

Principles: Involuntary Mental Health Treatment

*Publication #1040 - Adopted 12/01/2009, Amended 9/20/2014;
Amended 9/16/2017*

BACKGROUND

These principles relate to all individuals receiving or at risk of receiving involuntary mental health treatment, whether at a state hospital, a correctional facility, an Institute for Mental Disease (IMD), or in a community setting. Because legislation and regulatory proposals or changes can impact the rights of individuals who may be subject to involuntary mental health treatment, the following principles guide Disability Rights California (DRC) staff's policy advocacy in this area. See also *Principles: Conservatorship of Persons with Disabilities*, Pub #1037.

PRINCIPLES

DRC Opposes:

1. Expansion of involuntary mental health treatment to anyone who is not imminently dangerous to self or others, or gravely disabled.
2. Any interference with access to judicial review of commitment, regardless of the type of commitment. Access to the judicial system includes: the process for the commitment; burdens and standards of proof; right to legal representation; right to be present at proceedings; rules for obtaining and presenting evidence; and legal timelines for review.

3. Attempts to confine individuals in a county jail based on mental health condition or civil commitment.

DRC Supports:

1. Increased access to voluntary mental health treatment and community supports that enable individuals to live in the community and avoid institutionalization.
2. Ensuring people in facilities receive humane, effective, client-centered, culturally competent care and treatment services with adequate staffing levels.
3. Treatment in the least restrictive environment that is most protective of personal dignity and privacy.
4. Development of appropriate community services and supports for patients transferring out of state hospitals.
5. Protecting personal rights of people in facilities with any psychiatric diagnosis or commitment status. Personal rights include, but are not limited to, the right to: freedom from abuse and neglect; confidential communications with an attorney or patients' rights advocate; reasonable access to confidential telephone calls, mail, education, social interaction, personal visits, religious freedom and practice, recreation, medical treatment; and informed consent to medical or psychiatric treatment, including the right to refuse treatment.
6. The provision of appropriate, voluntary mental health and medical treatment, and appropriate continuity of care, when patients are confined in a county jail.
7. The provision of appropriate, transportation services to and from facilities.
8. Treatment that relies on the recovery model, including but not limited to those involving self-direction, individualized and person-centered treatment, empowerment, holistic measures, non-linear and strength-based treatment, peer support, respect, responsibility, and hope.
9. Prompt access to community placement including conditional release programs for all patients who the Department of State Hospitals (DSH) deems appropriate for such placement with reasonable supervision.

6600 Commitments

1. DRC does not oppose the appropriate and reasonable use of monitoring systems designed to address safety concerns regarding community placement of individuals committed under Welfare & Institutions Code Section 6600. However, we oppose efforts to restrict further community placement of patients who DSH or qualified mental health professional deems ready for community placement under appropriate supervision.

Lanterman-Petris-Short Act Commitments

1. Lanterman-Petris-Short Act (LPS) individuals include those on short-term psychiatric holds (WIC §§5150, 5250) and temporary and permanent conservatorships under WIC §5300 et seq. DRC advocates for the legal rights of all individuals committed under these sections, including individuals living in IMDs.
2. DRC supports:
 - a. The rights of individuals under LPS conservatorship or commitment to an individualized assessment regarding any limitations or deprivations imposed by the conservatorship or commitment.
 - b. Increasing individuals' ability under LPS conservatorship or commitment to receive voluntary services in the least restrictive setting appropriate to meet their needs and consistent with their choice.

Assisted Outpatient Treatment

1. Assisted outpatient treatment (AOT) is a costly program of court-ordered treatment that is of doubtful effectiveness. Any possible benefit is likely due to enhanced services, rather than court orders.
2. DRC opposes expansion of AOT statute because it interferes with the personal autonomy rights of individuals to make decisions and is based on mental health history and speculation about future behavior. It is inconsistent with the recovery model of mental health treatment that emphasizes self-direction, choice, and empowerment.
3. DRC supports using Mental Health Services Act funds and other public dollars to expand voluntary recovery-based community mental health programs such as Full Service Partnerships, peer support, and affordable and supportive housing, rather than for AOT.

4. When implementing AOT the following must be considered:
 - a. AOT must foster the use of voluntary services, protect mental health consumers' rights, and provide access to advocacy services.
 - b. Peers must be included in the county's decision-making process to implement AOT.
 - c. Counties implementing AOT must ensure there is sufficient training for advocates to protect rights and ensure due process throughout the process.
 - d. AOT must not be used to fill gaps in the community mental health system.
 - e. Any county implementing an AOT program must offer the same services on a voluntary basis.
 - f. Counties must not divert funds from voluntary mental health to pay for implementation of AOT.
 - g. Counties implementing AOT must protect confidentiality of medical information and only allow release of confidential health information with the client's consent.