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INVOLUNTARY MENTAL HEALTH TREATMENT

Mental Health America Policy Statement

Mental Health America (MHA) 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. It is essential that the rights of persons with mental health conditions to make decisions concerning their treatment be respected. MHA urges states to adopt laws that reflect the paramount value of maximizing the dignity, autonomy and self-determination of persons affected by mental health conditions. Voluntary admissions to treatment and services should be made more truly voluntary, and the use of advance directives should be implemented.

MHA believes that involuntary treatment 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 in the near future and to circumstances when no less restrictive alternative will respond adequately to the risk.[1] For involuntary treatment to be used, stringent procedural safeguards and fair and regular review are essential.

Background

Persons with mental health conditions 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 health conditions 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 health conditions 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 health conditions 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 recognizes that involuntary treatment may sometimes be necessary, we do not support the use of outpatient commitment except in the narrowest circumstances.

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

1. **Presumption of Competency**. It is a basic principle of American law 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.
2. **Declaration of Incompetency**. Every state has court procedures for determining when and if someone is incompetent. Only a tiny percentage of persons with mental health conditions 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.
3. **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.
4. **Standard. Serious Risk of Physical Harm to Themselves or Others in the Near Future.** Involuntary commitment 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.
5. **Least Restrictive Alternative**. Persons with mental health conditions 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. Continuum of Crisis Care. Before intervening legally to compel treatment, *Olmstead* principles [citation to new PS 25] require that the state provide a continuum of crisis care options that could resolve the danger to self or others without coercion. After the tragic shootings in Aurora, Colorado adopted a statewide crisis response plan that can serve as a model.[2]
6. **Procedural Protections**. Persons facing involuntary confinement have a right to substantial procedural protections. Those protections should include:
   - A judicial hearing at which at least one mental health professional is required to testify
   - The right to be represented by competent counsel, including appointed counsel if indigent
   - Brief pre-hearing detention.
   - The right to be free from “psychiatric boarding”[3] in hospital emergency rooms or other non-psychiatric centers. State and local governments should ensure that adequate funding exists to provide treatment at a psychiatric treatment facility.
   - An independent mental health evaluation.
   - The right to appeal an adverse decision, including the appointment of appellate counsel and waiver of appellate costs if indigent.
   - Short time limits on any commitment or procedures for regular review of continued confinement which are either automatic or readily accessible.

- Strict adherence to the "clear and convincing evidence" standard, as required by *Addington v. Texas*, 441 U.S. 418 (1979)

7. **Qualified Right to Refuse Treatment**. There are a growing number of effective treatments for mental health conditions, 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 health conditions, MHA 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). As the dissent in *Washington v. Harper* pointed out, those procedures should include an impartial decision maker focused on the best medical interest of the individual, not interests of the institution seeking compulsory treatment.[4]
8. **Opposition to Outpatient Commitment**. Although social problems caused by lack of access to mental health treatment (like the tragic murder addressed by Kendra's Law in New York) can be addressed by civil commitment proceedings, and at least 42 states and some MHA affiliates support outpatient commitment for that reason, MHA is opposed to outpatient commitment.[5] *Olmstead* principles (see Position Statement 25) require that non-coercive means be used before invoking the police power to compel treatment, and waiting lists show that there are inadequate treatment resources to meet the needs of people willing to participate voluntarily in their recovery from mental health conditions. Thus, while more community treatment resources are sorely needed, allocating scarce resources from people on waiting lists to a civilly committed class of people who are resisting treatment seems self-defeating, an egregious example of "Stage4" thinking (see B4Stage4). Moreover, intervening to compel treatment of people not deemed so seriously ill as to need custodial care imposes enforcement costs and contradicts the recovery principles that are essential to community integration.

Most importantly, outpatient commitment risks transforming the mental health system into a vehicle of social control over many people living in the community. Assertive community treatment is a proven methodology,[6] and community support teams are a critical step in community integration. But the non-coercive approach of community-based treatment as it currently exists is essential to its effectiveness in promoting recovery and the long-term autonomy and integrity of the mental health system.

Turning to the evidence, outpatient commitment has only been shown to be modestly more effective in reducing hospitalization or other adverse outcomes than noncompulsory outpatient treatment.[7] In any event, all mental health treatment programs should provide adequate, community-based outpatient services to consumers in their communities. Without adequate local services, implementation of involuntary outpatient commitment will underserve people who are voluntarily seeking treatment without any net gain in the number of people receiving outpatient services. 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).[8] Most dangerously, coercive outpatient treatment may drive people away from long-term treatment. Unless there is a full array of community mental health services, mandatory outpatient 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 does not support involuntary outpatient commitment, it also recognizes that it is a reality in communities across the nation. In communities where involuntary outpatient commitment is implemented, the following principles should be adhered to in order to insure that an individual's autonomy is not diminished[9]:

- Under no circumstances should such an arrangement be used to lengthen the period of involuntary treatment otherwise authorized by law.
- There should be substantial evidence that no less coercive arrangement would permit the person's safe release from involuntary status.
- 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.
- 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.
- Mandatory outpatient treatment is frequently used to compel medication. Compelled medication is not appropriate unless an independent determination is made that the patient will be dangerous to self or others in the near future, that the patient lacks the capacity to make an informed decision about the medication and that the proposed medication is in the patient's medical interest.

9. **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 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.
10. **Advance Directives**. Advance directives have proven to be useful instruments for maintaining and increasing the autonomy of persons with mental health conditions. MHA 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:
    - There should be sufficient protections in place to ensure that such directives are created voluntarily and with informed consent.
    - 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.
    - As long as the advance directive does not conflict with accepted medical practice, the person's choice of treatment should be honored.
    - There should be clear mechanisms for creating, modifying and revoking an advance directive. See, generally, MHA Position Statement 23, "Psychiatric Advance Directives."[10]

MHA affiliates and other advocates should periodically examine state laws and the practices of treatment facilities and the courts, including the criminal justice and probate systems as well as the private and public mental health systems, to minimize coercion in mental health treatment wherever and whenever it occurs. Special attention needs to be paid to eliminating any discrimination against persons with mental health conditions seeking to be discharged from treatment and to legislating and advocating the use of advance directives, in which the person directs his or her own treatment.

Effective Period

This policy was adopted by the Mental Health America Board of Directors on March 7, 2015. It is reviewed as required by the Mental Health America Public Policy Committee.

Expiration: December 31, 2020

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[1] This is the same standard accepted by the Bazelon Center: "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

The National Alliance on Mental Illness endorses a weaker standard, which Mental Health America does not support:

(9.2.7) States should adopt broader, more flexible standards that would provide for involuntary commitment and/or court ordered treatment when an individual, due to mental illness:

- (9.2.7.1) 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
- 9.2.7.2) is likely to substantially deteriorate if not provided with timely treatment; or
- (9.2.7.3) lacks capacity, which means that, as a result of the serious mental illness, 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.
- (9.2.8) 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.
- (9.2.9) 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, on the web at http://www.nami.org/Template.cfm?Section=NAMI_Policy_Platform&Template=/ContentManagement/ContentDisplay.cfm&ContentID=38253

[2] Overview adapted from "A Community-Based Comprehensive Psychiatric Crisis Response Service" Prepared by the Technical Assistance Collaborative, Inc. (April 2005):

- **24-Hour Crisis Telephone Lines**

The telephone is often the first point of contact with the crisis system for a person in crisis or a member of his/her support system. Telephone crisis services should be available 24 hours per day to provide assessment, screening, triage, preliminary counseling, information, and referral services. A primary role of telephone crisis personnel is to assess the need for face-to-face crisis intervention services and to arrange for such services when and if indicated.

- **Warm-Lines**

Warm lines are designed to provide social support to callers in emerging, but not necessarily urgent, crisis situations. Peer-run warm lines are a relatively new pre- and post-crisis service. Peers are current or former consumers of services who are trained to provide non-crisis supportive counseling to callers. Warm lines focus on the following:

(1) Building peer support networks and establishing relationships,

(2) Active listening and respect for consumer boundaries, and

(3) Making sure callers are safe for the night.

- **Walk-in Crisis Services**

Walk-in crisis services are provided through Urgent Care Centers in some communities. Services typically include:

(1) Screening and assessment;

(2) Crisis stabilization (including medication);

(3) Brief treatment; and

(4) Linking with services.

Single or multiple community agencies may be identified to address walk-in crisis and "urgent" situations on a 24-hour basis or through extended service hours.

- **Mobile Crisis Outreach**

Mobile crisis teams are one of the most innovative components of a CCS. Mobile teams have the capacity to intervene quickly, day or night, wherever the crisis is occurring (e.g., homes, emergency rooms, police stations, outpatient mental health settings, schools, etc.). These teams can serve persons unknown to the system and often work closely with the police, crisis hotlines, and hospital emergency services personnel.

Mobile teams can operate out of a wide variety of locations, either centralized or distributed throughout the community. Although some mobile crisis teams may specialize in serving adults or children exclusively, it is important to note that these teams often become involved in treating the entire family or other support system. Thus, an "extended intervention," which can include short-term counseling, may be necessary. In this instance, a mobile team member may act as the primary care provider until it is appropriate to transition the family into mainstream services. Some mobile teams may have broad authority and responsibilities for service management that include:

(1) Providing pre-screening assessments or acting as gatekeepers for inpatient hospitalization of consumers utilizing public services; and

(2) Managing and controlling access to crisis diversionary services.

In designing mobile crisis teams, it is critical to remember that what these teams do is far more important than the specific logistics of their operation. Some mobile teams operate 24 hours a day, whereas others operate only during nights and weekends, relying on community agencies or walk-in centers to handle crises during regular working hours. In some systems, mobile teams provide preventive support in the form of "wellness checks" for persons felt to be fragile or at risk. While one of the goals of a mobile crisis team is to link consumers to community support services, teams vary in their capacity to accomplish this task. Clear channels of access that are established between the team and community programs prior to team operations greatly enhance this effort.

Crisis Respite/Residential Services

On occasion, resolution of a crisis may require the temporary removal of a consumer from his or her current environment. The purpose of crisis respite/residential services is to provide the individual in crisis with support in a calm, protected, and supervised non-hospital setting. During this period, the person can stabilize, resolve problems, and link with possible sources of ongoing support. A range of settings for residential/respite crisis support should be available to meet the varying needs and desires of individuals.

Individual Residential Supports

Individual approaches serve one or two persons in a particular setting. Examples include **family-based crisis homes** where the person in crisis lives with a screened and trained "professional family." In addition to practical and emotional support from "family" members, professional providers visit the home daily to help the consumer develop a self-management treatment plan and connect with needed services.

- A **crisis apartment** is another model of providing individual support. In a crisis apartment, a roster of crisis workers or trained volunteer staff provide 24-hour observation, support, and assistance to the person in crisis who remains in the apartment until stabilized and linked with other supports.
- In a **peer support** model, groups of consumers look after the person in crisis in the home of one of their members providing encouragement, support, assistance, and role models in a non-threatening atmosphere.
- Finally, an **in-home support** approach, similar to a crisis apartment but in the person's own residence, can be considered if separation from the natural environment is not felt to be necessary. A similar range of services as described in the family-based peer model above are available to consumers in their own home.

Group Residential Supports

Group respite/residential approaches have the capacity to serve more than two consumers at a time.

These services are generally provided through crisis residences that combine two types of assistance – crisis intervention and residential treatment. **Crisis residences** offer short-term treatment, structure, and supervision in a protective environment. Services depend on the program philosophy, but can include physical and psychiatric assessment, daily living skills training, and social activities, as well as counseling, treatment planning, and service linking. Crisis residential services are used primarily as an alternative to hospitalization, but can also shorten hospital stays by acting as a stepdown resource upon hospital discharge.

Crisis Stabilization Units (CSUs)

Crisis Stabilization Unit services are provided to individuals who are in behavioral health crisis whose needs cannot be accommodated safely in the residential service settings previously discussed. CSUs can be designed for both voluntary and involuntary consumers who are in need of a safe, secure environment that is still less restrictive than a hospital. The goal of the CSU is to stabilize the consumer and reintegrate him or her back into the community quickly. The typical length of stay in a CSU is less than five days. Consumers in CSUs receive medication, counseling, referrals, and linkage to ongoing services. Multidisciplinary teams of behavioral health professionals staff CSUs, which generally cost two-thirds the amount of a daily inpatient stay.

23-Hour Beds

Twenty-three hour beds, also known as Extended Observation Units (EOUs), may be found in some communities as a stand-alone service or embedded within a CSU. Twenty-three hour beds and EOUs are designed for consumers who may need short, fairly intensive treatment in a safe environment that is less restrictive than hospitalization. This level of service is appropriate for individuals who require protection when overwhelmed by thoughts of suicide or whose ability to cope in the community is severely compromised. Admission to 23-hour beds is desirable when it is expected that the acute crisis can be resolved in less than 24 hours. Services provided include administering medication, meeting with extended family or significant others, and referral to more appropriate services.

Transportation

Transportation is an essential ingredient of the crisis system that ties all the service components together. The ability to transport individuals in need of crisis services in a safe, timely, and cost effective manner is critical to operations. The requirements for individuals who are authorized to transport persons in crisis vary between communities and may be determined by the legal status (voluntary versus involuntary) of the individual in need of treatment. In some circumstances, mobile teams will coordinate transport with local law enforcement or emergency medical vehicles to assist individuals in receiving necessary care. Transportation within a crisis service system may also take other, less expensive forms. For example, crisis systems may arrange with private commercial entities, such as taxi companies, to transport individuals who are willing and able to be transported for treatment, but who lack resources to make the trip. Regardless of how a crisis system decides to provide transportation, there are several key factors for consideration in arranging or providing transportation for individuals seeking crisis services.

These factors include:

(1) Reliability;

(2) Availability; and

(3) Skill level of those involved in the transport.

[3] "Psychiatric Boarding" occurs when someone in a serious mental health crisis is confined for an extended period of time in a hospital emergency room or other non-psychiatric center when no beds are available in a mental health facility. Hospital emergency rooms constitute a "more restrictive environment" where patients receive "less care than they would if they were in an evaluation and treatment center." *In re Det. of D.W.,*2014 Wash. LEXIS 604(Wash. Aug. 7, 2014). The Washington Supreme Court recently outlawed the practice of psychiatric boarding in that state.

[4] *Washington v. Harper*, 494 U.S.210, 238 (1990) (Stevens, J., dissenting). Justice Stevens further points out that "The liberty of citizens to resist the administration of mind altering drugs arises from our nation's most basic values." *Id*.

[5] Bazelon 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.

The Bazelon Center supports the right of each individual to fully participate in, and approve, a treatment plan and to decide which services to accept. The Bazelon Center encourages the articulation of treatment preferences in advance through the use of advance directives and/or a legally recognized health care agent.

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, *Id*.

Outpatient commitment is actually preferred by NAMI: "(9.2.13) Court-ordered outpatient treatment should be considered as a less restrictive, more beneficial, and less costly treatment alternative to involuntary inpatient treatment." NAMI, *Id*.

Among MHA's CA affiliates, MHA SF and MHA LA recently led the fight against implementation of the state outpatient commitment law while MHA Alameda and MHA Santa Barbara supported it.

[6] http://www.mentalhealthamerica.net/positions/evidence-based-healthcare

[7] In 2001, the RAND Institute for Civil Justice released a report on the outcomes of involuntary outpatient commitment in eight states. That report showed that while mandatory treatment programs can lead to good outcomes for some, "Outpatient commitment is not a 'silver bullet' and that it cannot work in the absence of intensive clinical services and mechanisms for enforcement of the court orders". See Ridgely, S., Brown, R., and Petrilla, J. *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States* (2001) http://www.rand.org/content/dam/rand/pubs/monograph_reports/2007/MR1340.pdf.

[9] In 2004, the New York Court of Appeals upheld the Constitutionality of Kendra's Law, an involuntary outpatient commitment statute. In its opinion, the court pointed out that since Kendra's Law provides only for outpatient commitment, and not outpatient treatment, the statutory safeguards survived due process. Further safeguards, specifically a finding of incapacity, were required in order for the state to compel medication. *In re K.L.*, 1 N.Y.3d 362 (2004).

[10] http://www.mentalhealthamerica.net/positions/psychiatric-advance-directives

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