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Testimony in Support of SB2121SD1 Relating to Mental Health

House Committees on Health and Human Services
Tuesday, March 13,2012 11 a.m.
State Capitol, Conference Room 329

The National Alliance on Mental Illness, Hawaii State Chapter, supports this bill which would allow interested persons" to file a written petition for the emergency admission of a person to a psychiatric facility.

Every day NAMI receives telephone calls from family members of people who are gravely ill. These family members are desperate because they are unable to assist their loved one to receive treatment. Rather they must watch the mental health of someone they love or deeply care about deteriorate on a daily basis. Frequently the ill family member's condition leads them to become homeless and sometimes physical complications come into play.

A person with a mental illness is just that, a person with a brain disease. When a person receives treatment for a mental illness when it first manifests itself and continues to receive treatment at times that the disease recurs the better the long term prognosis is for that person. Likewise, the longer or more frequently the disease goes untreated the more the likelihood that the persons prognosis will worsen.

NAMI Hawaii believes that the measures in this bill are sufficient to guarantee that only persons who are indeed severely mentally ill will be treated. The important issue is that those people with serious mental illnesses, who because of their illness don't realize that they are ill, be able to receive treatment.

Thank you for your consideration.

Kathleen Hasegawa
Executive Director

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TREATMENT ADVOCACY CENTER

MODEL LAW FOR ASSISTED TREATMENT

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Article 1. Statement of Purpose

§ 1.1 The consequences of untreated mental illness are as apparent as they are devastating: homelessness, criminalization, suicide, violence, victimization, lost productivity, permanently decreased medication responses, and the incalculable costs of unnecessary suffering. Due to advances in recent years, treatment is now available that can eliminate or substantially alleviate the symptoms of mental illness for most who suffer from it.

People with treated mental illness can now reclaim their lives. But first, there must be treatment.

Treatment voluntarily embraced is always preferable. However, mental illness is a biologically based disease that attacks the brain. As a result, mental illness renders many people incapable of voluntarily entering treatment because they are unable to make rational decisions or unaware that they are ill. When this occurs, such people may require assisted treatment to protect their lives as well as avoid tragic personal and societal consequences.

This Model Law is designed to be the legal framework for the provision of care to individuals who, due to the symptoms of severe mental illness, become either dangerous or incapable of making informed medical decisions concerning their treatment.

This Law's substantive and procedural components create a flexible mechanism that can be used to secure treatment for those who most need it while still distinguishing those for whom intervention is inappropriate. Paramount are the strict and plentiful safeguards which this Model Law establishes to protect both the rights and well-being of those subject to it.

Article 2. Definitions

§ 2.1 ***Assisted treatment***: the provision of treatment, in accordance with this Model Law, to individuals who are either dangerous or incapable of making informed medical decisions because of the effects of severe mental illness.

§ 2.2 ***Assisted outpatient treatment***: assisted treatment on an outpatient basis.

§ 2.3 ***Assisted inpatient treatment***: assisted treatment on an inpatient basis.

§ 2.4 ***Certificate***: form filed with the court by a psychiatrist or other physician to request an assisted treatment hearing for an individual currently in emergency treatment/observation.

§ 2.5 ***Chronically disabled***: may be shown by establishing that the person is incapable of making an informed medical decision and, based on the person's psychiatric history, the person is unlikely to comply with treatment and, as a consequence, the person's current condition is likely to deteriorate until his or her psychiatric disorder significantly impairs the person's judgment, reason, behavior or capacity to recognize reality and has a substantial probability of causing him or her to suffer or continue to suffer severe psychiatric, emotional or physical harm. [1]

Comment: These criteria for assisted treatment, modified from Montana Code (MONT. CODE ANN. § 53-21-126(1)), are aimed at providing assistance for those caught in the "revolving door," whereby a person's repeated deterioration due to non-compliance results in successive hospitalizations. Should a state desire separate inpatient and outpatient standards, this may be used exclusively as a standard for assisted outpatient treatment.

§ 2.6 ***Court***: the court for each jurisdiction designated to accept petitions and certificates for assisted treatment and related filings, decide on preliminary and *ex parte* motions, and all other functions assigned to it pursuant to this Model Law.

Comment: The court is responsible for receiving all filings and deciding all motions prior to the assisted treatment hearing. This splitting of functions between the Psychiatric Treatment Board, defined in § 2.12, and a full-time court is necessary as Psychiatric Treatment Boards are designed as part-time forums without a set location and are therefore neither sufficiently available for filings or always able to render timely rulings on motions.

§ 2.7 ***Danger to himself or herself***: may be shown by establishing that, by his or her behavior, a person is in the reasonably foreseeable future likely to either attempt suicide, to inflict bodily harm on himself or herself or[2], because of his or her actions or inaction, to suffer serious physical harm in the near future. The person's past behavior may be considered.[3]

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[1] States with similar statutory provisions include:
Alabama – ALA. CODE § 22-52-10.2 (1997).
Arizona – ARIZ. REV. STAT. ANN. §§ 36-501(29), -540(A) (West 1993 & Supp. 2000).
Idaho – IDAHO CODE §§ 66-317(n), -339(A) to (B) (Michie 2000).
Montana – MONT. CODE ANN. § 53-21-126 (1999).
North Carolina – N.C. GEN. STAT. § 122C-271(a)(1) (1999).

[2] States with similar "unable to protect themselves from otherwise avoidable threats" include:
Colorado – COLO. REV. STAT. ANN. § 27-10-102(5)(a) (West Supp. 2000).
Illinois – 405 ILL. COMP. STAT. ANN. 5/1-119 (West 1993).
Louisiana – LA. REV. STAT. ANN. § 28:2(10) (West Supp. 2001).
Massachusetts – MASS. GEN. LAWS ANN. ch. 123, § 1 (West Supp. 2001).
South Carolina – S.C. CODE ANN. §44-23-10(3) (Law. Co-op. 1985).

[3] States that consider past behavior include:
Arizona – ARIZ. REV. STAT. ANN. § 36-501(5)(a) (West 1993).
North Dakota – N.D. CENT. CODE § 25-03.1-02(11) (Supp. 1999).
Rhode Island – R.I. GEN. LAWS § 40.1-5-2 (1997).
South Dakota – S.D. CODIFIED LAWS § 27A-1-1(5) (2001).
Washington – WASH. REV. CODE ANN. § 71.05.245 (West Supp. 2001).
Washington – S.B. 5048, 57th Leg., 2001Reg. Sess. (Wash. 2001).

Comment: In addition to the traditional standard encompassing suicidal behavior, this definition of danger to oneself includes people exhibiting symptomatic behavior who, because of their illness, are either likely to seriously endanger themselves or are unable to protect themselves from otherwise avoidable threats to their safety.

§ 2.8 ***Danger to others***: may be shown by establishing that, by his or her behavior, a person is in the reasonably foreseeable future likely to cause or attempt to cause harm to another. Evidence that a person is a danger to others may include, but is not limited to:

(a) that he or she has inflicted, attempted or threatened in an objectively serious manner to inflict bodily harm on another;
(b) that by his or her actions or inactions, he or she has presented a danger to a person in his or her care; or
(c) that he or she has recently and intentionally caused significant damage to the substantial property of others.

Comment: The definition of dangerousness in subsection (a), or some variation of it, is standard in virtually every state. Those in subsections (b) and (c) are not. Subsection (b) is designed to address the danger that symptomatic behavior of someone with mental illness can represent to those in his or her care, particularly children. The harm to property criterion in subsection (c), which is included in the North Carolina Code (N.C. GEN. STAT. § 122C-3(11)(b)) and the Kansas Code (KAN. STAT. ANN. § 59-2946(f)(3)(a)), not only protects property but also reflects that someone who engages in the wanton destruction of the substantial property of others due to the symptoms of mental illness is likely to be a threat to the physical safety of others as well.

§ 2.9 ***Gravely disabled***: may be shown by establishing that a person is incapable of making an informed medical decision and has behaved in such a manner as to indicate that he or she is unlikely, without supervision and the assistance of others, to satisfy his or her need for either nourishment, personal or medical care, shelter, or self-protection and safety so that it is probable that substantial bodily harm, significant psychiatric deterioration or debilitation, or serious illness will result unless adequate treatment is afforded. [4]

Comment: Many gravely disabled standards have exceedingly limited application. Section 2.9 is modeled on Vermont's more expansive definition of "a person in need of treatment" which incorporates consideration of the person's ability to provide for his or her medical care and safety in addition to his or her minimum physical needs (VT. STAT. ANN. tit. 18, § 7101(17)(B)(ii)).

§ 2.10 ***Incapable of making an informed medical decision***: means that a person is unaware of the effects of his or her psychiatric disorder or that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or psychiatric treatment. Any history of the person's non-compliance with treatment or of criminal acts

[4] States that contain similar statutory provisions include:
Oregon – OR. REV. STAT. § 426.005(1)(d) (1999).
Mississippi – MISS. CODE ANN. § 41-21-61(e) (1999).
Montana – MONT. CODE ANN. § 53-21-126(1)(e) (1999).
Vermont – VT. STAT. ANN. tit. 18, § 7101(17) (2000).
Wyoming – WYO. STAT. ANN. § 25-10-101(a)(ix), -101(a)(ii) (Michie 1999).

related to his or her mental illness shall, if available, be considered. [5]

Comment: Modified from the Florida Code (FLA. STAT. ANN. § 394.455(15)).

§ 2.11 ***Petition***: form filed with a court to request an assisted treatment hearing based on the good faith belief of the petitioner that the subject of the petition is eligible for assisted treatment pursuant to the provisions of this Model Law.

§ 2.12 ***Psychiatric Treatment Board***: a judicially empowered decision-making body which shall consist of a physician (preferably a psychiatrist), a lawyer, and a third member, who either must be or has been a recipient of treatment for mental illness or either be or has been a close relative of such a person. All decisions of the Board must be approved by a majority of its members.[6]

Comment: Among its members, this board will have a collective range and degree of legal and psychiatric knowledge, as well as a familiarity with issues concerning individuals with mental illness, far greater than that of virtually any single judge. As they are not full-time tribunals, use of Psychiatric Treatment Boards will also mitigate the costs of administering this Model Law. Both Nebraska (NEB. REV. STAT. § 83-1017) and South Dakota (S.D. CODIFIED LAWS § 27A-10-9.1) provide for such tribunals in their codes.

§ 2.13 ***Respondent***: the person who is the subject of a petition or certificate.

§ 2.14 ***Severe psychiatric disorder***: a substantial impairment of a person's thought processes (e.g., delusions), sensory input (e.g., hallucinations), mood balance (e.g., mania or severe depression), memory (e.g., dementia), or ability to reason that substantially interferes with a person's ability to meet the ordinary demands of living. Severe psychiatric disorders are distinguished from:

(a) conditions which are primarily due to drug abuse or alcoholism, although severe psychiatric disorders may co-exist with these disorders;
(b) other known neurological disorders such as epilepsy, multiple sclerosis, Parkinson's disease, or Alzheimer's disease although such neurological disorders may also have psychotic features similar to those found in severe psychiatric disorders;
(c) normal age-related changes in the brain;
(d) brain changes related to terminal medical conditions;
(e) personality disorders as defined by the American Psychiatric Association's

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[5] States that utilize a similar "incapable of making an informed medical decision" include:
Florida – FLA. STAT. ANN. § 394.455(15) (West Supp. 2001).
Hawaii – HAW. REV. STAT. ANN. § 334-1 (Michie 2000).
New York – N.Y. MENTAL HYG. LAW § 9.01 (McKinney Supp. 2001).
Oklahoma – OKLA. STAT. ANN. tit. 43A, § 11-103(11) (West Supp. 2001).
Utah – UTAH CODE ANN. § 62A-12-234(10)(c) (2000).

[6] States that utilize an administrative body similar to the Psychiatric Treatment Board:
Minnesota – MINN. STAT. ANN. § 253B.19 Subd. 4c. (West Supp. 2001).
Montana – MONT. CODE ANN. § 2-15-211 (1999).
Nebraska – NEB. REV. STAT. ANN. §§ 83-1017, -1018 (Michie 1995 & Supp. 1998).
South Dakota – S.D. CODIFIED LAWS § 27A-10-9.1 (Michie 1999).

"Diagnostic and Statistical Manual of Mental Disorders" (APA-DSM);
(f) moderate, severe and profound mental retardation as defined by the APA-DSM; and
(g) pervasive developmental disorders, including autistic disorder, Rett's disorder and Asperger's disorder as defined by the APA-DSM.

Comment: The definition of severe psychiatric disorder is designed to encompass all severe mental illnesses, regardless of present or future diagnostic nomenclature. The listed exclusions are of disorders or conditions for which states typically develop separate statutory treatment schemes.

§ 2.15 ***Treating professional.*** While the care and evaluation of individuals with psychiatric disorders is best done by psychiatrists, demographic, geographic, and fiscal conditions do not always allow for it. Therefore, each jurisdiction should adopt a definition of treating professional that will allow for the highest quality of treatment without compromising its availability.

Comment: Although the Model Law makes use of this unspecified "treating professional," specific types of medical professionals are still designated to perform the most critical functions in the assisted treatment process.

§ 2.16 ***Trial release*****:** a procedure which allows a patient placed in an inpatient facility pursuant to an assisted treatment order to receive treatment while living in the community and remaining subject to the authority of the inpatient facility. [7]

Article 3. Voluntary Treatment

§ 3.1 ***Admission to voluntary treatment.*** A person in need of psychiatric care should be admitted into treatment voluntarily whenever possible.[8]

§ 3.2 ***Discharge from voluntary treatment.*** A voluntary patient may seek discharge at any time. Unless properly invoking provisions of this Model Law allowing for their retention, the psychiatric treatment facility must release voluntary patients who request to be discharged within 48 hours, not including Saturdays, Sundays or holidays. [9]

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[7] States with similar trial release standards include:
Arizona – ARIZ. REV. STAT. ANN. § 36-540.01 (West 1993).
Montana – MONT. CODE ANN. § 53-21-183 (1999).
New Mexico – N.M. STAT. ANN. § 43-1-21 (A)-(B) (Michie 2000).
West Virginia – W. VA. CODE ANN. § 27-2-1 (Michie Supp. 2000).
Wyoming – WYO. STAT. ANN. §§ 25-10-110(j), -127 (Michie 1999).

[8] States with similar voluntary admissions standards include:
Minnesota – MINN. STAT. ANN. § 253B.04 (West Supp. 2001).
Nebraska – NEB. REV. STAT. ANN. § 83-1001 (Michie Supp. 1998).
Pennsylvania – PA. STAT. ANN. tit. 50, § 7102 (West Supp. 1998).
Vermont –VT. STAT. ANN. tit. 18 § 7703 (2000).

[9] States with similar voluntary discharge procedures include:
Alaska –ALASKA STAT. § 47.30.685 (Michie 2000).
District of Columbia – D.C. CODE ANN. § 21-512 (1997).

Comment: This delay allows for the initiation of assisted treatment procedures for voluntary patients who request to be discharged, but are still in need of care and eligible for assisted treatment pursuant to this Model Law.

Article 4. Emergency Treatment/Observation—Certification

§ 4.1 ***Emergency treatment initiated by law enforcement officers.*** Any law enforcement officer with the power of arrest or any person generally designated to do so by the state, county or department of mental health may bring to a designated facility for evaluation any person the officer has reasonable cause to believe has a severe psychiatric disorder and, because of the disorder, is a danger to himself, herself or to others or is gravely disabled.[10]

§ 4.2 ***Emergency treatment initiated by others.*** Any psychiatrist, other physician, psychologist, or person who has been generally designated to do so by the state, county or department of mental health may initiate emergency treatment/observation based on a good faith belief that because of a severe psychiatric disorder a person is either a danger to himself or herself, a danger to others or gravely disabled. Any such person who determines the need for emergency treatment/observation but who is not authorized to transport such individuals to a psychiatric facility may direct any person enumerated in § 4.3 to do so.[11]

Comment: Section § 4.2 allows for the delineated types of medical professionals to transport non-protesting individuals or to arrange for the transportation of protesting individuals who they believe meet the criteria of this section to a psychiatric facility for evaluation.

§ 4.3 ***Transportation to emergency facility.*** Protesting individuals may only be transported by either law enforcement officers with the power of arrest or others who have been designated to perform this function by the state, county or department of mental health.[12]

Nebraska – NEB. REV. STAT. ANN. § 83-1019 (Michie Supp. 2000).
New Jersey – N.J. STAT. ANN. § 30:4-27.20 (West 1997).
Utah – UTAH CODE ANN. § 62A-12-230 (2000).

[10] States with similar statutory provisions include:
Arizona – ARIZ. REV. STAT. ANN. § 36-525 (West 1993).
Colorado – COLO. REV. STAT. ANN. § 27-10-105(1)(a) (West Supp. 2000).
Idaho – IDAHO CODE § 66-326(a) (Michie 2000).
Louisiana – LA. REV. STAT. ANN. R.S. § 28:53 (L)(1) (West Supp. 2001).
Washington – WASH. REV. CODE ANN. § 71.05.150(3)–(5) (West Supp. 2001).

[11] States with similar statutory provisions include:
Alaska – ALASKA STAT. § 47.30.705 (Michie 2000).
Florida – FLA. STAT. ANN. § 394.463(2)(a) (West 1998).
Georgia – GA. CODE ANN. § 37-3-41 (1995).
Hawaii – HAW. REV. STAT. ANN. § 334.59(3) (Michie 2000).
Louisiana – LA. REV. STAT. ANN. § 28:53(B)(1) (West Supp. 2001).
Nevada – NEV. REV. STAT. ANN. § 433A.160 (Michie 2000).
North Dakota – N.D. CENT. CODE § 25.03.1-25 (1995).

[12] States with similar provisions concerning transportation to emergency facilities include:
Delaware – DEL. CODE ANN. tit. 16, § 5122 (1995 & Supp. 2000).

§ 4.4 ***Evaluation.*** A psychiatrist or other physician shall evaluate an individual in emergency treatment/observation within 6 hours of the individual's placement in a designated psychiatric facility.[13]

§ 4.5 ***Immediate release.*** An individual shall be released from emergency treatment/observation unless the psychiatrist or other physician who performs the evaluation determines that the individual is either a danger to himself, herself or others or is gravely disabled.[14]

§ 4.6 ***Certification.*** If the examining psychiatrist or other physician who performs the evaluation determines, in his or her clinical opinion, that the individual is a danger to himself, herself or to others or is gravely disabled, he or she must file, or cause to be filed by another psychiatrist or other physician who has also examined the individual, a certificate with the court. The certificate must be filed with the court within 24 hours of the initial examination, not including Saturdays, Sundays or holidays.[15]

§ 4.7 ***Requirements of Certificate.*** The certificate shall be in writing, executed under oath, and shall include the following information:

(a) the name and address, if known, of the respondent;
(b) the name and address, if known, of the respondent's spouse, legal counsel, conservator or guardian and next-of-kin;
(c) the name and address, if known, of anyone currently providing psychiatric care to the respondent;
(d) the names and addresses, if known, of other persons with knowledge of respondent's

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Georgia – GA. CODE ANN. § 37-3-41 (1995).
Hawaii – HAW. REV. STAT. ANN. § 334-59 (Michie 2000).
Oregon – OR. REV. STAT. §§ 426.228, .233 (1999).

[13] States with similar emergency examination provisions include:
Maryland – MD. CODE ANN., HEALTH-GEN. I § 10-624 (2000).
New Hampshire – N.H. REV. STAT. ANN. § 135-C:28 (1996).
Washington – WASH. REV. CODE ANN. § 71.05.150 (West Supp. 2000).
Note: Washington law has a higher standard in that it requires emergency examinations to be made within three (3) hours of arrival at evaluation and treatment facilities.

[14] States with similar provisions for immediate release include:
Alaska – ALASKA STAT. §§ 47.30.700, .720 (Michie 2000).
Hawaii – HAW REV. STAT. ANN. § 334-59 (Michie 2000).
Kansas – KAN. STAT. ANN. §§ 59-2946, -2953 (Supp. 2000).
Louisiana – LA. REV. STAT. ANN. § 28:53 (West Supp. 2001).
Michigan – MICH. COMP. LAWS ANN. §§ 330.1401, .1429 (West 1999).

[15] States that require similar certification include:
Arizona – ARIZ. REV. STAT. ANN. § 36-526 (West 1993).
Colorado – COLO. REV. STAT. ANN. § 27-10-107 (West 1990).
Idaho – IDAHO CODE § 66-326 (Michie 2000).
Mississippi – MISS. CODE ANN. § 41-21-69 (1999).
Missouri – MO. ANN. STAT. §§ 632.305, .310, .315, .320 (West 2000).

mental illness who may be called as witnesses at the assisted treatment hearing;
(e) the name and work address of the certifying psychiatrist or other physician;
(f) the name and address of the facility in which the respondent is undergoing emergency treatment/observation;
(g) the certifying psychiatrist or other physician's statement that he or she has examined the respondent since the respondent was placed in emergency treatment/observation; and
(h) the certifying psychiatrist or other physician's statement that, in his or her clinical opinion, the respondent is a danger to himself, herself or to others or gravely disabled and the clinical basis for this opinion. [16]

§ 4.8 ***Criminal penalty.*** It shall be a crime to knowingly file, or cause to be filed, a certificate that contains a false material statement or information.[17]

§ 4.9 ***Initial responsibilities of court after certificate is filed.*** After the filing of the certificate, the court must:

(a) schedule a hearing on the certificate that will occur no more than 72 hours, not including Saturdays, Sundays and holidays, after the initial examination; and
(b) designate counsel for the respondent no less than 24 hours prior to the hearing.

§ 4.10 ***Notice of hearing on certificate.*** The court shall notify the certifying psychiatrist or other physician, respondent, and the respondent's legal guardian or conservator, if known, of the scheduled hearing on the certificate at least 24 hours in advance. The court must also attempt to notify of the pending hearing, at least 24 hours in advance, an adult member of respondent's household, if known, and up to five individuals of the respondent's choice. Notice may be either by mail, personal delivery, telephone, or reliable electronic means. Timely actual notice shall fulfill the notice requirement for any given individual.[18]

Comment: Allowing the respondent to select five people to be notified of the hearing is an unusually strong protection of the right to involve those who will best protect his or her interests in the assisted treatment

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[16] States with similar certificate requirements include:
Arizona – ARIZ. REV. STAT. ANN. §§ 36-523, -526 (West 1993).
Idaho – IDAHO CODE §§ 66-326, -329 (2000).
Kansas – KANSAS STAT. ANN. §§ 59-2946, -2957 (Supp. 2000).

[17] States with similar criminal penalties for filing a false certificate:
Alaska – ALASKA STAT. § 47.30.815(c) (Michie 2000).
Arkansas – ARK. CODE ANN. § 20-47-214(b)(1) (Michie 1991).
Rhode Island – R.I. GEN. LAWS § 40.1-5-38 (1997).
Vermont –VT. STAT. ANN. tit. 18, § 7104 (2000).
West Virginia – W. VA. CODE ANN. § 27-12-1 (Michie 1999).

[18] States that have similar notice standards:
Michigan – MICH. COMP. LAWS ANN. § 330.1453(1) (West 1999).
North Dakota – N.D. CENT. CODE § 25-03.1-12 (1995).
Oklahoma – OKLA. STAT. ANN. tit. 43A, § 5-412. (West Supp. 2001).
Rhode Island – R.I. GEN. LAWS § 40.1-5-8(2) (1997).

process.

§ 4.11 ***Duration of emergency treatment/observation.*** Absent the exercise of other applicable provisions of this Model Law, the period of emergency treatment/observation may last no more than 72 hours after the initial examination, not including Saturdays, Sundays or holidays. Anyone who is determined by the examining or a treating physician not to be a danger to himself, herself, or others or gravely disabled must be released from emergency treatment/observation. The initial assisted treatment hearing shall take place before the end of the treatment/observation period.[19]

Comment: Section 4.11 contains two valuable protections for individuals placed in emergency treatment/observation: (1) given the schedule of a typical court, the interval between the initiation of the assisted treatment process and the hearing is as short as it can be while still affording for the provision of adequate safeguards of the rights of the individual; and (2) the treating physician may, without court approval, terminate the proceedings and release the individual if at any point he or she is not a danger to himself, herself, or others or gravely disabled.

§ 4.12 ***Treatment during emergency treatment/observation.*** During the emergency treatment/observation period, treatment may be administered if the person is, in the clinical opinion of a treating professional, a danger to himself, herself, or others or is gravely disabled.[20]

Article 5. Petition for Assisted Treatment

§ 5.1 ***Petition.*** Any adult may file a petition for the assisted treatment of another person based on a good faith belief that, due to the effects of a severe psychiatric disorder, the person is either a danger to himself or herself, a danger to others, gravely disabled, or chronically disabled.

The petition shall be in writing, executed under oath, and shall include the following information:

(a) the petitioner's name, address and, if any, relationship to the respondent;
(b) the name and address, if known, of the respondent;
(c) the name and address, if known, of the respondent's spouse, legal counsel, conservator or guardian, and next-of-kin;

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[19] States with similar statutory provisions include:
Alaska – ALASKA STAT. §§ 47.30.710, .715, .720 (Michie 2000).
Arkansas – ARK. CODE ANN. § 20-47-210 (Michie 1991).
Colorado – COLO. REV. STAT. ANN. §§ 27-10-105, -106 (West 1990 & Supp. 2000).
Oklahoma – OKLA. STAT. ANN. tit. 43A, §§ 5-208, -209 (West Supp. 2001).
Wyoming – WYO. STAT. ANN. § 25-10-109 (Michie 1999), State of Wyoming, *available at* http://legisweb.state.wy.us/statutes/titles/title25/c10a01.html.

[20] States that allow treatment in similar instances during the emergency observation period:
Hawaii – HAW. REV. STAT. ANN. §§ 334-1, -59 (Michie 2000).
Louisiana – LA. REV. STAT. ANN. §§ 28:2, :53 (West Supp. 2001).
Oregon – OR. REV. STAT. §§ 426.228(4), .232 (2000).
Pennsylvania – PA. STAT. ANN. tit. 50, §§ 7301(A), 7302 (West Supp. 2000).

(d) the name and address, if known, of anyone currently providing psychiatric care to the respondent;
(e) that the petitioner has reason to believe the respondent meets the criteria for assisted treatment in § 7.3 (these criteria shall be described in simple language in the petition form);
(f) that the beliefs of the petitioner are based on specific behavior, acts, attempts, or threats, which shall be specified and described in detail; and
(g) the names and addresses, if known, of other persons with knowledge of respondent's mental illness who may be called as witnesses.[21]

§ 5.2 ***Request for temporary treatment order.*** A request for an *ex parte* order placing the respondent under care and treatment in an inpatient facility until the assisted treatment hearing may be included in the petition. The court may issue a temporary treatment order if it finds that the health or safety of the respondent will be placed in jeopardy absent immediate treatment. However, any treatment pursuant to the court's order must be subsequently determined necessary by a treating professional. On granting a temporary treatment order, the court shall direct the transport of the respondent to a designated treatment facility by either law enforcement officers with the power of arrest or others who have been designated to perform this function by the state, county or department of mental health. The temporary treatment order shall be in effect until either the assisted treatment hearing or the petition is dismissed or withdrawn, whichever occurs first.[22]

§ 5.3 ***Initial responsibilities of court after petition is filed.*** Within 24 hours[23], not including Saturdays, Sundays or holidays, of the filing of a petition for assisted treatment, the court must:

(a) determine whether the petition is sufficient to establish the reasonable belief that the respondent may be subject to assisted treatment and dismiss without prejudice those that do not;

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[21] States that contain a similar provision for petitions for assisted treatment include:
Arizona – ARIZ. REV. STAT. ANN. § 36-520 (West 1993).
California – CAL. WELF. & INST. CODE §§ 5201-2, 5204 (West 1998).
Colorado – COLO. REV. STAT. ANN. § 27-10-106 (West 1990).
Idaho – IDAHO CODE § 66-329(a)-(c) (Michie 2000).
Kansas – KAN. STAT. ANN. § 59-2957 (Supp. 2000).

[22] States that utilize a similar request for treatment order include:
Alaska – ALASKA STAT. § 47.30.700 (Michie 2000).
Arkansas – ARK. CODE ANN. §§ 20-47-210, -218 (Michie 1991).
Idaho – IDAHO CODE §§ 66-326, -329 (2000).
Illinois – 405 ILL. COMP. STAT. ANN. 5/3-607-608 (West 1993).
Kansas – KAN. STAT. ANN. §§ 59-2956, -2959 (Supp. 2000).

[23] States that specify that counsel must be designated within 24 hours of the petition's filing include:
Arkansas – ARK. CODE ANN. § 20-47-212(a) (Michie 1991).
Florida – FLA. STAT. ANN. § 394.467(4) (West Supp. 2001).
North Dakota – N.D. CENT. CODE § 25.03.1-13(2) (1995).
Texas – TEX. HEALTH & SAFETY CODE ANN. § 574.003. (Vernon 1992).

(b) schedule a hearing on any petition it does not dismiss for within 10 calendar days of when the petition was filed;[24]
(c) rule on any request for a temporary treatment order included in a petition it does not dismiss;
(d) if necessary, issue an order for the respondent to be examined pursuant to § 5.8;[25]
(e) designate counsel for the respondent of any petition it does not dismiss; and
(f) forward a copy of any petition it does not dismiss to the agency designated by the County to evaluate petitions as described in § 5.4.

§ 5.4 ***Designated counsel.*** The respondent shall have court-designated counsel.[26] The County shall investigate, with due diligence, the basis for any petition not dismissed by the court pursuant to § 5.3. An attorney will be designated for the petitioner[27] by the County if its investigation, performed with due diligence, finds probable cause that the respondent is eligible for assisted treatment under § 7.3. The County shall either designate counsel or notify petitioner of its decision not to designate counsel within 72 hours of receiving the petition from the court. If the County does not designate an attorney, petitioner may still put forth the petition. Both petitioner and respondent have the option of engaging counsel of his or her choice.

§ 5.5 ***Notice of hearing on petition.*** Within 24 hours, not including Saturdays, Sundays and holidays, of scheduling a hearing on a petition, the court shall mail notice of the hearing, which shall include a copy of the petition, to the respondent; respondent's legal guardian or conservator, if known; petitioner; petitioner's counsel, if known; an adult member of respondent's household, if known; and up to five individuals of the respondent's choice. The court shall, in addition, attempt to notify the respondent; respondent's legal guardian or

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[24] States that specify that a hearing must be scheduled for within ten calendar days of the petition's filing include:
Hawaii – HAW. REV. STAT. ANN. § 334-60.4(b) (Michie 2000).
Montana – MONT. CODE ANN. § 53-21-127(1)(b) (1999).
North Carolina – N.C. GEN. STAT. § 122C-268(a) (Supp. 2000).
Oklahoma – OKLA. STAT. ANN. tit. 43A, § 9-102(B) (West 1990).
Vermont – VT. STAT. ANN. tit. 18, § 7615(a) (2000).

[25] States that specify that the respondent is to be examined by a treating professional prior to admission include:
Idaho – IDAHO CODE § 66-329 (Michie 2000).
Illinois – 405 ILL. COMP. STAT. ANN. 5/3-702(a) (West 1993).
South Carolina – S.C. CODE ANN. § 44-17-530 (Law. Co-op. Supp. 2000).
Wyoming – WYO. STAT. ANN. § 25-10-110(e) (Michie 1999).

[26] Examples of states with similar procedures for appointing court-designated counsel for the *respondent* include:
Arizona – ARIZ. REV. STAT. ANN. § 36-536 (West 1993).
Arkansas – ARK. CODE ANN. § 20-47-212 (Michie 1991).
Louisiana – LA. REV. STAT. ANN. § 28:55 (West Supp. 2001).
Note: Attorneys are selected from the mental health advocacy service.
North Dakota – N.D. CENT. CODE § 25.03.1-13 (1995).

[27] Examples of states with similar procedures concerning appointment of court-designated counsel for the *petitioner*:
Alabama – ALA. CODE § 22-52-5 (1997).
Arkansas – ARK. CODE ANN. § 20-47-208 (Michie Supp. 1999).
Kansas – KAN. STAT. ANN. § 59-2965(e) (Supp. 2000).
North Dakota – N.D. CENT. CODE § 25.03.1-14 (1995).

conservator, if known; petitioner; and petitioner's counsel, if known, during that period by either telephone or other reliable electronic means. Timely actual notice shall fulfill the notice requirement for any given individual.[28]

§ 5.6 ***Criminal penalty.*** It shall be a crime to knowingly file, or cause to be filed, a petition that contains a false material statement or information.[29]

Comment: This section and the corresponding one for certificates, § 4.8, deter the abuse of the assisted treatment system by making it a crime to knowingly file a petition containing false material statements or information. As the classifications of crimes vary from state to state, one is not delineated. However, it is recommended that filing a false application be punishable by up to 6 months incarceration and/or a comparable monetary penalty.

§ 5.7 ***Evaluation.*** Except as otherwise delineated in this Model Law, the respondent must be examined by a treating professional prior to the hearing but not more than 7 calendar days before the petition is filed.[30]

§ 5.8 ***Petition filed without evaluation.*** A petition may be filed that is unsupported by an evaluation so long as the petition presents sufficient evidence to establish the reasonable belief that the respondent may be subject to assisted treatment. The court shall order the person who is the subject of the petition to be examined by a treating professional assigned by the department of mental health, or its designee, no less than 72 hours prior to the assisted treatment hearing.[31]

Comment: Unlike the codes of some states, the Model Law does not require a psychiatric evaluation

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[28] States that have similar provisions concerning notice of hearing on a petition include:
Idaho – IDAHO CODE § 66-329(f) (Michie 2000).
Illinois – 405 ILL. COMP. STAT. ANN. 5/3-609 (West 1993).
Michigan – MICH. COMP. LAWS ANN. § 330.1453 (West 1999).
North Dakota – N.D. CENT. CODE § 25-03.1-12 (1995).

[29] Examples of states that criminalize filing of a false petition include:
California – CAL. WELF. & INST. CODE § 5203 (West 1998).
District of Columbia – D.C. CODE ANN. § 21-591 (1984).
Illinois – 405 ILL. COMP. STAT. ANN. 5/6-102 (West 1993).
Oklahoma – OKLA. STAT. ANN. tit. 43A, § 5-103 (West 1990).
Wisconsin – WIS. STAT. ANN. § 51.15(12) (West Supp. 2000).

[30] There is a large variation among states' laws with respect to the requisite proximity between an individual's examination and the filing of a petition to involuntarily commit such an individual to assisted inpatient care. Time limits range from three days, as in Michigan (MICH. COMP. LAWS ANN. §§ 330.1434, .1435, .1455 (West 1999)) five days, as in New Hampshire (N.H. REV. STAT. ANN. §§ 135-C:35 to :37, :40 (1996)), and Vermont (VT. STAT. ANN. tit. 18, §§ 7612, 7614, 7615 (2000)), or seven days as in Maryland (MD. CODE ANN., HEALTH-GENERAL §§ 10-615 to 616, -632 (2000)). Some states have no such time requirement or allow up to thirty days.

[31] States that have similar procedures concerning petitions filed without an evaluation include:
Idaho – IDAHO CODE § 66-329 (Michie 2000).
Michigan – MICH. COMP. LAWS ANN. § 330.1434 (West 1999).
Nevada – NEV. REV. STAT. ANN. §§ 433A.200, .240 (Michie 2000).
North Dakota – N.D. CENT. CODE §§ 25-03.1-08, -10, -11 (1995).
Wyoming – WYO. STAT. ANN. § 25-10-110 (Michie 1999).

be filed with a petition for assisted treatment. This helps ensure that a petition can still be filed for individuals with mental illness who are in need of treatment but refuse to be evaluated.

Article 6. Assisted Treatment Hearing Procedures

§ 6.1 ***Ten-day treatment option.*** The respondent has the option of choosing 10 calendar days of inpatient treatment in lieu of being subject to the assisted treatment proceeding. This option is available to the respondent from the time he or she is served with the petition until the end of the petitioner's presentation of evidence at the hearing. At that point, the Psychiatric Treatment Board shall give the respondent a final chance to accept 10 days of treatment before it forecloses him or her from doing so, clearly expressing that it is the respondent's final opportunity to exercise this option. The respondent may select the ten-day treatment option prior to the hearing, in which case the treating facility shall file an affidavit of this election, signed by the respondent, with the court within 48 hours, not including Saturdays, Sundays or holidays. During the 10-day treatment period, the respondent may be discharged on the signature of both the treating medical professional and the medical director of the facility. At the expiration of the 10-day period, a respondent placed in treatment in accordance with this section shall be transferred to voluntary status, but may be subject to additional periods of assisted treatment pursuant to this Model Law.

Comment: This section allows individuals to choose 10 days of treatment instead of being subject to the Psychiatric Treatment Board's determination at the assisted treatment hearing, reducing the number of hearings held in exchange for potentially reduced initial periods of assisted treatment for those who elect this option. A person who takes this option may, if appropriate, be subject to additional care pursuant to the provisions of this Model Law.

The assisted treatment laws of many states allow for the subject of a petition to elect voluntary treatment to avoid a pending assisted treatment hearing, but make little or no provision to ensure the person stays in that treatment for any clinically significant period. The 10-day election in § 6.1 also permits those in need of care to choose to enter treatment voluntarily, but ensures that the treatment will before a clinically significant period.

§ 6.2 ***Continuance.*** The Psychiatric Treatment Board or the court may, for good cause, order a continuance of up to 48 hours or, if this period ends on a Saturday, Sunday or holiday, to the end of the next day on which the court is open. The continuance shall extend the emergency treatment/observation period or any temporary treatment order until the time of the hearing.[32]

Comment: This possible short continuance of the hearing date is afforded with the realization that gathering all the required individuals for the hearing may not always be possible on short notice and that the respondent may desire the extra time to prepare for the hearing or to decide whether or not to exercise his or her 10-day treatment alternative.

§ 6.3 ***Location of assisted treatment hearing.*** For those currently admitted to an inpatient facility

[32] The majority of states allow a continuance of the hearing date. The time limits range from 48 hours, as in West Virginia (W. VA. CODE ANN. § 27-5-2(5) (Michie 1999)) to fourteen days, as in Illinois (405 ILL. COMP. STAT. ANN. 5/2-107.1 (West Supp. 1999)) and Washington (WASH. REV. CODE ANN. § 71.05.210 (West Supp. 2001)).

operated by the department of mental health, or its designee, assisted treatment hearings shall be held at the respondent's psychiatric facility.[33]

Comment: For most patients, the psychiatric facility will be a more comfortable setting for a hearing than a courthouse. Use of this venue will also eliminate the costs and adverse clinical effects of transporting individuals to the hearing.

§ 6.4 ***Attendance at hearing.*** The hearing shall be open to anyone unless the respondent requests that it be closed, at which point only parties and their counsels, witnesses, members and staff of the Psychiatric Treatment Board, and court personnel may be present. However, the court may approve a motion of an individual to attend the trial upon a showing that the person has a substantial interest in the proceeding.[34]

Comment: By providing for closed hearings while still allowing the Psychiatric Treatment Board to permit the attendance of anyone who demonstrates a legitimate interest in the proceedings, this section balances the respondent's right to privacy with the interests of those closest to him or her.

§ 6.5 ***Expert testimony required at hearing.***

(a) For a hearing on a certificate, a treating professional who has examined respondent since he or she was placed under emergency treatment/observation shall testify.

(b) For a hearing on a petition, the testimony of a treating professional who has examined the respondent more recently than 7 calendar days before the petition was filed is required. Such testimony may be presented by affidavit, unless respondent's counsel requests of the petitioner or petitioner's counsel, in writing, the presence of such a treating professional at the assisted treatment hearing. A copy of this request must be filed with the court and made at least 72 hours, excluding Saturdays, Sundays and holidays, prior to the hearing. If planning to present the examining treating professional's testimony by affidavit, counsel for the petitioner must present a copy of the affidavit either to respondent's counsel or at the office of respondent's counsel at least 24 hours, excluding Saturdays, Sundays and holidays, prior to the hearing. The procedures applicable when the respondent has not been examined prior to the hearing are delineated in § 7.1.[35]

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[33] Examples of states that allow assisted treatment hearings to take place at the respondent's facility include:
Alabama – ALA. CODE § 22-52-10.6(f) (1997).
Ohio – OHIO REV. CODE ANN. § 5122.14 (Anderson 1998).
Oklahoma – OKLA. STAT. ANN. tit. 43A, § 1-107 (West Supp. 2001).
Oregon – OR. REV. STAT. § 426.095 (1999).
Pennsylvania – PA. STAT. ANN. tit. 50, § 7115(a) (West Supp. 2001).

[34] States with similar statutes addressing possible attendance at hearings:
Iowa – IOWA CODE ANN. § 229.12(2) (West 2000).
North Dakota – N.D. CENT. CODE § 25-03.1-19 (1995).
Ohio – OHIO REV. CODE ANN. § 5122.15(A)(6) (Anderson 1998).
Wisconsin – WIS. STAT. ANN. § 51.20(12) (West Supp. 2000).

[35] There are currently no states that require testimony by affidavit, but there are states that allow the written reports as evidence and do not require the examiner to testify in person:

Comment: Allowing for the possibility of the examining physician's testimony to be presented by affidavit will conserve resources—typically those of the department of mental health—when live testimony is not necessary.

§ 6.6 ***Evidence admissible at hearing.*** The Psychiatric Treatment Board may review any information it finds relevant, material, and reliable, even if normally excluded under rules of evidence.[36]

Comment: This relaxation of the rules of evidence allows for less expensive and more informal hearings in which the Psychiatric Treatment Board will have a greater wealth of information on which to base its findings, but still maintain the ability to disregard suspect exhibits or testimony.

§ 6.7 ***Record of hearing.*** No transcript is required to be kept of hearings before Psychiatric Treatment Boards.

Comment: Not transcribing the hearings will dramatically decrease their expense, while the need for transcription of initial assisted treatment hearings is eliminated by offering the *de novo* appeal to a court of record described in § 8.1.

§ 6.8 ***Rights of family members.*** A family member may file a motion for participation in the hearing. The Psychiatric Treatment Board may approve the preliminary motion of such an individual to participate in the hearing upon a showing that the person has a substantial interest in the proceeding. If the Psychiatric Treatment Board so approves, the family member may have the right to representation by counsel at his or her own expense, present evidence, cross-examine witnesses, and appeal.[37]

Comment: This establishes that a family member who demonstrates a sufficient interest in the assisted treatment proceeding may essentially become a party to it. These rights are based on those allowed in similar hearings by Kentucky (KY. REV. STAT. ANN. § 202B.160) to the parents of individuals with developmental disabilities; Kentucky's provision of these rights were considered favorably by the Supreme Court in *Heller v.*

Connecticut – CONN. GEN. STAT. ANN. § 17a-498(c) (West Supp. 2001).
Louisiana – LA. REV. STAT. ANN. § 28:54(D)(1) (West Supp. 2001).
Michigan – MICH. COMP. LAWS ANN. § 330.1461 (West 1999).
Ohio – OHIO REV. CODE ANN. § 5122.14 (Anderson 1998).
Virginia – VA. CODE ANN. § 37.1-67.3 (Michie Supp. 2000).

[36] States with similar procedures concerning the admissibility of evidence include:
California – CAL. WELF. & INST. CODE § 5256.4(b) (West 1998).
Illinois – 405 ILL. COMP. STAT. ANN. 5/3-207(b) (West 1993).
Iowa – IOWA CODE ANN. § 229.12(3) (West 2000).
Kansas – KAN. STAT. ANN. § 59-2965(c) (Supp. 2000).
Pennsylvania – PA. STAT. ANN. tit. 50, § 7303(c) (West Supp. 2000).

[37] States with a similar enumeration of family member's rights include:
Idaho – IDAHO CODE § 66-329(f), (j) (Michie 2000).
Maryland – MD. CODE ANN., HEALTH-GEN. I § 10-632 (2000).
South Carolina – S.C. CODE ANN. §§ 44-17-550, -570 (Law Co-op. 1985 & Supp. 2000).
Utah – UTAH CODE ANN. § 62A-12-234(9)(b)-(c) (2000).
Wyoming – WYO. STAT. ANN. § 25-10-110(d), (h) (Michie 1999).

Doe, 509 U.S. 312 (1993).

Article 7. Assisted Treatment Hearing Disposition

§ 7.1 ***Procedure after failure to comply with ordered evaluation.*** If the respondent presents good and credible reason why he or she was not present for an ordered evaluation, the Psychiatric Treatment Board shall continue the proceeding and issue another order for examination. A hearing concerning an individual who fails to comply, without good reason, with a court's evaluation order shall still proceed. At the conclusion of the argument of the parties, the Psychiatric Treatment Board may either order the respondent released, into treatment, or continue the proceedings so that the respondent may be evaluated. An individual's refusal, without good reason, to comply with an evaluation order may be used as evidence of his or her need for treatment and incapability of making an informed medical decision. If a continuance is ordered, the respondent shall be placed in a designated psychiatric facility and evaluated by a treating professional. The continuance shall be for no more than 72 hours or, if this period ends on a Saturday, Sunday or holiday, until the end of the next day on which the court is open.[38]

§ 7.2 ***Consent order.*** At the hearing, the petitioner and respondent may proffer a mutually agreed upon proposed assisted treatment order. The terms of the order must be consistent with those of an initial order for assisted treatment made pursuant to this Model Law. The proposed order must be accompanied by the testimony, which may be by affidavit, of a treating professional qualifying under § 6.5 that the suggested order is clinically appropriate for the respondent. At its discretion, the court may enter the proposed order without a full hearing. Once entered, the consent order has the same effect as an assisted treatment order issued pursuant to § 7.3.[39]

§ 7.3 ***Criteria for assisted treatment order.*** After reviewing the evidence presented at the hearing, the Psychiatric Treatment Board shall only order assisted treatment, which can be on either an inpatient or outpatient basis,[40] if it finds the following by clear and convincing evidence:

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[38] States with similar procedures concerning continuances after respondent fails to comply with ordered evaluation include:
Hawaii – HAW. REV. STAT. ANN. §§ 334-60.5, -126 (Michie 2000).
Iowa – IOWA CODE ANN. §§ 229.8, .10 (West 2000).
North Dakota – N.D. CENT. CODE § 25-03.1-10 (1995).
Utah – UTAH CODE ANN. § 62A-12-234 (2000).
Wyoming – WYO. STAT. ANN. § 25-10-110 (Michie 1999).

[39] Examples of states that utilize voluntary treatment agreements include:
Hawaii – HAW. REV. STAT. ANN. § 334-60.4 (Michie 2000).
New York – New York State Office of Mental Health, *AOT Procedural Questions about Investigation Process* (visited on 6/4/2001), *available at* http://www.omh.state.ny.us/omhweb/Kendra_web/KHome.htm.
West Virginia – W. VA. CODE ANN. § 27-5-2(6) (Michie 1999).
Wisconsin – WIS. STAT. ANN. § 51.20(8) (West Supp. 2000).

[40] States with assisted treatment orders most similar to the Model Law include:
Arizona – ARIZ. REV. STAT. ANN. § 36-540 (West Supp. 2000).

(a) that the person has a severe psychiatric disorder;
(b) that the person is either a danger to himself or herself, a danger to others, gravely disabled, or chronically disabled; and
(c) that, except for someone found to be a danger, the person is likely to benefit from assisted treatment.

Comment: The operative components of this section are defined in Article 2.

§ 7.4 ***Assisted treatment order.*** An order for assisted treatment, for its duration, subordinates the individual's right to refuse the administration of medication or other minor medical treatment to the department of mental health, its designee, or any other medical provider obligated to care for the person by the Psychiatric Treatment Board in its order. The treatment setting shall be the least restrictive possible appropriate alternative. An initial assisted treatment order requiring inpatient placement may be for up to 30 calendar days.[41] An order for assisted treatment on an outpatient basis may be for up to 180 calendar days.[42]

Comment: The order for assisted treatment incorporates the ability to treat the individual subject to it. Each of the possible standards for assisted treatment in § 7.3 requires a determination either that the respondent is dangerous or incapable of making an informed medical decision, thus obviating the need for a treatment order subsequent to the proceedings or the institution of a separate treatment order at the hearing.

§ 7.5 ***Services included in order for assisted outpatient treatment.*** An initial assisted treatment order directing care on an outpatient basis must include provisions for intensive case management, assertive community treatment, or a program for assertive community treatment. The order may also require the patient make use of and care providers to supply any or all of the following categories of services to the individual:

(a) medication;
(b) periodic blood tests or urinalysis to determine compliance with treatment;
(c) individual or group therapy;
(d) day or partial day programming activities;
(e) educational and vocational training or activities;
(f) alcohol or substance abuse treatment and counseling, and periodic tests for the presence of alcohol or illegal drugs for persons with a history of alcohol or substance

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North Dakota – N.D. CENT. CODE §§ 25-03.1-17, -21 (1995).
South Carolina – S.C. CODE ANN. § 44-17-580 (Law. Co-op. Supp. 2000).
South Dakota – S.D. CODIFIED LAWS § 27A-10-9.1 (Michie 1995).
Wyoming – WYO. STAT. ANN. § 25-10-110 (Michie 1999).

[41] States that specify a thirty day period of initial inpatient treatment include:
Alaska - ALASKA STAT. § 47.30.735(c) (Michie 2000).
New Mexico – N.M. STAT. ANN. § 43-1-11(C) (Michie 2000).

[42] States that specify a one-hundred eighty day period of initial outpatient treatment include:
Hawaii – HAW. REV. STAT. ANN. § 334.127(b) (Michie 2000).
Louisiana – LA. REV. STAT. ANN. § 28:56(A)(1) (West Supp. 2001).
Missouri – MO. ANN. STAT. § 632.330(2) (West 2000).
Oregon – OR. REV. STAT. § 426.228 (1999).

abuse;
(g) supervision of living arrangements; and
(h) any other services prescribed to treat the person's mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration.

Any material modifications of the provisions of the assisted treatment order to which the patient does not agree must be approved by the court.[43]

§ 7.6 ***Effect of assisted treatment determination on other rights.*** The determination that a person is in need of assisted treatment, either as an inpatient or outpatient, is not a determination that the patient is legally incompetent or incapacitated for any purpose other than those set out in this Model Law.[44]

Comment: This section ensures that an order for assisted treatment is for assisted treatment alone and does not otherwise impact an individual's legal status.

Article 8. Appeals

§ 8.1 ***Appeal or review of assisted treatment decision or status.*** Except where specifically prohibited by this Model Law, a decision of the Psychiatric Treatment Board may be appealed to an appropriate court of record within 10 calendar days of being entered. The hearing of an appeal is *de novo*[45] and must be held within 7 calendar days of the filing of the appeal. The subject of the assisted treatment decision, the petitioner, and family members allowed as parties pursuant to § 6.8 have the right to appeal. The court of record may review any

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[43] States that include an effective number of services in an order for assisted outpatient treatment include:
Georgia – GA. CODE ANN. § 37-3-1(12.2) (1995).
Hawaii – HAW. REV. STAT. ANN. § 334-122 (Michie 2000).
Minnesota – MINN. STAT. ANN. § 245.462 Subd. 21 (West Supp. 2001).
New York – N.Y. MENTAL HYG. LAW § 9.60 (McKinney Supp. 2001).
North Carolina – N.C. GEN. STAT. § 122C-3(27) (Supp. 2000).

[44] States with similar policies regarding legal status include:
Kansas – KAN. STAT. ANN. § 59-2948 (Supp. 2000).
Michigan – MICH. COMP. LAWS ANN. § 330.1489 (West 1999).
Mississippi – MISS. CODE ANN. § 41-21-101 (1999).
North Dakota – N.D. CENT. CODE § 25-03.1-33 (1995).
West Virginia – W. VA. CODE ANN. § 27-5-9(a) (Michie 1999).

[45] *De novo* – adj. Latin for "anew," which means starting over, as in a trial de novo. For example, a decision in a small claims case may be appealed to a local trial court, which may try the case again, de novo.
Six states specify that the hearing of an appeal is de novo: Alabama, California, Iowa, Maryland, Nebraska, and Virginia.
Alabama – ALA. CODE § 22-52-15 (1997).
California – CAL. WELF. & INST. CODE § 5334(f) (West 1998).
Iowa – IOWA CODE ANN. § 229.21 (West Supp. 2001).
Maryland – MD. CODE ANN., HEALTH-GEN. I § 10-708 (2000).
Nebraska – NEB. REV. STAT. ANN. § 83-1043 (Michie 1995).
Virginia – VA. CODE ANN. § 37.1-67.6 (Michie 1996).

information it finds relevant, material, and reliable, even if normally excluded under rules of evidence.[46]

Article 9. Safeguards

§ 9.1 ***Thirty-day review for medication side effects.*** Each patient in an inpatient treatment facility receiving medication pursuant to an assisted treatment order shall be examined every thirty days for serious side effects by a psychiatrist or physician other than his or her treating psychiatrist.[47]

Comment: For some patients, side effects from their medication can lead to their ultimate discontinuance of them. This independent review will increase the opportunity for detrimental side effects to be eliminated or mitigated while inpatients are subject to assisted treatment. Thus these independent reviews not only protect the patient's health, but also maximize the likelihood of his or her long-term medication compliance.

§ 9.2 ***Recommendation for alternative appropriate treatment.*** After an examination described in § 9.1, a non-treating psychiatrist or other physician who determines, in his or her clinical judgment, that the patient has serious side effects from his or her current medication shall suggest, if available, an alternative appropriate treatment that will have fewer side effects. The treating psychiatric professional shall either comply with this recommendation or bring the non-treating psychiatrist or other physician's written version of it to the facility's medical director, who shall then determine the patient's treatment. If the treating psychiatrist is the facility's medical director, the final decision shall be made by a medical professional

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[46] The time limit for appeals varies widely from state to state. Some states utilize a short time period such as the one specified in § 8.1 (Hawaii, Iowa, Maryland, and Texas). A thirty-day time period is more common (Delaware, Georgia, Idaho, Minnesota, North Dakota, Rhode Island, South Carolina, and Virginia). Still others specify a longer period of time (Minnesota – 45 days, Alabama – 65 days, Montana – 90 days) or fail to specify any length of time at all.

Alabama – ALA. CODE § 22-52-15 (1997).
Delaware – DEL. CODE ANN. tit. 16, § 5013 (1995).
Georgia – GA. CODE ANN. § 37-3-150 (1995).
Hawaii –HAW. REV. STAT. ANN. §§ 334-81 to 86 (Michie 2000).
Idaho – IDAHO CODE § 66-342(c) (Michie 2000).
Iowa – IOWA CODE ANN. §§ 229.17, .21 (West Supp. 2001).
Maryland – MD. CODE ANN., HEALTH-GEN. I § 10-708 (2000).
Minnesota – MINN. STAT. ANN. § 253B.19 (West Supp. 2001).
Montana – MONT. CODE ANN. § 53-21-131 (1999).
North Dakota – N.D. CENT. CODE § 25.03.1-29 (1995).
Rhode Island – R.I. GEN. LAWS § 40.1-5-8(k) (1997).
South Carolina – S.C. CODE ANN. § 44-17-620 (Law. Co-op. Supp. 2000).
Texas – TEX. HEALTH & SAFETY CODE ANN. § 574.070 (Vernon 1992).
Virginia – VA. CODE ANN. § 37.1-67.6 (Michie 1996).

[47] While no state requires medication reviews every thirty days by a second doctor, several states do provide for some type of medication review.

Georgia – GA. CODE ANN. § 37-3-83(c) (1995).
Pennsylvania – PA. STAT. ANN. tit. 50, § 7108 (West Supp. 2001)
Rhode Island – R.I. GEN. LAWS § 40.1-5-10(a) (1997).
Vermont – VT. STAT. ANN. tit. 18, § 7627(f) (2000).

generally appointed for this purpose by the department of mental health or its designee.

Comment: The procedure set out in § 9.2 guarantees that either a supervisor of the treating physician or an independent medical professional will choose between conflicting courses of care recommended by the treating psychiatric professional and the psychiatrist or physician who performs the periodic examination required by § 9.1.

§ 9.3 ***Grievance procedure.*** There shall be a one-step grievance procedure made available to patients on inpatient status. Grievances concerning treatment may be made to the medical director of each inpatient facility. Grievances about a patient's treatment regimen may be brought by the patient or on the patient's behalf by his or her legal guardian or conservator; his or her patient advocate; any party at a hearing for the institution of or renewal of assisted treatment; or his or her spouse, parent, adult child or, if there is no relative of such degree, his or her closest living relative. The grievance of a patient whose treating psychiatrist is the facility's medical director shall be ruled on by a medical professional generally appointed for this purpose by the department of mental health or its designee.[48]

Comment: In addition to the periodic medical review, the one-step grievance procedure set out in this section empowers the patient, or any one of a number of other individuals interested in his or her welfare, to request a modification of the patient's treatment from either the facility's medical director or an independent psychiatrist.

§ 9.4 ***Appeal of grievance to Psychiatric Treatment Board.*** Grievances that are disallowed may be appealed to the Psychiatric Treatment Board, which shall hear the appeal within 14 calendar days. All rulings on appeals of grievances by the Board are final. If the appeal of a grievance is denied, the patient it was brought either by or for is barred from appealing, and others from doing so on his or her behalf, any other grievances to the Psychiatric Treatment Board for a period of 90 days. This limitation of appeal does not otherwise alter the patient's right to bring grievances in accordance with the provisions of § 9.3.

Comment: The Model Law further strengthens patient protections by establishing the right to appeal disallowed grievances to the Psychiatric Treatment Board. The 90-day bar on appeals of grievances to the Board following a denial is to deter repetitious or frivolous appeals. Note that this limitation only restricts a patient's ability to appeal a grievance, not to bring one.

Article 10. Assisted Outpatient Treatment

§ 10.1 ***Enforcement of assisted outpatient treatment order.*** An assisted outpatient treatment order's requirement to maintain treatment can be enforced for non-compliance. On the signature of a supervising psychiatrist, the order may be enforced either at the patient's residence or a treatment center designated by the department of mental health or its designee, whichever the patient chooses. Patients who physically resist shall lose the privilege of selecting their

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[48] States that utilize a similar grievance procedure include:
Delaware – DEL. CODE ANN. tit. 16, § 5161(15) (1995).
Georgia – GA. CODE ANN. §§ 37-1-20(b)(12), 37-3-149 (1995).
Michigan – MICH. COMP. LAWS ANN. § 330.1483 (West 1999).
Missouri – MO. ANN. STAT. § 630.115(2) (West 2000).

treatment location and shall be treated at a designated treatment center.[49]

Comment: This section offers a non-compliant individual the choice of either accepting medication discreetly in his residence or in the less private, but for some less threatening, setting of a facility designated as a treatment center by the department of mental health or its designee.

§ 10.2 ***Transfer to inpatient care.*** The procedures used to determine whether a patient under an assisted treatment order who is on outpatient status should be placed in inpatient care are the same as those for initial placement in assisted treatment. A patient who meets the criteria for emergency treatment shall immediately be given care in an inpatient facility, but a hearing is still necessary to confirm this transfer to inpatient status. At the hearing, the Psychiatric Treatment Board shall order the patient's transfer to or continued placement in inpatient care, depending on his or her status pending the hearing, if such treatment setting is the least restrictive form that will meet the patient's clinical needs. A patient's failure to comply with an order for assisted treatment while in the community may be used as evidence that outpatient placement is not an appropriate treatment setting for that individual.[50]

Comment: Because there is one set of standards for placement in both inpatient and outpatient care, judicial affirmation of the transfer of a patient from outpatient to inpatient status is not necessary. However, recognizing the much greater restriction of liberty of inpatient as compared to outpatient status, the Model Law nonetheless requires judicial approval—either beforehand or afterwards, depending on whether there is an immediate need for inpatient care—for transfers from assisted outpatient to assisted inpatient treatment. Given the existing adjudication from the initial hearing that patients have already met the standard for assisted treatment, a more flexible standard centering on the clinical appropriateness of the new placement is used by the Psychiatric Treatment Board to evaluate such transfers.

Article 11. Trial Release

§ 11.1 ***Authorization for trial release.*** When appropriate, a treating physician may allow an inpatient under an assisted treatment order to receive care in the community by placing the patient on trial release. Trial release is subject to the patient's condition and compliance with a treatment plan developed prior to his or her release. The care of a patient on trial release will continue to be supervised by the releasing hospital. The trial release period may last until the expiration of the order for assisted inpatient treatment. The trial release period may not be extended. If appropriate, prior to the expiration of the trial release period, a petition should be

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[49] States with similar non-compliance enforcement procedures include:
Georgia – GA. CODE ANN. § 37-3-82 (1995).
Idaho – IDAHO CODE § 66-339C (Michie 2000).
Michigan – MICH. COMP LAWS ANN. § 330.1475(2) (West 1999).
Mississippi – MISS. CODE ANN. § 41-21-74 (1999).
New York – N.Y. MENTAL HYG. LAW § 9.60(n) (McKinney Supp. 2001).

[50] States with similar procedures for transfer from outpatient to inpatient status include:
Arizona – ARIZ. REV. STAT. ANN. § 36-540(E) (West Supp. 2000).
Idaho – IDAHO CODE § 66-339C (Michie 2000).
Maine – ME. REV. STAT. ANN. tit. 34-B, § 3870(4) (West Supp. 2000).
Mississippi – MISS. CODE ANN. § 41-21-74 (1999).
Utah – UTAH CODE ANN. § 62A-12-241 (2000).

filed requesting the renewal of the assisted treatment order and that the patient placed on outpatient status. [51]

Comment: The absence of the need for the Psychiatric Treatment Board to approve the transfer of an inpatient to outpatient status in trial release helps ensure that patients subject to assisted treatment orders will be cared for in the least restrictive setting.

§ 11.2 ***Notice of trial release.*** Notice of a patient being placed on a trial release anticipated to exceed 72 hours shall be mailed at least 72 hours in advance by the patient's inpatient facility to the petitioner;[52] patient's legal guardian or conservator, if known; patient's counsel, if known; an adult member of the patient's household, if known; and anyone recognized as a party at the initial assisted treatment hearing or any subsequent renewal hearings.[53]

§ 11.3 ***Revocation of trial release.*** A treating psychiatrist shall revoke a patient's trial release if he or she makes the determination that the patient has either substantially violated the conditions of his or her release or is in need of inpatient care. There is no hearing necessary to revoke trial release. After determining a patient should be removed from trial release, the treating psychiatrist may direct either law enforcement officers with the power of arrest or others who have been designated to perform this function by the state, county or department of mental health to return the patient to the releasing hospital.[54]

Comment: As with its initiation, the revocation of trial release may be done without recourse to the Psychiatric Treatment Board. This contemplates the uncertain condition of someone who is released after being hospitalized for any significant period.

Article 12. Review of Status

§ 12.1 ***Request for review of assisted treatment status.*** If the time for appeal of his or her most recent assisted treatment order or renewal has expired, a patient may request a review of his or

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[51] States with similar trial release procedures include:
Arizona – ARIZ. REV. STAT. ANN § 36-540.01 (West 1993).
Michigan – MICH. COMP. LAWS ANN. § 330.1474 (West 1999).
New Hampshire – N.H. REV. STAT. ANN. §§ 135-C:45(I), :50(I) (1996).
North Carolina – N.C. GEN. STAT. § 122C-277 (1999).
West Virginia – W. VA. CODE ANN. § 27-7-2 (Michie Supp. 2000).

[52] The Model Law places emphasis on notice to the petitioner in addition to those that some states specify.

[53] States with similar procedures concerning notification of trial release include:
Georgia – GA. CODE ANN. §§ 37-3-43(c)-(d), -85(d), -91(c) (Supp. 2000).
Maine – ME. REV. STAT. ANN. tit. 34-B, § 3870(B) (West Supp. 2000).
Minnesota – MINN. STAT. ANN. § 253B.16 (West 1998).

[54] State with similar procedures concerning the revocation of trial release include:
Alaska – ALASKA STAT. § 47.30.795(c) (Michie 2000).
Kentucky – KY. REV. STAT. ANN. § 202A.181(2) (Michie 1999).
New Hampshire – N.H. REV. STAT. ANN. § 135-C:51(I) (1996).
North Carolina – N.C. GEN. STAT. § 122C-277 (1999).

her assisted treatment status by the Psychiatric Treatment Board. The Psychiatric Treatment Board must review the request within 14 calendar days. A patient may request a review of status hearing no more than once every 90 days.

Comment: This is another of the Model Law's overlapping patient protections.

§ 12.2 ***Notice of status review hearing.*** Notice of the status review hearing shall be mailed at least 7 calendar days in advance to the patient; patient's legal guardian or conservator, if known; patient's counsel, if known; an adult member of the patient's household, if known; and anyone recognized as a party at the initial assisted treatment hearing or any subsequent renewal hearings. Timely actual notice shall fulfill the notice requirement for any given individual.

Article 13. Renewals

§ 13.1 ***Renewal of assisted treatment order.*** The process for renewing an assisted treatment order is the same as for the application for an original assisted treatment order by petition except that notice of the renewal hearing, as provided in § 5.5, shall also be sent to anyone recognized as a party at the initial assisted treatment hearing or any subsequent renewal hearings.[55]

§ 13.2 ***Duration of renewal period.*** The first renewal for an assisted inpatient treatment period may last up to 180 days and subsequent renewals up to 360 days thereafter. A subsequent renewal for an assisted outpatient treatment period may last up to 360 days.[56]

Comment: The successively longer periods of treatment reflect that patients who have been in an inpatient facility longer are more likely to stay for longer periods in the future. Note that the intervals between renewals are less significant than those in some state codes because, as set out in § 12.1, both inpatients and outpatients may request a review of their status every 90 days.

Article 14. Procedures for Discharge

§ 14.1 ***Discharge prior to the expiration of assisted treatment period.*** A patient in assisted inpatient treatment or on trial release may be discharged on the signature of both the treating medical

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[55] States with similar procedures concerning the renewal of an assisted treatment order include:
Kansas – KAN. STAT. ANN. §§ 59-2963, -2969 (Supp. 2000).
Michigan – MICH. COMP. LAWS ANN. § 330.1453 (West 1999).
Mississippi – MISS. CODE ANN. §§ 41-21-73, -83 (1999).
Note: Mississippi has greater notice requirements for renewal hearings than for initial commitment hearings.
Montana – MONT. CODE ANN. §§ 53-21-121(3), -128(1)(b) (1999).
Utah – UTAH CODE ANN. §§ 62A-12-234(5), -242 (2000).

[56] States that specify a similar duration for renewal periods include:
Colorado – COLO. REV. STAT. ANN. § 27-10-108, -109 (1990).
Kansas – KAN. STAT. ANN. § 59-2969(f) (Supp. 2000).
Louisiana – LA. REV. STAT. ANN. § 28:56(A)(1) (West Supp. 2001).
Michigan – MICH. COMP. LAWS. ANN. § 330.1472a (West 1999).
South Dakota – S.D. CODIFIED LAWS § 27A-10-14 (Michie1999).

professional and the medical director of the facility. A patient under an assisted treatment order who is on outpatient status may be discharged on the signature of the treating medical professional and the director of the outpatient program.[57]

§ 14.2 ***Notice of discharge.*** Notice of discharge from an assisted treatment order shall be mailed at least 72 hours before the planned discharge[58] to the petitioner; patient's legal guardian or conservator, if known; patient's counsel, if known; an adult member of the patient's household, if known; and anyone recognized as a party at the initial assisted treatment hearing or any subsequent renewal hearings.[59]

Comment: This notice is especially important in light of the Model Law's provisions for the release of patients prior to the expiration of the assisted treatment period ordered by the Psychiatric Treatment Board.

§ 14.3 ***Discharge plan requirement.*** Any patient placed on assisted treatment must be given a treatment plan at the time of discharge from inpatient care or an outpatient program or when placed on trial release for a period anticipated being greater than 72 hours. A treatment plan may include, but is not limited to suggested medication; individual or group therapy; day or partial day programming activities; services and training, including educational and vocational activities; residential supervision; intensive case management services; and living arrangements.[60]

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[57] Currently, there are no states that demand signatures of both the treating medical professional and the medical director of the facility. There are a number of states that specify either medical director or the medical professional.
Examples of states that use medical director:
Delaware – DEL. CODE ANN. tit. 16, § 5131(a) (Supp. 2000).
Georgia – GA. CODE ANN. § 37-3-85(b) (Supp. 2000).
Missouri – MO. ANN. STAT. § 632.390.1 (West 2000).
West Virginia – W. VA. CODE ANN. § 27-7-1 (Michie 1999).
Examples of states that specify medical professional include:
Arkansas – ARK. CODE ANN. § 20-47-213(e) (Michie 1991).
Kentucky – KY. REV. STAT. ANN. § 202A.171 (Michie 1999).
North Carolina – N.C. GEN. STAT. § 122C-277(a) (1999).

[58] Examples of states with similar procedures for notification prior to the planned discharge:
Arizona – ARIZ. REV. STAT. ANN. § 36-541.01(B) (West Supp. 1993).
Hawaii – HAW. REV. STAT. ANN. § 334-60.7 (Michie 2000).
Indiana – IND. CODE ANN. § 12-26-12-1 (Michie 1997).
Minnesota – MINN. STAT. ANN. § 253B.16 (West 1998).
Wyoming – WYO. STAT. ANN. § 25-10-116(b) (Michie 1999).

[59] States with a good listing of who to notify:
Arizona – ARIZ. REV. STAT. ANN. § 36-541.01(B) (West Supp. 1993).
Florida – FLA. STAT. ANN. § 394.463(3) (West 1998).
Minnesota – MINN. STAT. ANN. § 253B.16 (West 1998).
Wyoming – WYO. STAT. ANN. § 25-10-116(b) (Michie 1999).

[60] States with similar requirements for discharge planning include:
California – CAL. WELF. & INST. CODE § 5622 (West 1998).
Maryland – MD. CODE ANN., HEALTH-GEN. I § 10-809 (2000).
Montana – MONT. CODE ANN. § 53-21-180 (1999).
Oklahoma – OKLA. STAT. ANN. tit. 43A, § 7-102 (West Supp. 2001).

Comment: Requiring a comprehensive treatment plan prior to a transfer from inpatient to outpatient treatment or discharge will encourage continued contact with the mental health system by the patient and the provision of the best available services.

§ 14.4 ***Early discharge hearing.*** A hearing before the Psychiatric Treatment Board to determine the appropriateness of the discharge of a patient prior to the expiration of his or her assisted treatment period may be demanded as a matter of right by the petitioner; the patient's legal guardian or conservator, if known; an adult member of the patient's household, if known; and anyone recognized as a party at the initial assisted treatment hearing or any subsequent renewal hearings.

Article 15. Accountability

§ 15.1 ***Treatment provider liability.*** In addition to other limitations on liability set out elsewhere in the state code, persons providing care to patients placed in assisted treatment pursuant to this section shall only be liable for harm subsequently caused by or to individuals who are either discharged from assisted treatment, placed on outpatient status, or given trial release if the discharge or placement of the individual was not within the scope of the person's employment, or was reckless or grossly negligent.[61]

Comment: This limited liability waiver is a compromise between two necessarily competing interests. It is designed to allow treatment providers to make clinical decisions concerning the placement of patients under assisted treatment orders on trial release or discharging them altogether without undue consideration for possible tort liability. At the same time, redress for an individual harmed by the intentional, reckless or exceedingly inept actions of a treatment provider is still available.

Article 16. Patient Bill of Rights

§ 16.1 ***Rights of all individuals in assisted treatment.*** All patients placed in assisted treatment pursuant to this chapter have the following rights:

(a) The right to appointed counsel at the initial assisted treatment hearing, reviews of status, subsequent renewal hearings of orders for assisted treatment, and appeals of these proceedings.

(b) The right for the patient and his or her legal guardian or conservator, if known, to receive a written list of all rights enumerated in this chapter.

Virginia – VA. CODE ANN. §§ 37.1-98(A), 37.1-197.1(3) (Michie Supp. 2000).

[61] States with similar provisions concerning treatment provider liability include:
Alaska – ALASKA STAT. § 47.30.815(b) (Michie 2000).
Oregon – OR. REV. STAT. § 426.280 (1999).
Note: Oregon's treatment provider liability provision concerns outpatient commitment only.
Pennsylvania – PA. STAT. ANN. tit. 50, § 7114(a) (West Supp. 2001).

(c) The right to appropriate treatment, which shall be administered skillfully, safely, and humanely. Each patient placed in assisted treatment pursuant to this chapter shall receive treatment suited to his or her needs, which shall include such medical, vocational, social, educational, and rehabilitative services as the patient's condition requires.

(d) The right at all times to be treated with consideration and respect for his or her privacy and dignity.[62]

§ 16.2 ***Additional Rights of individuals in assisted inpatient treatment.*** In addition to those guaranteed in § 16.1, patients placed in assisted inpatient treatment have the following rights:

(a) The right to have preserved and safeguarded his or her personal property.

(b) The right to communicate freely with and be visited at reasonable times by his or her legal counsel or advocate and, unless prior court restriction has been obtained, to communicate freely with and be visited at reasonable times by his or her personal physician or psychologist.

(c) The right to communicate freely with others, unless specifically restricted in the patient's treatment plan because such communication is likely to be harmful to the patient or others.

(d) The right to receive visitors at reasonable times, unless specifically restricted in the patient's treatment plan because the contact is likely to be harmful to the patient or others.

(e) The right to have reasonable access to telephones, and to make and receive confidential calls, unless specifically restricted in the patient's treatment plan because such communication is likely to be harmful to the patient or others. This shall include a reasonable number of free calls if the patient is unable to pay for them and assistance in calling if requested and needed.

(f) The right to have ready access to letter writing materials, unless specifically restricted in the patient's treatment plan because such communication is likely to be harmful to the patient or others. This shall include, if the patient is unable to pay for them, a reasonable number of stamps without cost, the right to mail and receive unopened correspondence, and assistance in writing if requested and needed.

(g) The right to be provided with an adequate allotment of neat, clean, and seasonable clothing.

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[62] States with a similar listing of rights include:
Delaware – DEL. CODE ANN. tit. 16, § 5161 (1995 & Supp. 2000).
Florida – FLA. STAT. ANN. § 394.459 (West Supp. 2001).
Kansas – KAN. STAT. ANN. § 59-2978 (Supp. 2000).
Massachusetts – MASS. GEN. LAWS ANN. ch. 123, § 23 (West Supp. 2001).
Mississippi – MISS. CODE ANN. §§ 41-21-99, -101, -102 (1999).

(h) The right to maintain personal appearance according to the patient's personal taste, including head and body hair, unless inconsistent with health and safety.

(i) The right to keep and spend a reasonable sum of his or her own money for expenses and small purchases.

(j) The right to vote if otherwise eligible to do so. Voter registration forms, applications for absentee ballots, and absentee ballots shall be made available to patients.

Comment: Taken together, the rights of patients delineated in Article 16 offer both inpatients and outpatients substantial protection of both their rights and dignity.