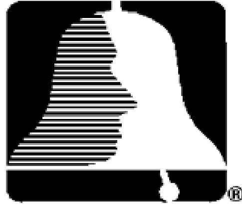

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MHA-SF Position Statement
Involuntary Mental Health Treatment

The Mental Health Association of San Francisco (MHA-SF) believes that effective protection of human rights and the best hope for recovery from mental illness comes from access to voluntary mental health treatment and services that are comprehensive, community-based, recovery-oriented and culturally and linguistically competent. Moreover, the rights of persons with mental illness to make decisions concerning their treatment must be respected. MHA-SF urges our state and locality to adopt laws that reflect a commitment to maximizing the dignity, autonomy and self-determination of persons affected by mental illnesses. Voluntary admissions to treatment and services should be made more truly voluntary, and the use of advance directives should be implemented.

Specifically, MHA-SF believes that involuntary treatment in an in-patient setting should only occur as a last resort and should be limited to instances where persons pose a serious risk of physical harm to themselves or others and to circumstances when no less restrictive alternative will respond adequately to the risk. [i] For involuntary treatment to be used, stringent procedural safeguards and fair and regular review are essential. MHA-SF is opposed to outpatient commitment.

Background
Persons with mental illnesses deserve the same degree of personal autonomy as other citizens with disabilities when it comes to receiving services. This has not always been the case. For years, persons with mental illnesses have been combating the centuries-old stereotype that they are not competent enough to make their own decisions, or to be in charge of their own mental health care. Today, we know otherwise, that persons with mental illness are not only capable of making their own decisions regarding their care, but that mental health treatment and services can only be effective when the consumer embraces it, not when it is coercive and involuntary. Involuntary mental health treatment is a serious curtailment of liberty.

Involuntary mental health treatment occurs in a variety of contexts. The most common type of involuntary mental health treatment is court-ordered commitment to an inpatient mental health facility. However, involuntary treatment also includes involuntary medication or other treatments including electro-convulsive therapy, whether court-ordered or imposed by mental health professionals, treatment imposed upon persons with mental illnesses in prisons and jails or as a condition of probation, supervision or parole, outpatient

commitment, and the use of guardianship or conservatorship laws. While MHA-SF recognizes that involuntary treatment may sometimes be necessary, we do not support the use of involuntary outpatient treatment.

MHA-SF recognizes that there are limited circumstances when involuntary commitment must be used as a last resort. Even in such circumstances, MHA-SF believes that involuntary commitment is only appropriate for a very small subset of people. When involuntary treatment is used, it must be based on the following principles and understandings which are designed to ensure that the rights of persons with mental illnesses are protected:

I. Presumption of Competency. A basic principle of law in the United States is that all adults are presumed to be "competent" – that is, they are presumed to be capable of making their own decisions about their own lives and their own medical care, including mental health treatment.

II. Declaration of Incompetency. Every state has court procedures for determining when and if someone is incompetent. Only a tiny percentage of persons with mental illnesses have ever been declared incompetent under these procedures. This corresponds with the reality that almost all persons with even the most serious mental illnesses are competent most of the time – that is, they are capable of making their own decisions about whether to seek treatment and support and what treatment and support they should receive.

III. Informed Consent. Informed consent is required for all medical care provided to persons who are competent. Unless and until a person has been declared to be incompetent, informed consent is required when mental health services are provided.

IV. Standard: Serious Risk of Physical Harm to Themselves or Others in the Near Future. Involuntary commitment to a mental hospital should be limited to persons who pose a serious risk of physical harm to themselves or others in the near future. Under no circumstances should involuntary commitment be imposed upon someone based upon a risk of harm to property or a risk of non-physical harm.

V. Least Restrictive Alternative. Persons with mental illnesses can and should be treated in the least restrictive environment and in a manner designed to preserve their dignity and autonomy and to maximize the opportunities for recovery.

VI. Procedural Protections. Persons facing involuntary confinement have a right to substantial procedural protections. Those protections should include:

A A judicial hearing and a right to jury trial at which at least one mental health professional is required to testify

B The right to be represented by competent counsel, including appointed counsel if needed

C An independent mental health evaluation

D The right to appeal an adverse decision, including the appointment of appellate counsel and waiver of appellate costs if needed

E Short time limits on any commitment or procedures for regular review of continued confinement which are either automatic or readily accessible to persons with serious mental illnesses confined in a hospital

F Involuntary commitment to a psychiatric hospital should only be imposed if supported by clear and convincing evidence. *Addington v. Texas, 441 U.S. 418 (1979)*

VII. Qualified Right to Refuse Treatment. There are a growing number of effective treatments for mental illnesses, including psychotropic medications. However, all medications pose some risks and many pose quite serious risks to the health of the persons who take them, particularly when medications are taken for extended periods to treat chronic illnesses. For this reason and because of its commitment to the autonomy and dignity of persons with mental illnesses, MHA-SF strongly agrees with the judgment of the United States Supreme Court that all persons, even persons lawfully convicted and serving a sentence of imprisonment, have a right to refuse medication and that medication may not be imposed involuntarily unless rigorous standards and procedures are met. *Washington v. Harper, 494 U.S.210 (1990).*

VII. Opposition to Involuntary Outpatient Treatment. MHA-SF is opposed to outpatient commitment. [ii] Outpatient commitment has not been shown to be effective in reducing hospitalization or other adverse outcomes. Studies have repeatedly shown that when persons with even the most serious mental illnesses are provided with appropriate and comprehensive community mental health services, they succeed (White House Conference on Mental Health Fact Sheet, 1999). Mandatory treatment has not been shown to add to the effectiveness of community mental health services and, indeed, may interfere with recovery by compromising personal responsibility and lowering self-esteem.

While MHA-SF does not support involuntary outpatient commitment, it also recognizes that it is a reality in communities across the nation. In communities where involuntary is implemented, the following principles should be adhered

to in order to insure that an individual's autonomy is not diminished:

A Under no circumstances should such an arrangement be used to lengthen the period of involuntary treatment otherwise authorized by law.

B There should be substantial evidence that no less coercive arrangement would permit the person's safe release.

C The need for involuntary community treatment should be based upon a significant history of highly unsuccessful community treatment despite the provision of comprehensive community supports.

D The person's failure to comply with an involuntary treatment order in the community should not, standing alone, be the basis for revocation of release or re-commitment. Such revocation or re-commitment should only be imposed upon persons who otherwise meet the standard for inpatient commitment – i.e., dangerousness to self or others.

IX. Voluntary Treatment Should be Truly Voluntary. Coercion occurs during many so-called "voluntary" admissions. *Zinermon v. Burch, 494 U.S. 113 (1990).* Persons facing involuntary commitment are routinely offered the option of becoming voluntary patients. However, in many treatment facilities, a person who has been voluntarily admitted is not free to leave when she or he chooses. Rather, it is common for mental health laws to permit the facility to detain a person for up to one week after she or he indicates a desire to leave. MHA-SF urges states to eliminate this form of admission and admit persons to mental health facilities in the same manner as persons are admitted to medical treatment facilities for non-psychiatric illnesses.

X. Advance Directives. Advance directives have proven to be useful instruments for maintaining and increasing the autonomy of persons with mental illnesses. MHA-SF urges states to create and enforce laws which permit persons with mental illnesses to designate in writing, while competent, what treatment they should receive should their decisional capacity be impaired at a later date. Such laws should reflect the following principles:

A. There should be sufficient protections in place to ensure that such directives are created voluntarily and with informed consent.

B. In the absence of a judicial finding that, absent involuntary treatment, the person is dangerous to self or others, a directive refusing treatment must be honored.

C. As long as the advance directive does not conflict with accepted medical

practice, the person's choice of treatment should be honored.

D. There should be clear mechanisms for creating, modifying and revoking an advance directive.

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0. [i] [ii] MHA-SF supports the standard accepted by the Bazelon Center for Mental Health Law: "The Bazelon Center opposes involuntary inpatient civil commitment except in response to an emergency, and then only when based on a standard of imminent danger of significant physical harm to self or others and when there is no less restrictive alternative." Position Statement on Involuntary Commitment," on the web at bazelon.org

[ii] [ii] MHA-SF does not support the weaker standard endorsed by the National Alliance on Mental Illness: " (8.2.7) States should adopt broader, more flexible standards that would provide for involuntary commitment and/or court ordered treatment when an individual: (8.2.7.1) is gravely disabled, which means that the person is substantially unable, except for reasons of indigence, to provide for any of his or her basic needs, such as food, clothing, shelter, health or safety; or (8.2.7.2) is likely to substantially deteriorate if not provided with timely treatment; or (8.2.7.3) lacks capacity, which means that, as a result of the brain disorder, the person is unable to fully understand– or lacks judgment to make an informed decision about– his or her need for treatment, care, or supervision. (8.2.8) Current interpretations of laws that require proof of dangerousness often produce unsatisfactory outcomes because individuals are allowed to deteriorate needlessly before involuntary commitment and/or court-ordered treatment can be instituted. When the "dangerousness standard" is used, it must be interpreted more broadly than "imminently" and/or "provably" dangerous. (8.2.9) State laws should also allow for consideration of past history in making determinations about involuntary commitment and/or court-ordered treatment because past history is often a reliable way to anticipate the future course of illness." Excerpts from the PUBLIC POLICY PLATFORM of The National Alliance on Mental Illness (NAMI), by the Public Policy Committee of the Board of Directors and the NAMI Department of Public Policy and Research, Fifth Edition, June 2001, on the web at nami.org.

The Bazelon Center also opposes outpatient commitment: "The Bazelon Center also opposes all involuntary outpatient commitment as an infringement of an individual's constitutional rights. Outpatient commitment is especially problematic when based on: • a prediction that an individual may become violent at an indefinite time in the future; • supposed "lack of insight" on the part of the individual, which is often no more than disagreement with the treating professional; • the potential for deterioration in the individual's condition or mental status without treatment; • an assessment that the individual is "gravely disabled." The above criteria are not meaningful. They cannot be accurately assessed on an individual basis, and are improperly rooted in speculation. Neither do they constitute imminent, significant physical harm to self or others— the only standard found constitutional by the Supreme Court. As a consequence, these are not legally permissible measures of the need for involuntary civil commitment—whether inpatient or outpatient—of any individual. Outpatient commitment is a dangerous formalization of coercion within the community mental health system. Such coercion undermines consumer confidence and causes many consumers to avoid contact with the mental health system altogether." Bazelon, op. cit. Outpatient commitment is actually preferred by NAMI: "(8.2.13) Court-ordered outpatient treatment should be considered as a less restrictive, more beneficial, and less costly treatment alternative to involuntary inpatient treatment." NAMI, op. cit.