Report of the INVOLUNTARY COMMITMENT TASK FORCE OF THE MAINE COMMISSION ON MENTAL HEALTH

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INVOLUNTARY COMMITMENT TASK FORCE

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EXECUTIVE SUMMARY

REPORT ON INVOLUNTARY OUTPATIENT COMMITMENT

In March of 1990, the Human Resources Committee of the 114th Legislature requested the Maine Commission on Mental Health to examine the issue of involuntary outpatient commitment of persons who are either a danger to themselves or others or are gravely disabled, for consideration by the next session of the Legislature.

Attached is the full report of the Involuntary Commitment Task Force, appointed by the Commission. The highlights of this report are as follows:

1. As embodied in Section 3801, 4.C of 34-B M.R.S.A., there is provided a procedure for the involuntary commitment of individuals only posing a likelihood of serious harm due to mental illness, which has not been utilized to any extent.

2. There currently exists a "convalescent status" where one may be discharged from a state mental health institute during their commitment, on condition that they comply with terms of treatment.

3. Involuntary commitment in outpatient settings raises obvious issues of clients' rights and protections, its enforcement and compliance and substantial increased costs, as confirmed in other jurisdictions.

The foregoing prompted the consensus of the Task Force to report that any type of involuntary outpatient commitment is <u>not desirable</u> for the state of Maine at this time; however, with these suggested changes to the present statutes:

1. That convalescent status be extended to community hospitals that are ready, willing, able and approved for provision of involuntary services.

2. That a treatment plan be required in the use of convalescent status.

3. That the time period for involuntary convalescent status be limited to six months.

4. That transportation to the receiving facility begin within three hours of notification of completion of the arrangements needed for transfer.

In addition to these findings and recommendations, the Task Force wishes to emphasize its finding that the request for a more extensive commitment capacity is actually a response to a lack of community services.

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REPORT ON INVOLUNTARY OUTPATIENT COMMITMENT

The following constitutes the report of the Outpatient Commitment Task Force. This task force was created by the Maine Commission on Mental Health, pursuant to a request by the Human Resources Committee in March, 1991. The impetus for this request was a bill introduced in the 114th Legislature to provide for the outpatient commitment of persons who are either a danger to themselves or others, or gravely disabled.

In response to the need to create as representative a working group as possible, the membership of the task force consisted of thirty six individuals, including consumers of mental health services, family members of persons with mental illness, advocates, providers of both inpatient and community, voluntary and involuntary mental health services, representatives of the Maine Commission on Mental Health and the Department of Mental Health and Mental Retardation and representatives of the legal system. The task force began its deliberations on May 9, 1990 and subsequently met on a monthly basis.

In attempting to organize itself, the task force divided into three work groups, whose broad categories of review were hospitalization and commitment standards, triggering mechanisms for commitment and the impact upon the community of outpatient commitment. Each group was assigned subtopics within the broad charge in order to ensure the most comprehensive review of the issues pertinent to the possible amendment of existing law. Consideration was given to outpatient commitment laws in other states, including an assessment of the impact of these laws by concerned individuals, including consumers, in those states.

The task force identified that several of the elements sought by individuals pursuing these changes already exist in law. The question was raised of expanding the involuntary commitment laws to include individuals who, while not an immediate danger to themselves or others, are at risk of harm due to their disability and inability to care for themselves. It was pointed out that Maine state law allows for the involuntary commitment of individuals posing a likelihood of serious harm due to mental illness and that the definition of serious harm includes the following:

> 3801.4.C. A reasonable certainty that severe physical or mental impairment or injury will result to the person alleged to be mentally ill as manifested by recent evidence of his actions or behavior which demonstrate his inability to avoid or protect himself from such impairment or injury, and, after consideration of less restrictive treatment settings and modalities, a determination that suitable community resources for his care are unavailable.

Another element that exists in law is convalescent status, which constitutes a form of involuntary commitment. In this case, individuals who have been involuntarily committed to either the Augusta or Bangor Mental Health Institute may be discharged during their period of commitment on the condition that they continue that they comply with terms of treatment, under threat of rehospitalization.

In light of this, the task force maintained a relatively narrow focus in its deliberations, considering the question of the need, possible effectiveness and propriety of the state of Maine developing the capacity to commit individuals to involuntary treatment in outpatient settings, independent of a hospitalization.

The task force struggled with issues of client rights and protections in its considerations. Several members were concerned by the abridgement of rights that would occur if such a capacity were created. The task force was unable to satisfactorily resolve the issues of enforcement and compliance, that is, how would non-compliance be indicated and measured, who would be responsible for the identification and reporting of non-compliance and to whom and, most troubling, who would be responsible for taking the non-compliant individual into custody. The inability to answer these questions to the satisfaction of a majority of task force members, especially in areas regarding client rights, resulted in a consensus emerging that this type of outpatient commitment capacity is not desirable for the state of Maine.

In considering the existing convalescent status statutes, the task force identified areas that it felt needed clarification and strengthening. One aspect involves the fact that convalescent status can only be used for patients who have been committed to the two state mental health institutes. **In light of the 114th Legislature having changed state law to allow community hospitals to accept involuntary commitments, the task force felt that, given the fact that convalescent status is seen to be an appropriate tool, it should be available to community hospitals.**

A second change relates to the requirement for a treatment plan for the person being released on convalescent status. Statutes currently make the requirement for a treatment plan optional, which the task force finds completely inappropriate, as the facility releasing the person on convalescent status should be able to clearly state the reasons for and benefits expected

from this decision. **As a result, the task force is recommending that the statutes be changed to require a treatment plan for all persons to be released on convalescent status, including the goals to be achieved during the period of convalescent status and a plan for services.**

The third recommended change in this area relates to the period of convalescent status for involuntary patients. Again expressing concerns about client rights, the task force struggled with the question of limits upon the time period during which the rights of an individual who is capable of living in the community should be abridged. **In an attempt to address these concerns and provide what it feels to be appropriate protections, the task force is recommending that the time period for convalescent status for involuntarily committed individuals be limited to six months.**

Another area of concern that was raised involved the actual process of commitment. As Maine state law currently states that the certifying examination resulting in commitment be completed no later than three days prior to hospitalization, several individuals stated that this is resulting in significant delays in transportation of the committed individuals to the receiving institutions, placing the clients in a potentially dangerous situation and creating an unfair burden upon the community provider who has the initial contact with the client. **As a result, the task force is recommending that the law be changed to require that transportation to the receiving facility begin within three hours of notification of completion of all arrangements needed for transfer.** The task force believes that this will result in an orderly process of transfer, more sensitive to client needs without placing an undue burden upon any of the participants.

There was also discussion of the possibility that consumers could find themselves in a situation in which they are aware of their treatment needs when their condition begins to worsen and have certain preferences for how those needs should be met, but might not be able to have this occur due the need for the person to be "committable" to obtain certain types of treatment and, by the time they are "committable", be unable to express these needs and wishes due to the nature of the illness. The task force discussed the possibility of having the consumer be able to predesignate an individual of his or her choice to make mental health care decisions and choices in the event of the incapacity of the individual. In examining Maine's durable power of attorney statutes, it was found that they cover this type of situation, an option not currently being exercised. **As a result, after exploring several proposed documents, the task force is recommending that the Maine Commission on Mental Health continue the exploration of this issue with the goal of working toward implementation of the following recommendations:**

1) That a sample durable power of attorney document be developed, designed to be usable by persons with mental illness, with examples of completed forms to facilitate utilization.

2) That recommendations for a program of education regarding the durable power of attorney document be developed, including proposals for implementation.

3) That an assessment of the availability of legal services to assist persons with mental illness in the completion of this document be made, with the results publicized in order to assist these individuals to obtain access to these services.

It should be noted that the task force encountered problems that it felt could not be addressed within the scope of its function. One clear issue is the fact that several of the problems that are sometimes proposed to be addressed by an outpatient commitment statute are the result of insufficient community mental health services. The task force strongly believed that many persons who are currently considered to be non-compliant or who frequently reach the point of illness that negatively affects their functioning while not quite requiring inpatient commitment would have their needs addressed in a comprehensive system that allowed for consumer choice to guide services and was sufficiently staffed to allow for service provision and monitoring at a level dictated by the individual's needs. The task force strongly supports all ongoing efforts to achieve this type of system and warns against stopgap measures that might attempt to address a lack of services through abridgment of individuals' rights.

Another issue of great concern involves existing resources for persons in need of involuntary inpatient care. Several task force members expressed concerns about what appears to be a reduced lack of access to the Augusta Mental Health Institute in light of the recent admissions protocol and agreement and census reduction efforts. Although significant time was devoted to discussion of this issue, the task force lacked the time and resources to sufficiently analyze the causes and effects of this situation and possible remedies that might be applied. The task force wishes to cite the existence of the problem and the reasons for not addressing it.

In light of the above discussion, the task force determined that there are issues in the commitment statutes that were not able to be addressed within the confines of the existing time and resource limits. The task force notes the need for continued study, as noted above, and would be willing to discuss this further with the members of the Human Resources Committee.

LEGISLATIVE DRAFT

An Act to Provide Greater Protections for Persons with Mental Illness Under the Involuntary Commitment Statutes

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 34-B MRSA 3863, sub. 4-A is amended to read:

Upon endorsement of the application and certificate by the judge or justice, any health officer or other person designated by the judge or justice may take the person into custody and transport him to the hospital designated in the application. The designated individual shall begin transporting the person within three hours of notification that all arrangements for patient transfer are complete. Necessary arrangements include the endorsement of the application and certificate and agreement by the receiving facility to evaluate the person for admission upon arrival.

Sec. 2. 34-B MRSA 3870 is amended to read:

3870. Convalescent Status

1. Authority. The chief administrative officer of a state mental health institute or the chief mental health officer of a hospital designated by the commissioner may release an improved patient on convalescent status when he believes that the release is in the best interest of the patient.

A. Release on convalescent status shall include provision for continuing responsibility to and by the state mental health institute or the hospital designated by the commissioner, including a plan of treatment on an outpatient or non-hospital basis, which will include the goals to be achieved during the period of convalescent status as well as a plan for services.

B. Before release on convalescent status under this section, the chief administrative officer of a state mental health institute or the chief mental health officer of a hospital designated by the commissioner shall make a good faith attempt to notify, by telephone, personal communication or letter, of the intent to release the patient on convalescent status and of the plan of treatment:

(1) The parent or guardian of a minor patient;
(2) The guardian of an adult incompetent patient, if any is known; or
(3) Upon obtaining the consent of the patient, the spouse or an adult next of kin of an adult competent patient, if any is known; or
(4) Upon obtaining the consent of the patient, the community provider with primary responsibility for provision of services.

C. The state mental health institute or hospital designated by the commissioner is not liable when good faith attempts to notify parents, spouse or guardian have failed.

2. Reexamination. Before a patient has spent six months on convalescent status, and at least every six months thereafter, the chief administrative officer of the state mental health institute or the chief mental health officer of the hospital designated by the commissioner shall re-examine the facts relating to the hospitalization of the patient on convalescent status.

3. Discharge. Discharge from convalescent status is governed as follows:

A. If the chief administrative officer of the state mental health institute or the chief mental health officer of the hospital designated by the commissioner determines that, in view of the condition of the patient, convalescent status is no longer necessary, he shall discharge the patient and make a report of the discharge to the commissioner.

B. The chief administrative officer or chief mental health officer shall terminate the convalescent status of a voluntary patient within 10 days after the day he receives from the patient a request for discharge from convalescent status.

C. Involuntarily committed persons on convalescent status shall, if they do not agree to continue in this status on a voluntary basis, be discharged within six months of their release on convalescent status.

4. Rehospitalization. Rehospitalization of patients under this section is governed as follows:

A. If, prior to discharge, there is reason to believe that it is in the best interest of an involuntarily committed patient on convalescent status to be rehospitalized, the commissioner, chief administrative officer of the state mental health institute or the chief mental health officer of the hospital designated by the commissioner may order the immediate rehospitalization of the patient.

B. If the order is not voluntarily complied with, and if the order is endorsed by a District Court Judge in the county in which the patient has his legal residence or is present, any health officer or police officer may take the patient into custody and transport him to:

(1) The state mental health institute, if the order is issued by the chief administrative officer of the state mental health institute; or

(2) The hospital designated by the commissioner, if the order is issued by the chief mental health officer of the hospital.

5. Notice of change of status. Notice of the change of convalescent status of patients is governed as follows.

A. If the convalescent status of a patient in a state mental health institute or a hospital designated by the commissioner is to be changed, either because of a decision of the chief administrative officer of the state mental health institute or the chief mental health officer of the hospital designated by the commissioner or because of a request made by a voluntary patient, the chief administrative officer of the state mental health institute or the chief mental health officer of the hospital designated by the commissioner shall immediately make a good faith attempt to notify, by telephone, personal communication or letter, of the contemplated change:

(1) The parent or guardian of a minor patient;
(2) The guardian of an adult incompetent patient, if any is known; or
(3) Upon obtaining consent of the patient, the spouse or adult next of kin of an adult competent patient; or
(4) Upon obtaining consent of the patient, the community provider with primary responsibility for provision of services.

B. If the change in convalescent status is due to the request of a voluntary patient, the chief administrative officer of the state mental health institute or the chief mental health officer of the hospital designated by the commissioner shall give the required notice within 10 days after the day he receives the request.

C. The state mental health institute or the hospital designated by the commissioner is not liable when good faith efforts to notify parents, spouse or guardian have failed.

STATEMENT OF FACT

This bill constitutes the results of a study of Maine's involuntary commitment laws conducted by the Maine Commission on Mental Health, at the request of the Joint standing Committee on Human Resources of the 114th Legislature.

Two proposed changes are contained in the bill. One will mandate that individuals responsible for transporting persons who have been committed to begin the process of transportation within three hours of approval of the application, to avoid lengthy, unnecessary and sometimes dangerous delays. The bill also expands the capacity to place patients on convalescent status to hospitals designated by the commissioner of the Department of Mental Health and Mental Retardation.