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Table of Contents

PART I - MENTAL RETARDATION .................................................................................................................. 1

I. LEGAL RIGHTS OF PERSONS WITH MENTAL RETARDATION GUARANTEED BY THE TEXAS PERSONS WITH MENTAL RETARDATION ACT ................................................................. 1
   A. All Texans with mental retardation have the following rights .......................................................... 1
   B. Additional Rights .......................................................................................................................... 2
   C. Rights of Residents with Mental Retardation Living in State or Locally-Operated Facilities ........... 2
   D. Rights of Persons with Mental Retardation in Commitment Proceedings ...................................... 3

II. GUARDIANSHIP ISSUES AND PERSONS WITH MENTAL RETARDATION AND MENTAL ILLNESS ................................................................................................................................. 3
   A. An "incapacitated person" includes .................................................................................................. 4
   B. Authority of a Guardian .................................................................................................................. 4
      1. Possible Powers and Duties of a Guardian .................................................................................... 5
      2. "Voluntary" Admission to Residential Facilities ............................................................................ 6
      3. Limitations on a Guardian's Power ............................................................................................... 7
         a. Marriage ................................................................................................................................. 7
         b. Sterilization, Abortion, and Non-therapeutic Surgery ............................................................... 7
            (1) Sterilization .......................................................................................................................... 7
            (2) Medically-Necessary Procedures Resulting in Sterilization .................................................. 7
            (3) Abortion .............................................................................................................................. 8
            (4) Non-therapeutic Surgery ...................................................................................................... 8
               (a) Cosmetic surgery .................................................................................................................. 8
               (b) Procedures Designed to Benefit Another ............................................................................. 8

III. ALTERNATIVES TO PERMANENT GUARDIANSHIP ........................................................................... 8
   A. Temporary Guardianship .................................................................................................................. 8
   B. Trusts ............................................................................................................................................... 9
   C. Durable Power of Attorney ............................................................................................................. 9
   D. Durable Power of Attorney for Health Care ................................................................................. 10
   E. Surrogate Consent for Persons in Hospitals or Nursing Homes ...................................................... 10
   F. Surrogate Consent for ICF-MR Clients ............................................................................................ 10

IV. LEGALLY ADEQUATE CONSENT ........................................................................................................ 10

V. THE REQUIREMENTS OF "LEGALLY ADEQUATE CONSENT" ................................................................. 11
   A. Legal Capacity .................................................................................................................................. 11
   B. Information and Understanding ....................................................................................................... 11
   C. Voluntariness .................................................................................................................................. 11

VI. WHEN "LEGALLY ADEQUATE CONSENT" IS REQUIRED ......................................................................... 11

VII. SPECIAL PROVISIONS FOR OBTAINING CONSENT FROM RESIDENTS OF ICF-MR .................. 12
PART II - MENTAL ILLNESS

I. THE COMMITMENT PROCESS

A. Types of Commitment Hearings
   1. Order of Protective Custody
   2. Temporary Commitment
   3. Extended Commitment
   4. Emergency Commitment for Persons With Mental Illness

B. The Individual Must Be Told About His or Her Rights
   1. Involuntary Commitments and Hearing Rights
      a. Attorney responsibilities at commitment hearings
      b. What may happen at the hearing?
      c. Commitment hearing outcomes
      d. Appeals

C. Rights of Individuals When They Are Involuntarily Committed for Mental Health Services
   1. Rights That Cannot Be Restricted
   2. Rights That Can Be Restricted Only by a Doctor or Treatment Team

D. Rights of Individuals Receiving Voluntary Inpatient Mental Health Services

E. The Right to Refuse Medication
   1. Medication Hearing
   2. If the Individual Is Required To Take Medication

F. Behavior Interventions Including Restraint and Seclusion in Mental Health Facilities
   1. Voluntary Behavioral Interventions
      a. Quiet Time
      b. Clinical Time Out
   2. Involuntary Behavioral Interventions
      a. Seclusion
      b. Restraint
      c. Chemical Restraint
      d. Chemical Sprays
      e. General Rights for Seclusion, Restraint, and Medication Restraint
         (1) Who can order restraint, seclusion, or medication restraint?
         (2) How long can the individual be restrained or secluded?
         (3) When can the individual be released from restraint or seclusion?
   3. Restraint During Medical or Dental Procedures
   4. Protective and Supportive Devices
      a. General Rights
      b. Protective Devices
      c. Supportive Devices
SPECIAL ISSUES IN CASES INVOLVING MENTAL DISABILITIES: Mental Capacity Relating to Mental Retardation and Mental Illness

PART I - MENTAL RETARDATION

INTRODUCTION

For persons with mental disabilities, including mental retardation or mental illness, every new day represents an ongoing struggle to be recognized as an individual who can succeed and, with some help and understanding from the non-disabled community, become a productive, contributing member of society. However, success will depend to a great extent on society’s willingness to give persons with disabilities the opportunity to succeed.

In the not-so-distant past, persons with disabilities were considered by many to be social deviants with intellectual limitations that called for dramatic and often fatal interventions. In fact, this view regarding treatment set the stage for the United States Supreme Court’s 1927 *Buck v. Bell* decision. In *Buck*, the Supreme Court affirmed the right of states to sterilize persons with mental disabilities. In fact, the court’s decision helped foster and legitimize the eugenics movement. This movement, which associated mental disabilities with a predisposition to crime, immoral behavior, and pauperism, resulted in the forced sterilization of thousands of persons with both developmental and mental disabilities.

Persons with mental disabilities were also subject to rather bizarre forms of treatment. For example, medical professionals thought that insulin might be an effective treatment for mental illness. Scientists also thought that infecting patients with malaria would be an effective way to treat mental illness. Scientists believed that the malaria’s side effects might cure mental illness. Psychosurgery was also used to treat mental illness. A surgical procedure commonly known as a lobotomy was used from the 1930s to the 1950s. This procedure involved severing the frontal lobe from the rest of the brain and often left patients with changed personalities, diminished intellectual faculties, and other severe problems.

These treatments, many of which are now considered to be barbaric, are part of a larger history that persons with disabilities share. What follows is a short discussion of the rights and protections that persons with mental retardation and mental illness now have under the law.

I. LEGAL RIGHTS OF PERSONS WITH MENTAL RETARDATION GUARANTEED BY THE TEXAS PERSONS WITH MENTAL RETARDATION ACT.

A. All Texans with mental retardation have the following rights:

- All rights guaranteed under the constitutions and the laws of the United States and the State of Texas, including but not limited to the right to vote, the right to marry, the right to travel, the right to freedom of speech and religion, etc.;

- The right to protection from exploitation and abuse wherever the person may be;

- The right to the least restrictive living setting appropriate to the person’s needs and abilities;

- The right to education regardless of degree of mental retardation, age, disability or residence;

- The right to equal opportunities in employment; to be considered for employment based upon actual job-related abilities rather than be rejected solely because of mental retardation;

- The right to equal housing opportunities and to be free of discrimination in housing based solely on mental retardation;

- The right to treatment and habilitative services based upon the person’s needs to maximize capabilities and enhance abilities to cope with the environment, within the limits imposed by resources available to the Texas Department of Mental Health and Mental Retardation (TDMHMR);

- The right to have habilitation and treatment skillfully, safely and humanely administered with full respect for the dignity and personal integrity of the person;

- The right to a formal determination of mental retardation made by a physician or
psychologist licensed in Texas or certified by TDMHMR;

- The right to contest the findings in the determination of mental retardation;
- The right to be presumed competent until declared incompetent by a court of law;
- The right to due process in guardianship proceedings;
- The right to fair compensation for labor; and
- The right to confidentiality of records and access to records.

B. Additional Rights

Persons receiving mental retardation services from TDMHMR and from local community MHMR centers have the following rights in addition to those described in section A above:

- The right to live in the least restrictive habilitation setting appropriate to the person's needs;
- The right to be treated and served in the least intrusive manner appropriate to the person's needs;
- The right to a written individualized habilitation plan, developed by appropriate specialists;
- The right to participate in planning the treatment and habilitation and to be informed in writing of progress at reasonable intervals;
- The right to withdraw from voluntary mental retardation services;
- The right to be free from mistreatment, neglect and abuse by service providers;
- The right to be free from unnecessary and excessive medication; including the right to be free from use of medication as a punishment, for the convenience of the staff, as a substitute for a rehabilitation program, or in quantities that interfere with the client's habilitation program;
- The right to submit grievances to the public responsibility committee; and
- The right to be informed of these rights guaranteed by the Texas Persons with Mental Retardation Act (MRPA) upon admission for mental retardation services.

C. Rights of Residents with Mental Retardation Living in State or Locally-Operated Facilities

All residents of state schools and any other facility operated by TDMHMR, or a community MHMR residential care facility, have the following rights in addition to the rights spelled out in sections A and B above:

- The right to an interdisciplinary team (IDT) recommendation to a residential care facility prior to admission or commitment, except for brief emergency stays. The IDT findings and recommendations shall be provided in writing to the person with mental retardation;
- The right to participate in all IDT meetings;
- The right to prompt and adequate medical and dental care and treatment provided in a manner consistent with community medical and dental standards, and performed under the supervision of licensed doctors and dentists;
- The right to be free from unusual or hazardous treatment procedures, experimental research, organ transplantation, or nontherapeutic surgery for experimental research;
- The right to a normalized residential environment--one that resembles regular family homes;
- The right to a humane physical environment--one that is clean, free of odors, temperature controlled, etc.;
- The right to communication and visits, including personal visits, phone calls, and mail;
- The right to personal property, and to have personal property kept safe and secure;
- The right to an administrative hearing to challenge a proposed transfer or discharge, or to challenge a referral to a community placement; and
- The right to be the beneficiary of a trust up to the amount of $250,000 that is not to be considered the property of that person. No part of this $250,000 may be assessed by TDMHMR to pay for the support and maintenance of the person.

D. Rights of Persons with Mental Retardation in Commitment Proceedings

When a person with mental retardation is the subject of an involuntary commitment proceeding, the MRPA sets out individual rights. These rights include the following:

- The right to notice of the commitment at least ten (10) days before the hearing. The notice must include the date, time, and place of the hearing, and a copy of the application for commitment;
- The right to representation at the hearing by an attorney who will be paid by the county if the individual cannot afford to pay;
- The right to present evidence and cross-examine witnesses;
- The right to be placed in a less restrictive setting instead of being committed, if an appropriate residential setting is available; and
- The right to appeal the court's decision.

No person can be committed to a TDMHMR facility unless an IDT recommends such placement during the six (6) months prior to the commitment hearing.


Chapter XIII of the Probate Code provides for the creation of guardianships for incapacitated persons.

A. An "incapacitated person" includes:

- a minor;
- an adult individual who, because of a physical or mental condition, is substantially unable to provide food, clothing, or shelter for himself or herself, to care for the individual's own physical health, or to manage the individual's own financial affairs;
- a person who must have a guardian appointed to receive funds due the person from any governmental source.

Note that a "determination of incapacity of an adult proposed ward . . . must be evidenced by recurring acts or occurrences within the preceding six-month period and not by isolated instances of negligence or bad judgment." (TEX. PROB. CODE ANN. § 684(c)).

B. Authority of a Guardian

The law protects against the appointment of a guardian with more authority than is actually required under the circumstances. By stating that a court may appoint either a guardian with full or limited authority "as indicated by the incapacitated person's actual mental or physical limitations," the law requires the scope of every guardian's authority to be determined by such limitations. Moreover, not only do the incapacitated person's actual limitations determine the scope of the guardian's authority, but the scope must not extend beyond the point "necessary to promote and protect the well-being of the [incapacitated] person." (TEX. PROB. CODE ANN. § 602). Furthermore, it must be reiterated that these requirements are applicable to the scope of the authority of both types of guardians--namely, guardians with limited authority and guardians with full authority.

The law, therefore, provides for the appointment of a guardian with limited powers if the court finds "that the person lacks the capacity to do some--not all--of the tasks necessary to care for himself or herself or to manage the individual's property." (TEX. PROB. CODE ANN. § 693(b)). Furthermore, the court must tailor the powers of a guardian in such a way that they "permit the individual to care for himself or herself or..."
to manage the individual's property commensurate with the individual's ability." (Id.) Furthermore, "[a]n incapacitated person for whom a guardian is appointed retains all legal and civil rights and powers except those designated by court order as legal disabilities by virtue of having been specifically granted to the guardian." (TEX. PROB. CODE ANN. § 675). This is true regardless of whether a guardian has been appointed with full or limited authority.

Under the criteria described above, the scope of the authority of every guardian must extend in such a way that every guardianship is tailored to meet the particular needs of the incapacitated individual for whom the guardianship is created, and only to the extent of those needs. It is therefore incumbent upon the attorney who represents an individual in a guardianship proceeding to engage in a careful fact-finding process in order to determine which powers and duties should be granted to the guardian and which should be retained by the incapacitated person. In making this assessment, the attorney should study recent evaluations of the incapacitated person's general functioning, including his or her social, intellectual, physical and educational condition, social skills, and adaptive behavior. The incapacitated person's adaptive behavior is in part measured by his or her ability to perform important life skills such as the ability to take care of one's hygiene, the ability to dress and feed oneself, the ability to take a bus, the ability to pay one's bills, the ability to live independently, etc. Attorneys can best evaluate the adaptive behavior and life skills of a proposed ward by consulting with his or her parents, friends, clergy, teachers, counselors, employers, service providers, and others who may have some knowledge concerning the proposed ward's adaptive behavior and life skills. Because many persons are biased about the abilities and capabilities of incapacitated persons, the attorney's assessment of the needs of the proposed ward with respect to guardianship should be based on consultations with many persons who are knowledgeable about the abilities and life skills of the incapacitated person.

1. Possible Powers and Duties of a Guardian

An order appointing a guardian with either full or limited authority must specify "the specific powers, limitations, or duties of the guardian with respect to the care of the person or the management of the person's property by the guardian...." (TEX. PROB. CODE ANN. § 693(c)). As previously noted, a guardian with either full or limited authority may be appointed for either a guardianship of the person or the estate, or both. The legislation outlines the general duties and powers of guardians of the person and of guardians of the estate, and it also suggests a number of specific powers and duties that may be granted to a guardian. (TEX. PROB. CODE ANN. §§ 767-770, §§ 771-782). Not surprisingly, most of the powers and duties that are specified in the Probate Code relate to the management of the ward's estate.

It must be reiterated that the scope of the guardian's powers and duties will depend upon several factors, including the following:

- the incapacitated person's actual mental and physical limitations (or the extent of his or her capacity to perform the necessary tasks to care for himself or herself and to manage the individual's property) (TEX. PROB. CODE ANN. §§ 602, 693);
- whether the guardian has full or limited authority over the incapacitated person (TEX. PROB. CODE ANN. § 693(c)(3));
- whether the guardian has been appointed by the court as a guardian of the person or the estate, or of both (TEX. PROB. CODE ANN. § 693(a));
- "the specific powers, limitations, or duties of the guardian with respect to the care of the person or the management of the person's property by the guardian ...." as delineated in the court's order (TEX. PROB. CODE ANN. § 693(b)(2)); and
- if, when necessary, the court's order has specified "the amount of funds from the corpus of the person's estate [that it] ... will allow the guardian to expend for the education and maintenance of the person ... ." (TEX. PROB. CODE ANN. § 693(a)(3)).

A list of the possible powers and duties that a guardian may have is provided below. In reviewing this list, however, one must bear in mind that the powers and duties of a guardian are at a minimum subject to the first four criteria listed above and may be subject to further criteria. For example, there are certain powers that a guardian may only exercise upon application to and specific order of the court (See, e.g.,
TEX. PROB. CODE ANN. § 774). Therefore, the attorney must carefully review the Probate Code in determining not only which powers and duties a guardian should have, but also in determining which powers and duties a guardian may be granted under the law. Moreover, some of the powers and duties listed below are mutually inconsistent, and thus cannot be granted to a single guardian with limited authority acting on behalf of only one incapacitated person. Furthermore, most incapacitated persons for whom the appointment of a guardian with limited authority is appropriate do not need the entire spectrum of protection suggested by this list. Finally, this list is not intended to be an exhaustive list of all the possible powers and duties that a guardian may have.

List of Possible Powers and Duties of a Guardian

- The right to have physical possession of the ward and to establish the ward's legal domicile. (TEX. PROB. CODE ANN. § 767(1)).
- The duty of care, control, and protection of the ward. (TEX. PROB. CODE ANN. § 767(2)).
- The duty to provide the ward with clothing, food, medical care, and shelter. (TEX. PROB. CODE ANN. § 767(3)).
- The power and authority to consent to medical, psychiatric, and surgical treatment other than the inpatient psychiatric commitment of the ward. (TEX. PROB. CODE ANN. § 767(4)).
- The power and authority to possess and manage the property of the ward. (TEX. PROB. CODE ANN. § 768).
- The power and authority to collect debts, rentals, or claims that are due to the ward. (TEX. PROB. CODE ANN. § 768).
- The power and authority to enforce all obligations in favor of the ward, and to bring and defend suits by or against the ward. (TEX. PROB. CODE ANN. § 768).
- The duty to take care of and manage the estate as a prudent person would manage the person's own property. (TEX. PROB. CODE ANN. § 768).
- The duty to account for all rents, profits, and revenues that the estate would have produced under prudent management. (TEX. PROB. CODE ANN. § 768).
- The power and authority to expend funds for the care, maintenance, and education of the incapacitated person. (TEX. PROB. CODE ANN. § 770(a) & 776(a)).
- The power and authority to receive and administer funds that are due the ward from a governmental source. (TEX. PROB. CODE ANN. § 782(a)). (See generally TEX. PROB. CODE ANN. §§ 767-782).

2. "Voluntary" Admission to Residential Facilities

The law states that "[a] guardian may apply for residential care and services provided by a public or private facility on behalf of an incapacitated person who has decision-making ability if the person agrees to be placed in the facility." (TEX. PROB. CODE ANN. § 770(a)). Thus, a guardian can only place a ward in a residential facility if the ward is able and willing to give his or her consent to admission. Furthermore, the law strictly states that "a guardian may not voluntarily admit an incapacitated person to a public or private in-patient psychiatric facility or to a residential facility operated by the Texas Department of Mental Health and Mental Retardation for care and treatment." (TEX. PROB. CODE ANN. § 770(b)).

"If care and treatment in a psychiatric or a residential facility are necessary, the person or the person's guardian may apply for services under . . . [various provisions of the] Health and Safety Code, or apply to a court to commit the person [under various provisions of the Health and Safety Code]." (TEX. PROB. CODE ANN. § 770(b)).

The law also provides for voluntary admission to a residential care facility for emergency care or respite care under various provisions of the Health and Safety Code. (TEX. PROB. CODE ANN. § 770(d)).

Furthermore, the law also provides that "[a] guardian of a person younger than 16 years of age may voluntarily admit an incapacitated person to a public or
private in-patient psychiatric facility for care and treatment." (TEX. PROB. CODE ANN. § 770(c)).

3. Limitations on a Guardian's Power
   In addition to the fact that a guardian may only exercise the specific powers and duties delineated in the court's order by which the appointment was made, a guardian may not exercise those powers specifically prohibited under the Probate Code (see, e.g., TEX. PROB. CODE ANN. § 770(b)). Moreover, there are also other powers not explicitly mentioned in the Probate Code that a guardian may not or should not exercise.

a. Marriage
   Most persons with disabilities are able to meet the requirements of legally adequate consent. However, for those incapacitated persons who are unable to give legally adequate consent, certain questions arise as to whether a guardian may give consent on behalf of the ward when consent is required in certain situations.

   Nevertheless, because a guardian is only allowed to exercise those powers that have been specifically granted by court order, including the power to consent, in most cases it will be obvious that a guardian cannot consent to marriage on behalf of the ward. (See Advocacy, Inc.'s handouts on Legally Adequate Consent and Guardianship for Texans with Disabilities).

   Furthermore, the Probate Code specifically states that "[a]n incapacitated person for whom a guardian is appointed retains all legal and civil rights and powers except those designated by court order as legal disabilities by virtue of having been specifically granted to the guardian." (TEX. PROB. CODE ANN. § 675).

b. Sterilization, Abortion, and Non-therapeutic Surgery
   (1) Sterilization
     Under Texas law, a guardian, whether with full or limited authority, does not have the authority to consent to a non-medically necessary sterilization. Furthermore, under Texas law, a judge cannot give a guardian the power to consent to sterilization for an incapacitated person if the sterilization is not medically necessary. Nor may parents of minor children consent to sterilization, unless the procedure is medically necessary. (See TEX. FAM. CODE ANN. § 151.001).

   In a 1969 Texas case, the Houston Court of Civil Appeals held that any order of a county probate court authorizing a guardian to consent to a sterilization not medically or physically necessary to preserve the incapacitated person's health would be "in excess of the power delegated by the statutes of Texas and would be invalid." (Frazier v. Levi, 440 S.W.2d 393, 395 (Tex. Civ. App.--Houston [1st Dist.] 1969, no writ)).

   Although the Frazier decision has not been specifically overruled, the supreme courts of other states have rendered significant decisions regarding the authority of a court to authorize sterilization of an individual with mental retardation and the standards for trial courts for authorizing such procedures. It is, therefore, possible that the Texas courts may overrule Frazier in the future. However, even if Frazier were overruled, the authority to authorize a sterilization would most likely lie with the court and not with the guardian.

   For more information about sterilization, see the Advocacy, Inc., handouts on Sterilization of Persons with Mental Disabilities and Legally Adequate Consent.

   (2) Medically-Necessary Procedures Resulting in Sterilization
     The Probate Code explicitly states that a guardian of the person has "the power to consent to medical, psychiatric, and surgical treatment .... " (TEX. PROB. CODE ANN. § 767(4)). This would presumably include medically-necessary procedures that result in sterilization.

     Whereas the usual sterilization procedure is performed for the sole purpose of birth control or sanitation, a medically-necessary procedure resulting in sterilization involves something that is required for the patient's health and one of the side effects or consequences of the medically-necessary procedure is sterilization (e.g., a medically-necessary hysterectomy for the treatment of cervical cancer). Under such circumstances, the medically-necessary procedure resulting in sterilization is properly referred to as "medical treatment," whereas sterilization for the sole purpose of birth control or sanitation is arguably not a form of medical treatment per se.

   (3) Abortion
     Generally, the same issues that arise with respect to a guardian's authority vis-à-vis sterilization arise with respect to abortion, and the same principles are probably applicable to both situations. Furthermore, the right to terminate a pregnancy has been recognized as a fundamental constitutional right, and thus can
arguably only be exercised by the woman herself--and not by a guardian.

However, in view of the fact that Frazier may be overruled and in view of the fact that abortion is less medically intrusive than sterilization (in the sense that it does not have an irreversible effect on a woman's ability to conceive), it is possible that Texas courts may in the future authorize abortion. However, even if Frazier is overruled and abortion is authorized in the future, a court order will most likely be necessary, and the guardian's present authority under the Probate Code to consent to medical treatment would not extend to abortions that are not medically necessary for treating the ward.

(4) Non-therapeutic Surgery
(a) Cosmetic surgery
There is no provision in the Probate Code that grants a guardian the authority to consent to cosmetic surgery that is not medically necessary.

(b) Procedures Designed to Benefit Another
In Little v. Little, 576 S.W.2d 493 (Tex. Civ. App.--San Antonio 1979, no writ), the court of appeals affirmed an order authorizing a guardian to consent to the removal of a kidney from a minor with mental retardation for the purpose of transplanting the kidney into the body of her brother. However, the court strictly limited its decision to the particular facts and circumstances presented in the case.

A guardian should definitely apply for a court order before consenting to any surgery or other medical procedure to be performed on the ward for the benefit of another. Moreover, the chances of obtaining such an order will in most likelihood be highly dependent on the existence of very restricted and unusual circumstances.

III. ALTERNATIVES TO PERMANENT GUARDIANSHIP
This section explores several alternatives to permanent guardianship that the attorney may wish to consider. For example, under certain circumstances, the appointment of a temporary guardian may be more appropriate and all that is required for a particular individual. Furthermore, if a guardianship of the estate is all that is necessary, the attorney should consider the possibility of establishing a trust for the incapacitated person's benefit. This section also considers the device of a durable power of attorney, surrogate decision-makers, the use of insurers and guarantors, and the designation of a representative payee for the receipt of Supplemental Security Income benefits.

A. Temporary Guardianship (TEX. PROB. CODE ANN. § 875-879)
The appointment of a temporary guardian under Section 875 of the Probate Code may serve as a viable alternative in situations in which there is an immediate, but only temporary, need for the appointment of a guardian. (TEX. PROB. CODE ANN. § 875).

The court may appoint a temporary guardian if it "is presented with substantial evidence that a person may be a minor or other incapacitated person, and the court has probable cause to believe that the person or person's estate, or both, requires the immediate appointment of a guardian . . . ." (TEX. PROB. CODE ANN. § 875(a)). A temporary guardianship may only be created in situations in which there is an imminent danger to the person or property. (TEX. PROB. CODE ANN. § 875(c)). The powers of the temporary guardian are limited "as the circumstances of the case require." (TEX. PROB. CODE ANN. § 875(a)); see also TEX. PROB. CODE ANN. §§ 876-879.

"A sworn written application for the appointment of a temporary guardian may be filed before the court appoints a temporary guardian. The application must be filed not later than the end of the next business day of the court after the date of appointment of the temporary guardian." (TEX. PROB. CODE ANN. § 875(c)). The application must contain certain information identifying the person who is the subject of the guardianship proceeding and the proposed temporary guardian, as well as the alleged imminent danger to the person or property. Id.

A hearing must "be held not later than the 10th day after the date of the filing of the application," except under special circumstances as specifically provided by law. (TEX. PROB. CODE ANN. § 875(f)(1)).

The court must "appoint an attorney to represent the proposed ward in all guardianship proceedings in which independent counsel has not been retained by or on behalf of the proposed ward." (TEX. PROB. CODE ANN. § 875(d)).

"[A] temporary guardianship may not remain in effect for more than 60 days," unless it is challenged or contested, in which case the court-appointed guardianship will expire upon either 60 days or the conclusion of the hearing or on the date a permanent guardian the court appoints for the proposed ward qualifies to serve as the ward's guardian. (TEX. PROB.
CODE ANN. § 875(h) & (k)).

Note that "[t]he court may not customarily or ordinarily appoint the Texas Department of Protective and Regulatory Services as a temporary guardian . . . . The appointment of the department as a temporary guardian . . . should be made only as a last resort." (TEX. PROB. CODE ANN. § 875(j)).

Finally, it should be reiterated that while the law provides for the creation of temporary guardianships for incapacitated persons, "[a] person for whom a temporary guardian has been appointed may not be presumed to be incapacitated." (TEX. PROB. CODE ANN. § 875(b)). (See also Advocacy, Inc.’s handout on Guardianship for Texans with Disabilities.)

B. Trusts (TEX. PROB. CODE ANN. §§ 867-873; TEX. HEALTH & SAFETY CODE ANN. § 552.018)

If a guardianship of the estate is desired for an incapacitated person, the attorney should investigate the alternative possibility of establishing a trust. The cost, flexibility, additional powers of trustees, and other advantages of trusts make them attractive alternatives to guardianship.

In addition, even if a guardian has been appointed, there may be reasons for creating a trust for the ward's benefit. Section 867 of the Probate Code provides for the creation of a trust for the management of guardianship funds. (See TEX. PROB. CODE ANN. §§ 867-873).

For persons admitted to state hospitals under the management and control of the Texas Department of Mental Health and Mental Retardation, there is a significant provision in the Texas Health & Safety Code that operates to shelter trust assets from state claims against their estates for the cost of their support and maintenance. The law states in pertinent part:

If a client only needs someone to act on his or her behalf with respect to property and financial matters, a durable power of attorney may be executed pursuant to Chapter XII of the Probate Code. (TEX. PROB. CODE ANN. § 481 et seq.). Although the individual who executes this type of instrument must have capacity at the time it is signed, he or she can designate whether it is effective immediately or becomes effective upon his or her subsequent disability or incapacity. (TEX. PROB. CODE ANN. § 490(a)).

Note that the appointment of a guardian of the estate serves to terminate this type of durable power of attorney. (TEX. PROB. CODE ANN. § 485).

D. Durable Power of Attorney for Health Care

Chapter 166 of the Health and Safety Code provides for the execution of a durable power of attorney for health care. (TEX. HEALTH & SAFETY CODE ANN. § 166.151 et seq.). It allows another person to make health care decisions for an individual who could do so but for his or her incapacity.

Note that the agent may not consent to certain health-related decisions, including: (1) voluntary inpatient mental health services; (2) convulsive treatment; (3) psychosurgery; and (4) abortion. (TEX. HEALTH & SAFETY CODE ANN. § 166.152(f)).

This type of durable power of attorney takes effect only if the individual who executes it becomes unable to make his or her own health care decisions and this fact is certified in writing by his or her physician. (TEX. HEALTH & SAFETY CODE ANN. § 166.152)

Finally, with this type of durable power of attorney, the court determines whether the appointment of a guardian has an effect on the authority of the agent. (TEX. HEALTH & SAFETY CODE ANN. § 166.152)

E. Surrogate Consent for Persons in Hospitals or Nursing Homes (TEX. HEALTH & SAFETY CODE ANN. § 597.021)

Under the Consent to Medical Treatment Act, an adult surrogate who has decision-making capacity may
consent to medical treatment on behalf of an incapacitated person who is in a hospital or nursing home licensed under Chapters 241 and 242 respectively. The list of possible persons who may act as such surrogates includes close relatives, clergy, and anyone identified by the individual before he or she became incapacitated to act on his or her behalf in the event he or she were to become incapacitated. The surrogate decision-maker may not consent to certain health related procedures, including voluntary inpatient mental health services and electro-convulsive treatment.

F. Surrogate Consent for ICF-MR Clients (TEX. HEALTH & SAFETY CODE ANN. § 597.021)

For persons with mental retardation who receive care in intermediate care facilities and who lack the capacity to make major medical or dental treatment decisions, an adult surrogate with decision-making capacity may consent on behalf of the client. The law provides a specific list of persons who may serve as a surrogate in these types of situations, all of whom must be actively involved and related to the patient. (TEX. HEALTH & SAFETY CODE ANN. § 597.021). In the absence of an actively involved relative, a treatment decision may be made by a surrogate consent committee established pursuant to law. (TEX. HEALTH & SAFETY CODE ANN. § 597.042-597.046)

IV. LEGALLY ADEQUATE CONSENT (TEX. HEALTH & SAFETY CODE ANN. § 597.041 et seq.)

In general, adults with disabilities have the right to control their own lives and make their own decisions. They must give consent to have limitations placed on their activities, or to participate in events that involve risk. For example, consent is necessary for medical operations or in order to participate in a program or activity.

On the other hand, a minor child (under the age of 18 years) usually cannot legally give her own consent. Therefore, the child's parent or guardian must consent for her. For example, parent's consent may be needed before a minor child can participate in a school outing. But once a child becomes an adult, the law presumes that she is able to give her own consent when it is needed. This presumption applies to all adults, including those with mental retardation, mental illness, and other disabilities. It does not matter whether an adult is actually able to make good decisions or not. Unless state law provides otherwise, an adult will have the legal right to make all of her own decisions until a judge rules that the adult is not able to give her own consent and appoints a guardian. If there is no guardian and no special state law granting someone other than a guardian the right to give consent, and the person with a disability is unable to give consent, no one will be able to consent on behalf of the person with a disability.

Several state laws address situations where there is no guardian, consent to major medical or dental treatment is needed, and the person with a disability is unable to consent. These laws, which address consent to medical procedures for adult residents of Intermediate Care Facilities for the Mentally Retarded (ICFs-MR), nursing homes, and hospital patients are summarized at the end of this section.

V. THE REQUIREMENTS OF "LEGALLY ADEQUATE CONSENT"

There are three general requirements for legally adequate consent: Legal Capacity, Information and Understanding, and Voluntariness.

A. Legal Capacity

The person giving the consent must have legal capacity in order for the consent to be valid. A person has legal capacity to give consent if he or she:

- Is over the minimum legal age (usually, age 18) AND
- has not had a guardian appointed by a court to handle her personal affairs or no previous guardianship is in effect.

B. Information and Understanding

In order for the consent to be valid, the person giving the consent must be told and must understand:

- the nature, purpose, consequences, risks, benefits of, and alternatives to the procedure for which legally adequate consent is needed; AND
- that refusing or taking away the consent will not risk future care and services.

Note that a person who does not speak English will be unable to give legally adequate consent unless the above information is provided in his or her native language.
C. Voluntariness

The last requirement of legally adequate consent is that the consent be given voluntarily. This means that the person gives his or her consent freely, and not because he or she is forced or pressured into it.

Note that a person does not need to be able to talk, read, or write to give legally adequate consent, so long as the above requirements are met and the person can communicate his or her consent.

VI. WHEN "LEGALLY ADEQUATE CONSENT" IS REQUIRED

Persons with mental retardation, mental illness, or any other disability have the same fundamental rights as others. Therefore, they must consent in all cases where consent would be required of a person who does not have a disability. State law gives some specifics about when a person with a disability must consent to services.

The Texas Persons with Mental Retardation Act (MRPA) requires that consent be obtained in a number of specific situations.

Legally adequate consent is required before a person with mental retardation may participate in a program or activity where consent would be required for a person who does not have mental retardation (for example, an alcohol or drug abuse program, or a program of behavior treatment employing aversive procedures).

Legally adequate consent is required before a person with mental retardation is admitted voluntarily for 24-hour residential care at a state school, state center, or community MHMR center. If consent cannot be obtained, the individual will have to be court-committed.

Legally adequate consent is required before a person with mental retardation may receive a determination of mental retardation, or (2) admitted voluntarily to nonresidential mental retardation services (such as a self-help skills program, a sheltered workshop program, or a money management program) at a state school, state center, or community MHMR center. However, if TDMHMR or a community MHMR center has made and documented all reasonable efforts to obtain legally adequate consent and cannot secure consent, both the determination of mental retardation and nonresidential mental retardation services can be provided without legally adequate consent. Although the law is not yet clear on this point, it seems that a state school or community center could also apply this provision and arrange for contract services (for example, through an ICF-MR or surrogate family home) to be provided to a person with mental retardation who could not consent.

Legally adequate consent is required before a voluntary resident of a state school, state center, or a community MHMR center may receive non-emergency medical or dental treatment. However, if medical treatment is needed by a resident of a TDMHMR facility and the parent of a minor or the guardian cannot be reached or fails to respond, TDMHMR can order the needed medical treatment upon the advice and consent of three (3) physicians. Dental services can be ordered upon the advice and consent of one dentist and two (2) physicians.

Legally adequate consent is required before a court-committed client in a state school, state center, or community MHMR center receives surgery. The MRPA authorizes medical care for clients in residential care facilities (which includes state schools, state centers, and community center operated facilities, but does not include privately operated ICF-MR or other facilities) without the need for obtaining consent, except for surgical procedures. This means that a state school, state center, or community MHMR center facility may provide medical care and treatment of a person with mental retardation even if that person or his or her parent (if a minor) or guardian objects to the medical care and treatment. However, surgical procedures may only be performed with consent. If the person who must consent cannot be located or fails to respond to a request for consent, clients of TDMHMR may be provided consent under the advice and permission of three (3) physicians or a dentist and two (2) physicians as discussed above. A state school or community center that wishes to perform surgery against the wishes of a guardian must obtain a specific court order authorizing the surgery.

Legally adequate consent is required before the contents of the records of the identity, diagnosis, evaluation, or treatment of the person with mental retardation may be shown to other persons. For more information, see Advocacy, Inc.’s handout Confidentiality of Mental Health and Mental Retardation Records.
VII. SPECIAL PROVISIONS FOR OBTAINING CONSENT FROM RESIDENTS OF ICFs-MR

In 1993, the Texas Legislature passed a special law that allows for surrogate decision-makers for some residents of ICFs-MR, nursing homes, and hospitals. TEX. HEALTH & SAFETY CODE ANN. § 597.041 et seq. If the ICF-MR determines that a resident of a community-based ICF-MR lacks the capacity to make a major medical or dental treatment decision, and is an adult who has no guardian or is under age 18 and has no parent, guardian, or managing or possessory conservator, an adult surrogate may consent on behalf of the resident. The surrogate decision-maker must have decision-making capacity and be willing to consent on behalf of the client. Consent given by the surrogate is valid and competent to the same extent as if it were given by the person with a disability. The surrogate must be chosen from the following list, in order of descending preference:

- an actively involved spouse;
- an actively involved adult child who has the waiver and consent of all other actively involved adult children of the client to act as the sole decision-maker;
- an actively involved parent or stepparent;
- an actively involved adult sibling who has the waiver and consent of all other actively involved adult siblings of the client to act as the sole decision-maker;
- any other actively involved adult relative who has the waiver and consent of all other actively involved adult relatives of the client to act as the sole decision-maker.

Surrogate decision-makers may not consent to experimental research, abortion, sterilization, electroconvulsive treatment, or management of client finances. If no guardian or surrogate decision-maker is available, TDMHMR must establish and maintain a list of individuals qualified to serve on a surrogate consent committee, to consist of three (3) to five (5) members. This committee (like the surrogate) may consent to major medical or dental treatment, psychoactive medication, or a highly restrictive procedure. Consent is based upon consensus of the committee members. Detailed requirements govern how the committee is established and how the committee functions. The committee's decision may be appealed to court.

Similar criteria are followed for the selection of a surrogate decision-maker for an adult patient in a hospital or nursing home who is comatose, who lacks the ability to understand and appreciate the nature and consequences of a treatment decision, or who is otherwise mentally or physically incapable of communication. This surrogate decision-maker may consent, on behalf of the patient, to medical treatment except for voluntary inpatient mental health services, electroconvulsive treatment, or a decision to withhold or withdraw life-sustaining treatment. TEX. HEALTH & SAFETY CODE ANN. § 313.001 et seq.

1 These provisions also apply to nursing facilities and state hospitals.
PART II - MENTAL ILLNESS

I. THE COMMITMENT PROCESS

Whenever an individual is held for psychiatric evaluation against that individual’s will for longer than 24 hours, he or she has the right to a court hearing. If the 24-hour detention period ends on a weekend or holiday, the individual must be released by 4 p.m. on the next business day, unless court papers are filed.

As part of the commitment process, the court must also find that the individual cannot receive the treatment needed in a less restrictive manner. This means that the individual has the right to treatment in a place that restricts his or her day-to-day life only as much as is necessary to protect and care for the individual and others around the individual. It also means that the type of treatment given to the individual is treatment which interferes as little as possible with the individual’s thinking, with taking care of personal needs, or with ability to work.

In determining where the individual should receive care, the law requires that the court, except in emergencies, consider the recommendation of a community mental health center regarding available appropriate alternatives to commitment at a state hospital.

A. Types of Commitment Hearings

1. Order of Protective Custody

This is a 14-day commitment. A hearing, called a probable cause hearing, must be held within seventy-two (72) hours from the time an individual is admitted to the hospital, or if the seventy (72) hours end on a weekend or holiday, on the next business day. The state must show that they have good reason (probable cause) to believe that an individual is mentally ill and that there is a substantial risk that the individual will seriously harm himself or herself or someone else if he or she is not confined. Only one physician must examine the individual and tell the judge why he or she believes that the individual needs to be hospitalized. If the judge decides that the individual should be hospitalized, the judge may order the individual to stay in the hospital up to fourteen (14) days.

2. Temporary Commitment

This is a commitment for up to ninety (90) days. A hearing must be held within fourteen (14) days from the time an individual is admitted to the hospital. Certificates signed by two doctors stating that they have examined the individual within thirty (30) days and saying why they believe that the individual should be hospitalized are necessary for this hearing. The doctors who sign the certificates are often not the ones who testify at the individual’s hearing. If the judge agrees with the doctors, the judge may order the individual to stay in the hospital for up to ninety (90) days. The individual has the right to a jury trial.

3. Extended Commitment

This is a 12-month commitment. An individual may only be committed on an extended commitment if he or she has received court-ordered in-patient treatment for sixty (60) days in a row during the past twelve (12) months. The individual will have a jury trial unless the individual or his or her attorney decides one is not wanted and waives this right in writing.

If this is the individual’s first extended commitment, at least one doctor must testify in person at this hearing that the condition for which the individual needs hospitalization will continue for more than ninety (90) days. If the judge or jury agrees, the individual will have to stay in the hospital for up to twelve (12) months. At the end of that twelve (12) months, if the individual’s doctor thinks he or she still needs to be in the hospital, the doctor can file papers with the court, and a hearing will be held. If the individual meets the commitment criteria, the court can commit the individual for another twelve (12) months.

Whether the individual is committed on an order of protective custody, or a temporary or extended commitment, the hospital has the right to discharge the individual at any time that the individual’s treatment team determines that the individual no longer needs court-ordered services.

4. Emergency Commitment for Persons With Mental Illness

An individual may be picked up and detained in two ways: either a judge can order a police officer to take him or her to a mental health facility, or a police officer can detain the individual and take him or her to an appropriate mental health facility without a judge's order or warrant. The decision to detain the individual on an emergency basis must be based on either personal observation or another person’s observation of the individual’s recent behavior that makes them believe that the individual is mentally ill and that poses a substantial and imminent threat to either his or her safety or someone else's safety. Examples of this kind of behavior include attempting suicide, striking another person, or a recent pattern of severe emotional
distress.

When the police pick up the individual, they must take the individual immediately to the nearest appropriate mental health facility. The individual may be placed in the nearest appropriate mental health facility unless there is none available. If there is none available, then the individual may be placed in an alternative approved facility.

Only in an extreme emergency can an individual be put in a jail, or any other nonmedical facility. If the individual is put there, he or she must be kept separate from people who have been charged or convicted of a crime.

An individual has the following rights after having been taken to a facility for emergency commitment:

- He or she must be examined by a doctor as soon as possible and, in any event, within twenty-four (24) hours after being picked up, regardless of what facility the individual has been placed in.

- He or she can only be admitted to the facility if the doctor who examines the individual determines that he or she is mentally ill and poses a substantial and imminent threat to himself or herself or others, and emergency detention is the least restrictive way to restrain the individual from harm.

Within twenty-four (24) hours after an individual has been admitted to the mental health facility, he or she must be told, orally and in writing, in the language best understood by the individual, or if the individual is hearing or visually impaired, in the way he or she communicates best, the following rights:

- The individual must be told where he or she is and why he or she has been detained.

- The individual must be told that this emergency detention could turn into a longer commitment if an involuntary commitment proceeding is begun. (See Advocacy, Incorporated's handout, The Commitment Process Under The Texas Mental Health Code.)

- The individual must be allowed to find an attorney of his or her choice and to talk with that attorney.

- The individual must be told that anything he or she says or how he or she acts while in the facility may be used by the judge in further proceedings, such as involuntary commitment, to decide if and how long the individual needs to stay in the facility.

- The individual must be allowed to leave the facility immediately unless the examining doctor finds that the individual is mentally ill and that he or she poses a substantial and imminent danger to himself or herself or others, and that the individual cannot be treated in a less restrictive manner.

- The individual must be told that he or she will not be allowed to leave the facility if the examining doctor decides that the individual is mentally ill and poses a substantial and imminent danger to himself or herself or others, and that the individual cannot be treated in a less restrictive manner.

- Whenever the individual is released from emergency commitment, the facility must arrange, at no charge to the individual, to take the individual back to where he or she was picked up, or to his or her home in Texas, or to another suitable place.

- If the individual is a minor or if the individual has a guardian, information about these rights must be also given to the individual’s parent or guardian.

B. The Individual Must Be Told About His or Her Rights

The individual must be informed of his or her rights in writing, and someone must explain them by speaking to the individual within 24 hours after arrival at the hospital.

1. Involuntary Commitments and Hearing Rights

Before an individual can be involuntarily confined to a hospital for more than 24 hours, the individual has the right to:

- have a court-appointed attorney within 24 hours of admission to the hospital;
• hire a private attorney of his or her choice, at the individual’s own expense;

• know when the hearing will be as soon as the judge sets a date;

• request that the commitment hearing be delayed for up to 30 days from when the original application was filed, if the individual or his or her attorney needs more time to prepare the individual’s case;

• be present at his or her hearing(s);

• testify at his or her hearing(s);

• cross-examine witnesses at his or her hearing(s);

• have language or sign interpreters to help the individual talk to his or her attorney and the judge;

• ask the court in its discretion to authorize the cost of an independent psychiatrist for his or her defense;

• have his or her case heard by a judge who is an attorney;

• have the hearing recorded by a court reporter;

• have the hearing held at a place that will not scare the individual or make him or her feel bad;

• have the hearing held at the courthouse;

• request a closed hearing so that only the judge, the attorneys for both sides and the people who will testify stay in the hearing room. However, it is up to the judge to decide whether or not to give an individual a closed hearing. If having a lot of people in the room scares the individual or makes him or her too embarrassed to talk to the judge, then ask for a closed hearing.

• have a jury hear the individual’s case if the state is trying to commit the individual on a 90-day temporary commitment. For a 12-month extended commitment, the individual’s attorney can waive the individual’s right to a jury if the attorney explains to the judge on the record the reason a jury trial is being waived).

### a. Attorney responsibilities at commitment hearings

The attorney is required by law to:

• talk to the individual;

• look at the individual’s records;

• contact witnesses before the day of the hearing so that he or she will have enough time to prepare the individual’s case;

• find out what the individual wants and represent his or her point of view. For example, an individual may not want to stay in the hospital or does not agree with the prescribed treatment;

• explore treatment alternatives that might be available to the individual and present them to the judge, and advocate for the least restrictive alternative, if the individual so desires;

• explain the legal consequences of each choice the individual makes.

It is also good legal practice for the individual’s attorney to:

• explain what is going to happen at the hearing;

• explain what the other side is likely to ask the individual;

• explain what choices the individual may be offered at the hearing.

### b. What may happen at the hearing?

• Most hearings are held at the hospital.
• The individual will sit at a table with the judge, the attorneys for the state, and the individual’s attorney.

• The state will call witnesses to testify about why the individual needs to be hospitalized. Doctors, social workers, and other hospital workers may give their opinion about the individual’s condition. Family members may also talk about any recent incidents that made them believe the individual should be in the hospital.

c. Commitment hearing outcomes
Depending upon the type of hearing, the judge may:

• discharge the individual;

• hold the individual for 14 days in the hospital if probable cause is shown (Order of Protective Custody);

• commit the individual for 90 days to the hospital (Temporary Commitment);

• commit the individual for 12 months to the hospital (Extended Commitment);

• commit the individual to an out-patient program.

• If an individual is committed to out-patient services, the judge will tell the head of the community mental health program to provide mental health services for the individual. This person must tell the judge if the individual does not do the things that he or she has been ordered. The judge may then call a new hearing to decide if the individual should go to a hospital.

d. Appeals
When the individual does not agree with the judge’s order, the individual or his or her attorney may:

• file a written appeal of the judge’s decision within ten (10) days of the date that the order was signed;

• request a rehearing or a modification of the commitment order;

• file a written petition for habeas corpus.

C. Rights of Individuals When They Are Involuntarily Committed for Mental Health Services

1. Rights That Cannot Be Restricted
The individual has fundamental rights that commitment does not abrogate. These rights include the following:

• The right to treatment in the least restrictive appropriate setting. This means the individual has the right to treatment in a place that restricts his or her day-to-day life only as much as is necessary to protect the individual and others around the individual. It also means that the individual’s treatment should interfere as little as possible with his or her thinking, with taking care of personal needs, or with ability to work.

• The right to a humane treatment environment that is clean and safe where the individual won’t be harmed.

• The right to proper mental health and medical treatment.

• The right to an independent evaluation by another doctor of the individual’s choice, as long as the individual pays the cost.

• The right to enough privacy for the individual’s personal needs, as long as this does not place the individual or other people in danger.

• The right to be told about his or her rights within one (1) day (24 hours) of the individual’s admission to the facility. The individual must be told about these rights both orally and in writing, in the language the individual understands best. If the individual is hearing or vision impaired, these rights must be communicated to the individual in the way he or she understands best. If the individual is a minor, or if the individual has a guardian, information about these rights must
also be given to the individual’s parent or guardian.

- The right to a written individual treatment plan based on the individual’s own needs that describes the individual’s diagnosis, specific problems and specific needs. It must also contain a description of the short-term and long-term treatment goals, and a projected timetable for their attainment. Individual staff responsibility must be stated, and criteria needed for release to a less restrictive environment must also be stated. The plan must be reviewed on a regular basis to make sure it is the best way to help the individual.

- The right to participate in the development of his or her treatment plan, if the individual wants to participate. If the individual is under 16 years old, or if the individual has a guardian, the individual’s parent or guardian can also participate in developing the treatment plan.

- The right to information about the medications the individual’s doctor has prescribed, including the name of the medication, the dosage and schedule, the type of medication, the benefits expected from that type of medication, and the side effects and risks of the medication.

- The right to refuse to be a part of a research program. The individual does not have to agree to try new, experimental drugs or treatment.

- The right to be informed, in writing, at admissions and discharges of Advocacy, Inc.’s address and telephone number.

- The right to send and receive uncensored mail.

- The right to find a lawyer to represent himself or herself, and the right to talk with and to write to the individual’s lawyer.

- The right to have the individual’s family notified of the individual’s discharge, if the individual wants them to know.

- The right to refuse electroconvulsive therapy (ECT). However, if the individual is sixteen (16) years old or older, and a judge has decided that the individual is incompetent, then the individual’s guardian can consent to ECT but only if the individual would have agreed to the treatment if the individual were not incompetent. If the individual is under sixteen (16) years of age, ECT may not be used under any circumstances.

- If the individual has made an Advanced Directive (see Advocacy, Inc.’s handout, How to Make an Advanced Directive) and included information about ECT, the Advanced Directive must be followed when the individual becomes incompetent, regardless of what the individual’s guardian may desire.

- The right to have treatment records kept confidential, unless the individual signs a release or files a lawsuit, or the court orders release of the individual’s records.

- All family rights including the right to marry and have children (unless a judge has taken custody of the individual’s children away from the individual, the individual can still make decisions for his or her children).

- The right to give consent or refuse to give consent to treatment with medication. If the individual refuses to consent to medication and the individual is in a state hospital, the law says that the individual cannot be forced to take medication unless the hospital gets a court order, or the individual is having a medication-related emergency. A medication-related emergency is a situation in which it is immediately necessary to administer medication to a patient to prevent immediate and serious harm to the patient or someone else because of the patient’s actions or threats. The doctor must petition the court to order the medication, and the medication can only be ordered after a
hearing. The individual has the right to be present at the hearing and to be represented by an attorney at the hearing, at no cost to the individual. If the judge orders the medication, the individual can be required to take it.

2. Rights That Can Be Restricted Only by a Doctor or Treatment Team

The individual’s doctor or treatment team can restrict some of the individual’s rights while he or she is receiving involuntary mental health services in a mental health facility:

Only the individual’s doctor can order that physical restraints be used on the individual. If restraints are ordered, they must be taken off as soon as possible. Anytime physical restraints are used, it must be noted in the individual’s treatment record by the individual’s doctor.

The individual has the following rights, unless the individual’s doctor states in the individual’s record that the individual can’t have these rights:

- The right to wear the individual’s own clothes and use his or her personal belongings.

- The right to have visitors in the facility, to talk by telephone, or to write to people outside the facility. The individual’s letters must not be opened, read, or changed by anyone in the facility unless the individual wants them to be. The doctor can sometimes limit the individual’s right to have visitors and to write and talk with other people if the reasons for limiting these rights are put in the individual’s treatment record. Even if the doctor does set limits, the individual always has the right to talk confidentially with and to write confidentially to a lawyer who has agreed to represent him or her.

- The right to socialize with others, including the opposite sex; but the individual’s doctor may order these activities to be supervised.

- The right to physical activity and grounds privileges.

- The right, when the individual is discharged, to a plan for the individual’s continued treatment (if the individual needs continued treatment) that covers both the individual’s mental health and physical needs. The individual has the right to refuse the services in this plan, unless a judge says the individual does not have this right.

D. Rights of Individuals Receiving Voluntary Inpatient Mental Health Services

- The right to ask the individual’s treatment team to decide if he or she needs to stay at the facility or if he or she is ready to leave.

- The right to leave the facility within ninety-six (96) hours after the individual signs a written request to leave, unless the hospital files an involuntary commitment application.

- Nobody can ask a judge to order the individual to stay at a facility while the individual is a voluntary patient, except for two reasons:

- First, the doctor can ask for court-ordered mental health services if he or she thinks the individual needs to be committed. A judge may decide that the individual needs to be committed because the individual will hurt himself or herself or others if the individual is not committed. The judge may also decide that the individual needs to be committed if the individual’s doctor believes that the individual will suffer distress and become unable to take care of himself or herself if he or she is not committed.

- Second, the doctor can ask for court-ordered mental health services if the individual refuses necessary treatment, or if the individual is not able to agree to treatment and the individual’s doctor thinks that the individual needs treatment. The judge may commit the individual if the individual is likely to hurt himself or herself or others if he or she is committed. The judge may also commit the individual if the individual’s doctor testifies that he or she believes that the individual will suffer distress and become unable to take care of himself or herself if he or she is not committed.
• When the hospital decides the individual is ready to be discharged, the individual can decide if he or she wants the staff to tell the individual’s family the date of the individual’s discharge. If the individual does, the staff will contact the individual’s family. If the individual does not agree that the staff can tell his or her family that the individual is being discharged, the staff cannot do so.

If the individual believes one of his or her rights has been violated, the individual should contact his or her treatment team, the facility’s Consumer Rights Officer, TDMHMR’s Office of Consumer Services and Rights Protection, or the Public Responsibility Committee. If the individual has a complaint of abuse or neglect, he or she should call the Texas Department of Protective and Regulatory Services at 1-800-252-5400.

E. The Right to Refuse Medication

The individual can refuse medication if the individual is in a hospital for psychiatric care (either a state facility or private psychiatric hospital) under an emergency commitment, a voluntary commitment, or under an order of protective custody.

The individual can be required to take medication under the following circumstances:

• There is an emergency because the individual’s recent behavior shows the individual is likely to hurt himself or herself or others; or

• The individual is under 16 years of age and the individual’s guardian or parent consents for the individual; or

• The individual is involuntarily committed under a 90-day commitment order and a judge decides the individual is likely to hurt himself or herself or others, cannot make this decision for himself or herself, and that the medication will help the individual get well.

The individual must be told certain information about the medication before he or she is given the medication. The individual must be told this information both orally and in writing, in the language the individual understand best, or if the individual is visually or mentally impaired, in the way he or she communicates best. If the individual has a guardian or is under 16 years old, then the individual’s guardian or parent must also be given this information. The individual must be told:

• What specific condition is being treated with the medication;

• How the medication will help the individual;

• What might happen to the individual’s mental health if he or she refuses the medication;

• Any significant side effects and risks the individual may have if the individual takes the medication;

• Any alternatives to taking the medication and why the doctor thinks they will not work as well for the individual;

• How long and how often the individual will be taking the medication; and

• If the individual decides to take the medication, that he or she can change his or her mind at any time.

If someone other than the prescribing doctor gives the individual the above information, the prescribing doctor must meet with the individual personally within two (2) days (excluding weekends and holidays) to answer the individual’s questions.

The individual also has the right to have an independent examination or evaluation by another doctor of the individual’s choice at the individual’s own cost. If the individual asks for an independent examination or evaluation, it must be arranged for the individual by the hospital.

Staff must note in the individual’s records whether the individual agrees to take the medication or not, or whether it is given to the individual under emergency conditions or under a judge’s order.

If the individual consents to take medication, the individual’s consent must be voluntary and given without feeling pressured to agree. If the individual has a guardian, the individual’s guardian can consent to the medication.

The individual cannot be forced to take medication unless it is an emergency. In a non-emergency situation, if the individual refuses medication, the
individual’s doctor must file an application with the court for an order authorizing the administration of medication. A hearing will be held.

1. Medication Hearing

The individual must be allowed to attend with an attorney—one will be appointed by the court, if necessary. The individual has the right to a court-appointed attorney; if the individual wishes to hire his or her own lawyer, the individual may do so.

The judge will determine if the individual lacks the capacity to make a decision about whether to take the medication, and if treatment with the medication is in the individual’s best interest.

The judge must also consider:

- the individual’s expressed preferences regarding treatment with psychoactive medication (if the individual has an advanced directive, the judge has to consider it. See Advocacy, Inc.’s handout regarding Advanced Directives);
- the individual’s religious beliefs;
- the risks and benefits, from the perspective of the patient, of taking psychoactive medication;
- the consequences to the individual if the psychoactive medication is not administered;
- The individual’s prognosis if the individual is treated with psychoactive medication; and
- alternatives to treatment with psychoactive medication.

After the judge makes a decision, the individual can appeal the decision.

2. If the Individual Is Required To Take Medication

If a judge has decided that the individual must take medication, the individual has to take it until the individual’s 90-day commitment order has ended. The individual’s doctor can increase or lower the dosage of the individual’s medication, and can give the individual another medication in the same class without additional approval from the court. But the class (or classes) of medication the individual has been ordered to take cannot be changed without a court order. The class (or classes) of medications approved by the court will be attached to the order.

F. Behavior Interventions Including Restraint and Seclusion in Mental Health Facilities

1. Voluntary Behavioral Interventions

During the individual’s stay in a mental health facility, there may be times when the individual needs assistance controlling his or her behavior. There are two forms of behavioral interventions that can be used when the individual begins to feel out of control or when the individual’s behavior is disruptive.

a. Quiet Time

Staff cannot force the individual to begin or end quiet time. The individual can end his or her quiet time whenever he or she wants to. Quiet time is used only when the individual feels as if he or she needs a place that is quiet and away from other people in order to either calm down or prevent the individual from getting angry or upset. The individual must ask staff if he or she can go to a safe place and stay there until he or she feels ready to interact with others again. If staff try to block the individual’s exit from the quiet time room or threaten the individual with restraint or seclusion or other consequences if the individual leaves the quiet time room, then this is no longer considered quiet time. Instead, it would be considered seclusion and the staff must follow the rules (explained below) regarding seclusion. If the individual’s doctor believes that the individual should not be alone for long periods of time, some restrictions can be placed on where the individual can go for quiet time.

b. Clinical Time Out

When the individuals feel out of control or the individual’s behavior is disruptive, staff can ask the individual to go to a safe place for clinical time out. The difference from quiet time is that the staff ask the individual to do it. No one can keep the individual from leaving the clinical time out area if the individual wants to. If anyone blocks the individual’s exit from the clinical time out area, then the individual is being secluded (see Seclusion and Restraint below). The individual does not have to agree to go into clinical time out and cannot be physically guided or pushed into it. If the individual is, then he or she is being secluded or restrained (see Seclusion and Restraint below). Clinical time out may not be used as a punishment, for the convenience of staff, or as a substitute for treatment.
For example, staff cannot ask the individual to take a clinical time out because there is not enough staff on the unit, or because the individual chooses not to go to classes, or because the individual chooses not to take his or her medications. Staff can request that the individual stay in clinical time out for up to thirty (30) minutes. After 30 minutes, the staff has to discuss the individual’s behavior with the individual to determine if he or she needs to continue clinical time out. Remember, the individual does not have to stay the full 30 minutes; he or she can leave at any time.

If the individual’s behavior is dangerous to himself or herself or someone else, quiet time and clinical time out may not work, but should be tried before more restrictive interventions are used.

2. Involuntary Behavioral Interventions
   a. Seclusion
      Seclusion is a place where there are no dangerous objects with which the individual can hurt himself or herself. It also has to be a place where the individual can be watched and cannot leave until he or she is no longer dangerous to himself or herself or others. The individual’s doctor will determine what changes the individual needs to make in the individual’s behavior in order to be released, and the doctor must tell the individual exactly what behaviors the individual must show in order to be released.

      Once the individual is placed in seclusion, the individual must be watched by a staff member who is of the individual’s same sex, unless the individual has a good reason to want someone of the opposite sex. They are required to check on the individual at least every 15 minutes. If the individual is given emergency medications and placed in seclusion, the individual must be watched continuously to receive help if problems occur from the medications. This continuous observation can be done with a video camera.

   b. Restraint
      When the individual is restrained, it means that all or part of the individual’s body movement is restricted. In order to restrict the movement of the individual’s body, various devices can be used. Examples are leather restraints on the individual’s wrists and ankles used to tie the individual to a chair or bed, a vest that can be used to tie the individual to a chair or bed, a body net that can be wrapped around the individual, a geri-chair or chair that has a tray fastened to it, and other devices that are designed to keep the individual from moving. All of the devices that can be used on the individual must be safe, and should be made in a way to cut down on physical discomfort.

      If the individual is placed in restraint, a staff member of the individual’s same sex must watch the individual at all times to make sure the individual is okay and to keep the individual safe from others. If the individual has a good reason to want a staff member of the opposite sex to watch him or her, then the individual must tell his or her doctor.

      There are some people who may get worse when treated with seclusion or restraint. Many people who have been physically and/or sexually abused fear being locked up or tied down because of bad memories. If the individual believes that he or she has good reasons not to have seclusion and/or restraint used as a treatment, then the individual must tell his or her doctor. The individual needs to tell his or her doctor about the experience or issue that makes the individual believe he or she should not be treated with seclusion and restraint. The individual should tell his or her doctor before a need for seclusion or restraint arises. (See Advocacy’s handout, How to Make an Advanced Directive.) There may be times when the individual’s doctor believes that the individual must be secluded or restrained, even though the individual thinks it will make him or her worse. When this happens, the doctor has to justify why he or she thinks seclusion or restraint is the only way to keep the individual and others safe, and must write the reason in the individual’s medical record.

   c. Chemical Restraint
      It is prohibited in the State of Texas to use chemicals to restrain an individual. This means that medications that are given to sedate the individual rapidly can only be given in the case of an emergency and under the circumstances described in this handout. These medications are usually given by injection and are referred to as emergency medications. If the individual is secluded or restrained, there should no longer be an emergency, and staff should not use a chemical restraint. If there is ever a situation where the only way to keep the individual from hurting himself or herself is to put the individual in restraint and give the individual medication, then the individual has to be watched continually until the individual is released. In order to do this, the staff may place a video camera near the individual to monitor the individual’s behavior. Chemical restraint cannot be given for nonviolent behaviors.
d. Chemical Sprays

Chemical sprays that are intended for temporary restraint such as tear gas and pepper spray cannot be used under any circumstances while the individual is in the mental health facility. It is illegal.

e. General Rights for Seclusion, Restraint, and Medication Restraint

Restraint, seclusion, and medication restraint can only be used in an emergency situation or in certain circumstances for medical and dental procedures (see Restraint during Medical and Dental Procedures, below). An emergency is when there is a possibility of immediate death or serious bodily harm to the individual and/or the possibility of serious physical or emotional harm to others.

Seclusion, restraint, and medication restraint are types of interventions that should only be used as a last resort, and they are only supposed to last long enough to help the individual regain control. The staff that works with the individual is required to use other ways to calm the individual down if possible before they use seclusion or restraint. Once staff begin to restrain or seclude the individual, they must use the least amount of physical force that is reasonable and necessary for that situation. In order for the individual to be placed in seclusion or restraint, a doctor--or a registered nurse, if a doctor is not immediately available--has to initiate the process. Only a doctor can order restraint.

Restraint, seclusion, and medication restraint cannot be used as coercion, punishment, retaliation, for convenience of staff or other individuals, or as a substitute for effective treatment or habilitation.

If the individual is restrained, secluded, or restrained by medication more than two (2) times in any 30-day period, the individual and the individual’s treatment team must have a meeting to review alternative strategies for dealing with behaviors necessitating the use of restraint, seclusion, or medication restraint. If the number of incidents of restraint or seclusion is not reduced, the individual and his or her treatment team will consult with the medical director or designee to explore alternative treatment strategies.

While the individual is in restraint, seclusion, or medication restraint, the individual has all of the same rights that the individual has at any other time during the individual’s hospitalization. (See Advocacy, Incorporated's handouts entitled, Legal Rights under Emergency Commitment, Rights of People Receiving Voluntary Inpatient Mental Health Services, and Rights of People Receiving Involuntary Inpatient Mental Health Services.)

The individual’s right to have his or her personal property can be restricted by the individual’s doctor when the individual is placed in seclusion or restraint. All personal items that can be used to harm the individual or someone else can be taken away, including the individual’s clothing. The individual should have safe clothing issued to him or her if his or her clothing is taken away. The individual’s property must be put up for safekeeping and returned to him or her once he or she is out of seclusion or restraint.

While the individual is in restraint, seclusion, or medication restraint, the individual has the right to be treated with dignity and respect. The individual also has the right to go to the bathroom at least once every two (2) hours, have something to drink once every two (2) hours, take a bath at least once a day, eat all regularly scheduled meals and snacks, and the environment must be comfortable and well ventilated. If the individual is put in restraint, the individual has the right to be able to move his or her limbs or exercise for five (5) minutes out of every hour. The staff member who is watching the individual during seclusion and restraint is required to check for adequate respiration and circulation, especially if the individual is in restraint.

(1) Who can order restraint, seclusion, or medication restraint?

Only a doctor can order restraint, seclusion, or medication restraint if a doctor is immediately available. If a doctor is not immediately available, a clinically privileged registered nurse may initiate restraint or seclusion, but not medication restraint.

Before a doctor or clinically privileged registered nurse can order restraint, seclusion, or medication restraint, they must view the individual and the individual’s behaviors to determine if the restriction is necessary. A doctor, if not immediately available when restraint or seclusion is first started, must approve the restraint or seclusion in person or by phone within an hour after the individual has been placed in restraint or seclusion. After that they must evaluate the individual face-to-face once every 12 hours.

(2) How long can the individual be restrained or secluded?

The maximum length of time that the individual can be restrained or secluded is based on the individual’s age. If the individual is an adult, the time cannot exceed four (4) hours. If the individual is
between the ages of nine (9) and seventeen (17) years old, the time cannot exceed two (2) hours. If the individual is younger than nine (9) years old, the time cannot exceed one (1) hour.

However, if, after this initial period of time, the doctor or registered nurse does not believe that the individual is ready to be let out of restraint or seclusion, they can continue the restraint or seclusion up to twelve (12) hours. If the individual is in restraint or seclusion for twelve (12) hours, and it is decided that the individual is not ready to be let out, a doctor must evaluate the individual face-to-face. The doctor then has to write a new order in the individual’s record and sign it with the date and time of the new order clearly stated.

(3) When can the individual be released from restraint or seclusion?

If the individual is no longer an imminent danger to himself or herself or others for fifteen (15) minutes, the individual must be evaluated by the clinically privileged nurse or doctor for release on a 30-minute trial period, even if the maximum length of time prescribed in the order has not expired. If the individual falls asleep while he or she is restrained, then the individual must be released from as many restraints as possible. If the individual falls asleep in seclusion, the door must be unlocked and opened.

3. Restraint During Medical or Dental Procedures

Seclusion or restraint can also be used for medical or dental care as needed. This includes the use of quarantine when the individual has a contagious disease. If the individual needs medical care or dental care, and in order to provide that care, the doctor has to keep the individual or a part of the individual’s body from moving, then the doctor can use restraint, but only if using restraint or seclusion is part of the facility’s written medical or nursing procedures, and the procedures are recorded in the individual’s record. The individual has the right to be free from any form of restraint that is not medically necessary. Restraint and seclusion cannot be used during a medical or dental treatment as a means of coercion, discipline, convenience, or retaliation by staff.

4. Protective and Supportive Devices

a. General Rights

Protective and supportive devices cannot be used as coercion, punishment, retaliation, for convenience of staff or other individuals, as a substitute for effective treatment or habilitation, or in an emergency. They must be part of the individual’s treatment plan, and must be reviewed at each treatment plan review. Remember, the individual is supposed to be included in the meeting where the individual’s treatment plan is reviewed.

b. Protective Devices

Protective devices may be used to keep the individual from hurting the individual when other, less restrictive interventions will not work. Protective devices include any device that the individual cannot remove. Examples of protective devices are helmets for people with seizures, use of bed rails to prevent people from falling out of bed, and seat belts to prevent people from falling out of wheelchairs.

The use of protective devices requires a doctor’s order. If the individual continues to be placed in a protective device after one (1) week, then the individual and his or her treatment team must review the continued need for the device. At that meeting, the individual must be informed of what is being done to help the individual no longer need the protective device.

c. Supportive Devices

Supportive devices may be used to help the individual have better support, like for sitting up or standing up, or to help the individual develop and maintain normal body functioning. An example of a supportive device is a posey vest for an individual who is not able to support themselves when they are sitting up in a chair.

The use of supportive devices requires a doctor’s order. Before a supportive device can be used, the individual and his or her treatment team must talk over the need for the device. During this meeting there has to be an occupational or physical therapist present, or a registered nurse who is familiar with the individual and the individual’s needs. The individual’s treatment team must document in the individual’s treatment plan the purpose for the device, why it needs to be used, and what the team will try to do in the future so the device won’t be needed.