4. Suggestions for Policy Language and Forms
   Services Suited to Condition – Standards of Care
   Abuse I - Sexual Incident form
   Abuse III – Threaten, Degrade
   Dignity & Respect
   Personal Property Protection - Property Waiver
   Video Surveillance in an Inpatient LPH/U
   Voluntary Admission form (DCH-0086)
   Explanation of Involuntary Process (see Chapter 4) x 2

SUGGESTED POLICY LANGUAGE FOR PROVISION OF SERVICES

Although the mental health code and administrative rules address the issue of what must be included in a treatment plan or individual plan of service (IPOS), and the process for planning is identified and further clarified in the revised practice guideline, the standard of care related to enactment of the treatment plan/IPOS may be outlined elsewhere.

Policy Language may include:

"Services shall be provided in accordance with all applicable standards of care or treatment required by any of the following:

1. All state or federal laws, rules or regulations governing the provision of community mental health services; and

2. obligations of a provider established under the terms of a contract oe employment agreement with CMH; and

3. CMH policies and procedures; and

4. written guidelines or protocols of a provider; and

5. written directives from a supervisor consistent with any of the above; and

6. a recipient's individual plan of service

Name of Hospital
Alleged Sexual Incident

I, _____ am alleging involvement in a sexual incident
Patient name

On_____. I request the assistance of _____ hospital staff to do
Date

the following:

☐ I wish to have a physical examination by a physician in relation to this incident.

☐ I do not wish to have a physical examination by a physician in relation to this incident.

☐ I wish to have a physician/designee notify a family member or friend of this incident

Name:_____ Phone: _____

☐ I do not wish to have a physician/designee notify a family member or friend of this incident.

Signatures:

_____
Patient Name Date

_____
Witness Name (staff) Date

_____
Witness Name (staff) Date

****In all incidents of alleged sexual abuse, the police and Adult Protective Services will be notified, and a "rape kit" will be completed, unless the recipient refuses this procedure.**

CLARIFICATION LANGUAGE FOR ABUSE III

MHC 330.1722. (1) A recipient of mental health services shall not be subjected to abuse or neglect.
AR 330.7001 (c) Abuse class III means the use of language or other means of communication by an employee, volunteer, or agent of a provider to degrade, threaten, or sexually harass a recipient.

A. "Threaten" means any of the following:
- to utter intentions of injury or punishment against:
- to express a deliberate intention to deny the well-being, safety, or happiness of somebody unless the person does what is being demanded.

B "Degrade" means any of the following:
- treat humiliatingly: to cause somebody or something a humiliating loss of status or reputation, or cause somebody a humiliating loss of self-esteem
- make worthless: to cause people to feel that they or other people are worthless and do not have the respect or good opinion of others
- *(syn)* degrade, abase, debase, demean, humble, humiliate: These verbs mean to deprive of self-esteem or self-worth; to shame or disgrace.

Degrading behavior shall be further defined as any language or epithets that insult the person's heritage, mental status, race, sexual orientation, gender, intelligence, etc.

Examples of behavior that is degrading, and must be reported as Abuse includes, but is not limited to:

a. Swearing at recipients
b. Using foul language at recipients
c. Using racial or ethnic slurs toward or about recipients
d. Making emotionally harmful remarks toward recipients
e. Causing or prompting others to commit the actions listed above

CLARIFICATION LANGUAGE FOR TREATMENT WITH DIGNITY AND RESPECT

A. All recipients of mental health services in hospitals and centers operated by the Department of Community Health and their family members shall be treated with dignity and respect.

B. DEFINITIONS:

1. Dignity - to be treated with esteem, honor, politeness; to be addressed in a manner that is not patronizing or condescending; to be treated as an equal; to be treated the way any individual would like to be treated.
2. Respect - to show deferential regard for; to be treated with esteem, concern, consideration or appreciation; to protect the individual's privacy; to be sensitive to cultural differences; to allow an individual to make choices.

C. Treatment with dignity and respect shall be further clarified by the recipient or family member and considered in light of the specific incident, treatment goals, safety concerns, laws and standards, and what a reasonable person would expect under similar circumstances.

D. Examples of treating a person with dignity and respect include but are not limited to calling a person by his or her preferred name, knocking on a closed door before entering, using positive language, encouraging the person to make choices instead of making assumptions about what he or she wants, taking the person's opinion seriously, including the person in conversations, allowing the person to do things independently or to try new things.

E. All department employees, volunteers, contractual service providers and employees of contractual service providers shall treat recipients and their family members with dignity and respect, being sensitive to conduct that is or may be deemed offensive to the other person. Staff shall refrain from coarse or vulgar language in the presence or hearing of recipients/family members.

F. In addition to the above, showing respect for family members shall include:

1. Giving family members an opportunity to provide information to the treating professionals;
2. Providing family members an opportunity to request and receive educational information about the nature of disorders, medications and their side effects, available support services, advocacy and support groups, financial assistance and coping strategies.
3. Information shall be received from or provided to family members within the confidentiality constraints of Section 748 of the Mental Health Code.

PATIENT PERSONAL PROPERTY
WAIVER OF RESPONSIBILITY

I _____ assume full responsibility for the following valuables/that I will to keep in my possession: _____

_____

_____

_____

_____

By signing this form, I am requesting to keep these items in my possession. I understand that the hospital will not be responsible for replacement or reimbursement, if lost or stolen.

_____ _____
Patient Signature Date

_____ _____
Significant Other/Guardian Signature (if needed) Date

_____
Relationship to Patient

_____ _____
Staff Signature Date

Only one date per form allowed. If any items listed are placed into the hospital safe, it shall be noted and initialed by hospital staff.

PATIENT PERSONAL PROPERTY
WAIVER OF RESPONSIBILITY

I *Beverly Sobolewski* assume full responsibility for the following valuables/that I will to keep in my possession:

silver colored ring with blue & white stones

gold colored necklace on 18" chain

By signing this form, I am requesting to keep these items in my possession. I understand that the hospital will not be responsible for replacement or reimbursement, if lost or stolen.

Beverly Sobolewski — Patient Signature

10/10/2009 — Date

Helen Kowakczyk — Significant Other/Guardian Signature (if needed)

10/10/2009 — Date

mother/guardian — Relationship to Patient

Dianne L. Baker — Staff Signature

10/10/2009 — Date

Only one date per form allowed. If any items listed are placed into the hospital safe, it shall be noted and initialed by hospital staff.

Recipient
or
Guardian
& staff

PATIENT PERSONAL PROPERTY
WAIVER OF RESPONSIBILITY

I *Beverly Sobolewski* assume full responsibility for the following valuables/that I will to keep in my possession: _____

~~*silver colored ring with blue & white stones*~~ *Recinded 10/22/09(BS or HK) DLB*

gold colored necklace on 18" chain

By signing this form, I am requesting to keep these items in my possession. I understand that the hospital will not be responsible for replacement or reimbursement, if lost or stolen.

Beverly Sobolewski — *10/10/2009*
Patient Signature — Date

Helen Kowakczyk — *10/10/2009*
Significant Other/Guardian Signature (if needed) — Date

mother/guardian
Relationship to Patient

Dianne L. Baker — *10/10/2009*
Staff Signature — Date

Only one date per form allowed. If any items listed are placed into the hospital safe, it shall be noted and initialed by hospital staff.

VIDEO SURVEILLANCE RECORDING
Licensed Psychiatric Inpatient Unit

DISCUSSION DRAFT GUIDELLINE
August 2010

A. For purposes of patient and staff safety, it is permissible to record (to a digital recorder, DVO, VHS tape, or other recording device) video surveillance images in a licensed psychiatric inpatient unit limited to the following areas:

1. Entry/hallway leading to psychiatric unit entrance
2. Hallways within the psychiatric unit
3. Nursing station area
4. Noisy and quiet social activity areas [otherwise known as day rooms] within the psychiatric unit.
5. Occupational/activity therapy room\
6. Group therapy, noisy and quiet social activity areas where group or activity therapy is provided, staff offices, and consultation rooms (does not include exam/treatment room where a physical examination occurs) if there is no audio transmission or recording of the discussions that are occurring within the room.
7. Seclusion/Restraint room

B. Video monitoring screens used to view surveillance images must located in a place and manner that will ensure that a patient or other unauthorized person can not view an image on the video monitoring screen.

C. If recording of surveillance video images will be made, signage must be posted at the entry way to the psychiatric unit and on the psychiatric unit advising patients and visitors of the recording of surveillance videos. Notice of the recording of surveillance videos should also be included in the patient handbook/unit information sheet provided to newly admitted patients and family/visitors.

D. Recording of surveillance videos may only be conducted if the hospital has promulgated safety features to ensure that video images are not accessed, viewed, or copied without the consent and approval of a responsible administrator designated by the hospital's CEO.

E. Prior to the implementation of the recording of surveillance video images, a hospital policy/procedure must be promulgated and approved by the recipient rights advisor that at minimum, addresses the following issues:

1. Identify the locations where video surveillance images will be recorded and saved.

2. Describe the mechanism by which patients and visitors will be advised of the hospital's recording of surveillance videos.
3. Describe promulgated security provisions that will ensure that only authorized personnel have access to view recorded surveillance videos. At a minimum, the policy/procedure should identify

   a. Who may authorize viewing of recorded surveillance videos.

   b. Under what circumstances may recorded surveillance videos be reviewed.

   c. Who with proper authorization may view recorded surveillance videos.

   d. Safeguards to prevent and detect unauthorized viewing of recorded surveillance videos.

   e. Under what circumstances may recorded surveillance video images be copied to a DVD and what steps will be taken to prevent any distribution of the DVD.

   f. Documentation that will be maintained of each instance of authorized access, viewing, duplication, or distribution of any recorded surveillance videos.

   g. Specify when a subpoena or court order is necessary prior to providing to a third party a copy of a recorded surveillance video.

   h. Steps to be taken to retrieve any distributed recorded surveillance video when the purpose for which the video was distributed no longer exists.

Admission Date

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

ADULT FORMAL VOLUNTARY ADMISSION APPLICATION

TO: The Director Of_____

I,_____, wish to request formal voluntary admission to your hospital.
I understand **the hospital may continue to hold me for a period of up to 3 day, excluding Sundays and holidays, after I give written notice of my intention to leave the hospital.** The written notice shall be on a form which shall be given to me immediately when I request it or when I inform the hospital of my desire to leave.

I also understand that **if I still wish to leave, and if the director of the hospital believes that pursuant to Chapter 4 of the Michigan Mental Health Code I still require hospital treatment, the director may, within those 3 days, file an application and necessary clinical certifications(s) with the probate court for my continued hospitalization and treatment.** Under such circumstances, **I will have to remain in the hospital pending the court hearing.**

I understand the admission is temporary and that I will be discharged when, in the hospital director's opinion, I am no longer clinically suitable for inpatient treatment.

I agree to disclose such information as is required by law to determine my financial status and ability to pay for mental health services. I understand that, if the mental health services are to be publicly supported, a financial determination will be made subsequent to admission and that a notice of the determination and appeal procedure will be sent to me as required by law.

I have been informed as to whether the community mental health services program serving the county in which I live contracts with this hospital for inpatient care. If it does, I further understand that information concerning my admission and treatment will be shared with them if there is any expectation on my part and the hospital's that the community mental health services program will be expected to reimburse the hospital, in whole or in part, for the services I am provided.

Person to be admitted (adult applicant):

Name	County of Residence
Street address/PO Box	Date of Birth
City, State, Zip Code	Phone #
Guardian (applicant)	Patient Advocate designated in psychiatric advance directive (applicant)

Signature of Adult Applicant: _____ Date: _____

Signature of Guardian: _____ Date: _____
OR
Signature of Patient Advocate: _____ Date: _____

This legal form is approved for use by the State Department of Community Health and cannot be altered or abridged without formal approval.

Signature to acknowledge oral explanation of rights of recipients of mental health services (MCL 330.1416):

Signature of Applicant:	Date:
Signature of Witness:	Date:

Signature to acknowledge receipt of a copy of the application (MCL 330.1416):

Signature of Applicant:	Date:
Signature of Witness:	Date:

Additional person designated by applicant to receive a copy of this application (if requested):

Name:
Address:
Date mailed or provided:

ACTION BY HOSPITAL:

A determination of clinical suitability for formal voluntary admission shall be based on the following criteria:

a. The individual has a condition that the hospital director determines can benefit from the inpatient treatment that is provided by the hospital.

b. Appropriate alternatives to hospitalization have been considered by the hospital, and with the consent of the individual, the community mental health program in the individual's county of residence.

c. Adequate alternative treatment is not available or suitable at the time of admission as determined by the hospital, and with the consent of the individual, the community mental health program in the individual's county of residence.

(Administrative Rule 330.4031)

☐ Clinically suitable for formal voluntary admission

☐ Not clinically suitable for formal voluntary admission because, _____

_____

_____

☐ The required oral explanation to the individual to be admitted was not given at this time since in my opinion the individual is not presently capable of comprehending the explanation because: _____

_____

_____

Signed:_____ Date_____

Physician's Signature

AUTHORITY: PA 258 of 1974, as amended Administrative Code, Rule 330.4031	The Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.

Involuntary Hospitalization - Brief Summary for Patients

Someone is worried about your mental health and wants you to be seen by a doctor to decide if you need help from the hospital. However, you do NOT want to be admitted!

This concerned person writes examples of the behavior they are worried about and why they believe you need help from the hospital. The concerned person writes this information on a form called a **Petition**. (The petition may be given to the police so they know you need to go to the hospital. The police may need to bring you to the hospital.)

The petition is then given to the hospital or screening center. The doctor at the hospital/screening center will meet with you to decide if your behavior is serious enough for you to require staying at the hospital for help. If the doctor decides you need help from the hospital, the doctor will write out the reasons why you need help at the hospital. The form the doctor will write on is called a **First Clinical Certificate**.

Now, a different doctor needs to meet with you within 24 hours of being at the hospital. This doctor will also be deciding if your behavior is serious enough to require staying at the hospital. If this second doctor decides you need help from the hospital, the doctor will write out the reasons on a form also called a Certificate, but this one is known as the **Second Clinical Certificate**.

Now that you are in the hospital you may make at least 2 phone calls. You will have a lawyer who will work with you. You can also get your own lawyer as long as you pay for the services the lawyer provides to you.

You will be working with _____ staff to assure you have access to the care you need. A psychiatrist will meet with you within the first 24 hours of your stay. Your psychiatrist will meet with you everyday that you are in the hospital. You will be evaluated for medication and treatment options. Your physician or nurse will explain the risks and benefits to any medication recommended for your treatment.

You can decide if you want to take the recommended medications. You have a right to refuse treatment until there is a deferral conference or a court order for your treatment, **unless** you are in immediate danger to your own safety, the safety of others or property.

Deferral Conference or Court Hearing

You have the right to Due Process (your time in court). Your attorney will meet with you within 3 days of your admission. You must have met with your attorney with in the first 3 days but no less 1 full day (24 hours) before your scheduled deferral conference. (your attorney can't wait until a couple hours before your deferral conference to meet with you for the first time)

Your physician and the staff will provide input and recommendations for your treatment during the deferral process.

If you are working with Community Mental Health, you will have a case manager meet with you. Your case manager will provide recommendations and information regarding your care during the deferral conference.

When you have your deferral conference your attorney will be present, as well s hospital treatment staff and a representative from the CMH. You will have several options:

1. You may decide to DEFER (delay) going to court. This means you are agreeing to take medication and participate in therapy/treatment now and when you are discharged. This is called "stipulating to the treatment".

    - When you DEFER, it can last for 90 days; anytime in the next 90 days you can change your mind and ask for a court hearing.
      You are now considered a "voluntary patient".

    - The hospital can also ask for a court hearing at anytime if you decide not to participate in treatment. The hospital will ask for a hearing to determine if you need inpatient treatment and if so, the court will order you to take medications and participate in treatment. You are now an "involuntary patient".

Some people prefer to DEFER their court hearing because it keeps the involuntary commitment to hospitalization off their permanent legal record.

2. You can decide to have a hearing and appear before the PROBATE JUDGE and let the judge decide if you need to be in the hospital for mental health treatment.

3. You may request a JURY TRIAL, allowing the jury to decide if you need to be in the hospital for mental health treatment. (you have to request a jury trail before the first witness takes the stand at the hearing with the probate judge – option 2 described above.)

You have many rights under the Michigan Mental Health Code during hospitalization and treatment. You will be provided with a rights booklet at admission. This book is a guide to your rights as a patient. If you have questions or would like to make a complaint regarding your rights, we have a Rights Advisor at the hospital you can talk to.

For more information on Recipient Rights please call or ask staff to contact the Rights Advisor at: _____

Statements for Persons Hospitalized Involuntarily:

- **A psychiatrist will examine you within 24 hours of your admission to the Mental Health Unit** (excluding legal holidays). If you do not require mental health treatment, you will be discharged immediately. Otherwise, you will be held in the hospital pending a court hearing. If the doctor considers you appropriate for it, you may be given the opportunity to sign a formal *voluntary*.
- You are entitled to copies of the petition and clinical certificates that are filed concerning you.

- **You will be given a full court hearing within seven days** (excluding Sundays and holidays) **to determine whether or not there is a legal basis to forcibly treat you for a mental illness.**
- You have the right to attend the commitment hearing.
- Unless other arrangements are made, you will be represented by a court appointed attorney.
- You have the right to a jury trial. (This may delay your hearing date)
- You have the right to obtain an independent clinical evaluation.
- You have the right to refuse medication before your hearing, unless it is determined that you are in danger of physically hurting yourself, or others.

- **Instead of having a court hearing, you may choose to "defer" it.**
- Within 3 days (excluding Sundays and holidays), a meeting will take place including you, your attorney, a CMH worker, an MHU team member, and a person of your choice.
- You will be told of the type of treatment being offered to you while you are in the hospital, and after you are discharged.
- The nature and possible consequences of convening the commitment hearing will be explained to you.
- You will be given the opportunity to sign the deferral form. If you choose this option, you will be expected to follow the treatment prescribed for you, both while in the hospital and out of the hospital for a period of 90 days.
- During the deferral period you or the treatment team may demand a hearing at any time.

For more information about these, and the other rights you are entitled to under the Michigan Mental Health Code, please refer to the "Your Rights" booklet in your blue admission packet.

Frequently Asked Questions:

Question: ***I am told I have to go before the judge, am I in legal trouble?***
Answer: You are not being charged with any kind of crime, you are involved in the legal system because of a petitioner's concern about your well being due to a perceived mental illness.

Question: ***I have other court hearings scheduled, for other reasons; will these be addressed during my commitment hearing?***
Answer: It is unlikely that your other legal issues will be discussed during your commitment hearing, unless it relates to needing treatment for a mental illness. A ruling will only be made concerning mental health treatment during this hearing. If you are scheduled for a different court hearing that you are likely to miss due to your hospitalization, please let the treatment team know, so that it can be addressed with the appropriate court.

Question: ***I was told that if the judge places me on a treatment order, it goes on my permanent record, what does this mean?***
Answer: If you are placed on a treatment order, your information will be entered in to the Law Enforcement Information Network (L.E.I.N.) and the State Police will be notified of your status. This information can only be removed by court order.

Question: ***What is a "60/90 day" order?***
Answer: A 60/90 day treatment order is a court order compelling a person to undergo combined mental health treatment for a period of 90 days. This means that a Community Mental Health agency or a private physician as applicable will manage your care on an outpatient basis during those 90 days. The order provides that you may also be treated in the hospital for up to 60 of those days. The hospitalization does not have to take place all at once, but can be applied as needed during the 90 days.

Question: ***If I am placed on an order or if I defer, do I have to take all the medications that are prescribed for me?***
Answer: Yes. The doctor will take your preferences under consideration, but you will be expected to take all of the medications that are prescribed. If you have been court ordered, and you refuse to accept the medications, they may be administered to you forcibly. If you have signed a deferral, and you refuse the medications, the treatment team may demand a hearing.

Question: ***What is the residential placement I see on the deferral and/or commitment order?***
Answer: When you no longer meet criteria for the hospital, you may be placed in a crisis residential program, on a short term basis. This residential setting is less restrictive than the hospital. Occasionally there is a need for a long-term program. Placement in a setting outside of the hospital is only given on an "as-needed" basis, most recipients go home or into the care of their families when they leave the hospital.