TASK FORCE TO REVIEW MAINE'S LAWS CONCERNING INVOLUNTARY COMMITMENT

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Co-Chairs

Report to:

Joint Standing Committee on Health and Human Services

In accordance with
Resolves 1995, Chapter 13

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Department of Mental Health, Mental Retardation and Substance Abuse Services

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Jill Duson, Esq.	Public Member
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Other Participants

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Senator Jill Goldthwait, RN	Maine Senate
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EXECUTIVE SUMMARY

In response to Resolves 1995, Chapter 13, passed by the 117th Legislature, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) convened a Task Force to Review Maine's Laws Concerning Involuntary Commitment, composed of consumers, family members, mental health professionals, community mental health providers, hospital officials and law enforcement officials, among others. This Task Force met ten times between October 1996 and January, 1997, reviewed Maine's statutes in comparison to those of other states, considered a wide range of possible options, and came to consensus on 16 recommendations for strengthening and improving Maine's laws on involuntary commitment. These recommendations clustered into four issue areas:

- Public concerns about the potential for violence in the community related to mental illness
- The current involuntary treatment statute does not adequately reflect the move to community-based systems of care
- Some procedures need modification and clarification
- The need for more consumer-responsive alternative care options

While not recommending any entirely new legislation, the Task Force proposed several modifications to existing laws. These modifications are intended to improve the state's ability to respond to individuals who may require mandated treatment in the community, while also respecting the needs and constitutional rights of people diagnosed with mental illness.

BACKGROUND AND PROCESS

In 1995, the 116th Legislature passed L.D. 885, Resolve to Create a Task Force to Review the State's Involuntary Commitment Law (Resolves 1995, Chapter 13). In the winter of 1995-1996, the Health and Human Services Committee, based on the degree of change occurring at the time within the mental health system, granted the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS, or "the Department") a one-year extension of the original deadline for the Task Force.

In response to Resolve 13, the Department appointed a Task Force to review Maine's laws concerning involuntary commitment. The Task Force, which has been working since October, 1996, was designed to bring together representatives of the constituencies potentially affected by changes in the law, provide them with a formal opportunity to discuss the issues, assess the strengths and weaknesses of the current law, and propose changes as needed.

Resolve 13 called upon the Commissioner of DMHMRSAS to appoint a 15-member task force composed of, but not limited to, consumers, family members, mental health professionals, community mental health providers, consumer and family advocates, hospital officials, and law enforcement officials. In response to this mandate, the Commissioner's Office requested nominations from the constituencies identified in the Resolve, and finalized appointments in September, 1996 (see Task Force Membership, page 1). In addition, District Court Judge Courtland Perry, Judy Regina (representing the Maine Sheriff's Association's Mental Health Initiative), and Chris Leighton from the Attorney General's Office were asked to serve as advisors to the Task Force. A number of other individuals also participated during the Task Force deliberations.

The full Task Force met ten times between October and January. At the first meeting, former State Representative Mike Fitzpatrick (the sponsor of Resolve 13) provided a legislative context for the Task Force. He pointed out that involuntary treatment is an issue of perennial concern in the legislature, and that events over the past year made the work of this group even more important. He urged the group to construe its mandate broadly, and to focus on areas of major concern to the general public. By the end of the first meeting, the Task Force had defined the potential scope of its work to include modifying existing statutes; consolidating relevant statutes into a single law; drafting new legislation that would significantly alter the status quo; making no legislative changes; or proposing revisions to programs, policies, or practices.

Helen Bailey from Maine Advocacy Services and Deputy Chief Richard Mears, representing the Maine Police Chiefs Association, were elected co-chairs of the group. The two co-chairs, along with Dr. Ulrich Jacobsohn and Cathy Bustin Baker were designated as a subcommittee to meet with interested groups and individuals concerning the Task Force's recommendations.

TASK FORCE DELIBERATIONS

The group began its deliberations by describing personal experiences that seemed to point to potential problems with the current involuntary commitment statute. During this discussion, Task Force members identified 19 areas of concern, ranging from alleged misuse of the protective custody provision to an apparent lack of community-based services in rural areas.

As the discussion unfolded, members of the group identified and requested additional statutes for review. Several related statutes were reviewed and discussed with reference to their potential relevance to involuntary commitment (see Appendix B).

Early in its deliberations, the Task Force discussed Maine's involuntary commitment statute in relation to commitment laws in other states. The group read and discussed several review articles that compare and contrast state involuntary commitment statutes (see Appendix B). According to these reviews, Maine's statute is rated as "moderately stringent" with reference to commitment criteria and evidentiary requirements.

Judge Perry also led a discussion about the construction and operationalization of Maine's statute. In contrast to some other states, Maine's law is structured to ensure that attention is paid to the treatment needs of the individual being committed, and that standards are maintained for the introduction of evidence. After substantial discussion, the group concluded that Maine's current statute is basically sound and does not require wholesale revision, although minor modifications might be necessary.

The group then turned its attention toward specific provisions of the involuntary commitment statute. The Task Force thoroughly reviewed the laws pertaining to involuntary commitment (34-B, MRSA, Article III: Involuntary Hospitalization) to identify specific sections for potential revision. During this process, individuals presented their concerns to the Task Force, along with draft legislative language or policy proposals designed to address their concerns. By the end of its deliberations, the Task Force had reviewed the law in depth, and had reached consensus on proposed legislative changes to a number of sections of the law (see Appendix A).

The Task Force also spent several meetings in a wide-ranging discussion about so-called "outpatient commitment" or "community commitment" laws. Considerable time was spent discussing the problem as perceived by members of the general public, who are concerned about people living in the community who may not be receiving (or who may choose not to accept) needed treatment. Substantial discussion also occurred about the fears of potential misuse of outpatient commitment that many consumers of services express, as well as the potential costs of implementing a new outpatient commitment law.

The Task Force reviewed the variety of mechanisms used by different states to mandate community treatment, the legal issues involved in outpatient commitment laws, and the available empirical evidence concerning the effectiveness of such laws as implemented in other states (see Appendix B). Some of the concerns raised in other states have included the difficulty of creating a legal definition of the target population that will selectively encompass the individuals of

concern; lack of adequate enforcement capacity; and the potential diversion of resources from treatment to legal costs.

By the end of its deliberations, the Task Force had come to consensus on sixteen recommendations to strengthen and improve Maine's laws on involuntary commitment (see next section). While not recommending a new outpatient commitment law, the group proposed several modifications to existing laws that will improve the state's ability to respond to individuals who may require mandated treatment in the community.

SUMMARY OF ISSUES AND RECOMMENDATIONS

During its deliberations, the Task Force identified and explored a wide variety of issues related to involuntary inpatient and outpatient commitment. Task Force members had the opportunity to discuss these issues as a group and to share their concerns with the Commissioners of the Department of Corrections (DOC) and the Department of Mental Health, Mental Retardation and Substance Abuse Services. Those discussions, and the proposals that grew out of them, led to the recommendations that are summarized below.

Some of the recommendations require legislative action; these recommendations are cross-referenced to the proposed legislation in Appendix A. Other recommendations will require administrative action on the part of DMHMRSAS and other state agencies.

The recommendations of the Task Force cluster into four major issue areas: public concerns about the potential for violence in the community; the need for changes in current laws to reflect the move towards a community-based system of care; the need for minor adjustments and modifications in the current law; and the need to develop more consumer-responsive alternative care options.

ISSUE: PUBLIC CONCERNS ABOUT THE POTENTIAL FOR VIOLENCE IN THE COMMUNITY RELATED TO MENTAL ILLNESS

From the outset, Task Force members expressed the opinion that the public is primarily concerned about a relatively small number of individuals who may pose a threat due to their mental illness. The Task Force focused on potential ways to strike a balance between these individual's needs and constitutional rights, and the public's right to safety from actions which may, under certain circumstances, pose a danger. To this end, the Task Force discussed the possibility of amending current statutes, proposing new outpatient commitment legislation, or recommending programmatic alternatives to the status quo.

The Task Force made four recommendations that directly or indirectly respond to this issue. Recommendation #1 addresses the need for information about potential dangerousness to be communicated between responsible parties. Recommendation #2 proposes a joint initiative with the Department of Corrections (DOC) to mandate community treatment for individuals who are mentally ill and who have demonstrated criminal behavior. Recommendation #3 (which appears in the second issue area) extends periodic patient review requirements to community hospitals that provide involuntary commitment, and expands the current "convalescent status" provision of the commitment statute to community hospitals that provide involuntary commitment, thereby allowing individuals who are committed to be discharged to the community under certain circumstances. These revisions may be extended to include other community hospitals in the future. This issue, Recommendation #16, appears in the last issue area. This recommendation urges the Department to ensure that a variety of non-coercive crisis prevention and intervention programs are available in each local service area in order to reduce the number of individuals whose problems escalate to the point of needing more coercive interventions.

Recommendation #1: Statutory Language Should Be Adopted That Clearly Articulates the Responsibility to Share Information About Possible Dangerousness Under Certain Circumstances

The Task Force approved statutory language that outlines an evaluator's duty to inform others of the potential danger an individual may pose. This recommendation seeks to underscore the fact that professionals have a responsibility to other people involved in interacting with or evaluating an individual in crisis, as well as to the individual him or herself. It strives to clarify the limits of "confidentiality" as a justification for refusing to disclose pertinent information to others.

Proposed revision to Section 34B, §1207 (6): Duty to Provide Information. Any person conducting an evaluation of a mental health client in a professional capacity who has a clear and substantial reason to believe that the client poses an imminent danger of inflicting serious physical harm on the evaluator or others has a duty to provide information regarding such danger or harm to any other person to whom that client's care or custody is being transferred. For purposes of this subsection, an evaluation includes professionally recognized methods and procedures for the purpose of assessing and treating mental illness, and includes, but is not limited to, interviews, observation, testing, and assessment techniques conducted by a person licensed as a physician, psychologist, nurse, clinical social worker, or clinical professional counselor.

Recommendation #2: DOC and DMHMRSAS Should Work Together to Ensure Treatment Compliance for Potentially Violent Offenders Diagnosed With Mental Illness

The Task Force concluded that DMHMRSAS should work with the DOC to use conditions of probation to mandate treatment for a small number of individuals. This will require DMHMRSAS to ensure that mental health consultation and services are available during the pre-sentencing, and probationary phases, so that there is a reasonable likelihood that mandated treatment will be effective. It will also require that DMHMRSAS and DOC work collaboratively to monitor and enforce compliance with mandated treatment interventions.

The Task Force recommended that adoption of statutory language that would require DMHMRSAS to provide mental health liaison services to the courts and the DOC (17-A, Section 1204(D) and 34-B, Section 1220). The specific responsibilities of such liaisons would include: providing pre-sentencing reports when required; evaluating the appropriateness of mental health services that may be imposed as a condition of probation; assessing the availability of mental health services that may be recommended; reporting to the court and the DOC; and assisting individuals in obtaining those mental health services.

In addition, the Task Force made the following recommendations:

(1) Community Supervision. Community supervision would be provided jointly by regional probation and parole officers and a mental health worker assigned by DMHMRSAS. The mental health worker will oversee the treatment components and the individual's response to treatment. The probation and parole officer will oversee compliance with probation conditions, and revoke probation if those conditions are violated.

(2) Program Monitoring. A centralized MIS capacity should be established by DMHMRSAS and DOC to track persons entering into this system and to monitor their progress during the course of their involvement with this program. An evaluation will be designed to determine whether the program is realizing its goals.

ISSUE : THE CURRENT INVOLUNTARY TREATMENT STATUTE DOES NOT ADEQUATELY REFLECT THE MOVE TO COMMUNITY-BASED SYSTEMS OF CARE

The current involuntary commitment law and related statutes were crafted at a time when all involuntary treatment programs were located at either the Augusta Mental Health Institute (AMHI) or the Bangor Mental Health Institute (BMHI). Now that the state mental health system is evolving into a community-based system of care, some statutory provisions and administrative policies need to be modified to reflect changing system needs.

The Task Force made five recommendations in this area. Three out of the five deal with transportation, either clarifying and codifying existing practices or establishing new transportation policies. These issues are increasingly important in a decentralized, community-based system of care.

The other two recommendations in this section (the extension of convalescent status to community hospitals and the requirement to have psychiatric testimony at involuntary commitment hearings) reflect needed changes in clinical practice to reflect the new role of community hospitals in involuntary commitment.

Recommendation #3: Periodic Review Requirements and the Use of "Convalescent Status" Should be Extended to Community Hospitals

The law currently requires that state mental health institutes periodically review an individual's need for continuing hospitalization. The Task Force recommended that this requirement be extended to community hospitals and that the frequency of examinations be changed to every 30 days to reflect good practice (34-B, Section 3871. Discharge)

In addition, the current involuntary commitment law allows individuals who are committed to AMHI or BMHI to be discharged to the community, under certain circumstances, on "convalescent status" (CS). An individual who is still legally committed to the institution while on CS, can be rehospitalized, if needed, without going through another commitment process. This provision allows individuals to be discharged to the community as soon as they are ready, while allowing a higher level of supervision than would be possible were they to be formally discharged.

The Task Force identified several problems with the way CS is implemented, including variability between regions and some apparent misunderstanding about certain provisions. The group felt that these problems could be remedied through statewide training (see Recommendation #15).

However, the Task Force felt that the CS provision is an effective tool for providing a more highly supervised level of community care than is now standard practice, and for ensuring immediate rehospitalization, should that become necessary for the involuntarily committed individual on convalescent status. The Task Force therefore recommends that this tool be made available to all community hospitals who provide involuntary treatment. (Revision to 34-B, Section 3870)

Recommendation #4: DMHMRSAS Should Pay for Pre-Commitment and Post-Commitment Transportation Costs

The Task Force recommended that DMHMRSAS pay for transportation and additional reasonable costs associated with maintaining custody of individuals during the pre-commitment and post-commitment process (Revision of 34-B, 3864(9)). The Department should also pay for the transportation costs community hospitals incur by transporting individuals to and from commitment hearings (Revision of 34-B, 3864(5)(B)). All transportation arrangements should be based on an ongoing collaboration between DMHMRSAS, community mental health crisis providers, and the providers of transportation services.

By taking such action, DMHMRSAS would limit local community costs related to the implementation of the involuntary commitment law and underscore its commitment to building the collaborative relationships required to establish and maintain a community-based system of care. This clarification of fiscal responsibility is not anticipated to have a major fiscal impact, since DMHMRSAS currently pays for most costs associated with transportation.

Recommendation #5: Counties Should Pay the Transportation Expenses of Individuals Incarcerated in Correctional Facilities Who Are Admitted to Hospitals Under the Involuntary Commitment Law

The Task Force recommended that a statutory change be made to clarify who pays for the transportation of individuals under these circumstances (Revision of 34-B, 3863, Section 4(C)). This changewould clarify existing policy, since counties currently pay these expenses.

Recommendation #6: DMHMRSAS Should Ensure that the Least Stigmatizing Means of Transportation Available Are Used Whenever Possible

The Task Force had considerable discussion about the fact that transportation is often provided through means that may be stigmatizing (e.g. marked law enforcement vehicles) and/or overly expensive (e.g. ambulances). Although it was agreed that security provisions are sometimes necessary, it was felt that the department should adopt a policy of providing the least stigmatizing form of transportation available that is consistent with security and clinical concerns. (Revisions of 34-B, sections 3862, 2(C)(4); 3863, 4(A); 3674, (9)).

Recommendation #7: Psychiatric Testimony Should Be Required at Involuntary Commitment Hearings

In a community-based system, hospital stays are used to stabilize the condition of individuals in crisis. As the length of such stays decrease, it is critical that in-hospital and discharge treatment plans reflect the best combination of treatment, support, and medication options available. The Task Force therefore recommends that "expert psychiatric testimony" be required to augment other clinical testimony at involuntary commitment hearings so that questions involving medication and other medical concerns can be directly answered during the hearing. (Revision of 3864, 5(F))

ISSUE: SOME PROCEDURES NEED MODIFICATION AND CLARIFICATION

After reviewing the literature comparing involuntary commitment statutes across different states, the Task Force concluded that Maine's involuntary commitment law represents a solid, moderate approach to the need to balance the rights of individuals diagnosed with mental illness with public safety concerns. However, the 20-year old law needs some relatively minor modifications to reflect changes in policy and practice that have taken place since it was first enacted.

Recommendation #8: Adopt an Amended Version of the Probable Cause Standard

The probable cause provision in the current involuntary commitment law is scheduled to sunset at the end of this legislative session. If the Task Force's recommendation concerning this provision is not implemented, the law enforcement community will lose a tool that has proven valuable in the time since this section of the law was first enacted. Specifically, the probable cause standard allows a law enforcement officer to take an individual into custody based on reliable information from a third party. Without such a standard, the officer would be required to personally observe behavior before taking action in this regard.

Proposed Revision to 34-B, 3862, Sec. 1(C): When, in formulating probable cause, the law enforcement officer relies upon information provided by a third party informant, the officer shall confirm that the informant has reason to believe, based upon the informant's recent personal observations of or conversations with the person, that the person may be mentally ill and that due to that condition the person presents a threat of imminent and substantial physical harm to self or to other persons.

Adoption of this revised probable cause standard would assist law enforcement in making critical assessments of individuals in crisis. The amended standard also clarifies the standard for reliable third-party information (Revision of 34-B, 3862, Section 1(C)).

Recommendation #9: Reduce the Time Allowed Between the Certifying Examination and the Date of Admission to a Mental Health Facility

The Task Force recommended that the maximum number of days that can elapse between events be shortened from three days to two to reflect good practice and current resource capabilities (Revision of 34-B, 3861, Sections 1 and 2 and revision of 3863, Section 2(A)).

Recommendation #10: Reduce the Maximum Length of Recommitment Time

The Task Force recommended that the maximum length of time for recommitment be reduced from one year to six months to conform with good practice standards (Revision of 34-B, 3864, Section 7. Commitment).

Recommendation #11: Underscore the Prohibition on Incarcerating Individuals Diagnosed With Mental Illness Who Have Not Been Charged With a Crime

While another statute (L.D. 1507) made this practice illegal, the Task Force felt it was necessary to underscore the importance of this prohibition by inserting similar language into the involuntary commitment law (Revision of 34-B, 3863, Section 2(A). Custody Agreement).

Recommendation #12: DMHMRSAS Should Establish Immediate Timeframes for Implementing a Statewide Strategy to Prevent Unlawful Incarceration of People Diagnosed With Mental Illness

The Task Force recommended that Section 2 Of L.D. 1507--An Act To Prevent The Use Of Correctional Facilities For The Detention Of The Mentally Ill--be fully implemented, and that DMHMRSAS report back on the results of that implementation.

Recommendation #13: Delete Section on Treatment of Dually Diagnosed Persons

Based on its review, the Task Force recommended repeal of this section because it sets a standard for persons with mental retardation who are also mentally ill that is different from the standard applied to persons who are mentally ill and not mentally retarded. There is a distinct concern that this language is discriminatory and accomplishes nothing beneficial for persons with mental retardation, and is unnecessary given current practice.

Recommendation #14: Ensure Timely Notification of an Individual's Involuntary Commitment Status

The Task Force recommended revisions which require that consumers be notified about their commitment in a timely manner, so that they may exercise their rights under the statute. These revisions would also protect individuals who have been involuntarily committed from potential harm by prohibiting notification of their commitment status to persons who are viewed as posing potential harm to them (Revision of 34-B, 3863, Section 6. Notice).

ISSUE: THE NEED FOR MORE CONSUMER-RESPONSIVE ALTERNATIVE CARE OPTIONS

Task Force members agreed that developing a wide range of services that reflect consumer-identified needs is key to developing an effective system of care and enhancing public safety.

Recommendation #15: Training in the Law Must Take Place at All Levels and on a Wide Variety of Subjects

During its deliberations, the Task Force became aware that many of the problems associated with the involuntary commitment statute stem from failures to implement the law correctly, rather than from weaknesses in the statute itself. Therefore, the Task Force recommended that DMHMRSAS lead the development of a comprehensive training initiative for all those potentially involved in the involuntary commitment process, including law enforcement officers, mental health professionals, consumers, and members of the judiciary, in the use of the involuntary commitment and related matters.

This recommendation is based on the Task Force's expressed concerns about a broad range of issues. These include: the limited enforcement power given to advance directives and other consumer preferences, the practice of not giving individuals the option of choosing one of the clinicians examining them prior to the initial commitment hearing, and the sometimes coercive nature of the environment that may surround individuals who are given a "choice" between being voluntarily or involuntarily committed during periods of crisis.

Training efforts should cover the following areas:

- Filing the involuntary commitment application (blue paper) and the certificate of examination
- Facilitating a choice of examiners for the commitment hearing
- Using the convalescent status provisions
- Understanding and using "least restrictive forms" of transportation to transport individuals during the involuntary commitment process
- Conducting risk assessments related to violent behavior
- Determining appropriate sanctions against those with mental illness who have been convicted of a crime
- Respecting the role of family members and others close to those being considered for involuntary commitment
- Understanding the impact of a history of physical and sexual abuse trauma on the lives of people diagnosed with mental illness
- Using advanced directives and other consumer preference-related documents
- Providing peer support services, such as "warm lines" and other crisis prevention and intervention services
- Reducing discrimination against people with disabilities

Recommendation #16: DMHMRSAS Should Ensure that Alternatives to Involuntary Treatment Exist in all Local Service Areas

Task Force members agreed that alternative interventions must be developed to reduce the need for coercive treatment interventions such as involuntary commitment. Therefore, the Task Force recommended that DMHMRSAS create a range of interventions that engage consumers in treatment within their own communities, where they are more likely to receive the kinds of support they need to improve their health and enhance their quality of life. These interventions would include preventive interventions, such as crisis planning and more systematic use of advanced directives; rehabilitation interventions, such as work opportunities that provide incentives for engagement; and community-based alternatives to hospitalization.

The Task Force also recommended that DMHMRSAS develop policies that promote collaboration among law enforcement, service providers, crisis team members, and peer advocates to provide a continuum of community-based services that prevent the escalation of behavior that often leads to the involuntary commitment of persons diagnosed with mental illness.

OTHER ISSUES

Senator Jill Goldthwaite met with the Task Force to discuss her bill, "An Act to Authorize a Physician's Assistant to Sign Papers for Emergency Involuntary Commitment". It was her purpose to assess the Task Force's interest in extending the authority to perform the certifying examination to physician's assistants and nurse practitioners. She believes that this would be more efficient and effective for some very rural hospitals, which do not always have physicians onsite. The Task Force members examined the relevant licensing regulations and discussed the matter at some length. The group ultimately decided not to recommend any changes to the section of the statute as it pertains to who may perform the certifying examination. Sen. Goldthwaite was notified of the Task Force's decision. She will proceed with her bill.

APPENDIX A:

PROPOSED LEGISLATION

34-B, 1207, is amended to read as follows:

6. Duty to Provide Information. Any person conducting an evaluation of a mental health client in a professional capacity who has a clear and substantial reason to believe that the client poses an imminent danger of inflicting serious physical harm on the evaluator or others has a duty to provide information regarding such danger or harm to any other person to whom that client's care or custody is being transferred. For purposes of this subsection, an evaluation includes professionally recognized methods and procedures for the purpose of assessing and treating mental illness, and includes, but is not limited to, interviews, observation, testing, and assessment techniques conducted by a person licensed as a physician, psychologist, nurse, clinical social worker, or clinical professional counselor.

17-A, MRSA, sec. 1204(D) is amended as follows:

Retain 1-3 and enact 4

4. Before imposing any condition of psychiatric outpatient or inpatient treatment, or of mental health counseling, the court may request a report to be submitted by an agent of the Department of Mental Health, Mental Retardation and Substance Abuse Services who has been designated pursuant to 34-B, MRSA, sec. 1220 for the purpose of assessing the appropriateness of psychiatric or mental health treatment for the individual and the availability of such services. Whether or not such report is requested, the court shall notify the designated agent of the Department of Mental Health, Mental Retardation and Substance Abuse Services, when any conditions of probation are imposed that include psychiatric outpatient or inpatient treatment, or mental health counseling. Notice shall include the name and last known address of the individual placed on probation, name and address of the attorney of record, and the conditions of probation.

34-B, MRSA, sec. 1220 is enacted as follows:

Mental health services to persons on probation. The Department shall designate at least one individual within each of its seven areas, as set out in 34-B, MRSA, sec. 3607, to act as liaison to the district and superior courts of the state of Maine and to the Department of Corrections in its administration of probation and parole services and the Intensive Supervision Program.

To obtain evaluations from people who meet one of the following qualifications: a licensed psychiatrist; a licensed psychologist; a nurse certified by the American Nurses' Association as a psychiatric and mental health nurse or as a clinical specialist in adult psychiatric and mental health nursing; a social worker licensed as a licensed clinical social worker or as a licensed master social worker; or a licensed clinical professional counselor.

1. The liaison shall have the following duties:

A. To provide reports in a timely fashion on behalf of the Department in response to any requests made by a court pursuant to 17A, MRSA, sec. 1204(D) and to undertake or to cause to be undertaken, such inquiries or evaluations as are necessary to complete the reports.

B. To obtain evaluations as may be required by this section from appropriately qualified and trained individuals.

C. To receive any notices of imposition of a condition of probation given pursuant to 17A, MRSA, sec. 1204(D) and thereupon to assess or to obtain an assessment of the appropriateness and availability of the mental health services necessary to the individuals meeting the conditions of probation as imposed.

D. If after completion of the assessment as required by either subsection 1(A) or 1(B), the evaluator and/or the liaison are of the opinion, based upon his or her professional judgment, that the mental health services necessary to the individuals meeting the conditions of probation are inappropriate given the individual's clinical condition or that the mental health services are unavailable, the liaison shall notify the court, the probation officer, the individual on probation and his or her attorney, if known.

E. If after completion of the assessment as required by either subsection 1(A) or 1(B) above, the evaluator and/or the liaison are of the opinion, based upon his or her professional judgment, that the mental health services necessary to the individuals meeting the conditions of probation are appropriate given the individual's clinical condition and the evaluator and/or the liaison know that the services are available, then the liaison shall assist the individual in obtaining the mental health services.

34-B, 3801 is amended as follows:

1-B. Least restrictive form of transportation. "Least restrictive form of transportation" means the vehicle used for transportation and any restraining devises that may be used during transportation that impose the least amount of restriction and stigmatizing impact upon the individual being transported.

Article III
INVOLUNTARY HOSPITALIZATION

FLAGS :

34B § 3861. Reception of involuntary patients

1. Nonstate mental health institution. The chief administrative officer of a nonstate mental health institution may receive for observation, diagnosis, care and treatment in the institution any person whose admission is applied for under any of the procedures in this subchapter. An admission may be made under the provisions of 3863 only if the certifying examination conducted pursuant to section 3863(2) was completed no more than 2 days before the date of admission.

A. The institution, any person contracting with the institution and any of its employees when admitting, treating or discharging a patient under the provisions of sections 3863 and 3864 under a contract with the department, for purposes of civil liability, must be deemed to be a governmental entity or an employee of a governmental entity under the Maine Tort Claims Act, Title 14, chapter 741. b! 1989, c. 906 (new). ?b

B. Patients with a diagnosis of mental illness or psychiatric disorder in nonstate mental health institutions that contract with the department under this subsection are entitled to the same rights and remedies as patients in ~~state mental health institutes~~ hospitals as conferred by the constitution, laws, regulations and rules of this State and of the United States. b! 1989, c. 906 (new). ?b

C. Before contracting with and approving the admission of involuntary patients to a nonstate mental health institution, the department shall require the institution to:

(1) Comply with all applicable regulations;

(2) Demonstrate the ability of the institution to comply with judicial decrees as those decrees relate to services already being provided by the institution; and

(3) Coordinate and integrate care with other community-based services. b! 1989, c. 906 (new). ?b

D. Beginning July 31, 1990, the capital, licensing, remodeling, training and recruitment costs associated with the start-up of beds designated for involuntary patients under this section must be reimbursed,

within existing resources, of the Department of Mental Health, Mental Retardation and Substance Abuse Services. b! 1989, c. 906 (new); 1995, c. 560, Pt. K, @82 (amd); @83 (aff). ?b

b! 1989, c. 906 (amd); 1995, c. 560, Pt. K, @82 (amd); @83 (aff). ?b

2. ~~State mental health institute~~. Hospital The chief administrative officer of a ~~state mental health institute~~ hospital~~.~~

A. May receive for observation, diagnosis, care and treatment in the hospital any person whose admission is applied for under section 3831 or under section 3863; and provided that the certifying examination conducted pursuant to section 3863(2) was completed no more than 2 days before the date of admission. b! 1983, c. 459, @7 (new). ?b

B. May receive for observation, diagnosis, care and treatment in the hospital any person whose admission is applied for under section 3864 or is ordered by a court. b! 1993, c. 336, @1 (amd). ?b

Any person contracting with a ~~state mental health institute~~ hospital when admitting, treating or discharging a patient, within the state institute, under the provisions of sections 3863 and 3864 under a contract with the department for purposes of civil liability is deemed to be an employee of a governmental entity under the Maine Tort Claims Act, Title 14, chapter 741.

b! RR 1993, c. 2, @36 (cor). ?b

Section history:

1983, c. 459 , § 7 (NEW). 1989, c. 906 , § (AMD). 1993, c. 336 , § 1 (AMD). RR 1993, c. 2 , § 36 (COR). 1995, c. 560 , § K82 (AMD). 1995, c. 560 , § K83 (AFF).

FLAGS :

34B § 3862. Protective custody

1. Law enforcement officer's power. If a law enforcement officer has reasonable grounds to believe, based upon probable cause, that a person may be mentally ill and that due to that condition the person presents a threat of imminent and substantial physical harm to that person or to other persons, the law enforcement officer:

A. May take the person into protective custody; and b! 1983, c. 459, @7 (new). ?b

B. If the officer does take the person into protective custody, shall deliver the person immediately for examination by an available licensed physician or licensed clinical psychologist, as provided in section 3863.

C. When, in formulating probable cause, the law enforcement officer relies upon information provided by a third party informant, the officer shall confirm that the informant has reason to believe based upon the informant's recent personal observations of or conversations with person, that the person may be mentally ill and that due to that condition the person presents a threat of imminent and substantial physical harm to self or to other persons. b! 1993, c. 596, @1 (amd). ?b

b! 1995, c. 62, @1 (amd). ?b

1-A. Law enforcement officer's power.

b! 1995, c. 62, @2 (rp). ?b

2. Certificate not executed. If a certificate relating to the person's likelihood of serious harm is not executed by the examiner under section 3863, the officer shall:

A. Release the person from protective custody and, with his permission, return him forthwith to his place of residence, if within the territorial jurisdiction of the officer; b! 1983, c. 459, @7 (new). ?b

B. Release the person from protective custody and, with his permission, return him forthwith to the place where he was taken into protective custody; or b! 1983, c. 459, @7 (new). ?b

C. If the person is also under arrest for a violation of law, retain him in custody until he is released in accordance with the law. b! 1983, c. 459, @7 (new). ?b

b! 1983, c. 459, @7 (new). ?b

3. Certificate executed. If the certificate is executed by the examiner under section 3863, the officer shall undertake forthwith to secure the endorsement of a judicial officer under section 3863 and may detain the

person for a reasonable period of time, not to exceed 18 hours, pending that endorsement.
b! 1983, c. 459, @7 (new). ?b

4. Transportation costs. The costs of transportation under this section shall be paid in the manner provided under section 3863. Any person transporting an individual to a hospital under these circumstances must use the least restrictive form of transportation available that meets the security needs of that situation.
b! 1983, c. 459, @7 (new). ?b

Section history:

1983, c. 459 , § 7 (NEW). 1993, c. 596 , § 1,2 (AMD). 1993, c. 596 , § 4 (AFF). 1995, c. 62 , § 1,2 (AMD).

FLAGS :
34B § 3863. Emergency procedure

A person may be admitted to a mental hospital on an emergency basis according to the following procedures.
b! 1983, c. 459, @7 (new). ?b

1. Application. Any health officer, law enforcement officer or other person may make a written application to admit a person to a mental hospital, subject to the prohibitions and penalties of section 3805, stating:

A. His belief that the person is mentally ill and, because of his illness, poses a likelihood of serious harm; and b! 1983, c. 459, @7 (new). ?b

B. The grounds for this belief. b! 1983, c. 459, @7 (new). ?b
b! 1983, c. 459, @7 (new). ?b

2. Certifying examination. The written application shall be accompanied by a dated certificate, signed by a licensed physician or a licensed clinical psychologist, stating:

A. He has examined the person on the date of the certificate~~, which date may not be more than 3 days before the date of admission to the hospital~~; and b! 1983, c. 459, @7 (new). ?b

B. He is of the opinion that the person is mentally ill and, because of his illness, poses a likelihood of serious harm. b! 1983, c. 459, @7 (new). ?b
b! 1983, c. 459, @7 (new). ?b

2-A. Custody agreement. A state, county or municipal law enforcement agency may meet with representatives of those public and private health practitioners and health care facilities that are willing

and qualified to perform the certifying examination required by this section in order to attempt to work out a procedure for the custody of the person who is to be examined while that person is waiting for that examination. Any agreement must be written and signed by and filed with all participating parties. In the event of failure to work agreement that is satisfactory to all participating parties, the procedures of section 3862 and this section continue to apply.

As part of an agreement the law enforcement officer requesting certification may transfer protective custody of the person for whom the certification is requested to another law enforcement officer, a health officer if that officer agrees or the chief administrative officer of a public or private health practitioner or health facility or the chief administrative officer's designee. Any arrangement of this sort must be part of the written agreement between the law enforcement agency and the health practitioner or health care facility. In the event of a transfer, the law enforcement officer seeking the transfer shall provide the written application required by this section.
b! 1995, c. 143, @1 (amd). ?b

Under no circumstances, either under the procedures of Section 3862, pursuant to a custody agreement or under any other circumstance, may a person with mental illness be detained or confined in any jail, local correction detention facility unless that person is being lawfully detained in relation to or is serving a sentence for commission of a crime.

3. Judicial review. The application and accompanying certificate must be reviewed by a Justice of the Superior Court, Judge of the District Court, Judge of Probate or a justice of the peace.

A. If the judge or justice finds the application and accompanying certificate to be regular and in accordance with the law, the judge or justice shall endorse them. b! 1993, c. 596, @3 (amd). ?b

B. A person may not be held against the person's will in the hospital under this section, whether informally admitted under section 3831 or sought to be involuntarily admitted under this section, unless the application and certificate have been endorsed by a judge or justice, except that a person for whom an examiner has executed the certificate under subsection 2 may be detained in a hospital for a reasonable period of time, not to exceed 18 hours, pending endorsement by a judge or justice, if:

(1) For a person informally admitted under section 3831, the chief administrative officer of the hospital undertakes to secure the endorsement immediately upon execution of the certificate by the examiner; and (2) For a

person sought to be involuntarily admitted under this section, the person or persons transporting the person sought to be involuntarily admitted to the hospital undertake to secure the endorsement immediately upon execution of the certificate by the examiner. b! 1993, c. 596, @3 (amd). ?b

C. Notwithstanding paragraph B, subparagraphs (1) and (2), a person sought to be admitted informally under section 3831 or involuntarily under this section may be transported to a hospital and held for evaluation and treatment at a hospital pending judicial endorsement of the application and certificate if the endorsement is obtained between the soonest available hours of 7:00 a.m. and 11:00 p.m. b! 1995, c. 364, @1 (amd). ?b

b! 1995, c. 364, @1 (amd). ?b

4. Custody and transportation. Custody and transportation under this section are governed as follows.

A. Upon endorsement of the application and certificate by the judge or justice, law enforcement 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. Transportation of an individual to a hospital under these circumstances must involve the least restrictive form of transportation available that meets the clinical needs of that individual. b! 1983, c. 459, @7 (new). ?b

B. The Department of Mental Health, Mental Retardation and Substance Abuse Services is responsible for any transportation expenses under this section, including return from the hospital if admission is declined. The department shall utilize any 3rd-party payment sources that are available. b! 1995, c. 560, Pt. K, @37 (amd); @83 (aff). ?b

b! 1995, c. 560, Pt. K, @37 (amd); @83 (aff). ?b

C. When a person who is under sentence or lawful detention related to commission of a crime and who is incarcerated in a jail, local correction or detention facility is admitted to a hospital under any of the procedures in this sub-chapter, the county where the incarceration originated shall pay all expanses incident to transportation of the person between hospital and the jail, local correction or detention facility.

5. Continuation of hospitalization. If the chief administrative officer of the hospital recommends further hospitalization of the person, the chief administrative officer shall determine the suitability of admission, care and treatment of the patient as an informally admitted patient, as described in section 3831.

A. If the chief administrative officer of the hospital determines that admission of the person as an informally admitted patient is suitable, the chief administrative officer shall admit the person on this basis, if the person so desires. b! 1995, c. 496, @2 (amd). ?b

B. If the chief administrative officer of the hospital determines that admission of the person as an informally admitted patient is not suitable, or if the person declines admission as an informally admitted patient, the chief administrative officer of the hospital may seek involuntary commitment of the patient by filing an application for the issuance of an order for hospitalization under section 3864, except that if the hospital is a designated nonstate mental health institution and if the patient was admitted under the contract between the hospital and the department for receipt by the hospital of involuntary patients, then the chief administrative officer may seek involuntary commitment only by requesting the commissioner to file an application for the issuance of an order for hospitalization under section 3864.

(1) The application must be made to the District Court having territorial jurisdiction over the hospital to which the person was admitted on an emergency basis.

(2) The application must be filed within 5 days from the admission of the patient under this section, excluding the day of admission and any Saturday, Sunday or legal holiday. b! 1995, c. 496, @2 (amd). ?b

C. If neither readmission nor application to the District Court is effected under this subsection, the chief administrative officer of the hospital to which the person was admitted on an emergency basis shall discharge the person immediately. b! 1995, c. 496, @2 (amd). ?b

b! 1995, c. 496, @2 (amd). ?b

6. Notice. Upon admission of a person under this section, and after consultation with the person, the chief administrative officer of the hospital shall notify, as soon as possible regarding ~~mail notice of~~ the fact of admission, the person's ~~to~~:

A. ~~His~~ guardian, if known; b! 1983, c. 459, @7 (new). ?b

B. ~~His~~ spouse; b! 1983, c. 459, @7 (new). ?b

C. ~~His~~ parent; b! 1983, c. 459, @7 (new). ?b

D. His adult child; or b! 1983, c. 459, @7 (new). ?b

E. One of next of kin or a friend, if none of the listed persons exists. b! 1983, c. 459, @7 (new). ?b

b! 1983, c. 459, @7 (new). ?b

7. Post-admission examination. Every patient admitted to a hospital shall be examined as soon as practicable after his admission.

A. The chief administrative officer of the hospital shall arrange for examination by a staff physician or licensed clinical psychologist of every patient hospitalized under this section. b! 1983, c. 459, @7 (new). ?b

B. The examiner may not be the certifying examiner under this section or under section 3864. b! 1983, c. 459, @7 (new). ?b

C. If the post-admission examination is not held within 24 hours after the time of admission, or if a staff physician or licensed clinical psychologist fails or refuses after the examination to certify that, in his opinion, the person is mentally ill and due to his mental illness poses a likelihood of serious harm, the person shall be immediately discharged. b! 1983, c. 459, @7 (new). ?b

b! 1983, c. 459, @7 (new). ?b

Except that if the chief administrative officer has reason to believe that notice to any of the above individuals would pose risk of harm to the person admitted, then notice shall not be effected to that individual

Section history:

1983, c. 459 , § 7 (NEW). 1985, c. 815 , § (AMD). 1987, c. 736 , § 53 (AMD). 1989, c. 568 , § 1,3 (AMD). 1993, c. 592 , § 1 (AMD). 1993, c. 596 , § 3 (AMD). 1995, c. 62 , § 3 (AMD). 1995, c. 143 , § 1 (AMD). 1995, c. 364 , § 1 (AMD). 1995, c. 496 , § 2 (AMD). 1995, c. 560 , § K37 (AMD). 1995, c. 560 , § K83 (AFF).

FLAGS :

34B § 3864. Judicial procedure and commitment

1. Application. An application to the District Court to admit a person to a mental hospital, filed under section 3863, subsection 5, paragraph B, shall be accompanied by:

A. The emergency application under section 3863, subsection 1; b! 1983, c. 459, @7 (new). ?b

B. The accompanying certificate of the physician or psychologist under section 3863, subsection 2; and b! 1983, c. 459, @7 (new). ?b

C. The certificate of the physician or psychologist under section 3863, subsection 7, that:

(1) He has examined the patient; and

(2) It is his opinion that the patient is a mentally ill person and, because of his illness, poses a likelihood of serious harm. b! 1983, c. 459, @7 (new). ?b b! 1983, c. 459, @7 (new). ?b

D. A certificate, signed by the chief administrative officer of the hospital certifying that a copy of the application and the accompanying attachments have been given personally to the patient, and that the patient has been notified of his right to retain an attorney or to have an attorney appointed; of his right to select or to have his attorney select an independent examiner; instructions on how to contact the District Court.

E. A copy of the notice and instructions given to the patient.

2. Detention pending judicial determination. Notwithstanding any other provisions of this subchapter, a person, with respect to whom an application for the issuance of an order for hospitalization has been filed, may not be released or discharged during the tendency of the proceedings, unless:

A. The District Court orders release or discharge upon the request of the patient, or the patient's guardian, parent, spouse or next of kin; b! 1995, c. 496, @3 (amd). ?b

B. The District Court orders release or discharge upon the report of the applicant that the person may be discharged with safety; b! 1995, c. 496, @3 (amd). ?b

C. A court orders release or discharge upon a writ of habits corpus under section 3804; or b! 1995, c. 496, @3 (amd). ?b

D. Upon request of the commissioner, the District Court orders the transfer of a patient in need of more specialized treatment to another hospital. In the event of a transfer, the court shall transfer its file to the District Court having territorial jurisdiction over the receiving hospital. b! 1995, c. 496, @3 (new). ?b
b! 1995, c. 496, @3 (amd). ?b

3. Notice of receipt of application. The giving of notice of receipt of application and date of hearing under this section is governed as follows.

A. Upon receipt by the District Court of the application and accompanying documents specified in subsection 1, the court shall cause written notice of the application and date of hearing:

(1) ~~To be given personally or by mail to the person within a reasonable time before the hearing, but not less than 3 days before the hearing~~ To be mailed within two days of filing to the person; and

(2) To be mailed to the person's guardian, if known, and to his spouse, his parent or one of his adult children or, if none of these persons exist or if none of them can be located, to one of his next of kin or a friend, except that if the chief administrative officer has reason to believe that notice to any of the above individuals would pose risk of harm to the person who is the subject of the application, notice to such other individual shall not be effected. b! 1983, c. 459, @7 (new). ?b

B. A docket entry is sufficient evidence that notice under this subsection has been given. b! 1983, c. 459, @7 (new). ?b

b! 1983, c. 459, @7 (new). ?b

4. Examination. Examinations under this section are governed as follows.

A. Upon receipt by the District Court of the application and the accompanying documents specified in subsection 1, and at last three days after the person who is the subject of the examination was notified by the hospital of the proceedings and of his right to retain counsel and/or to select an examiner the court shall ~~forthwith~~ cause the person to be examined by 2 examiners.

(1) Each examiner must be either a licensed physician or a licensed clinical psychologist.

(2) One of the examiners shall be a physician or psychologist chosen by the person or by his counsel, if the chosen physician or psychologist is reasonably available.

(3) Neither examiner appointed by the court may be the certifying examiner under section 3863, subsection 2 or 7. b! 1983, c. 459, @7 (new). ?b

B. The examination shall be held at the hospital or at any other suitable place not likely to have a

harmful effect on the mental health of the person. b! 1983, c. 459, @7 (new). ?b

C. If the report of the examiners is to the effect that the person is not mentally ill or does not pose a likelihood of serious harm, the application shall be ordered discharged forthwith. b! 1983, c. 459, @7 (new). ?b

D. If the report of the examiners is to the effect that the person is mentally ill or poses a likelihood of serious harm, the hearing shall be held on the date, or on the continued date, which the court has set for the hearing. b! 1983, c. 459, @7 (new). ?b

b! 1983, c. 459, @7 (new). ?b

5. **Hearing.** Hearings under this section are governed as follows.

A. The District Court shall hold a hearing on the application not later than 15 days from the date of the application.

(1) On a motion by any party, the hearing may be continued for cause for a period not to exceed 10 additional days.

(2) If the hearing is not held within the time specified, or within the specified continuance period, the court shall dismiss the application and order the person discharged forthwith.

(3) In computing the time periods set forth in this paragraph, the District Court Civil Rules shall apply. b! 1983, c. 459, @7 (new). ?b

B. The hearing must be conducted in as informal a manner as may be consistent with orderly procedure and in a physical setting not likely to have harmful effect on the mental health of the person. If the setting is outside the hospital to which the patient is currently admitted, the ~~hospital~~ Department of Mental Health, Mental Retardation and Substance Abuse Services shall bear the responsibility and expense of transporting the patient to and from the hearing. If the patient is to be admitted to a hospital following the hearing, then the responsible hospital shall transport the patient to the admitting hospital. If the patient is to be released following the hearing, then the responsible hospital shall return the patient to the hospital or, at the patient's request, return the patient to the patient's place of residence. b! 1995, c. 496, @4 (amd). ?b

C. The court shall receive all relevant and material evidence which may be offered in accordance with

accepted rules of evidence and accepted judicial dispositions.

(1) The person, the applicant and all other persons to whom notice is required to be sent shall be afforded an opportunity to appear at the hearing to testify and to present and cross-examine witnesses.

(2) The court may, in its discretion, receive the testimony of any other person and may subpoena any witness. b! 1983, c. 459, @7 (new). ?b

D. The person shall be afforded an opportunity to be represented by counsel, and, if neither the person nor others provide counsel, the court shall appoint counsel for the person. b! 1983, c. 459, @7 (new). ?b

E. In addition to proving that the patient is a mentally ill individual, the applicant shall show:

(1) By evidence of the patient's actions and behavior, that the patient poses a likelihood of serious harm; and

(2) That, after full consideration of less restrictive treatment settings and modalities, inpatient hospitalization is the best available means for the treatment of the person. b! 1983, c. 459, @7 (new). ?b

F. In each case, the applicant shall submit to the court, at the time of the hearing, testimony, <u>including expert psychiatric testimony,</u> indicating the individual treatment plan to be followed by the hospital staff, if the person is committed under this section, and shall bear any expense for witnesses for this purpose. b! 1983, c. 459, @7 (new). ?b

G. A stenographic or electronic record shall be made of the proceedings in all judicial hospitalization hearings.

(1) The record and all notes, exhibits and other evidence shall be confidential.

(2) The record and all notes, exhibits and other evidence shall be retained as part of the District Court records for a period of 2 years from the date of the hearing. b! 1983, c. 459, @7 (new). ?b

H. The hearing shall be confidential and no report of the proceedings may be released to the public or press, except by permission of the person or his counsel and with approval of the presiding District Court Judge, except that the court may order a public

hearing on the request of the person or his counsel. b! 1983, c. 459, @7 (new). ?b
b! 1995, c. 496, @4 (amd). ?b

6. Court findings. Procedures dealing with the District Court's findings under this section are as follows.

A. The District Court shall so state in the record, if it finds upon completion of the hearing and consideration of the record:

(1) Clear and convincing evidence that the person is mentally ill and that the person's recent actions and behavior demonstrate that the person's illness poses a likelihood of serious harm;

(2) That inpatient hospitalization is the best available means for treatment of the patient; and

(3) That it is satisfied with the individual treatment plan offered by the hospital to which the applicant seeks the patient's involuntary commitment. b! 1995, c. 496, @5 (amd). ?b

B. If the District Court makes the findings described in paragraph A, subparagraphs 1 and 2, but is not satisfied with the individual treatment plan as offered, it may continue the case for not longer than 10 days, pending reconsideration and resubmission of an individual treatment plan by the hospital. b! 1983, c. 459, @7 (new). ?b
b! 1995, c. 496, @5 (amd). ?b

7. Commitment. Upon making the findings described in subsection 6, the court may order commitment to a hospital for a period not to exceed 4 months in the first instance and not to exceed ~~one year~~ six months after the first and all subsequent hearings.

A. The court may issue an order of commitment immediately after the completion of the hearing, or it may take the matter under advisement and issue an order within 24 hours of the hearing. b! 1983, c. 459, @7 (new). ?b

B. If the court does not issue an order of commitment within 24 hours of the completion of the hearing, it shall dismiss the application and order the patient discharged immediately. b! 1995, c. 496, @6 (amd). ?b
b! 1995, c. 496, @6 (amd). ?b

8. Continued involuntary hospitalization. If the chief administrative officer of the hospital to which a person has been committed involuntarily by the District Court recommends that continued involuntary

hospitalization is necessary for that person, the chief administrative officer shall notify the commissioner. The commissioner may then, not later than 30 days prior to the expiration of a period of commitment ordered by the court, make application in accordance with this section to the District Court that has territorial jurisdiction over the hospital designated for treatment in the application by the commissioner for a hearing to be held under this section.

b! 1995, c. 496, @6 (amd). ?b

9. Transportation. Excepting expenses associated with 3863(10), a continued involuntary hospitalization hearing which requires transportation of the patient to and from any hospital to any court which has committed the person shall be provided at the expense of the Department of Mental Health, Mental Retardation and Substance Abuse Services. ~~Unless otherwise directed by the court, the sheriff of the county in which the District Court has jurisdiction and in which the hearing takes place shall provide transportation to any hospital to which the court has committed the person.~~ Transportation of an individual to a hospital under these circumstances must involve the least restrictive form of transportation available that meets the clinical needs of that individual and in compliance with departmental regulations.

b! 1983, c. 459, @7 (new). ?b

10. Expenses. With the exception of expenses incurred by the applicant pursuant to subsection 5, paragraph F, the District Court shall be responsible for any expenses incurred under this section, including fees of appointed counsel, witness and notice fees and expenses of transportation for the person.

b! 1983, c. 459, @7 (new). ?b

11. Appeals. A person ordered by the District Court to be committed to a hospital may appeal from that order to the Superior Court.

A. The appeal is on questions of law only. b! 1983, c. 459, @7 (new). ?b

B. Any findings of fact of the District Court may not be set aside unless clearly erroneous. b! 1983, c. 459, @7 (new). ?b

C. The order of the District Court shall remain in effect pending the appeal. b! 1983, c. 459, @7 (new). ?b

D. The District Court Civil Rules and the Maine Rules of Civil Procedure apply to the conduct of the appeals, except as otherwise specified in this subsection. b! 1983, c. 459, @7 (new). ?b

b! 1983, c. 459, @7 (new). ?b

Section history:

1983, c. 459 , § 7 (NEW). 1995, c. 496 , § 3-6 (AMD).

FLAGS :
34B § 3865. Hospitalization by federal agency

If a person ordered to be hospitalized under section 3864 is eligible for hospital care or treatment by any agency of the United States, the court, upon receipt of a certificate from the agency showing that facilities are available and that the person is eligible for care or treatment in the facilities, may order him to be placed in the custody of the agency for hospitalization. b! 1983, c. 459, § 7(new). ?b

1. Rules and rights. A person admitted under this section to any hospital or institution operated by any agency of the United States, inside or outside the State, is subject to the rules of the agency, but retains all rights to release and periodic court review granted by this subchapter. b! 1983, c. 459, § 7(new). ?b

2. Powers of chief administrative officer. The chief administrative officer of any hospital or institution operated by a federal agency in which the person is hospitalized has, with respect to the person, the same powers as the chief administrative officer of hospitals or the commissioner within this State with respect to detention, custody, transfer, conditional release or discharge of patients. b! 1983, c. 459, § 7(new). ?b

3. Court jurisdiction. Every order of hospitalization issued under this section is conditioned on the retention of jurisdiction in the courts of this State to, at any time:

A. Inquire into the mental condition of a person hospitalized; and b! 1983, c. 459, § 7(new). ?b

B. Determine the necessity for continuance of his hospitalization. b! 1983, c. 459, § 7(new). ?b
b! 1983, c. 459, § 7(new). ?b

Section history:

1983, c. 459 , § 7 (NEW).

FLAGS :
34B § 3866. Members of the Armed Forces

1. Admission to hospital. Any member of the Armed Forces of the United States who was a resident of the State at the time of his induction into the service and who is determined by a federal board of medical officers

to have a mental disease not incurred in line of duty shall be received, at the discretion of the commissioner and without formal commitment, at either of the state hospitals for the mentally ill, upon delivery at the hospital designated by the commissioner of:

A. The member of the Armed Forces; and b! 1983, c. 459, § 7(new). ?b

B. The findings of the board of medical officers that he is mentally ill. b! 1983, c. 459, § 7(new). ?b b! 1983, c. 459, § 7(new). ?b

2. Status. After delivery of the member of the Armed Forces at the hospital designated by the commissioner, his status shall be the same as if he had been committed to the hospital under section 3864. b! 1983, c. 459, § 7(new). ?b

Section history:

1983, c. 459 , § 7 (NEW).

FLAGS :

34B § 3867. Transfer from out-of-state institutions

1. Commissioner's authority. The commissioner may, upon request of a competent authority of the District of Columbia or of a state which is not a member of the Interstate Compact on Mental Health, authorize the transfer of a mentally ill patient directly to a ~~state mental health institute~~ hospital in Maine, if:

A. The patient has resided in this State for a consecutive period of one year during the 3-year period immediately preceding commitment in the other state or the District of Columbia; b! 1983, c. 459, § 7(new). ?b

B. The patient is currently confined in a recognized institution for the care of the mentally ill as the result of proceedings considered legal by that state or by the District of Columbia; b! 1983, c. 459, § 7(new). ?b

C. A duly certified copy of the original commitment proceedings and a copy of the patient's case history is supplied; b! 1983, c. 459, § 7(new). ?b

D. The commissioner, after investigation, deems the transfer justifiable; and b! 1983, c. 459, § 7(new). ?b

E. All expenses of the transfer are borne by the agency requesting it. b! 1983, c. 459, § 7(new). ?b b! 1983, c. 459, § 7(new). ?b

2. Receipt of patient. When the commissioner has authorized a transfer under this section, the superintendent of the ~~state mental health institute~~ hospital designated by the commissioner shall receive the patient as having been regularly committed to the mental health institute under section 3864. b! 1983, c. 459, § 7(new). ?b

Section history:

1983, c. 459 , § 7 (NEW).

FLAGS :

34B § 3868. Transfer to other institutions

1. To other hospitals. The commissioner may transfer, or authorize the transfer of, a patient from one hospital to another, either inside or outside the State, if the commissioner determines that it would be consistent with the medical needs of the patient to do so.

A. Whenever a patient is to be transferred, the commissioner shall give written notice of the transfer to the patient's guardian, his parents or spouse or, if none of these persons exists or can be located, to his next of kin or friend. Except that if the chief administrative officer of the hospital to which the patient is currently admitted has reason to believe that notice to any of the above individuals would pose risk of harm to the person, then notice shall not be effected to that individual. b! 1983, c. 459, § 7(new). ?b

B. In making all such transfers, the commissioner shall give due consideration to the relationship of the patient to his family, guardian or friends, in order to maintain relationships and encourage visits beneficial to the patient. b! 1983, c. 459, § 7(new). ?b b! 1983, c. 459, § 7(new). ?b

2. To federal agency. Upon receipt of a certificate of an agency of the United States that facilities are available for the care or treatment of any involuntarily hospitalized person and that the person is eligible for care and treatment in a hospital or institution of the agency, the chief administrative officer of the hospital may cause his transfer to the agency of the United States for hospitalization.

A. Upon making such a transfer, the chief administrator of the hospital shall notify the court which ordered hospitalization and the persons specified in subsection 1, paragraph A. b! 1983, c. 459, § 7(new). ?b

B. No person may be transferred to an agency of the United States if he is confined pursuant to conviction of any felony or misdemeanor or if he has been acquitted of the charge solely on the ground of

mental illness, unless before the transfer the court originally ordering confinement of the person enters an order for transfer after appropriate motion and hearing. b! 1983, c. 459, § 7(new). ?b

C. Any person transferred under this section to an agency of the United States is deemed to be hospitalized by the agency pursuant to the original order of hospitalization. b! 1983, c. 459, § 7(new). ?b b! 1983, c. 459, § 7(new). ?b

Section history:

1983, c. 459 , § 7 (NEW).

FLAGS :

34B § 3869. Return from unauthorized absence

If any patient committed under section 3864 leaves the grounds of the hospital without authorization of the chief administrative officer of the hospital or his designee, or refuses to return to the hospital from a community pass when requested to do so by the chief administrative officer or his designee, law enforcement personnel of the State or of any of its subdivisions may, upon request of the chief administrative officer or his designee, assist in the return of the patient to the hospital. b! 1983, c. 459, § 7(new). ?b

Section history:

1983, c. 459 , § 7 (NEW).

FLAGS :

34B § 3870. Convalescent status

1. Authority. The chief administrative officer of a ~~state mental health institute~~ hospital may release an improved patient on convalescent status when he believes that the release is in the best interest of the patient. The chief administrative officer of a hospital may release an improved patient on convalescent status when he believes that the release is in the best interest of the patients, and, when releasing an involuntarily committed patient, he has obtained the approval of the commissioner after submitting a plan for continued responsibility.

A. Release on convalescent status may include provisions for continuing responsibility to and by the ~~state mental health institute~~, hospital including a plan of treatment on an outpatient or nonhospital basis. b! 1983, c. 459, § 7(new). ?b

B. Before release on convalescent status under this section, the chief administrative officer of a ~~state mental health institute~~ hospital 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, if any:

(1) The parent or guardian of a minor patient;

(2) The legal guardian of an adult incompetent patient, if any is known; or

(3) The spouse or adult next of kin of an adult competent patient, if any is known, unless the patient requests in writing that the notice not be given~~.~~, and if the chief administrative officer of the hospital to which the patient is currently admitted has reason to believe that notice to any of the above individuals would pose risk of harm to the person, then notice shall not be effected to that individual. b! 1983, c. 459, § 7(new). ?b

C. The ~~state mental health institute~~ hospital is not liable when good faith attempts to notify parents, spouse or guardian have failed. b! 1983, c. 459, § 7(new). ?b

D. Before releasing a patient on convalescent status, the chief administrative officer of the hospital shall advise the patient, orally and in writing, of the treatment available while the patient is on convalescent status, and if the patient is a voluntary patient, of his right to request termination of the status, of if involuntarily committed, the means whereby and conditions under which rehospitalization may occur.
b! 1983, c. 459, § 7(new). ?b

2. Reexamination. Before a patient has spent a year on convalescent status, and at least once a year thereafter, the chief administrative officer of the ~~state mental health institute~~ hospital shall reexamine the facts relating to the hospitalization of the patient on convalescent status. b! 1983, c. 459, § 7(new). ?b

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

A. If the chief administrative officer of the ~~state mental health institute~~ hospital 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! 1983, c. 459, § 7(new). ?b

B. The chief administrative 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. b! 1983, c. 459, § 7(new). ?b

b! 1983, c. 459, § 7(new). ?b

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 or the chief administrative officer of the ~~state mental health institute~~ hospital who has obtained the approval of the commissioner for seeking rehospitalization, may issue an order for the immediate rehospitalization of the patient. b! 1983, c. 459, § 7(new). ?b

B. Repealed

C. If the order is not voluntarily complied with, an involuntary commitment patient on convalescent leave may be returned to the hospital in the following manner:

(1) The order in sub-section A is issued;

(2) The order is brought before a District Court Judge or Justice of the Peace; and

(3) Based upon clear evidence that return to the hospital is in the patient's best interest, the District Court Judge or Justice of the Peace may endorse return to the hospital.

Based upon this endorsement, the law enforcement officer may take the patient into custody and arrange for his/her transportation in accordance with the provisions of 34-B MRSA ss.3863(4).

Nothing in this paragraph is intended to preclude the use of protective custody by law enforcement officers pursuant to section 3862.

b! 1987, c. 736, @54 (amd). ?b

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~~ hospital is to be changed, either because of a decision of the chief administrative officer of the ~~state mental health institute~~ hospital or because of a request made by a voluntary patient, the chief administrative officer of the ~~state mental health institute~~ hospital 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) The spouse or adult next of kin of an adult competent patient, unless the patient requests in writing that the notice not be given~~.~~, and if the chief administrative officer of the hospital to which the patient is currently admitted has reason to believe that notice to any of the above individuals would pose risk of harm to the person, then notice shall not be effected to that individual. b! 1983, c. 459, § 7(new). ?b

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~~ hospital shall give the required notice within 10 days after the day he receives the request. b! 1983, c. 459, § 7(new). ?b

C. The ~~state mental health institute~~ hospital is not liable when good faith attempts to notify parents, spouse or guardian have failed. b! 1983, c. 459, § 7(new). ?b

b! 1983, c. 459, § 7(new). ?b

Section history:

1983, c. 459 , § 7 (NEW). 1987, c. 736 , § 54 (AMD).

FLAGS :
34B § 3871. Discharge

1. Examination. The chief administrative officer of a ~~state mental health institute~~ hospital shall, as often as practicable, but no less often than every ~~12 months~~, 30 days examine or cause to be examined every patient to determine his mental status and need for continuing hospitalization.
b! 1983, c. 459, @7 (new). ?b

2. Conditions for discharge. The chief administrative officer of a ~~state mental health institute~~ hospital shall discharge, or cause to be discharged, any patient when:

A. Conditions justifying hospitalization no longer obtain; b! 1983, c. 459, @7 (new). ?b

B. The patient is transferred to another hospital for treatment for his mental or physical condition; b! 1983, c. 459, @7 (new). ?b

C. The patient is absent from the ~~state mental health institute~~ hospital unlawfully for a period of 90 days; b! 1983, c. 459, @7 (new). ?b

D. Notice is received that the patient has been admitted to another hospital, inside or outside the State, for treatment for his mental or physical condition; or b! 1983, c. 459, @7 (new). ?b

E. Although lawfully absent from the ~~state mental health institute~~, hospital the patient is admitted to another hospital, inside or outside the State, for treatment of his mental or physical condition, except that, if the patient is directly admitted to another hospital and it is the opinion of the chief administrative officer of the ~~state mental health institute~~ hospital that the patient will directly reenter the ~~state mental health institute~~ hospital within the foreseeable future, the patient need not be discharged. b! 1983, c. 459, @7 (new). ?b
b! 1983, c. 459, @7 (new). ?b

3. Discharge against medical advice. The chief administrative officer of a state mental health

institute may discharge, or cause to be discharged, any patient even though the patient is mentally ill and appropriately hospitalized in the ~~state mental health institute~~, hospital if:

A. The patient and either the guardian, spouse or adult next of kin of the patient request his discharge; and b! 1983, c. 459, @7 (new). ?b

B. In the opinion of the chief administrative officer of the hospital, the patient does not pose a likelihood of serious harm due to his mental illness. b! 1983, c. 459, @7 (new). ?b
b! 1983, c. 459, @7 (new). ?b

4. Reports.
b! 1995, c. 496, @7 (rp). ?b

5. Notice. Notice of discharge is governed as follows.

A. When a patient is discharged under this section, the chief administrative officer of the hospital shall immediately make a good faith attempt to notify the following people, by telephone, personal communication or letter, that the discharge has taken or will take place:

(1) The parent or guardian of a minor patient;

(2) The guardian of an adult incompetent patient, if any is known; or

(3) The spouse or adult next of kin of an adult competent patient, if any is known, unless the patient requests in writing that the notice not be given or unless the patient was transferred from or will be returned to a state correctional facility. b! 1995, c. 496, @8 (amd). ?b

Except that if the chief administrative officer of the hospital to which the patient is currently admitted has reason to believe that notice to any of the above individuals would pose risk of harm to the person, then notice shall not be effected to that individual.

B. The hospital is not liable when good faith attempts to notify parents, spouse or guardian have failed. b! 1995, c. 496, @8 (amd). ?b
b! 1995, c. 496, @8 (amd). ?b
Section history:

1983, c. 459 , § 7 (NEW). 1995, c. 496 , § 7,8 (AMD).

FLAGS :
34B § ~~3872. Treatment of dually diagnosed persons~~

~~In the case of a patient who has been admitted to a state mental health institute on a voluntary or involuntary basis and who has also been diagnosed as mentally retarded, the chief administrative officer of the state mental health institute shall, after the patient has been a resident for a period of no more than 6 months, determine whether the patient is capable of giving informed consent to continued hospitalization. b! 1985, c. 615 (new). ?b~

~~If at that time the chief administrative officer of the state mental health institute determines that the patient is not capable of giving informed consent to continued hospitalization, the patient may be admitted for extended care and treatment only after judicial certification pursuant to the procedures contained in section 5475. b! 1985, c. 615 (new). ?b~

~~For the purpose of this section the state mental health institutes shall be considered facilities under section 5461, subsection 5.~~ b! 1985, c. 615 (new). ?b
Repealed.

Section history:

APPENDIX B:

MATERIALS DISTRIBUTED TO TASK FORCE

APPENDIX B: MATERIALS DISTRIBUTED

JOURNAL ARTICLES

Guidelines for the Psychiatric Hospitalization of Minors. Four Alternatives to the Guidelines for the Psychiatric Hospitalization of Minors: Clinical and Legal Considerations. American Journal of Psychiatry, 1982, 139, 971-975.

Guidelines for Legislation on the Psychiatric Hospitalization of Adults. American Journal of Psychiatry, 1993, 140, 672-679.

Drake, R.E., , Teague, G.B., and Warren, S. Dual diagnosis: The New Hampshire program. Addiction and Recovery, 1990, 35-39.

Dvoskin, J., and Steadman, H.J. Using intensive case management to reduce violence by mentally ill persons in the community. Hospital and Community Psychiatry, 1994, 45 (7), 679-684.

Grisso, T., and Appelbaum, P.S. (1995) Executive Summary - MacArthur Treatment Competence Study.

LaFrance, A. Mental commitment: The judicial function -- A case perspective. The Journal of Psychiatry and Law, 1995, special reprint, Federal Legal Publications, Inc.

Maloy, K.A. Critiquing the empirical evidence: Does involuntary outpatient commitment work? MH Resource Center, Inc., 1992.

Mulvey, E., Geller, J.L., and Roth, L.H. The promise and peril of involuntary outpatient commitment. American Psychologist, 1987, 42 (6), 571-584.

Ross, R.E., Rothbard, A.B., and Schinnar, A.P. A framework for classifying state involuntary commitment statutes. Administration and Policy in Mental Health, 1996, 23 (4), 341-356.

Rubin, W.V., Snapp, M.B., Panzano, P., and Taynor, J. Variation in civil commitment processes across jurisdictions: An approach for monitoring and managing change in mental health systems. The Journal of Mental Health Administration, 1996, 23 (4), 375-388.

Schwartz, S.J., Costanzo, C.E. Compelling treatment in the community: Distorted doctrines and violated values. Loyola of Los Angeles Law Review - Disability Symposium, 1987, 20, 1329-1429.

Torrey, E.F., and Kaplan, R.J. A national survey of the use of outpatient commitment alternatives to the hospital for acute psychiatric treatment

Warner, R. Programs in the mainstream: Innovative and nontraditional programs, Alternatives to the Hospital for Acute Psychiatric Treatment,

GOVERNMENT DOCUMENTS

Augusta Mental Health Institute Leave Policy

Bangor Mental Health Institute Leave Policy

Rights of Recipients of Mental Health Services for Adults

Rights of Recipients of Mental Health Services Who are Children in Need of Treatment

Maine Commission on Mental Health. Report of the Involuntary Commitment Task Force, March, 1991

STATUTES

Title 22	Part 3. Public Health
Title 34-B	Alcohol Commitment Statute
Title 34-B	Article III. Involuntary Commitment
PL, Ch. 431	An Act to Prevent the Use of Correctional Facilities for the Detention of the Mentally Ill
PL, Ch. 454	An Act Related to Medical Treatment Decisions for Psychotic Disorders
PL, Ch. 593	An Act to Clarify the Requirements of Disclosure of Information Pertaining to Mentally Disabled Clients
PL, Ch. 596	An Act to Amend the Laws Regarding Protective Custody

PROPOSED LEGISLATION:

An Act to Require Postrelease Supervision of Prisoners Who are Identified as High Risk Offenders

An Act to Authorize a Physician's Assistant to Sign Papers for Emergency Involuntary Commitment

APPENDIX C:

RESOLVES 1995, CHAPTER 13

APPROVED

MAY 25 '95

BY GOVERNOR

CHAPTER

13

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED AND NINETY-FIVE

H.P. 662 - L.D. 885

Resolve, to Create a Task Force to Review the State's Involuntary Commitment Law

Sec. 1. Task force established. Resolved: That the Task Force to Review Maine's Laws Concerning Involuntary Commitment, referred to in this resolve as the "task force," is established; and be it further

Sec. 2. Task force membership; cochairs. Resolved: That the task force consists of 15 members appointed by the Commissioner of Mental Health and Mental Retardation and the members must include representatives of all parties affected or potentially affected by a change to the laws concerning involuntary commitment, including, but not limited to, consumers, family members, mental health professionals, community mental health service providers, advocates for clients and families, hospital officials and law enforcement officials. The task force shall select at its first meeting 2 members to serve as cochairs; and be it further

Sec. 3. Appointments. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The Commissioner of Mental Health and Mental Retardation shall notify the Executive Director of the Legislative Council upon making the appointments. When the appointment of all members is complete, the Chair of the

Legislative Council shall convene the first meeting of the task force no later than November 15, 1995; and be it further

Sec. 4. Duties. Resolved: That the task force shall identify and review the existing state statutes pertaining to involuntary commitment and determine if any changes need to be made to those statutes; and be it further

Sec. 5. Staff assistance. Resolved: That the task force may request staffing and clerical assistance from the Department of Mental Health and Mental Retardation; and be it further

Sec. 6. Reimbursement. Resolved: That the members of the task force are not entitled to reimbursement for travel or other expenses; and be it further

Sec. 7. Report. Resolved: That the task force shall submit its report together with any accompanying legislation to the Second Regular Session of the 117th Legislature by January 30, 1996.

APPENDIX D:

PARTICIPANT INFORMATION

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