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To: Interested Stakeholders  
Fr: Ronald S. Welch, Director  
Re: New Mental Health Laws  
Da: April 25, 2008

The following information was prepared by the Attorney General's Office to provide a summary of new mental health laws related to involuntary hospitalization enacted by the state legislature in 2007 and 2008.

1. Reporting requirement – ch. 89 (L.D.711)

- Non-state hospitals with psychiatric beds must notify DHHS within 24 hours if an involuntarily admitted patient has died, attempted suicide, or sustained a serious injury.
- DHHS must forward this notice within 3 days of receipt to the Disability Rights Center.
- Effective September 19, 2007

2. Certification of blue paper applications – ch. 178 (L.D. 681)

- The law has been clarified so that a physician's assistant, certified psychiatric clinical nurse specialist or nurse practitioner, as well as a licensed physician or licensed clinical psychologist, can make a blue paper certification outside a hospital emergency room.
- Effective September 19, 2007

3. General changes to the commitment laws – ch. 319 (L.D. 1885)

- Usage of "psychiatric hospital," as opposed to "hospital" has been clarified and standardized throughout "Subchapter IV, Hospitalization," the mental health hospitalization law.
- The definition of "patient" has been expanded to describe not only persons receiving care in inpatient beds, but also persons being assessed for commitment in hospital emergency departments.
- The Commissioner of DHHS can now investigate not only complaints of patients in psychiatric hospitals, but also complaints of patients who are being evaluated in general hospital emergency rooms for commitment. The commissioner also has clear statutory authority to visit non-psychiatric hospitals in order to review blue paper procedures.
- A judicial officer now has clear authority to review a faxed blue paper. Under the law, a faxed judicial signature remains valid.
- A hospital may now hold a patient involuntarily for up to 24 hours (formerly 18 hours) while a placement and judicial endorsement are being sought. (The hospital's authority to hold a voluntary patient for up to 16 hours following a request to leave is unchanged.)

- The person seeking a patient's admission, rather than the law enforcement officer or ambulance service transporting the patient, is now responsible for ensuring that the blue paper is judicially endorsed.
- The statute now describes the content of examiners' reports: the examiners must report whether a person is a mentally ill person (involuntary commitment standard) or has a severe and persistent mental illness (progressive treatment program standard), and they must report whether the person presents a likelihood of serious harm.
- The law no longer requires that an application for commitment be dismissed if the two examiners report that the person is not mentally ill or does not pose a likelihood of serious harm. (However, this change in law does not prevent the Attorney General's office from determining that there is inadequate evidence to go forward with the hearing.)
- Effective September 19, 2007

#### 4. Involuntary medication – ch. 446 (L.D. 1033)

- DHHS must promulgate rules for a clinical review process for involuntary treatment (repealed by ch. 580 before rulemaking was complete).
- Applications for involuntary commitment may include a request for an order of involuntary treatment.
  - If authorization for involuntary treatment is requested, one of the two independent examiners must be a licensed physician (amended by ch. 472), whom the patient may choose.
  - If the court finds that (i) the person lacks capacity, (ii) the person is unable or unwilling to comply with recommended treatment, (iii) the need for treatment outweighs risks, and (iv) the recommended treatment is the least intrusive appropriate option, then the court can give treatment authority to the hospital or appoint a surrogate.
  - The court must find that failure to treat this illness is likely to produce lasting or irreparable harm to the patient or that, without the recommended treatment, the illness or commitment may be significantly extended.
  - The hospital and patient may agree to changes in the plan, but if the patient does not agree, the hospital can apply to court for a change in the plan.
- Effective September 19, 2007

#### 5. Involuntary medication – ch. 472 (L.D. 1986)

- If authorization for involuntary treatment is requested with an application for involuntary commitment, one of the examiners for the commitment hearing must be a licensed physician or psychologist, and one examiner must be a licensed physician, certified nurse practitioner or registered physician assistant.
- Effective January 10, 2008

#### 6. Involuntarily medication – ch. 580 (L.D. 2193), amending ch. 446

- Chapter 446 had required DHHS to promulgate rules to provide for a clinical review panel to determine whether patients can be required to accept involuntarily treatment as an alternative to the administrative hearing process described in the Rights of Recipients rule. Chapter 580

repealed that provision, outlining the clinical review panel process in statute and prohibiting the administrative hearing process as a method for authorizing involuntary treatment.

- Chapter 446 includes the following criteria for the clinical review panel process:
  - Both state psychiatric hospitals and community psychiatric hospitals with contracts with DHHS can convene clinical review panels;
  - The clinical review panel must consist of at least two licensed professional staff, one of whom must have prescribing authority;
  - Specified information that must accompany the treating physician's request for a clinical review panel includes a second opinion as to the patient's capacity to give informed consent and information about the proposed treatment.
  - Specified notice and time requirements must be followed;
  - The patient is entitled to assistance from a lay advisor at no cost, or may hire a lawyer for representation;
  - All meetings of the clinical review panel except meetings held for deliberation and making findings and conclusions are open to the patient and his lay advisor or attorney;
  - To approve treatment, the clinical review panel must find that (i) the patient lacks informed capacity, (ii) the patient is unwilling or unable to comply with the proposed treatment, (iii) the need for treatment outweighs risks and benefits, (iv) the proposed treatment is the least intrusive appropriate option, and (v) either failure to treat is likely to produce lasting harm or, without treatment, the patient's illness or commitment may be significantly extended;
  - Patients in community hospitals may request review of clinical review panel decisions by DHHS; and
  - Appeal of clinical review panel findings is to Superior Court.
- Effective April 8, 2008

Disclaimer: This summary touches on highlights of the changes, but is not comprehensive. To see the full scope of the changes, go to the laws cited in the summary.