their mental health care.

Thomson, by proposing A.B. 1800, seeks to address the problems of deinstitutionalization. Deinstitutionalization, the process by which mental hospitals were depopulated throughout the United States, carried a promise of building warm, caring treatment facilities in the community as a replacement for the cold confinement of the state mental hospital. Community treatment facilities were to be built as the state mental institutions depopulated. Thirty years after the depopulation began, the promise of caring treatment in the community has rung hollow.

Thomson's A.B. 1800 seeks to expand the government's ability to provide coerced treatment so the mentally ill who now cannot gain access to treatment will be able to do so. According to Thomson and those who seek to reform LPS, California's commitment process is too adversarial and does not allow patients in need the opportunity to access treatment. Meanwhile, newly developed psychotropic drugs can mitigate the effects of mental disorder more effectively than ever before.

While A.B. 1800 expands the government's ability to coerce treatment, it also represents a return to hospitalization for the mentally ill. It represents a turn away from the goal of LPS which was to rely on hospitalization as a last resort while providing adequate voluntary treatment facilities in the community. If passed, A.B. 1800 would implement a hospital-based treatment paradigm as California's mental health approach.

In this Note I discuss the case for increasing the government's ability to involuntarily commit the mentally ill. I describe the standpoints and arguments presented by both sides to the current controversy over California's proposal to expand coerced treatment and ultimately side with the Psychosocial Rehabilitation model. Part II gives background on the government's authority to commit the mentally ill. Part III introduces the contemporary problem of the mentally ill and discusses the prevalence of the mentally ill on the streets and in prison. Part IV discusses the call for expanding coerced treatment by LPS reformers and points out the failure of the reformers' revised criterion to achieve their stated goals. Part V describes the weaknesses of expanding coerced treatment and implementing the medical model. In Part V the Psychosocial Rehabilitation model elucidates a comprehensive approach to treatment that focuses on the promise of realizing adequate treatment in the community.

II. THE GOVERNMENT'S AUTHORITY TO COMMIT THE MENTALLY ILL: EXPANSION AND CONTRACTION

The government's authority to involuntarily commit the mentally ill has historically been based on two doctrines: the police power and the *parens patriae* authority. The police power is the authority to detain an individual who is a danger to herself or a third party in order to secure the safety of the community.¹² The *parens patriae* power gives the government the authority to act like a parent and care for a citizen who is not able to care for herself.¹³ While the authority to commit has been justified with the use of both doctrines, the U.S. Supreme Court has come to recognize the *parens patriae* authority as the acceptable basis of commitment statutes.¹⁴ An analysis of A.B. 1800, and the movement to expand coerced treatment of the mentally ill, must rely on an examination of *parens patriae* and the lessons history has to offer. Courts and legislatures have deprived the mentally ill of their due process rights in the past by too expansively construing the boundaries of the *parens patriae* power.¹⁵ In response to this abuse of power, Federal and State courts mandated procedural and substantive safeguards under the Due Process Clause to secure the liberty interests of the mentally ill. In the name of providing treatment to those who need it, reformers of LPS seek to compromise these safeguards.

Parens patriae is the government authority to commit incompetent persons who pose a threat to themselves.¹⁶ The authority's genesis can be traced to the power of the English Crown to protect the property interests of its incompetent or insane subjects.¹⁷ Historically, *parens patriae* never sanctioned the confinement or control of the person.¹⁸ Steven Schwartz and Cathy Costanzo explain that "[i]t explicitly was not an expression of any duty to promote the health of, or provide treatment to, disabled persons."¹⁹ Nevertheless, *parens patriae* has been utilized to curtail the liberty of those diagnosed with a mental disorder for the sake of forcing treatment on those society deems in need.²⁰ Thus, a doctrine that originated as a tool to secure property interests, evolved into a rationale to force treatment in hospital

¹² See Steven J. Schwartz & Cathy E. Costanzo, *Compelling Treatment in the Community Distorted Doctrines and Violated Values*, 20 LOY. L.A. L. REV. 1329, 1336 (1987).

¹³ *Id.* at 1337.

¹⁴ See *Addington v. Texas*, 441 U.S. 418, 426 (1979). *Addington* was the first case in which the entire Court validated the *parens patriae* authority as the basis for the government's ability to detain the mentally disabled. The Court's holding in this case represented a gradual shift from validating involuntary confinement due to danger to self from the police to the *parens patriae* power. See also Schwartz & Costanzo, *supra* note 12, at 1344.

¹⁵ See generally Schwartz & Costanzo, *supra* note 12.

¹⁶ See generally *id.*

¹⁷ *Id.* at 1338.

¹⁸ *Id.* at 1339.

¹⁹ *Id.* at 1340.

²⁰ *Id.* at 1341.

settings. The scope of the parental authority expanded to promote the health of, and provide treatment to, disabled persons.

In the early part of this century, this movement to expand the government's authority to commit the mentally ill led to the building of state hospitals. Social reformers, like Dorothea Dix, strove for the recognition of mental illness as a disease that requires treatment and hospitalization.²¹ Although mental health reformers saw confinement as the answer to the previously unaddressed issue of the mentally ill, the government's treatment of the mentally ill was notoriously inadequate and inhumane. State mental hospitals came to be a depository; a place where patients were treated poorly, deteriorated for years, and simply perished.²² In time, what began as a great promise to provide for the needs of the mentally ill evolved into a disgraceful symbol of the nation's failure to care for its mentally ill. Hospitals became warehouses of deserted and physically abused patients, who were crammed into these understaffed, and fetid state institutions.²³

Courts aided the movement towards institutionalization by broadly interpreting the *parens patriae* authority and relaxing commitment standards for those "in need of treatment."²⁴ Treatment was even imposed on those able to make competent decisions for their well being.²⁵ In Schwartz's view, the "benevolent paternalism knew no bounds; the perversion of a protective doctrine continued unabated."²⁶ By 1955 over half a million people were involuntarily committed in state mental hospitals.²⁷ Although the *parens patriae* authority originally was not a mandate to force treatment on those who could benefit from treatment, in time that is exactly what it came to be.

²¹ Meyers, *supra* note 11, at 373.

²² *Id.* at 373.

²³ See, e.g., ALBERT DEUTSCH, *THE SHAME OF THE STATES* (1948). Deutsch's chilling expose details the appalling conditions that he discovered during tours of a number of state mental institutions. The following is typical of what he saw:

As I passed through some of Byberry's wards, I was reminded of the pictures of the Nazi concentration camps. . . . I entered buildings swarming with naked human beings herded like cattle and treated with less concern, pervaded by a fetid odor so heavy, so nauseating, that the stench seemed to have almost a physical existence of its own. I saw hundreds of patients living under leaking roofs, surrounded by molding, decaying walls, and sprawling on rotting floors. . . . I saw dirt and filth in many wards.

Id. at 41-42.

²⁴ See, e.g., *Hammon v. Hill*, 228 F. 999 (W.D. Pa. 1915); *Mayock v. Martin*, 2456 A.2d 574 (Conn. 1968); *In re Brown*, 44 P.2d 304 (Idaho 1968).

²⁵ For an interesting fictional critique of the government's commitment standards see KEN KESEY, *ONE FLEW OVER THE CUCKOO'S NEST* (1999).

²⁶ Schwartz & Costanzo, *supra* note 12, at 1341.

²⁷ Barry Meier, *Experiment of Privatized Mental Hospitals Shows Benefits*, N.Y. TIMES, Dec. 28, 1999, at A16.

Leaders, activists, and courts eventually struck back against the expansion of the *parens patriae* authority and the “massive curtailment of liberty” it presented.²⁸ In a process that came to be known as deinstitutionalization, the mentally ill would be released from involuntary hospitalization with the plan that there would be community treatment facilities to provide for their needs. President John F. Kennedy’s statement that “[t]he time has come for a bold new approach” underscored the calling for reform of America’s mental health care system.²⁹ The advent of antipsychotic³⁰ and antidepressant medications that significantly alleviated psychiatric symptoms led psychiatrists and policymakers to conclude that severe mental illness could now be treated outside of state institutions.³¹ Under the Kennedy administration, Congress passed the Community Mental Health Centers Construction Act³² to supply federal funds for a system of community-based mental health services. The Kennedy administration hoped that Community Mental Health Centers (“CMHCs”) would eventually supplant state mental hospitals, allowing “the cold mercy of custodial isolation” to be replaced with the “open warmth” of care in the community.³³ Hospitalization, which had become a euphemism for a lifetime of neglect in custodial confinement, came under criticism for its ineffectiveness and cruelty.³⁴

Courts stepped into the fray by imposing due process requirements on commitment standards and recognizing the substantive right to liberty of the mentally ill. While validating the use of *parens patriae* authority as a justification for the involuntary commitment of the mentally ill, courts invalidated vague statutory commitment standards.³⁵ By imposing due process requirements, courts perpetuated deinstitutionalization so the liberty interests of the mentally ill would be protected.

In *O’Connor v. Donaldson*, the United States Supreme Court held that “a state cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members.”³⁶ Although the

²⁸ *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

²⁹ HENRY A. FOLEY & STEVEN S. SHARFSTEIN, *MADNESS AND GOVERNMENT* 164 (1983).

³⁰ Antipsychotic medications are also frequently referred to as neuroleptic or psychotropic medications. Among the most common are Thorazine (chlorpromazine), Haldol (haloperidol) and Prolixin (fluphenazine). See Ellen W. Clayton, *From Rogers to Rivers: The Rights of the Mentally Ill to Refuse Medication*, 13 AM J. L. & MED. 7, 13 (1987).

³¹ John E. B. Myers, *Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change*, 29 VILL. L. REV. 367, 390 (1984).

³² Pub. L. No. 88-164, 77 Stat. 282 (1963).

³³ FOLEY & SHARFSTEIN, *supra* note 29, at 165.

³⁴ Ronald L. Wisor, *Community Care, Competition and Coercion: A Legal Perspective on Privatized Mental Health Care*, 19 AM. J. L. & MED. 145, 147 (1993).

³⁵ Schwartz & Costanzo, *supra* note 12, at 1341.

³⁶ *O’Connor v. Donaldson*, 422 U.S. 563, 575 (1975).

O'Connor Court did not address whether involuntary commitment could be justified absent a showing of dangerousness, it made clear that public intolerance, poor living conditions, or the mere presence of mental illness would not constitute such justification.³⁷

In *Lessard v. Schmidt*, a decision that radically altered the landscape of mental health law, a federal district court went on to explicitly require proof that an individual is both mentally ill and dangerous in order to be involuntarily detained.³⁸ Other courts made it clear that state detention of the mentally ill under the police power could only be accomplished with a detailed demonstration of dangerousness.³⁹

The Ninth Circuit, in *Doe v. Gallinot*, also required a showing of dangerousness for the involuntary detainment of the mentally ill.⁴⁰ The current “grave disability” criterion embedded in California’s commitment statute, which allows for the involuntary commitment of an individual who is unable to provide for his or her needs for food, clothing, or shelter, is in fact a dangerousness standard.⁴¹ In these cases, the threat of harm is the inability to care for oneself.

As a result of the stricter standards for civil commitment and procedural safeguards mentioned above, the population of involuntarily committed persons in mental hospitals naturally declined.⁴² The advent of antipsychotic and antidepressant medications also spurred the evacuation of mental hospitals and led to a new approach to mental health care.⁴³ With the discovery of thiorazine and lithium for the alleviation of schizophrenia, and antidepressants for the treatment of bipolar disorder, leading psychiatrists believed that mental illness could be adequately treated outside the hospital.⁴⁴ Antipsychotic medications are effective in treating dramatic symptoms such as auditory hallucinations, suspicious delusions, and disorganized thoughts.⁴⁵ Leading psychiatrists believe that the administration of psychotropic medication is central to the treatment of the mentally ill.⁴⁶

With this shift in the accepted paradigm of treatment, the development of due process rights for the mentally ill, and acts of leaders like John F. Kennedy, deinstitutionalization was well on its way. Deinstitutionalization

³⁷ *Id.* at 575.

³⁸ 349 F. Supp. 1078 (E.D. Wis. 1972).

³⁹ Schwartz & Costanzo, *supra* note 12, at 1342 n.53.

⁴⁰ 657 F.2d 1017 (9th Cir. 1981).

⁴¹ CAL. WELF. & INST. CODE § 5008(h) (Deering 2001).

⁴² Wisor, *supra* note 34, at 148.

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ LPS REFORM, *supra* note 11, at 71.

⁴⁶ *Id.*

succeeded in removing the mentally ill from mental hospitals. Between 1955 and 1996, state mental hospital populations fell from over 550,000 to 59,000.⁴⁷

III. TRANSINSTITUTIONALIZATION: MENTALLY ILL ON THE STREETS AND IN PRISONS

While the population of state mental institutions plummeted, the population of mentally ill homeless on the streets and in prison increased dramatically. In a process that some in the psychiatric field have called “transinstitutionalization,”⁴⁸ the mentally ill have suffered from poverty and criminalization.⁴⁹ Deinstitutionalization’s promise of “open warmth” and care in the community has rung hollow in the ears of the massive population of mentally ill people on the street and in prison. Frequently, procedural and substantive safeguards that restrict involuntary treatment are cited as the reason for deinstitutionalization’s failure and the sorry plight of many with “nowhere to go.”⁵⁰ Dissenters argue that the problem lies in deinstitutionalization’s failure to provide viable mental health facilities in the community.⁵¹

Transinstitutionalization is the process by which the mentally ill population has moved from hospital facilities to prison facilities. There are over 830,000 mentally ill people in the criminal justice system either in jail, on probation, or on parole.⁵² Joseph Glazer, president of the Mental Health Association in New York, pointed to the lack of available community mental health services as a major cause of this problem.⁵³ The National Institute of Mental Health has evaluated the CMHC programs and has discovered that patients being released from state psychiatric hospitals were not, with only occasional exceptions, receiving aftercare from the CMHCs.⁵⁴ Glazer stated that “the vast majority of people who encounter the

⁴⁷ Meier, *supra* note 27, at A16.

⁴⁸ *The O'Reilly Factor: What Should Be Done with the Mentally Ill* (Fox News Network broadcast, Aug. 13, 1999) (transcript on file with Lexis-Nexis) [hereinafter *O'Reilly Factor*].

⁴⁹ The mentally ill homeless, like the homeless in general, face unsympathetic laws that make being homeless a crime. In spite of the homeless' inability to simply find any other place to live, the Supreme Court has unsympathetically refused to apply Eighth Amendment standards to antihomeless laws which make being without shelter a status crime. *Pottinger v. City of Miami*, 810 F. Supp. 1551 (S.D. Fla. 1992); *Johnson v. City of Dallas*, 61 F.3d 442 (5th Cir. 1995); *City of Milwaukee v. Nelson*, 439 N.W.2d 562 (Wis. 1989).

⁵⁰ E. FULLER TORREY, *NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL* 29–34 (1988). See generally RAE L. J. ISAAC & VIRGINIA C. ARMAT, *MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL* (1990).

⁵¹ *O'Reilly Factor*, *supra* note 48.

⁵² *Id.*

⁵³ *Id.*

⁵⁴ E. Fuller Torrey, *Let's Stop Being Nutty About the Mentally Ill*, MANHATTAN INST. CITY J., Summer 1997, at 5.

criminal-justice system for mental health reasons don't belong there, can be treated, should be someplace else, but our system fails to have the capacity to move people who shouldn't be in the criminal-justice system out of it."⁵⁵ That a major portion of the mentally ill population has been put in prison instead of into treatment has been pointed to as a major failure of deinstitutionalization.

Deinstitutionalization also has been hailed as a great failure because of the number of mentally ill who are homeless. Studies estimate that between thirty and forty percent of those living on the streets suffer from mental illness.⁵⁶ On the streets, the mentally ill do not receive the treatment they need. They suffer from the same problems that are endemic to the homeless in general such as criminalization, victimization, and poverty, which are exacerbated by their diminished ability to cope with and understand their situation. With no place to live and no place to go, the plight of the mentally ill homeless is a great tragedy.

E. Fuller Torrey, noted psychiatrist and head of the National Alliance for the Mentally Ill, has called deinstitutionalization a social experiment "undertaken upon remarkably little data and a multitude of flawed assumptions."⁵⁷ Where the involuntarily committed at least have access to food, shelter, and medication, many question the wisdom of deinstitutionalization and the rights based crusade for due process rights. Torrey discusses the failure of deinstitutionalization:

Many who are deinstitutionalized, however, are worse off than if they had remained in the hospital. They can be found talking to themselves in public streets and parks, living in cardboard boxes or subway tunnels beneath the city in the middle of winter, or escaping the cold in public libraries. Hundreds of thousands of the deinstitutionalized mentally ill have died prematurely from accidents, suicide, or untreated illnesses. All too frequently, the consequences of this failed social experiment have been tragic and fatal.⁵⁸

If the number of mentally ill people on the streets and in jail is a measure of the success of deinstitutionalization, then no one will disagree that it has been a complete failure.

⁵⁵ *O'Reilly Factor*, *supra* note 48.

⁵⁶ Wisor, *supra* note 34, at 151.

⁵⁷ Torrey, *supra* note 54, at 5.

⁵⁸ *Id.*

IV. THE CALL FOR REFORM

A. EARLY INTERVENTION WITH MEDICINAL TREATMENT

In light of deinstitutionalization's failure to provide community health alternatives for the mentally ill, there has been a call for reform from practitioners and family members of the mentally ill.⁵⁹ These reformers believe that the prevalence of the mentally ill on the street and in prisons requires a change in California's commitment law as it is embodied in the LPS. In their view, California's commitment procedure is "one of the most adversarial, costly and difficult to administer involuntary treatment systems in the United States."⁶⁰ These reformers argue that the procedural and substantive safeguards of the LPS Act do not take into consideration that mental illness is a physical disorder of the brain which, if not treated, will lead to irreversible deterioration.⁶¹ Patients must receive psychotropic medication during early stages of the disorder in order to prevent the costs of this deterioration.⁶² Furthermore, since the very nature of mental illness causes the mentally ill to have an aversion to taking medication, these reformers believe that the government's power to coerce treatment must be expanded.⁶³ Early intervention must be allowed to force the mentally ill to take their medication before the destructive effects of mental illness takes its toll on the person's life personally, socially, and medically.

LPS reformers argue that mental illness is a physical disorder of the brain that can be mitigated if treated early with medication.⁶⁴ Early intervention with medicinal treatment theoretically prevents decompensation and the maladaptive behavior that deteriorates social and personal aspects of a mentally ill person's life. Those who are in favor of more expansive commitment standards that allow for easier coerced treatment, such as those proposed in A.B. 1800, point to studies that utilize magnetic resonance imaging ("MRI") and positron emission tomography

⁵⁹ LPS REFORM, *supra* note 11, at 2.

In 1995, the leadership of two organizations, the Los Angeles County Affiliates of the National Alliance for the Mentally Ill ("NAMI") and the Southern California Psychiatric society, agreed to put together a task force to explore a growing awareness of the difficulty to convey needed treatment with any consistency to people so impaired by mental illness that they required involuntary help. The group was first known as the 'LPS Task Force' and later as the 'LPS Reform Task Force.' ... Some came from the point of view of having tried unsuccessfully to get treatment for a family member; others from the frustration of having tried unsuccessfully to provide such treatment.

Id.

⁶⁰ *Id.* at 1.

⁶¹ *Id.* at 5.

⁶² *Id.*

⁶³ *Id.* at 10.

⁶⁴ *Id.*

("PET") scans.⁶⁵ These reformers argue that these studies prove that incapacitating mental disorders such as schizophrenia and manic-depressive illness are caused by chemical processes in the brain.⁶⁶ They further argue that since the symptoms of these patients' illnesses can be mitigated with medication, mental illness is a chemical process of the mind which need only be counteracted with the proper chemical antidote.⁶⁷ Because of this chemical nature of mental illness, LPS reformers essentially believe that social and personal counseling, as well as the volition of the patient, are priorities subordinate to quick and brash medicinal intervention.

Proponents of coerced treatment believe that an aggravating factor endemic to mental illness that calls for more expansive commitment standards is that the mentally ill do not have an insight into their disorder. Proponents of coerced treatment point to studies that confirm that approximately half of all individuals diagnosed with schizophrenia and manic-depressive disorder have significantly impaired insight into their condition.⁶⁸ They argue that in practical terms this means that approximately half of those who suffer from schizophrenia and manic-depressive disorder will not seek treatment voluntarily regardless of the conditions of the treatment facilities. Based on these facts proponents of involuntary commitment denounce liberty-protecting provisions of commitment statutes.⁶⁹ Torrey stated that "since lawyers working for the American Civil Liberties Union and the Bazelon Center in Washington, D.C., have changed state laws to make it exceedingly difficult to treat the mentally ill involuntarily, roughly half of these individuals are untreated at any given time. They constitute most of the mentally ill population who are homeless or in jail, and who commit acts of violence."⁷⁰ Because the mentally ill do not realize the harm that their illness can cause, proponents of expanding coerced treatment such as Torrey argue that the government must force treatment on the mentally ill.⁷¹

Proponents of LPS reform argue that early intervention is required to minimize the potential damage caused by mental disorders. Once the disease has progressed, a period of rehabilitation, both social and vocational, may have to be completed to achieve the maximum recovery. Because of new medications, people with mental illness experience fewer symptoms and fewer side effects. But if early intervention could be accomplished "the next generation of people with mental illness may need

⁶⁵ Torrey, *supra* note 54, at 5.

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ LPS REFORM, *supra* note 11, at 7.

⁶⁹ Torrey, *supra* note 54, at 5.

⁷⁰ *Id.*

⁷¹ *Id.*

to recover only from the illness and not both from the illness and the effects of the illness on their life circumstances.”⁷²

In support of their position that coerced treatment has beneficial results, LPS reformers cite to a Harbor-U.C.L.A. Medical Center (“Harbor”) study.⁷³ This study shows that those mentally ill who were not released after a probable cause hearing fared much better in terms of relapses.⁷⁴ This large study in the Los Angeles area focused on detained mentally ill persons for which probable cause was found. The Harbor study included 250 admissions to the hospital’s acute care settings.⁷⁵ After one year of observation, treatment outcomes were compared between those for whom probable cause had been found and those for whom it was not.⁷⁶ The patients who were detained for a longer period of time were more likely to enter outpatient treatment after release than the patients who were released early.⁷⁷ Additionally, patients for whom probable cause was found suffered lower recidivism rates.⁷⁸

LPS reformers believe that the criteria for involuntary treatment embodied in LPS must be updated to “provide for treatment before tragic social and medical detriments occur.”⁷⁹ In order to effect such a goal the reformers propose the following as the criteria for involuntary treatment:

Because of a mental illness, the individual is either a passive or an active danger to self or others; or gravely disabled which means that the person is unable to provide for his/her basic needs (e.g., food, clothing, shelter, health or safety), or to take advantage of such resources when they are provided; or has recently substantially deteriorated from a former level of functioning, or is likely to substantially deteriorate if not provided with timely treatment and the person is unable to appreciate, or understand, or lacks *consistent* judgment to make informed decisions about his/her need for treatment, care or community living structure.⁸⁰

According to the LPS reformers, this criterion for detainment will allow the government to intervene for those who lack the ability to evaluate the benefits of treatment.⁸¹ It is the LPS reformers’ view that current commitment law does not take into consideration the mentally ill’s lack of capacity to make informed decisions. They argue that the mentally ill suffer

⁷² LPS REFORM, *supra* note 11, at 1.

⁷³ David S. Stone, *Hollywood on the Screen and on the Streets: The Cuckoo’s Nest of LPS*, 31 LOY. L.A. REV. 983–93 (1998).

⁷⁴ LPS REFORM, *supra* note 11, at 43.

⁷⁵ *Id.*

⁷⁶ *Id.* at 43–44.

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.* at 9.

⁸⁰ *Id.*

⁸¹ *Id.* at 10.

from physical disorders of the brain which deprive them of their judgement.⁸² The conclusion they draw is that the government must allow physicians to administer medication when, in their professional opinion, the mentally ill may be harmed.⁸³

B. THE L.P.S. REFORMERS' COMMITMENT CRITERION DOES NOT MEET THEIR STATED GOALS AND IS UNCONSTITUTIONAL

While the reformers' revised formulation of California's commitment standard allows the government greater ease in detaining more of the mentally ill, one must question its effectiveness in achieving the reformers' stated goal. The reformers stated goal is to force the mentally ill to take their medication before it is "too late." Insofar as the proposed criterion allows for detainment of those who by reason of mental illness cannot utilize basic needs when they are provided, the proposed criterion does allow for early intervention. However, the criterion is grossly overbroad. The proposed criterion allows for the generalized expansion of detainment for the mentally ill but only incidentally allows for early intervention.

This revised criterion is also much broader than the "dangerousness" standard. The current standard for involuntary commitment is that an individual, as a result of a mental disorder, is either a danger to himself or others, or is "gravely disabled," which is defined as unable to provide for food, clothing, or shelter.⁸⁴ LPS, in its current form, allows for involuntary detainment only when it is required to prevent imminent harm. The reformers' proposed criterion focuses on imposing treatment when in a physician's view treatment would be to the patient's benefit and mental illness compromises the patient's ability to consent. By expanding the criterion for commitment from "dangerousness" to "risk of substantial deterioration," many more mentally ill can be detained.

If the main goal of the reformers is to provide treatment without unduly impeding on the constitutional rights of the mentally ill, then the above criterion seems poorly crafted. According to the United States Supreme Court in *O'Connor v. Donaldson*, one cannot involuntarily detain without more "a nondangerous individual who is capable of surviving safely in freedom."⁸⁵ And in *Lessard v. Schmidt*, the federal district court explicitly required proof that an individual is both mentally ill and dangerous in order to be involuntarily detained.⁸⁶ The reformers' criterion ignores these constitutional mandates. The criterion allows for the mentally ill to be

⁸² *Id.*

⁸³ *Id.*

⁸⁴ CAL. WELF. & INST. CODE § 5008(h) (Deering 2001).

⁸⁵ 422 U.S. 563, 576 (1975).

⁸⁶ 349 F. Supp. at 1093.

deprived of their freedom when they are capable of surviving in freedom. Although the *parens patriae* authority “explicitly [is] not an expression of any duty to promote the health of, or provide treatment to, disabled persons,” the LPS reformers seek to expand the government’s commitment power primarily to promote the health of the mentally ill.⁸⁷ In so far as it provides for detainment with the mere showing of potential dangerousness, it runs afoul of the liberty interest of the mentally ill.

One who cannot provide for food, clothing or shelter by reason of mental illness is clearly a danger to herself. While the reformers may argue that allowing for the commitment of the mentally ill when they present a “passive danger” to themselves is simply another expression of constitutional doctrine, they do not recognize their departure from acceptable constitutional standards. Furthermore, one wonders if the reformers have given up on the wisdom of deinstitutionalization. In selecting a hospital-based approach to the problem of the mentally ill, the reformers’ criterion is a departure from deinstitutionalization’s mandate for a voluntary treatment system. By reestablishing hospitalization as the approach to the problem of the mentally ill, instead of voluntary care, the reformers seek to return to the very paradigm which was denounced as flawed during deinstitutionalization.

C. A.B. 1800’S COMMITMENT CRITERION IS ALSO UNCONSTITUTIONAL

California Assemblywoman Helen Thomson, like the LPS Reformers, also seeks to expand involuntary treatment for the mentally ill. Her standard, just like that of the LPS Reformers, allows for the generalized detainment of the mentally ill whether or not their disease is in its early stages. By making a previous history of mental illness a predicate to involuntary hospitalization, Helen Thomson’s proposal, A.B. 1800,⁸⁸ mainly will apply to those mentally ill with progressed disorders. While Thomson’s proposal does not mandate early medicinal intervention, it is still an unconstitutional infringement on the rights of the mentally ill. The fact that her plan provides for outpatient treatment is another unconstitutional impingement.⁸⁹ Both A.B. 1800 and the LPS Reformers’ provisions are unjustified curtailments of liberty.

A.B. 1800 proposes an amendment to the definition of “gravely disabled” within the meaning of the LPS statute. Helen Thomson’s bill

⁸⁷ Schwartz & Costanzo, *supra* note 12, at 1340.

⁸⁸ A.B. 1800, 1999–2000 S. (Cal. 2000).

⁸⁹ A.B. 1800 creates a contractual six-month Assisted Outpatient Treatment Program for those who have been certified for involuntary commitment and qualify for treatment on an outpatient basis. *Id.* § 6(b).

allows for detainment if a person “has a prior history of mental illness and again presents clear evidence of a recurrence that poses a serious risk of substantial deterioration that is likely to result in serious harm to the person in the absence of treatment.”⁹⁰ Like the LPS reformers’ revised commitment criterion, Thomson’s formulation allows for detainment when there is nothing more than a potential for harm. In this regard, Thomson’s bill suffers from the same constitutional ailments as the LPS Reformers’ formulation.

Thomson’s formulation ignores the mandates of *O’Connor*, *Lessard*, and *Gallinot*⁹¹ which require a showing of dangerousness. The language of the criterion itself is based on risk of likely harm. It seems that Helen Thomson is ignoring the admonitions of the *O’Connor* court that a “State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom.”⁹² If implemented, A.B. 1800 would allow for an unconstitutional curtailment of liberty such that a group of people may be deprived of their rights and confined against their will.

Thomson’s revised definition of “gravely disabled” fails to address the issue of early intervention in much the same way that the LPS reformulation fails. Thomson’s language of “substantial deterioration” and “clear evidence of recurrence” does not seem to allow for early intervention at all. Even for the LPS reformers, A.B. 1800 does not meet the goals necessary to implement their plan of early intervention with medicinal treatment. By requiring a history of mental illness, A.B. 1800 is not pointed at the goal of stopping mental illness before social and personal deterioration has occurred. Thomson’s A.B. 1800 is tailored for the general detention of the mentally ill and represents a hospital-centered approach to mental illness.

D. THE FARCE OF OUTPATIENT COMMITMENT

Helen Thomson is promoting her bill by stating that it provides “assisted outpatient treatment for the severely mentally ill.”⁹³ The language of her amendment provides for a community assisted treatment program for qualifying detained persons.⁹⁴ This provision for outpatient commitment

⁹⁰ *Id.* § 2(h)(1)(A).

⁹¹ *Doe v. Gallinot*, 657 F.2d 1017 (9th Cir. 1982).

⁹² *O’Connor v. Donaldson*, 422 U.S. 563, 576 (1975).

⁹³ HELEN M. THOMSON, SUMMARY OF A.B. 1800 (2000).

⁹⁴ Persons committed pursuant to Sections 5150 and 5250 shall be placed in community assisted outpatient treatment programs for 180 days if all of the following conditions exist:

The treating physician thinks that he or she requires continuing treatment and care under supervised conditions to maintain and improve recovery and the person is sufficiently stable to benefit from community placement.

The person agrees to community assisted treatment.

appeals to the notion that treatment in a less restrictive environment does not offend the Constitution. The option of outpatient commitment as a less restrictive alternative for the mentally ill has come under harsh criticism for its hollow logic.⁹⁵

Outpatient commitment is designed to ensure that treatment is administered to nondangerous persons who can live safely in community settings.⁹⁶ Schwartz states, “[outpatient commitment] is therefore not an exercise of governmental power to protect incompetent individuals who pose a serious physical threat to themselves; rather it is an expression of the much enlarged authority which developed over the past century to promote the health or interests of persons considered to be mentally infirmed.”⁹⁷ This is exactly the expanded exercise of the *parens patriae* authority that the Supreme Court and lower courts have disapproved of.⁹⁸

The fact that Thomson’s bill ostensibly allows for outpatient commitment only upon the consent of the detained mentally ill does not cure this constitutional ailment. Those who choose to go into an outpatient program pursuant to Thomson’s enactment do so having only the alternative of staying detained in a hospital. This “consent” of the patient makes the nature of the treatment no less coerced.

The LPS Reformers argue for the implementation of a “Community Assisted Treatment” (“CAT”) program that is very similar to the one provided for in Thomson’s bill. The LPS Reformers’ Community Assisted Treatment program allows for the option of discharging a person from a restrictive, expensive inpatient setting to a less restrictive environment without disrupting the person’s continuity of treatment and recovery.⁹⁹ LPS reformers argue that CAT is less restrictive and more favorable to some patients than today’s conservatorship laws.¹⁰⁰ CAT allows the patient to voluntarily agree to participate in a supervised, mutually decided upon,

The person does not present an immediate harm to self or others.

A community assisted treatment program is available and willing to accept the person.

A community treatment plan is prepared by the treating physician and the community treatment program and [*sic*] is agreed to by all parties.

A.B. 1800, §5260.

In the event the patient does not or cannot abide by the terms of the agreed upon community treatment plan, including medication compliance, and the person poses a risk of substantial deterioration, the person may be returned to inpatient treatment for the remaining days of the underlying involuntary treatment certification.³

Id. § 5261.

⁹⁵ See generally Schwartz & Costanzo, *supra* note 12.

⁹⁶ *Id.* at 1346.

⁹⁷ *Id.*

⁹⁸ *O’Connor*, 422 U.S. at 576; *Gallinot*, 657 F.2d at 1021–22.

⁹⁹ LPS REFORM, *supra* note 11, at 52.

¹⁰⁰ *Id.*

community treatment plan in order to provide the services necessary to develop his or her stable recovery.¹⁰¹ Those in favor of expanding commitment criterion are doing so in part because they say that it would mean putting the mentally ill in less restrictive outpatient programs.

Schwartz and Costanzo discuss how the distortion of the doctrine of the least restrictive alternative has historically led to the unconstitutional commitment of the mentally ill. The doctrine of the least restrictive alternative is an interpretive guideline for evaluating the form and extent of a proposed intrusion on constitutional rights.¹⁰² The Supreme Court revived the doctrine and articulated the principle least drastic means test in *Shelton v. Tucker*.¹⁰³ Schwartz and Costanzo discuss how the doctrine has been distorted into a clinical setting analysis. Instead of evaluating the degree to which different treatment alternatives impinged on the liberty of the treated, the doctrine was used to justify involuntary treatment.¹⁰⁴ Properly used, the doctrine is a guideline to evaluate the extent of freedom restricted by state action as measured by physical freedom and the fundamental right to control one's body.¹⁰⁵ Schwartz and Costanzo state, "[i]t was not long before the least drastic means analysis was converted in some jurisdictions to a clinical setting determination; the issue there was no longer the standards or the methods selected as the proper measure of civil commitment, but rather the place where involuntary treatment would occur."¹⁰⁶

Involuntary commitment to community programs works no less intrusion on the fundamental freedom of people labeled as mentally ill. It makes no difference that the patient is confined to an "outpatient" community facility if his or her freedom has been invaded. The Constitution requires a showing of dangerousness to justify the restriction on physical liberty that outpatient commitment presents. Neither Thomson's commitment criterion nor the LPS reformer's provision would be constitutionally upheld even if proponents maintain that less of an invasion on a mentally ill person's liberty is presented by outpatient commitment.

¹⁰¹ *Id.* at 12.

¹⁰² Schwartz & Costanzo, *supra* note 12, at 1349.

¹⁰³ 364 U.S. 479 (1960).

[E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgement must be viewed in the light of the less drastic means for achieving the same basic purpose.

Id. at 488 (citations omitted).

¹⁰⁴ Schwartz & Costanzo, *supra* note 12, at 1356.

¹⁰⁵ *Id.* at 1356–57.

¹⁰⁶ *Id.* at 1356.

In addition to the Constitutional ailments, Thomson's outpatient treatment program, which places mentally ill persons in outpatient programs, does not take into consideration that such services do not currently exist. Without substantially more mental health programs created in the community, the provision for such a contingency within the law will be useless.

It seems that Thomson's provision for outpatient treatment in her bill begs the questions unanswered by deinstitutionalization. Rarely do commentators publish anything other than scathing criticisms about the failure of most states to develop adequate community support services.¹⁰⁷ Comprehensive community care is a myth. In the absence of a meaningful alternative, outpatient commitment is no more than a theoretical possibility. To achieve the beneficial purposes of the model, a comprehensive system of community services is necessary so that appropriate treatment can be provided according to the unique needs of each individual. In order for Thomson's bill to be more than the empty promise of deinstitutionalization, there must be the funding and the initiative to do what thirty years of deinstitutionalization has failed to do.

V. FOCUS ON COERCED TREATMENT IS SHORTSIGHTED AND DOES NOT TAKE INTO CONSIDERATION A COMPREHENSIVE APPROACH TO TREATMENT

Coerced treatment does not address the pervasive effect a mental disorder has on a mentally ill person's life. Mentally ill persons need long term social and personal counseling and help coping with their diseases so that they may adapt to their mental illnesses and become productive members of society. Proponents of expanding coerced treatment do not consider that commitment standards already permit for coerced treatment when it is necessary. Expanding the commitment criterion to allow for coerced treatment at less severe stages of mental illness is the wrong focus; it does not provide the long-term continuous treatment that is necessary for effective rehabilitation. Furthermore, these proponents do not realize that characterizing mental illness solely in terms of a chemical brain disorder that requires involuntary treatment dehumanizes the mentally ill. Focusing on expanding coerced treatment only exacerbates the public's stigma of the mentally ill by playing on the public's fear that the mentally ill are violent. Those with mental disorders do have an insight into their illness and will seek treatment if there are attractive alternatives. In fact, it is the dearth of these needed treatment alternatives that is the true root of the social problem of mental illness.

¹⁰⁷ Torrey, *supra* note 54.

A. COERCED TREATMENT IS NOT AN EFFECTIVE MEANS OF
REHABILITATION

A major oversight of Thomson's proposal and the LPS Reformers' formulation, is that treatment must persist for a long enough period of time for there to be effective rehabilitation. Many attack the current system because it results in what is known as the "revolving door" syndrome. Mentally ill persons are confined to treatment facilities for periods of time that are too short to be effective in the long term and then released into the community, only to be returned to the facility once their conditions have worsened again.

Thomson's bill sought to address this issue by extending the current 180-day limit on intensive treatment to one full year.¹⁰⁸ The rationale for this change is that intensive treatment for a longer period of time will be more effective and therefore reduce recidivism. Extending the time of commitment also has the facially appealing feature of directly addressing the two most noted problems associated with the mentally ill. Instead of being imprisoned or homeless, the mentally ill will be confined to a facility where treatment will be provided.

Thomson, however, overlooks that even if a mentally ill person is confined to a treatment facility for the full year,¹⁰⁹ he or she is likely to decompensate if treatment does not persist after release from the facility. Coerced treatment is ill suited to teaching the mentally ill how to cope with their disorders in their day-to-day lives. Coerced treatment does not teach the mentally ill to manage their disorders on their own, without the forced supervision of mental health professionals. So while Thomson's proposal to extend the time of commitment may superficially remove the symptoms of mental illness, incarceration and homelessness, it does not improve fundamental aspects of the problem of the mentally ill.

The mentally ill, as well as society at large, are not well served by the expansion of coerced treatment via modification of the commitment criterion. The current criterion allows for coerced treatment when it is truly needed and constitutionally permitted. Once a mentally ill person has become a danger to himself or others, the impingement on the person's freedom is justified for as long as it takes to remove the danger. Expansion

¹⁰⁸ A.B. 1800, § 5300(a).

¹⁰⁹ A mentally ill person is not likely to stay confined to a facility for the full duration of commitment permitted under the law. As intensive care stabilizes the mentally ill person's condition, he or she becomes ineligible for coerced treatment. Once a mentally ill person who has been detained does not present symptoms which merit detention under section 5000, he or she must be released from confinement. Merely extending the maximum period of time the law will permit detention does not directly provide for long-term treatment of the mentally ill because of the limited duration of coerced treatment. Interview with James Preis, Director, Mental Health Advocacy Services, in Los Angeles, Cal. (Jan. 15, 2000).

of coerced treatment beyond that which is necessary to curb dangerousness is pernicious.

B. COERCED TREATMENT IS PROMPTED BY THE PUBLIC'S FEAR THAT THE MENTALLY ILL ARE VIOLENT

Coerced treatment is fed by and exacerbates a public stigma over the mentally ill. Common features of mental disorders include strange behaviors that induce people into believing that the mentally ill are different and should be treated differently. The number of mentally ill homeless on the streets perpetuates the public perception that the mentally ill are in need of forced treatment.

The misconception that the mentally ill are violent is another major factor contributing to the call for expanded coerced treatment. California is not the first state to consider expanding coerced treatment for the mentally ill. A.B. 1800 is similar to a bill recently signed into law in New York. New York's amendment of their involuntary treatment law was dubbed "Kendra's Law," for Kendra Webdale, a thirty-two-year-old woman who died after being shoved in front of a train, allegedly by a man with a long history of mental illness and hospital commitments."¹¹⁰ Kendra's Law is a testament to the public fear that the mentally ill are a social danger who need to be confined.

Almost two-thirds (60.9 %) of those polled in a study said they believed schizophrenia patients are prone to violence against others.¹¹¹ In reality, the mentally ill are responsible for about 4% of all violent crimes.¹¹² Proponents of the advancement of forced treatment are using the stereotype of the violent mental patient to advance their agenda. They have developed email lists and web sites dedicated to disseminating stories about violent crimes supposedly committed by mentally disabled persons.¹¹³ In reality, people diagnosed with mental illness account for a very small percentage of the violence in American society. Yet, the misperception that the mentally ill are violent and dangerous adds to the call for expanding coerced treatment.

¹¹⁰ Dan Morain, *Measure on Detaining Mentally Ill Planned*, L.A. TIMES, Dec. 16, 1999, at A5.

¹¹¹ TALKING POINTS TO FIGHT EXPANSION OF COERCED TREATMENT, COALITION ADVOCATING FOR RIGHTS, EMPOWERMENT AND SERVICES (2000) [hereinafter TALKING POINTS].

¹¹² Marquis & Morain, *supra* note 7.

¹¹³ Kate Randall, *More Than a Quarter Million Mentally Ill in America's Jails and Prisons*, <http://wsws.org/articles/1999/jul1999/pris-j15.shtml>; Karen Samples, *Families Often Cope Alone with Violent Mentally Ill*, http://enquirer.com/e...08/29/loc_families_often_cope.html.

C. COERCED TREATMENT CAUSES THE MENTALLY ILL TO AVOID
TREATMENT ALTOGETHER

The movement for expanding coerced treatment of the mentally ill is based on the belief that the mentally ill will not seek treatment on their own. Proponents of expanding coerced treatment argue that the mentally ill have an aversion to treatment and that in the absence of coerced treatment, the mentally ill will allow their disease to progress unabated.¹¹⁴ In a recent study in which researchers analyzed the responses of 1,444 adults, three-quarters of the respondents said they believe schizophrenia patients are unable to make treatment decisions.¹¹⁵ By broadening the commitment criterion, those in favor of expanding coerced treatment hope to provide mental health care to the unwilling mentally ill.

While proponents of expanding coerced treatment believe it is necessary, the mentally ill are competent to make decisions about their treatment as mental illness does not invariably impair decision making capacities.¹¹⁶ There are successful programs in which the mentally ill participants voluntarily undergo treatment. The Village is one such mental health treatment facility which is entirely voluntary.¹¹⁷ Studies show that the mentally ill do realize that their mental disorders cause difficulties in their lives, and they will take measures to seek treatment.¹¹⁸

Additionally, strengthening the imposition of unwanted treatment on those who avoid it creates an adversarial relationship between the patient and the doctor.¹¹⁹ In The Well-Being Project, a research project supported by the California Department of Mental Health, scientists found that 55% of clients interviewed who had experienced forced treatment reported that fear of forced treatment caused them to avoid all treatment for their psychological or emotional problems. Forty-seven percent of all the clients who were interviewed reported that fear of forced treatment caused them to avoid treatment altogether.¹²⁰

Furthermore, the movement for coerced treatment obscures the central problem of the mentally ill in light of the failure of deinstitutionalization. If the unquestionable failure of deinstitutionalization is the lack of adequate community health care services, then should not the solution be to provide for such community health care services? Instead of addressing this

¹¹⁴ Torrey, *supra* note 54.

¹¹⁵ TALKING POINTS, *supra* note 111.

¹¹⁶ MacArthur Treatment Competence Study, <http://ness.sys.virginia.edu/macarthur>.

¹¹⁷ *See infra* Part VI.B.

¹¹⁸ *See id.*

¹¹⁹ Mark Ragins, *Recovery: Changing from a Medicinal Model to a Psychosocial Rehabilitation Model*, 5 J. CAL. ALLIANCE FOR MENTALLY ILL 8, 8 (1994).

¹²⁰ TALKING POINTS, *supra* note 111.

germane problem, advocates of expanding coerced treatment wish to turn back the clock. Viewing coerced treatment as the main solution to the problem of the mentally ill takes us back to a hospitalization-centered paradigm, and defies the sound logic behind the impetus to free the mentally ill from the cold confinement of the mental ward. The movement for expanding coerced treatment draws attention away from the long-term community facilities which are necessary for effective rehabilitation of the mentally ill.

VI. THE PSYCHOSOCIAL REHABILITATION MODEL: THE MENTALLY ILL WILL CHOOSE ATTRACTIVE COMMUNITY TREATMENT IF IT EXISTS

A. PSYCHOSOCIAL REHABILITATION AS A RESPONSE TO COERCED TREATMENT

The movement to expand coerced treatment, if successful, will implement a hospital-centered paradigm of treatment. As an approach to the problem of the mentally ill, this method seeks to coerce treatment in a supervised setting while requiring the administration of psychotropic drugs. Those who do not support expanding coerced treatment disagree with the notion that medicinal intervention should be central to the model treatment. Instead of hospitalization, proponents of the psychosocial rehabilitation model seek to address the myriad of issues that are not addressed by the medical model.¹²¹ Fixation on medicating mentally ill patients places too much emphasis on the disease and too little attention on the person. The person must come first. One proponent summed up the sentiment of the Psychosocial Rehabilitation Models with a quote from a famous movie: "Treat the person, not the Disease."¹²²

The psychosocial rehabilitation model in many ways is structured as a response to the medical model. It states that marginalization and lack of understanding of the mentally ill make infeasible the promise of adequate community care. A.B. 1800 represents the social movement towards coerced treatment that is based on the false assumptions of the medical model. Ignoring the complexity of the problem, and groping for an easy answer, A.B. 1800 is motivated by the exasperation that is the very source

¹²¹ Ragins, *supra* note 119. Bill Anthony, Director of the Center of Psychiatric Rehabilitation at Boston University, tells us, "The Recovery Vision transcends the arguments about whether severe mental illness is caused by physical and/or psychosocial factors. Recovery, as we currently understand it, means growing beyond the catastrophe of mental illness and developing new meaning and purpose in one's life." Dan E. Weisbard, *Publisher's Note*, 5 J. CAL. ALLIANCE FOR MENTALLY ILL 1, 1 (1994).

¹²² Interview with James Preis, Director, Mental Health Advocacy Services, in Los Angeles, Cal. (Jan. 15, 2000).

of the problem. The result is that the mentally ill are stigmatized, and the sacrifice and understanding needed for the solution are dismissed as unrealistic.

The essential philosophy of the self-help model is one in which a self-defined group of mental health clients decides its own goals and methods, making all major decisions. The self-help model is not one set model; it can take many forms. Self-help groups can be support groups, independent living programs, drop-in/advocacy/independent living services centers, client run housing, self-supporting businesses and artistic groups.¹²³ Some self-help groups are autonomous and fully independent, while others are factored into a larger mental health program.¹²⁴

The Psychosocial Rehabilitation Model states that the problem of mental illness “may be as much in our conceptual model of treatment and recovery as in the inherent nature of the conditions.”¹²⁵ Schizophrenics in third world countries are regularly reported to have better outcomes than in the United States.¹²⁶ Dr. Ragins, board certified psychiatrist specializing in community mental health, states, “people with schizophrenia who explain their conditions *spiritually*, instead of medically, apparently fare better.”¹²⁷

Dr. Ragins disapproves of the two-step process¹²⁸ endorsed by the medical model because it delays recovery and focuses too much on the illness. This model creates discordance between the professionals focusing on the illness, while the people being treated focus on their entire lives.¹²⁹ A broader perspective can be obtained by accepting other models that focus on the recovery process and that seek to promote helping relationships with the mentally ill.¹³⁰ The medical model seeks to remedy the symptoms of mental illness without taking into consideration the emotional trauma that illness and hospitalization can invoke. Coerced treatment creates an adversarial relationship between professional and patient while the

¹²³ TALKING POINTS, *supra* note 111.

¹²⁴ *Id.*

¹²⁵ Ragins, *supra* note 119, at 8.

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ First, treat the illness, then rehabilitate the person. *Id.*

¹²⁹ *Id.*

¹³⁰ *Id.* Dr. Ragins proposes one concept of recovery used with alcoholics that he believes is a helpful guide to forming a treatment paradigm:

1. Accepting having a chronic, incurable illness, that is a permanent part of them, without guilt or shame, without fault or blame.
2. Avoiding complications of the condition (e.g., by staying sober).
3. Participating in an ongoing support system both as a recipient and a provider.
4. Changing many aspects of their lives including emotions, interpersonal relationships, and spirituality both to accommodate their illness and grow through overcoming it.

Id.

Psychosocial Rehabilitation Model adopts a cooperative method based on treating the patient and not the illness.

The Psychosocial Rehabilitation Model is based on the idea that people must take responsibility for their own recoveries to help themselves for their own benefit.¹³¹ William A. Anthony, Ph.D., Executive Director of Boston University's Center for Psychiatric Rehabilitation, states that "[r]ecovery...means growing ... beyond mental illness and developing new meaning and purpose in one's life. It means taking charge of one's life even if one cannot take complete care of one's symptoms."¹³² Instead of forcing treatment on the mentally ill, the Psychosocial Rehabilitation Model seeks to help the mentally ill cure themselves.

Dr. Anthony believes that much of the "chronicity" of mental illness is due to the way the mental health system and society treat people with severe mental illness.¹³³ Contributing to chronicity are factors such as stigma, lowered social status, restrictions on choice and self-determination, lack or partial lack of rehabilitation opportunities, and low staff expectations.¹³⁴

B. THE VILLAGE

In pockets of California, pioneers of small but aggressive programs are proving the success of comprehensive treatment programs. Providing medication is part of the regimen, but this is only one factor in the treatment program. The focus of these holistic treatment programs is to "wrap people in a blanket of services so snugly they can't just slip away."¹³⁵ The Village in Long Beach, California is one of the most reputed of these wrap-around programs in the state.¹³⁶ Martha Long, director of the Village, states "[m]ost people with psychiatric illness have had the fight beat out of them."¹³⁷

¹³¹ *Id.* at 9.

¹³² William A. Anthony, *The Recovery Vision*, 5 J. CAL. ALLIANCE FOR MENTALLY ILL 5, 5 (1994).

¹³³ *Id.* Dr. Anthony believes that the last major revolution in vision occurred 20 years ago, when he helped to unchain people with mental illness. He offers an account of a conversation Pinel had at the time:

Pinel immediately led him to a section for the deranged, where the sight of the cells made a painful impression on him. He asked to interrogate all the patients. From most, he only received insults and obscene apostrophes. It was useless to prolong the interview. Turning to Pinel: "Now citizen, are you mad yourself to seek to unchain such beasts?" Pinel replied calmly: "Citizen, I am convinced that these madmen are so intractable only because they have been deprived of air and liberty."

Id.

¹³⁴ *Id.*

¹³⁵ Julie Marquis & Dan Morain, *The Village*, L.A. TIMES, Nov. 23, 1999, at A24.

¹³⁶ *Id.*

¹³⁷ *Id.*

Long summed up the Village's treatment approach by stating, "Basically, we ask people, 'What do you want and need?' . . . [w]hat we want to do is give people a picture of what their life could be like" if they decide to help themselves.¹³⁸ More than medical services, the Village treatment program seeks to address all the issues in a mentally ill person's life that contribute to maladaptive behavior. This is done in the form of "job training, housing assistance, money management and general 'life coaching.'"¹³⁹ Each client is assigned to a team of caseworkers that includes a psychiatrist.¹⁴⁰ Whereas the medical model makes hospitalization central to treatment, those at the Village see hospitalization as a failure. The professionals at the Village do not like to see their clients decline to that point.¹⁴¹

The Village has been hailed as a great success. In October, 1999, 63% of the Village's 276 clients lived independently in housing around the community.¹⁴² The balance of the clients lived in board-and-care facilities or with their families.¹⁴³ Just over 3% were hospitalized.¹⁴⁴ Ten percent were in school.¹⁴⁵ The program is such a success there are only two openings every two months.¹⁴⁶

VII. CONCLUSION

Expanding coerced treatment is not the answer.

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*