

Guidelines for Legislation on the Psychiatric Hospitalization of Adults

RESOURCE DOCUMENT

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"The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. Views expressed are those of the authors."
-- *APA Operations Manual*.

This document represents the culmination of a series of efforts by APA over a number of years to develop an affirmative proposal concerning the standards, procedures, and consequences of civil commitment. An APA committee and several task forces began such work in the mid-1970s. In 1980, the Council on Governmental Policy and Law,¹ chaired by Dr. Alan Stone, renewed this effort, with the assistance of Mr. Clifford Stromberg, who served as legal consultant to APA in the development of the guidelines and was the chief draftsman of the document. Drafts of the guidelines were reviewed and discussed extensively among the district branches and area councils during 1981-1982. The guidelines were further reviewed by the Assembly and by a specially appointed Assembly task force.²

These guidelines have been prepared and approved by the American Psychiatric Association to assist psychiatrists, legislators, and the public in considering possible revisions of civil commitment laws. APA believes that these guidelines constitute a responsible set of proposals that would improve the process of psychiatric hospitalization in many states. However, because local laws, community conditions, and medical practices vary, state and local psychiatric associations and individual psychiatrists may properly support provisions that differ in many respects from these general guidelines. (Within the guidelines, several optional provisions are given in brackets; italicized words preceding the brackets indicate material to be replaced.)

An extensive commentary describing the legal and clinical rationales for each provision of the guidelines has also been prepared. The commentary and further information concerning the guidelines can be obtained from the Government Affairs Division, American Psychiatric Association.

These guidelines deal with emergency psychiatric evaluation, voluntary admission, involuntary hospitalization, right to treatment, right to refuse treatment, patients' rights, and legal immunity for mental health personnel, as well as a number of related issues.

¹The Council on Governmental Policy and Law included Dr. Alan A. Stone (chairperson), Richard Bonnie, Esq., Dr. Thomas Pfaehler, Dr. Shirley Phelps, Dr. Richard Rada, Dr. David Starrett, Dr. Laurence Tancredi, Dr. Hugo Van Dooren, and Dr. Andrew Watson.

²The members of the APA Assembly Task Force on the Model Law were Dr. Thomas Pfaehler (chairperson), Dr. Jerome Beigler, Dr. Thomas Callahan, Dr. Merlin Johnson, Dr. Alfred Margulies, Dr. Ralph O'Connell, Dr. Pete Palasota, and Dr. Roger Peele. Clifford Stromberg, Esq., served as legal consultant to the task force.



The American Psychiatric Association is a national medical specialty society, founded in 1844, whose 36,500 physician members specialize in the diagnosis and treatment of mental and emotional illnesses including substance use disorders.

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Section 1: Short Title

These provisions governing the psychiatric hospitalization of adults may be cited as Title I of the Mental Health Code.¹

Section 2: Legislative Purposes

This Act is intended to achieve and shall be construed so as to promote these legislative purposes:

1. To make psychiatric evaluation, care, and treatment available to persons who suffer from severe mental disorders and can benefit from treatment and to encourage voluntary rather than involuntary admission whenever hospitalization is necessary;
2. To safeguard the legal rights of patients in a manner that will advance and not impede the therapeutic and protective purposes of psychiatric hospitalization;
3. To provide workable procedures for obtaining consent to and administering medications and other treatments;
4. To provide legal immunity for reasonable, good-faith efforts to implement this Act and legal penalties for knowing, willful efforts to subvert this Act; and
5. To provide a statutory framework for the promulgation of regulations by the Department of Mental Health.

Section 3: Definitions

As used in this Act, the terms below shall have the meanings indicated:

“Aversive therapy” means any treatment or procedure that, because it is believed to be painful or physically uncomfortable to the patient, is administered in order to reduce the frequency or intensity of a behavior, except that “aversive therapy” does not refer to verbal therapies, seclusion, or physical restraints used in conformity with subsection 10.F., or psychotropic medications which are not used for purposes of aversive conditioning.

“Consistent with the least restrictive alternative principle” means that 1) each patient committed solely on the ground that he is likely to cause harm to himself or to suffer substantial mental or physical deterioration shall be placed in the most appropriate and therapeutic available setting, that is, a setting in which treatment provides the patient with a realistic opportunity to improve and which is no more restrictive of his physical or social liberties than is believed conducive to the most effective treatment for the patient, and 2) each patient committed solely or in part on the ground that he is likely to cause harm to others shall be placed in a setting in which treatment is available and the risks of physical injury or property damage posed by such placement are warranted by the proposed plan of treatment.

“Court” means the court or judicial officer designated under the laws of this State for the discharge of the functions described in this Act.

“Emergency situation” means a situation in which the patient exhibits substantial behavior that is self-destructive or assaultive, threatens significant damage to the property of others, or indicates that the patient is suffering extreme anxiety amounting to panic, or sudden exacerbation of his severe mental disorder.

“Experimental treatment” means any treatment other than one that is commonly accepted for treatment of the mental disorder involved (or is supported by widely accepted scientific studies) and is provided by a qualified health professional, if such treatment poses a significant risk of harm to the patient.

“Informed consent to treatment” means a knowing and voluntary decision to undergo treatment, evidenced in writing, and made by a person who has the capacity to make an informed decision, after staff of the treatment facility have explained to the person the nature and effects of the proposed treatment.

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“Lacks capacity to make an informed decision concerning treatment” means that the person, by reason of his mental disorder or condition, is unable, despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment or is unable to engage in a rational decision-making process regarding such hospitalization or treatment, as evidenced by inability to weigh the possible risks and benefits.

“Likely to cause harm to himself or to suffer substantial mental or physical deterioration” means that, as evidenced by recent behavior, the person 1) is likely in the near future to inflict substantial physical injury upon himself, or 2) is substantially unable to provide for some of his basic needs, such as food, clothing, shelter, health, or safety, or 3) will if not treated suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own.

“Likely to cause harm to others” means that, as evidenced by recent behavior causing, attempting, or threatening such harm, a person is likely in the near future to cause physical injury or physical abuse to another person or substantial damage to another person's property.

“Patient” means any person receiving evaluation, care, or treatment under this Act, except that for purposes of the rights provided in Section 10, “patient” shall refer only to persons in residential treatment programs.

“Person” means, for purposes of any provision of this Act authorizing the commitment or treatment of a “person,” an individual aged 18 years or older.²

“Psychosurgery” means any procedure that, by direct access to the brain, removes, destroys, or interrupts the continuity of brain tissue which is histologically normal (as distinguished from normal in its physiological or psychological functioning) for the primary purpose of altering behavior or treating a mental disease or disorder. Psychosurgery includes the implantation of electrodes with such an effect and for such a purpose, with or without subsequent electrocoagulation. Psychosurgery does not include neurosurgical procedures designed to treat reliably diagnosed intractable physical pain or epilepsy.

“Severe mental disorder” means an illness, disease, organic brain disorder, or other condition that 1) substantially impairs the person's thought, perception of reality, emotional process, or judgment, or 2) substantially impairs behavior as manifested by recent disturbed behavior.³

“Treatment facility” means a community mental health facility, a general medical facility providing psychiatric services, or other psychiatric facility or program meeting applicable licensing standards that has been approved for the provision of services under this Act by the Department of Mental Health, provided that no jail or other correctional facility shall be approved as a treatment facility for any persons other than those who could otherwise lawfully be detained there.

Section 4: Emergency Psychiatric Evaluation

4.A. Detention by a police officer.

1. A police officer may take a person into custody and transport the person to a treatment facility for emergency psychiatric evaluation if and only if:
 - a. the person would otherwise be subject to lawful arrest and the police officer believes that the person is in need of emergency psychiatric treatment; or
 - b. the police officer has probable cause to believe that the person has attempted suicide within the last 48 hours; or
 - c. the police officer has probable cause to believe, based on his personal observation and investigation or based on the petition of any interested adult under subsection 4.C. and such corroboration as the police officer deems necessary in the circumstances, that the person is suffering from a severe mental disorder as a result of which he is likely to cause harm to himself or to others or is manifestly unable to care for some of his basic needs, and that immediate hospitalization is necessary to prevent harm to the person or to others; or

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d. he is acting upon the certification of a licensed physician under subsection 4.B.

2. Any person taken into custody pursuant to this subsection shall be presented promptly to a treatment facility. Correctional facilities shall not be used as temporary shelter for such persons except for the protective custody of the person pending transportation to a treatment facility.

3. Upon or shortly after taking a person into custody, the police officer shall take reasonable precautions to safeguard and preserve the personal property of the person unless a guardian or responsible relative is able to do so. Upon presenting a person to a treatment facility, the police officer shall inform the staff in writing of the facts that caused him to take the person into custody and shall specifically state whether the person is otherwise subject to arrest.

4.B. Certification by a licensed physician. A person may be taken into custody by a police officer, or accepted by an ambulance service, and transported and presented to a treatment facility for emergency psychiatric evaluation, when a licensed physician certifies in writing that he has examined the patient in the last 72 hours or has ongoing medical responsibility for the person and has knowledge of his current condition and that on such basis he has probable cause to believe that such person is suffering from a severe mental disorder as a result of which: he lacks capacity to make an informed decision concerning treatment; and he is 1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or 2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

4.C. Petition by any interested adult. Any interested adult may petition for, or present a person for, emergency psychiatric evaluation by alleging on the basis of personal observation that he has probable cause to believe that such person is suffering from a severe mental disorder as the result of which: he is likely to cause harm to himself or to others or is manifestly unable to care for some of his basic needs; and immediate hospitalization is necessary to prevent harm to the person or to others.

4.D. Treatment facility determination.

1. Upon the presentation of a person to a treatment facility pursuant to this Section 4, the facility shall accept the person and shall promptly examine him to determine whether he meets the criteria for emergency evaluation and treatment set forth in paragraph 2.

2. The person shall be admitted for emergency evaluation and treatment only if the examining psychiatrist determines that there is probable cause to believe that the person suffers from a severe mental disorder as the result of which: he lacks capacity to make an informed decision concerning treatment; and he is a) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or b) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

3. If the examining psychiatrist determines that there is not probable cause to believe that the person meets the criteria for emergency evaluation and treatment, the person shall be released. If a person was presented to the treatment facility by a police officer and was otherwise subject to lawful arrest, he shall remain under the custody of police officers.

4.E. Advice of rights. The treatment facility shall advise any person admitted for emergency evaluation and treatment of the purposes and possible duration of emergency evaluation and of his rights under this Act as soon after admission as his medical condition permits.

4.F. Hearing on emergency evaluation.

1. Each person who is admitted to a treatment facility shall receive a preliminary hearing before the court within 5 business days of admission or be discharged, unless he has, after consultation with counsel, executed a written waiver of such hearing. The hearing shall be informal and subject to such rules as the court sets consistent with fundamental fairness.

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2. The court shall determine at the close of the hearing, or within 5 business days of the patient's admission, whether he should be discharged. A patient shall then be discharged, unless the court determines that there is probable cause to believe that he satisfies the criteria for 30-day commitment provided in Section 6, and unless within 2 business days of the court's decision a petition for such commitment is filed with the court.

4.G. Duration of emergency evaluation and treatment. The period of emergency evaluation and treatment shall in no case exceed 14 days.

Section 5: Voluntary Admission

5.A. Admission.

1. A treatment facility may admit a person if after examining the patient a *psychiatrist* [optional provision: “a physician”] on the staff or with privileges at the treatment facility believes the person is mentally ill and in need of hospitalization and if the person gives written consent to admission. Prior to such admission, the person shall be advised orally and given a written statement of his rights under this Act, provided that, if his condition upon admission makes such advice infeasible and the medical reasons are entered in the record, such advice may be deferred until the patient's medical condition permits, for not more than 48 hours. Each patient shall be asked to sign an acknowledgment that he has been so advised and has consented to voluntary admission for treatment.

2. Initial consent to voluntary admission for treatment shall be valid for 60 days. Thereafter, a patient may remain at the treatment facility for periods of up to 180 days each upon a signed consent executed after the patient has had an opportunity to consider with such persons as he wishes his need for continued hospitalization and treatment.

3. If *the responsible psychiatrist* [optional provision: “the responsible physician”] has substantial reason to believe that a person seeking to admit himself or to consent to further hospitalization lacks capacity to make an informed decision concerning treatment, he shall obtain, in addition to the consent of the patient, the informed consent of the patient's next of kin or guardian. *The responsible psychiatrist* [optional provision: “The responsible physician”] shall renew his effort to obtain the informed consent of the patient if the patient regains the capacity to make an informed decision concerning treatment.

5.B. Discharge or petition for 30-day commitment. Any patient who is voluntarily admitted to a treatment facility shall be discharged within 5 business days of his written request for discharge (and any patient who indicates his desire to be discharged but is unable to write shall be helped to put his request in writing), unless a petition for 30-day commitment is filed within that period by the treatment facility or the patient's next of kin or guardian.

5.C. Conversion from involuntary to voluntary status. A patient who is subject to involuntary hospitalization pursuant to Sections 4, 6, or 11 of this Act may at any time convert to voluntary status if *the responsible psychiatrist* [optional provision: “the responsible physician”] agrees that such conversion is made in good faith and that the patient is an appropriate patient for voluntary hospitalization.

Section 6: 30-Day Commitment

6.A. Petition.

1. Persons who are present at a treatment facility under voluntary admission but have requested discharge, and persons present at a treatment facility for emergency psychiatric evaluation, may be committed involuntarily for a period of up to 30 days upon a petition filed by the treatment facility or by the next of kin or guardian, and other persons may be so committed upon a petition filed by any interested adult. The petition shall allege that such person meets the criteria set forth in subsection 6.C. The petition shall set forth the facts supporting the allegations and, in the case of petitions filed by a treatment facility, shall describe why the patient requires treatment. The petition shall be filed with the court, which shall have copies promptly served upon the patient, the next of kin or guardian, and the patient's attorney if known.

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2. The copies of the petition served by the court shall be accompanied by a notice advising of the person's rights concerning the proceeding.

6.B. Summons for evaluation; psychiatric report.

1. Upon the filing of a petition for 30-day commitment of a person who is not currently under emergency evaluation or voluntary admission, the court shall issue a summons to the person to submit to an examination (on an outpatient basis) conducted by a psychiatrist at a treatment facility or a private psychiatrist. The examining psychiatrist shall promptly prepare a report on his examination and file it with the court. The court shall have copies promptly served upon the patient, the next of kin or guardian, and the patient's attorney if known.

2. A person served with a summons to submit to a psychiatric examination may in lieu of such examination submit a report of a psychiatrist stating that he has recently examined the person or has ongoing medical responsibility for the person and knowledge of his current condition and that in his opinion the person does not meet the criteria for involuntary commitment. The petition for commitment may then be dismissed by the court or continued.

*6.C. Criteria for 30-day commitment.*⁴ A person may be involuntarily committed for a period of up to 30 days if, after the hearing provided in subsection 6.D., the court determines, on the basis of clear and convincing evidence, that

1. the person is suffering from a severe mental disorder; and
2. there is a reasonable prospect that his disorder is treatable at or through the facility to which he is to be committed and such commitment would be consistent with the least restrictive alternative principle; and
3. the person either refuses or is unable to consent to voluntary admission for treatment; and
4. the person lacks capacity to make an informed decision concerning treatment; and
5. as the result of the severe mental disorder, the person is a) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or b) likely to cause harm to others.

6.D. Hearing on 30-day commitment.

1. Every person as to whom a petition for 30-day commitment has been filed shall be notified by the court sufficiently in advance to be able to prepare for the hearing and shall receive a prompt hearing. For persons confined for emergency psychiatric evaluation or currently under voluntary admission, this hearing shall take place within 3 business days of the filing of the petition.

2. The respondent shall be present at the hearing unless the court finds a) that he has knowingly and voluntarily waived such right after consulting with counsel, or b) that because his behavior at the hearing is so disruptive it cannot reasonably continue in his presence. Hearings shall be held in the treatment facility whenever feasible given the other functions of the court.

3. Any respondent who is unable to pay for counsel shall have the right to be provided with counsel to prepare for and represent him at the hearing. [Optional provision: "Any respondent who is unable to pay for an examination for purposes of the hearing shall have the right to be provided with one examination by a licensed psychiatrist at the expense of the (state or local government)."]

4. The District Attorney or County Counsel shall represent the interests of the State at the hearing. [Optional provision: "If the District Attorney or County Counsel fails to proceed with the commitment, the next of kin or a petitioning party may retain counsel to do so in his stead, and the reasonable costs of such counsel shall be paid by the (state or local government)."]

5. The rules governing evidentiary and procedural matters at hearings under this Act shall be applied so as to facilitate informal, efficient presentation of all relevant, probative evidence and resolution of issues with due

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regard to the interests of all parties. Hearsay evidence may be received, and experts and other witnesses may, consistent with law, testify to any relevant and probative facts at the discretion of the court.

6. Patients shall not have a “right to remain silent” at a psychiatric examination or hearing conducted pursuant to this Act, provided that no patient shall be held civilly or criminally liable for not speaking or testifying. Any information obtained from or disclosed by the patient during the course of evaluation or treatment is admissible in any hearing provided in this Act without regard to whether it would otherwise be privileged, provided that no disclosure made by the patient during the course of evaluation or treatment or in any proceeding conducted under this Act, and no opinion testimony based on such disclosures, may be admitted against the patient on the issue of guilt in a criminal proceeding unless he places his mental condition in issue in such proceeding and unless the disclosure or opinion is relevant to such an issue raised by him.

7. The hearing shall be closed to the public, unless the respondent requests that it be open or the court determines for other good cause that the hearing should be open. The court shall keep a complete record, written or recorded, of every hearing.

8. At the conclusion of the hearing, or within one business day thereafter, the court shall make its findings, including specific findings as to whether the commitment is warranted because the person is a) likely to cause harm to others, or b) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or c) both a) and b). As to any person found likely to cause harm to himself or to suffer substantial mental or physical deterioration, the court shall further make findings as to whether commitment is warranted because the person a) is likely in the near future to inflict substantial physical injury upon himself, or b) is substantially unable to provide for some of his basic needs, such as food, clothing, shelter, health, or safety, or c) will, if not treated, suffer severe and abnormal mental, emotional, or physical distress and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own.

9. The court shall enter an order discharging the person unless it finds by clear and convincing evidence that the person satisfies all of the criteria for commitment in subsection 6.C., in which event it shall enter an order committing the person for evaluation and treatment for a period of “up to 30 days.” If at any time during 30-day (or any subsequent) commitment a patient is absent without permission, the order of commitment constitutes a continuing authorization to the treatment facility and to any police officer to procure his return.

Section 7: Informed Consent to Medication or Other Treatment—Voluntary Patients

7.A. Informed consent. Except in an emergency situation, a treatment facility shall, prior to beginning any course of medication or other treatment for a patient who is subject to voluntary admission under Section 5, obtain informed consent to treatment. If the patient does not lack capacity to make an informed decision concerning treatment, the consent shall be his own. If he does lack such capacity, the consent shall be that of his next of kin or guardian, provided that such a patient may receive appropriate medications or other treatments, except as limited by subsection 8.C., until such time as the consent or refusal to consent of such next of kin or guardian can be obtained.

7.B. Revocation of consent. A voluntary patient (or the next of kin or guardian who consented to treatment on his behalf) may revoke consent to treatment at any time by a reasonably clear statement in writing (and patients who indicate a desire to revoke consent but are unable to write shall be helped to put their statement in writing). If such consent is revoked, the treatment shall be promptly discontinued, provided that a course of treatment may be concluded or phased out where necessary to avoid the harmful effects of abrupt withdrawal.

7.C. Refusal to consent. Except in an emergency situation, any voluntary patient (himself or through his next of kin or guardian) shall have the right to refuse any and all medications or other treatments. If appropriate medications or treatments are refused, the facility may then discharge the patient and shall not be liable in any respect for such action.

Section 8: Informed Consent to Medication or Other Treatment—Involuntary Patients

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8.A. Consent during emergency evaluation. Following admission and during the period of emergency evaluation provided in Section 4, the treatment facility may administer medications or other treatments to a patient, except as limited by subsection 8.C., consistent with good medical practice and without the informed consent of the patient or his next of kin or guardian. However, prior to administering any such medication or other treatment, the staff shall explain the purposes, nature, and effects of the treatment and shall request the patient's consent to it, unless *the responsible psychiatrist* [optional provision: “the responsible physician”] determines that the patient's condition makes doing so infeasible or harmful to him and enters the reasons for not doing so in the record.

8.B. Consent during 30-day or subsequent commitments. Since it is a prerequisite to involuntary commitment that the person lacks capacity to make an informed decision concerning treatment, the treatment facility shall be authorized to administer medications or other treatments to such persons, except as limited by subsection 8.C., consistent with good medical practice and without their consent. Although consent to treatment is not required, during the course of treatment *the responsible psychiatrist* [optional provision: “the responsible physician”] shall consult with the patient and his next of kin or guardian and give consideration to the views they express concerning treatment and any alternatives.

8.C. Special therapies. Notwithstanding subsections A and B above, a treatment facility shall not administer aversive therapy, experimental treatment, psychosurgery, or any other special therapy designated by the Department of Mental Health except as provided by law or in regulations promulgated by the Department of Mental Health.

8.D. Other medical/surgical treatments. Consent for other medical/surgical treatments not intended primarily to treat a patient's mental disorder shall be obtained in accordance with applicable law.

Section 9: Provision of Treatment

9.A. General duty to provide treatment. Every patient shall be provided with prompt, competent, and appropriate treatment that offers him a realistic prospect of improvement. Patients shall be afforded treatment by sufficient numbers of duly qualified personnel in facilities that meet applicable licensing and accreditation standards, that conform to applicable regulations of the Department of Mental Health, and that are able adequately to care for and treat the patients they serve.

9.B. Individual treatment plan.

1. A written individual treatment plan shall be prepared, with the participation of the patient to the extent he is able, during voluntary admission or emergency psychiatric evaluation or, if a person has been subject to neither, then within 7 days of the beginning of a patient's 30-day commitment. The individual treatment plan shall be approved by *the responsible psychiatrist* [optional provision: “the responsible physician”], and the course of treatment actually administered shall conform to the plan.

2. The patient's progress in attaining the objectives in the treatment plan shall be noted in his records, and revisions in the plan shall be made as appropriate. The patient and, if the patient desires, the next of kin or guardian shall be afforded an opportunity to participate in considering any substantial change in the treatment plan.

3. The individual treatment plan shall be available upon request to the patient and to any other person designated by him, provided that *the responsible psychiatrist* [optional provision: “the responsible physician”] may preclude disclosure of the individual treatment plan to the patient or others for a period not to exceed 7 days from the request if he states in writing why disclosure would be harmful to the patient.

9.C. Administration of medications and other treatments.

1. Medications and other treatments shall be prescribed, ordered, and administered only in conformity with accepted clinical practice. Medication shall be administered only in accordance with the written order of a physician or upon a verbal order noted in the patient's medical record and subsequently signed by the physician. Medication shall be administered only by a qualified physician, qualified nurse, or qualified other persons pursuant to procedures approved by the Department of Mental Health. The attending physician shall

review regularly the drug regimen of each resident patient under his care and shall monitor any symptoms of harmful side effects. Prescriptions for psychotropic medications shall be written with a termination date not exceeding 30 days thereafter but may be renewed.

2. Medications and other treatments shall be administered in accordance with all applicable law.

3. If a patient is given any psychotropic or other medication that has an effective duration of action including the day of a court hearing, the facts concerning its administration and effects, and the patient's mental status and behavior in the absence of medication, shall be brought to the attention of the court.

9.D. Other medical/surgical care. All patients shall be provided with prompt, regular, and competent medical care for physical ailments under the supervision of a licensed physician. Every patient shall have a reasonably complete physical examination at appropriate intervals.

Section 10: Rights of Patients

10.A. Preservation of rights. No right of any person (including but not limited to the right to register and vote at elections; rights to acquire, use, and dispose of property including contractual rights; rights to sue and be sued; rights relating to licenses, permits, privileges, and benefits under law; and rights concerning domestic relations) shall be denied or reduced solely by reason of his having been evaluated, committed, or treated under this Act, except as otherwise specifically provided herein or in other applicable law. A finding of lack of capacity to make an informed decision concerning treatment under Section 6 shall not alone establish lack of competence for any other purpose. A treatment facility may for clinical reasons preclude a patient who is believed to lack competence from making substantial dispositions of his property until his competence to do so can be decided by a court.

10.B. Right to treatment. Patients shall have a right to treatment to the extent provided in Section 9 and subsections 10.C. and 10.D.

10.C. Healthful and humane environment. Every patient shall have the right to a healthful and humane environment. Every treatment facility shall provide a clean, sanitary, safe, and comfortable environment in a structure that complies with applicable licensing requirements governing physical facilities, nutrition, health and safety, and medical services and, for aspects of care for which there are not mandatory requirements, with generally accepted professional standards. In addition, every patient shall have a right to a humane psychological environment that protects him from harm or abuse, provides reasonable privacy, promotes personal dignity, and provides opportunity for improved functioning.

10.D. Least restrictive alternative and leaves of absence.

1. Every patient shall have the right to treatment consistent with the least restrictive alternative principle.
2. Leaves of absence may be granted in appropriate cases at the discretion of the treatment facility. Police officers shall be authorized to and shall, at the request of a treatment facility, take into custody and return to the treatment facility any person who has been committed there and leaves without proper authorization or does not return at the end of an authorized leave of absence.

10.E. Institutional labor.

1. Patients shall have the right to perform labor as part of a therapeutic program.
2. Patients may not be required to perform labor except that, to the extent they are able, they may be required to perform a) tasks necessary to care for their personal possessions, b) routine, nondegrading housekeeping tasks necessary to maintain their living quarters, or c) other tasks which *the responsible psychiatrist* [optional provision: “the responsible physician”] approves and which are monitored as part of a therapeutic program for the patient. No patient shall be subjected to any loss of any right under this Act (as distinguished from a privilege that is conferred as part of a therapeutic program) because of his refusal to perform such tasks.

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3. Any patient labor that confers an economic benefit upon the institution beyond merely supplementing employee performance of housekeeping tasks shall be compensated on a reasonable basis in accordance with applicable law, and the proceeds of such labor shall be paid to the patient or his designee.

*10.F. Restraints and seclusion.*⁵

1. Restraints and seclusion may be of therapeutic benefit to some patients and therefore may be administered in conformity with good medical practice.
2. Every patient shall have the right to be free from unwarranted or inappropriate restraints or seclusion.
3. A patient may be physically restrained or placed in seclusion only at the written order of a physician or upon a verbal order noted in the patient's record and subsequently signed by the physician.
4. During any period in which a patient is restrained or secluded, he shall be checked periodically and cared for properly to assure his well-being.

10.G. Corporal punishment. Every patient shall have the right to be free from corporal punishment.

10.H. Nutrition. Every patient shall have the right to a nutritionally sound and medically appropriate diet.

10.I. Exercise and recreation. Every patient shall have reasonable opportunities for physical and outdoor exercise and access to recreational areas and equipment. Reasonable limitations may be set by general rules or, for clinical reasons, in particular cases.

10.J. Visitors. Every patient shall have the right to receive visitors of his choosing with reasonable privacy. Reasonable limitations on access of visitors may be set by general rules or, for clinical reasons, in particular cases.

10.K. Communications.

1. Every patient shall have the right to send and receive mail. Reasonable rules governing inspection (but not reading) of incoming mail may be enforced, provided that they are necessary to substantial health care purposes and that they preserve the patient's rights of privacy to the extent compatible with his clinical status.
2. Every patient shall have the right to reasonably private access to telephones, including the right to make long-distance calls to the extent he can arrange for payment for such calls.
3. A treatment facility shall provide reasonable assistance to patients in exercising their communication rights. Reasonable limitations on use of the mails and telephones may be set by general rules or, for clinical reasons, in particular cases.

10.L. Practice of religion. Every patient shall have the right to practice or refrain from practicing a religion, and pressure shall in no event be placed on those who do not wish to practice a religion. The treatment facility shall provide appropriate assistance so that patients wishing to practice a religion have a reasonable opportunity to do so.

10.M. Personal possessions. Every patient shall have the right to keep, use, and store personal possessions and to maintain and use bank accounts or other sources of personal funds unless precluded from doing so by order of a court. Reasonable limitations may be set by general rules or, for clinical reasons, in particular cases.

10.N. Notice of rights. As soon after admission as his medical condition permits, a patient shall be advised orally and given a written statement of his rights under this Act, and such a statement of rights shall be posted so that it is available to patients.

10.O. Nonretaliation. No patient shall be retaliated against or subjected to any adverse change of conditions or

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treatment solely because of his having asserted his rights.

10.P. Access to counsel. A patient may at any time have a telephone conversation with or be visited by his lawyer.

Section 11: Successive Periods of Commitment

11.A. 60-day recommitment.

1. Any person who has been subject to a 30-day commitment pursuant to section 6 may be recommitted for up to 60 days upon a petition by the treatment facility or by the next of kin or guardian. The petition may be filed with the court at any time prior to the expiration of the 30-day commitment. The petition shall include a statement as to why the person still meets the criteria for involuntary commitment, what treatment has been provided and what progress has been made, why a further period of commitment is warranted, and the identity of the person who has knowledge concerning the case. The petition shall be promptly served by the court on the patient, the next of kin or guardian, and the patient's attorney.
2. The patient shall be entitled to a hearing before the court on the petition on or before the first business day following the expiration of the 30-day commitment and shall have all other rights to which he was entitled at the hearing on 30-day commitment.
3. The court shall order that the person be discharged unless it determines a) by clear and convincing evidence that the person still satisfies the criteria for involuntary commitment, and b) that there is a reasonable prospect that a substantial therapeutic purpose would be served by a further period of commitment.

11.B. 180-day recommitments.

1. Any person who has been subject to 60-day recommitment pursuant to subsection 11.A. may be recommitted for up to 180 days upon a petition filed with the court by the treatment facility or by the next of kin or guardian. The petition shall include a statement as to why the person still meets the criteria for involuntary commitment, what treatment has been provided and what progress has been made, why a further period of commitment is warranted, and the identity of the person who has knowledge concerning the case. The petition shall be promptly served by the court on the patient, the next of kin or guardian, and the patient's attorney.
2. The patient shall be entitled to a hearing before the court on the petition on or before the first business day following expiration of the operative period of commitment and shall have all other rights to which he was entitled at the hearing on 30-day commitment.
3. The court shall order that the person be discharged unless it determines a) by clear and convincing evidence that the person still satisfies the criteria for involuntary commitment, and b) that there is a reasonable prospect that a substantial therapeutic purpose would be served by a further period of commitment.
4. Additional recommitments for periods of up to 180 days each may be ordered in accordance with paragraphs 1-3 of subsection 11.B. when warranted.

11.C. Waiver of hearings. A patient may waive any hearing to which he is entitled under this Section 11 upon a written waiver that the court finds is knowingly and voluntarily executed by the patient.

Section 12: Discharge

12.A. Periodic review. The responsible psychiatrist [optional provision: "The responsible physician"] shall review periodically whether a patient still meets the criteria for lawful commitment, and if he concludes that the patient does not, he shall undertake discharge procedures as provided herein.

12.B. Patients likely to harm themselves or suffer substantial deterioration. As to a patient committed because he

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was likely to cause harm to himself or to suffer substantial mental or physical deterioration, if *the responsible psychiatrist* [optional provision: “the responsible physician”] concludes that the patient no longer meets the criteria for lawful commitment, he may discharge the patient directly.

12.C. Patients likely to harm others. As to a patient committed solely because or partly because he was likely to cause harm to others, if *the responsible psychiatrist* [optional provision: “the responsible physician”] concludes that the patient no longer meets the criteria for lawful commitment or that the patient's treatment program has been completed or is unlikely to provide further benefits, he shall apply to the court for an order discharging or transferring the patient, as may be appropriate.⁶ The application shall set forth the relevant facts. The court may conduct an informal hearing, subject to such procedures as the court sets. Nothing in this subsection shall reduce any rights to hearings that patients have pursuant to other provisions of this Act.

12.D. Temporary delays. Discharge of any patient may be delayed for a reasonable period of time in order to arrange transportation or lodging for the patient or for other good cause.

12.E. Discharge and recommitment. A person who has been discharged from emergency evaluation, 30-day commitment, or a subsequent period of commitment may be recommitted only pursuant to the same procedures provided in this Act and upon a showing of some new circumstances warranting such commitment that were not known at the time of discharge.

12.F. Release to outpatient treatment. *The responsible psychiatrist* [optional provision: “The responsible physician”] may, as part of an individual treatment plan for a patient who is involuntarily committed, release such patient to outpatient treatment upon the condition that if the patient fails to follow through with or respond acceptably to such outpatient treatment, he may be returned to inpatient treatment for the remainder of the operative period of commitment.

12.G. Habeas corpus. Nothing in this Act shall limit any other legal rights or remedies concerning discharge that a patient may have or acquire pursuant to law, regulation, or policy, including the right to petition for a writ of habeas corpus.

Section 13: Confidentiality and Disclosure of Information

Guidelines for this topic are contained in the American Psychiatric Association's “Model Law on Confidentiality of Health and Social Service Records” (available on request from the APA Division of Government Relations).

Section 14: Representation of Patients

14.A. Right to counsel at hearings. Every patient shall have a right to counsel to represent him at court hearings under this Act, except that a patient need not be provided with counsel for the preliminary hearing on emergency evaluation provided in subsection 4.F.

14.B. Resolution of grievances in treatment facilities. Every treatment facility shall establish a fundamentally fair procedure for the assertion, resolution, and redress of patients' grievances and shall have a patients' representative or similar person who shall hear patients' grievances, attempt to resolve problems, and protect patients' interests.

14.C. Representation by next of kin or guardian. Any right of patients provided in this Act may be exercised on behalf of a patient who is unable to exercise such right by a next of kin or guardian, in accordance with law.

Section 15: Transportation

Whenever a patient is to be brought to or from a treatment facility or is to be transferred to another facility or to a home, the court may direct the sheriff, state police, or other appropriate authorities to furnish suitable transportation.

Section 16: Nonderogation of Patients' Rights

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Rights conferred upon patients by this Act shall be in addition to, and nothing in this Act shall revoke or reduce, any rights, privileges, or immunities that a patient may have or acquire by law, regulation, or policy.

Section 17: Costs of Care

In accordance with law, indigent public patients shall receive care and treatment under this Act without charge to them. Patients committed under this Act who are able to pay may be required to pay some reasonable costs of care and treatment, and to that end treatment facilities and the State shall be authorized to recover such costs from them or their estate, their family, custodians of their property, or third parties liable for the costs of their care or treatment, in conformity with law. The liability of patients, their families, and others for the long-term care of patients committed as likely to cause harm to others shall be specially limited by regulations of the Department of Mental Health.

Section 18: Immunities and Penalties

18.A. Immunities.

1. In the absence of willful misconduct or gross negligence, no officer, director, staff member, or employee of a treatment facility shall be liable for acts or omissions within the scope of his employment related to admission, evaluation, care, treatment, nonadmission, transfer, removal of restrictions upon, or discharge of a person, pursuant to this Act:
2. No other person who, acting in good faith and with a reasonable basis, participates in any of the processes provided in this Act shall be liable for such actions.
3. Notwithstanding any other provision of this Act, no police officer; no officer, director, staff member, or employee of a treatment facility; and no other person or entity performing actions pursuant to this Act shall be liable for any action of a patient who is discharged from or is absent from a treatment facility pursuant to this Act.
4. Under no circumstances shall any person performing actions pursuant to this Act have a duty to, or be liable for failing to, notify, advise, or warn anyone concerning the nonadmission, transfer, removal of restrictions on, or discharge of any person.

18.B. Penalties.

1. Any person who knowingly and willfully gives substantial, false information or takes other wrongful action for the purpose of distorting, corrupting, or interfering with the processes provided in this Act shall be subject to a civil fine and shall be liable for injunctive relief and money damages, in addition to any other liability under law.
2. Any person who takes into custody, admits for evaluation or commitment, detains for a further period of time, discharges, or administers medication or treatment to a patient or takes other action affecting the substantial rights of a patient, doing so knowingly and willfully in substantial violation of this Act, shall be subject to a civil fine and shall be liable for injunctive relief and money damages, in addition to any other liability under law. This paragraph shall not be invoked in cases of minor, merely technical, or otherwise justifiable breaches of the provisions of this Act.

Section 19: Regulations

The Commissioner of Mental Health is empowered to promulgate regulations to implement this Act that are consistent with its provisions.

Section 20: Construction

20.A. Gender and number. As used in this Act, pronouns shall refer to both male and female persons equally, and articles shall refer equally to singular and plural persons and things.

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20.B. Severability. If any provision of this Act or its application to any person or circumstance is held invalid, it is the legislative intent that such invalidity not affect other provisions or applications which can be given effect apart from that which is invalidated, and to this end the provisions of this Act shall be deemed severable.

20.C. Construction against implied repeal. This Act is intended as a unified, general Act covering its subject matter, and, accordingly, none of its provisions shall be deemed to be repealed by implication by subsequent legislation if such a construction reasonably can be avoided.

ADDENDUM

This addendum contains guidelines for states that do not wish to undertake a comprehensive revision of their civil commitment laws but do wish to add provisions for the commitment of persons who are likely to “suffer substantial mental or physical deterioration.”

Such states may adopt the definitions of “consistent with the least restrictive alternative principle,” “lacks capacity to make an informed decision concerning treatment,” “likely to cause harm to himself or to suffer substantial mental or physical deterioration,” and “severe mental disorder” given in Section 3 of the complete guidelines, as well as the following provisions.

Emergency Psychiatric Evaluation

Detention by a police officer. A police officer may take a person into custody and transport the person to a treatment facility for emergency psychiatric evaluation if:

a) [as in current state law], or b) [as in current state law]; or c) The police officer has probable cause to believe, based on his personal observation and investigation, or based on the petition of any interested adult and such corroboration as the police officer deems necessary in the circumstances, that the person is suffering from a severe mental disorder as a result of which he is likely to cause harm to himself or others or is manifestly unable to care for some of his basic needs and that immediate hospitalization is necessary to prevent harm to the person or to others.

Certification by a licensed physician. A person may be taken into custody by a police officer, or be accepted by an ambulance service, and transported and presented to a treatment facility for emergency psychiatric evaluation when a licensed physician certifies in writing that he has examined the patient in the last 72 hours or has ongoing medical responsibility for the person and has knowledge of his current condition, and that on such basis he has probable cause to believe that such person is suffering from a severe mental disorder as the result of which: he lacks capacity to make an informed decision concerning treatment; and he is 1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or 2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

Treatment facility determination. Upon the presentation of a person to a treatment facility, the facility shall accept the person and shall promptly examine him to determine whether he meets the criteria for emergency evaluation and treatment set forth below.

The person shall be admitted for emergency evaluation and treatment only if the examining psychiatrist determines that there is probable cause to believe that the person suffers from a severe mental disorder as the result of which: he lacks capacity to make an informed decision concerning treatment; and he is 1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or 2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

Criteria for Commitment

A person may be involuntarily committed for a period of up to 7 days if, after the hearing, the court determines, based upon clear and convincing evidence, that:

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1. the person is suffering from a severe mental disorder; and
2. there is a reasonable prospect that his disorder is treatable at or through the facility to which he is to be committed and such commitment would be consistent with the least restrictive alternative principle; and
3. the person either refuses or is unable to consent to voluntary admission for treatment; and
4. the person lacks capacity to make an informed decision concerning treatment; and
5. as the result of the severe disorder, the person is a) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or b) likely to cause harm to others.

Informed Consent to Medication or Other Treatment—Involuntary Patients

Since it is a prerequisite to involuntary commitment that the person lacks capacity to make an informed decision concerning treatment, the treatment facility shall be authorized to administer medications or other treatments to such persons consistent with good medical practice without their consent, except insofar as particular laws or regulations require consent for special therapies. Although consent to treatment is not required, during the course of treatment *the responsible psychiatrist* [optional provision: “the responsible physician”] shall consult with the patient and his next of kin or guardian and give consideration to the views they express concerning treatment and any alternatives.

FOOTNOTES

¹These guidelines deal only with persons who may be hospitalized for psychiatric care and treatment under the civil commitment process; they do not deal with persons who may be confined for forensic evaluation or other purposes under the criminal justice process.

²For provisions concerning persons under the age of 18, refer to the American Psychiatric Association's “Guidelines for Psychiatric Hospitalization of Minors” (1).

³Mental retardation, epilepsy, or other developmental disabilities do not, in themselves, constitute a severe mental disorder. States may wish to provide by other provisions of law for persons whose use of or addiction to intoxicating substances warrants hospitalization.

⁴Refer to the commentary for a discussion of the disposition of various types of persons who do not meet the criteria in subsection 6.C.

⁵These provisions establish only a basic framework for the use of restraints and seclusion. More detailed guidelines are being prepared by the American Psychiatric Association to deal with the many subtle problems that arise.

⁶Many psychiatrists believe that it is preferable for them to make discharge decisions as to all patients, whether committed as dangerous to others or on some other ground, unless the psychiatrist at his option seeks judicial consideration of a particular case. Some states may prefer this approach.

⁷Insert the time period under existing law.

REFERENCE

1. American Psychiatric Association: Guidelines for the psychiatric hospitalization of minors, and Four alternatives to the guidelines for the psychiatric hospitalization of minors: clinical and legal considerations. *Am J Psychiatry* 139:971-975. 1982

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