

“Mental Health Code of Puerto Rico”

Act No. 408 of October 2, 2000, as amended

(Contains amendments incorporated by:

Act No. 183 of August 6, 2008)

(Amendments non-incorporated:

Act No. 88 of May 17, 2012)

To establish prevention, treatment, recovery and rehabilitation needs for mental health; to create the “Bill of Rights” for adults and minors who receive mental health services; to make uniform all matters related to the proceedings concerning these rights; to establish the basic principles of the levels of care for mental health services; to repeal Act No. 116 of June 12, 1980, known as the “Mental Health Code of Puerto Rico,” and to establish penalties.

STATEMENT OF MOTIVES

Mental health is the state of wellbeing as a result of the functional interaction between the person and his/her environment, and the harmonious interaction between him/herself and several factors, such as his/her perception of reality and interpretation of the same; his/her primary biological needs and the way of satisfying the same; his/her psychic, mental and spiritual potential and the way of elevating the same to their highest level; his/her sense of humor and capacity to enjoy the genuine pleasures life offers us; the confidence in him/herself and the acknowledgment of his/her limitations; the satisfaction upon achievements and strength of mind upon defeats; the acknowledgement of social rights and obligations as basic needs for the sound and pacific coexistence; solidarity with the values he/she believes in, and respect and tolerance for the ones he/she disagrees with; the capacity to grow and mature depending on his/her own life experiences and those of others; the affective resonance upon happy and sad situations; and lastly, the capacity to give and receive love generously.

We ratify that overseeing the mental health of our country is and must be a matter of full interest for the government of Puerto Rico. Mental health is a main element for a peaceful coexistence and a good quality of life.

The Mental Health Code of Puerto Rico was created by virtue of Act No. 116 of June 12, 1980, as amended. Since then, the life of Puerto Ricans has changed significantly during the last decades. These changes have been characterized by a significant increase in the incidence of mental disorders in adults and minors. In order to face the demands of the increase of these disorders, as well as the need to provide adequate mental health services for the persons who need them, a series of reforms have emerged, including the Health Reform of Puerto Rico, with the incorporation of managed care, and mental health insurances and coverage for all the medical

indigent, which has had a transcendental effect on the mental health services offered in Puerto Rico, thus providing new options for treatment, recovery and rehabilitation in the mental health field.

In order to guarantee that these services be offered within the quality standards established by this Act, it is important that the government intervenes in the implementation of the processes of technical assistance, facilitation, monitoring during the process, as well as evaluation and licensing of all the institutions that provide mental health services.

In accordance with the changes that we have experienced during the past years and with the commitment the Government of Puerto Rico has to provide greater access to excellent health services, and based on the urgent need our society has to improve the mental health of its citizens in the dawn of a new millennium, and with the ultimate purpose of achieving that we live in peaceful coexistence and harmony, this Act has the firm purpose of recording the incorporation of all those social, technological and sociological innovations in the health field that would strengthen family and community life, attending our cultural and social environment, thus guaranteeing all citizens that receive it, the rights established in our constitutional structure.

This Act also highlights the importance and transcendence community and pastoral organizations have in relation to the prevention, treatment, recovery and rehabilitation of persons who suffer mental problems related to alcohol and controlled substance abuse. These organizations have historically proven to be highly efficient handling this social problem, and have proven to be zealous guards of our country's welfare.

The intention of this Legislature is that the foregoing act does not diminish, in any way, the leeway that community-based organizations have traditionally had to handle the aforementioned problem. Any interpretation to the effect that the field of action of these organizations would be reduced with the approval of this Act would be contrary to the intentions of this Legislature.

We also acknowledge and support the huge effort that re-educated and rehabilitated ex-addicts make following the guiding light of their commitment to eliminate the social malady of alcohol and controlled substances abuse, participating in community programs that pursue the re-education and rehabilitation of other addicts.

Be it enacted by the Legislature of Puerto Rico:

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This Act shall be known as the "Mental Health Code of 2000".

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Section 1.03. — Statement of Motives. (24 L.P.R.A. § 6152 note)

The Mental Health Code of Puerto Rico has the following main objectives and purposes: to update all treatment, recovery and rehabilitation needs; to protect any population affected by mental disorders with adequate services for the person; to unequivocally establish their rights to receive mental health services, including minors; to promote the eradication of prejudices and stigmas against any person who suffers a mental disorder; to provide precise guidelines to mental health professionals as to the rights of people who receive mental health services; to determine all necessary processes to safeguard all rights provided in this Act; to bring into line all changes undergone by the institutions that provide services with the establishment of the Health Reform; emphasize and establish the basic principles and levels of care in the services rendered; to highlight the recovery and rehabilitation aspects as integral parts of the treatment, as well as prevention.

Section 1.04. — Principles that Shall Govern the Mental Health Care System. (24 L.P.R.A. § 6152)

The principles that govern the interpretation of this Act are the following:

(a) *Access to the services; which includes the following components:*

- (1) Availability of the services to be rendered, which shall be in accordance with the needs and characteristics of the population to be served, with their age and stage of development, gender, socio-cultural context, diagnosis, severity of the symptoms and signs, level of care needed, and the current and prospective capacity to function. The perspective of the integral development of a person shall be part of the provision of the services to be offered.
- (2) The adequate proportion and location of the mental healthcare services shall be accessible, especially to communities with high incidence of mental disorders. To this end, the indirect mental healthcare provider shall maintain a network of direct mental healthcare service providers that meets the access requirements set forth by this Act.
- (3) Emergency and hospitalization services that are offered everyday, twenty-four (24) hours a day. The rest of the levels of care shall be offered within a schedule depending on the needs of the population being attended.
- (4) The rendering of mental healthcare services shall include the participation of persons with mental disorders, including those with diagnoses correlating to drug and/or alcohol abuse and dependency and comorbid conditions, in their treatment, rehabilitation, and recovery and shall consider all alternatives available offered by government and community entities through a collaboration or referral system.

(b) *Ongoing care system.* —

[The system of] treatment, recovery and rehabilitation services for persons with mental disorders shall be [one of] ongoing care based upon the intensity of the levels of care that the person needs. As the person recovers, he/she would evolve through each greater-autonomy level of care. The person shall then continue to receive the next service corresponding to the process of recovery and evolution of his/her disorder. The ongoing care shall contain services, from greatest-intensity levels, which shall be progressing into greater-autonomy levels, befitting his/her diagnosis, the severity of symptoms and signs, and the general functioning level that he/she presents and gradually acquires, which shall be represented by the diverse services of coordinated care within the system. These are organized by greater-intensity and greater-autonomy levels. The purpose is to promote that the person moves from a greater-intensity level to a greater-autonomy level. The levels are perceived according to the severity of symptoms and signs and the person's behavior. This services concept includes the following services, such as emergency, hospitalization, intensive outpatient care, partial hospitalization, outpatient maintenance, with or without medications, live-in treatment programs for minors and adults, and transitional services, among others. Transitional services include live-in programs organized by gender, age and stage of life, pre-vocational or occupational readiness services, such as halfway homes, recovery homes, long-term care homes, and support and recovery services from for-profit or nonprofit community-based organizations, among others.

(c) *Comprehensive care system.* —

The system for the care to be offered shall be developed on an ongoing basis, whereby all care needed by the population with mental disorders, or at risk [of having them], shall be planned, including those services that would be provided as necessary in the community and in other agencies for the person and his/her family. Some of the necessary elements for the development of a comprehensive system are:

- (1) Early identification and intervention. — It is based on solving the mental disorder in a more effective, economical and humane way, at its beginnings when there is less deterioration (in mild and moderate levels), which means that the intervention shall occur as early as possible in the development of the mental disorder.
- (2) Evaluation. — This procedure establishes a methodology for the clinical and professional determination of the nature of the problem, the diagnosis, the severity of the symptoms and signs, the factors that contribute to its development, and the identification of the personal and family resources that may help in the recovery. All the above-mentioned are important for the development of an individualized treatment, recovery and rehabilitation plan.
- (3) Outpatient treatment. — It is the least-intensive, greatest-autonomy level of care. It consists of regular visits by the person and/or his/her family to the institution providing mental healthcare services, to receive, if necessary, the following services, such as individual, group, family or couple's psychotherapy or counseling and pharmacotherapy, among others.
- (4) Maintenance outpatient services with medication. — This service shall offer evaluation and re-evaluation of a mental disorder diagnosed as chronic, providing pharmacotherapy for specific periods for the clinical revision, according to the care standards that govern good professional practices and the prescription of medications.
- (5) Intensive outpatient services. — This is a less intensive level of care, in comparison with the hospitalization and partial hospitalization. In it, the person goes to treatment at least three

(3) times a week or twelve (12) hours a week, putting into practice the individualized plan by an inter- or multidisciplinary team.

(6) Partial hospitalization. — Is a structured and intensive ambulatory treatment program in which the person attends from four (4) to five (5) days a week, with approximately from fifteen (15) to eighteen (18) intervention hours by an inter- or multidisciplinary team, who shall put into practice the individualized treatment plan.

(7) Emergencies. — This service shall be accessible during non-working hours, seven (7) days a week, twenty-four (24) hours a day, whereby a screening is conducted, as well as an evaluation, the stabilization of symptoms and signs, and if necessary, hospitalization or a referral to the corresponding treatment in another level of care.

(8) Hospitalization. — It refers to the most restrictive service alternative whereby treatment and rehabilitation are offered by means of having a person institutionalized in a hospital. Provided, That a hospital includes any institution engaged in providing care for persons with mental disorders, or a general hospital that has a ward duly licensed by the applicable regulatory entity to render mental healthcare services.

(9) Transitional services. — These are intermediate services between a greater intensity service and one of less supervision and structure, in order to prepare the person to deal with his/her environment, according to his/her diagnosis and the severity of the symptoms and signs at that time. Its goal is the person's recovery so that he/she may be able to function adequately in the community using the skills that aid him/her to achieve his/her autonomy. These services are characterized for having different levels of supervision, so that the person may evolve according to his/her recovery. This system should allow referrals at the level of care according to his/her condition, without having to go through all the levels.

(10) Live-in treatment programs for minors. — These are services provided within a highly restrictive and intensive level of care surpassed only by hospitalization. These services are designed specifically to address mental health conditions, including disorders correlative to alcohol, drug dependency, or comorbid conditions which are difficult to manage at their homes or in their communities, in minors who have failed to respond to all other less restrictive levels of treatment, and these integrate clinical and therapeutic services organized and supervised by an interdisciplinary team within a structured setting, twenty-four (24) hours a day, seven (7) days a week. The objective of this modality of treatment is to promote, strengthen, and restore adaptive functions in minors and their families, at their homes and their communities, so that they may continue their treatment at a less intensive and less restrictive level. Populations suffering from psychiatric disorders together with drug and/or alcohol dependency may not be intermingled with the population of youths who only suffer from non-addictive mental disorders.

(11) Live-in treatment programs for adults. — These are services provided within a highly restrictive and intensive level of care surpassed only by hospitalization. These services are designed specifically to address mental health conditions, including disorders correlative to alcohol, drug dependency, or comorbid conditions which are difficult to manage at their homes or communities, in patients who have not responded to all other less restrictive levels of treatment, and these integrate clinical and therapeutic services organized and supervised by an interdisciplinary team within a structured setting, twenty-four (24) hours a day, seven (7) days a week. The objective of this modality of treatment is to promote, strengthen, and restore adaptive functions in patients and their families, at their homes and their

communities, so that they may continue their treatment at a less intensive and less restrictive level. Populations suffering from psychiatric disorders together with drug and/or alcohol dependency may not be intermingled with the population of persons who only suffer from non-addictive mental disorders.

(d) *Person's autonomy.* —

The person's autonomy refers to his/her capability to make a decision by him/herself and to choose between the several alternatives proposed in terms of the treatment, recovery and rehabilitation services to be offered to him/her. Treatment and care shall be based on the promotion of the best practices of self-determination and personal responsibility consistent with his/her own needs and desires. Autonomy shall be preserved whenever possible, and when not possible because of the person's condition, medical provisions shall be made in order to ensure the person's welfare. The following principles and guidelines shall be followed:

(1) Participation. — Any person who receives services in the care system shall be involved in every aspect of the arrangement of his/her care, treatment and support, according to his/her individual capacity.

(2) Consent for care. — Care, treatment and support programs shall consider that which is the closest possible to the preferences of the person who receives such services, provided it is adequate to his/her capacity and condition.

(3) The least restrictive alternative. — Treatment, care and support shall be provided to those persons who receive services in the least invasive and restrictive manner possible, within an environment that offers him/her safety and an effective care.

(e) *In the best interest of the person.* —

The criterion for imposing orders, whether for evaluation or treatment, shall be based on the person's best interest, a concept that shall vary depending upon the context in which it is used. For the purposes of this Act, the following shall be taken into consideration:

The person's best interest shall be based on the clinical opinion and recommendations made by the inter- or multidisciplinary group of professionals and on the person's past and present wishes, if he/she is capable. In order to have a better understanding of the person's best interest, his/her participation shall be promoted, depending on his/her possibilities and capability, as well as the participation of other persons, such as family members or other significant persons.

(f) *Representation and right to express for participants of mental health services.* —

Any person who requires mental health services, and the parents or legal guardian of a person who receives mental health services have the right to express his/her needs or satisfaction and to make recommendations regarding the services being received or offered. They have the right to contribute, make recommendations, and to participate, per se or through a representative, in the development and planning of strategies and services he/she needs.

(g) *Mandatory evaluation.* —

This principle establishes that a court may order any person to submit to a comprehensive evaluation to determine which of the mental healthcare treatment services he/she needs when such person shows that he/she suffers from a mental disorder by his/her behavior and who is at immediate risk of harming him/herself or others or damaging property, or who has engaged in acts that indicate the he/she cannot manage everyday life without the supervision or assistance of other persons for being unable to feed, protect or caring for him/herself, thus increasing his/her chances of dying or experiencing physical weakening to the point of putting his/her life in jeopardy.

(h) *Involuntary placement in a level of care determined in accordance with the needs identified in the evaluation.* —

The involuntary placement in a level of care of greater intensity shall be used when a person exhibits behavior relative to a mental disorder whereby he/she might inflict immediate physical harm upon him/herself or others or damage property, when the severity of symptoms and signs so indicate, according to the best practices of psychology, social work, psychiatry, and modern medicine, or when the person has issued significant threats that might yield the same outcome after the immediate evaluation and the comprehensive evaluation. This involuntary placement may be extended to another less-intensive level of care. If there is no will nor consent from the person, his/her parents, or legal guardians to participate in the treatment, the court may order involuntary or mandatory treatment, even if in a less-intensive and greater-autonomy level of care, according to what is recommended by the inter- or multidisciplinary team and to the procedures established by this Act.

(i) *Principles for the early intervention of disorders relative to alcohol and drug abuse, and of antisocial behavior in minors.* —

With the purpose of preventing problems relative to drug, alcohol use and abuse and antisocial behavior in youths from turning into problems of greater proportions, specific prevention, outreach, and early intervention programs shall be established for children, teenagers, and their families. Minors at high risk of developing a substance dependency and violent, criminal, or antisocial behaviors are those who early on exhibit problems in terms of a mental illness, their conduct, or their scholastic performance, or who belong to dysfunctional families, or have a history of substance use or abuse. Therefore, in addition to first-order, second-order, and third-order therapeutic interventions, early intervention and prevention programs, such as scholastic tutoring, sports and/or artistic activities supervised by the proper professionals, parent support and guidance interventions, and a design for spare-time management or recreation by the proper professionals, among others, shall be deemed to be preventive therapeutic interventions under this Act.

(j) *Services provided for adults with severe mental disorders.* —

Adults who suffer from severe mental disorders shall be provided with ongoing, congruent, and comprehensive services, according to the disorder and the level of severity and care by category, through collaborations between the public and private sectors, so as to develop the following initiatives among the providers of mental healthcare services:

- (1) Support and promote the family-oriented and community oriented services, as well as of case management;
- (2) support and promote the development of support groups for persons who suffer mental and emotional disorders, and their families;
- (3) promote the participation of persons who receive mental healthcare services, their families or representatives in the planning of mental healthcare services;
- (4) establish maintenance programs with medication, when applicable to the person's treatment and disorder, in accordance with the regulations established by federal entities and the Mental Health and Addiction Services Administration;
- (5) develop collaborative services or strategies to participate in outreach activities and/or provide services to those persons who are identified as in need of treatment under these strategies;

- (6) establish priorities in the evaluation, diagnosis, and interdisciplinary treatment of persons with drug and alcohol dependency, with special attention to persons with multiple diagnoses as to mental and comorbid conditions from which most of these patients usually suffer, and
- (7) offer intervention strategies to prevent relapses and to sustain long-term maintenance for substance abuse and dependency disorders and to efficiently manage symptoms and signs and circumstances which trigger other coexisting medical and mental disorders.

(k) *Multi-strategic collaborative interventions in vulnerable high-incidence communities.* —

Communities that experience the impact of sustained and consistent violence also require the educational programs that can be provided [by] the corresponding government agencies, insurers, MBHOs, providers from for-profit or nonprofit community-based organizations, and mental healthcare professionals, to work with the different manifestations of violence and the triggering factors for mental and emotional disorders, including substance, abuse, dependency-related disorders and disorders induced by substances, i.e. drugs and/or alcohol.

Section 1.05 — Applicability of the Act. (24 L.P.R.A. § 6152a)

This Act shall apply to any person who needs, requests, receives or has received mental healthcare services, including services for any abuse or dependency-related disorder and substance (drugs and/or alcohol)-induced disorders; to any public or private institution that plans, administers or coordinates such services; and to any network of direct or indirect mental healthcare providers, including, but not limited to:

- (a) Psychiatric hospitals, psychiatric wards, psychiatric hospitalization quarters or wards and/or psychiatric quarters or wards to treat addictions, or addiction medicine, in general hospitals or psychiatric hospitals that provide these services, as well as for-profit or nonprofit community-based organizations.
- (b) Emergency rooms, partial hospitalization or day treatment, intensive outpatient treatment, and/or outpatient treatment, live-in treatment programs for minors and adults, and transitional services.
- (c) Rehabilitation services.
- (d) Community outreach services.
- (e) Services administered and coordinated by indirect mental healthcare service providers.
- (f) Mental healthcare administration and coordination under the Puerto Rico Government Health Plan and private plans.

Section 1.06. — Definitions. (24 L.P.R.A. § 6152b)

Except otherwise provided in this Act, the following terms shall have the following definitions:

- (a) *Abuse.* — Means any action or omission by a mental health professional, private or public institution, or by any other person toward the adult or minor who receives mental health services, during his/her process of treatment, recovery and rehabilitation. The abuse may be manifested as:
 - (1) *Physical abuse.* — Any act or omission resulting in physical harm to the person, or other forms of harm such as sexual abuse, including any form that may cause death.
 - (2) *Emotional abuse.* — Any omission of a necessary action, excessive unjust or improper action in which the adult or the minor, is humiliated, insulted, intimidated, threatened, or

persecuted, among others, or his/her autonomy to receive clinical services or while receiving them has been ignored.

(b) *Access to services.* — Means the guarantee that all persons receiving mental healthcare services shall receive such services in accordance with their clinical condition and the level of service which best suits their condition at the time they request such services.

(c) *Administration.* — Means the Mental Health and Addiction Services Administration.

(d) *Administrator.* — Means the Administrator of the Mental Health and Addiction Services Administration.

(e) *Health facility administrator.* — Means the professional licensed by the Board of Examiners of Health Service Administrators of the Commonwealth of Puerto Rico, who has the mission of administering, directing, planning, organizing, coordinating, controlling, evaluating, and making proper use of the human, material and financial resources of the health program or facility.

(f) *Adult.* — Means any person of eighteen (18) years of age or more. For the purposes of this Act, any minor who has been legally emancipated shall receive services for minors.

(g) *Security agent.* — Means any state or municipal police officer, or any custody officer duly identified as such.

(h) *Isolation.* — Means the therapeutic measure consisting of the involuntary confinement of an adult or minor with mental disorders, in a room, isolated from others, in which he/she is physically restricted from leaving for a certain period, and requires specific care and proceedings.

(i) *Release.* — Means the suspension order, final or temporary, of the services offered by a providing institution to any person, be it through voluntary or involuntary admission.

(j) *Express authorization.* — Means the process by which a person, freely, without any threat, intimidation or coercion, issues a written authorization to a third party to receive or obtain his/her confidential information, pursuant to the procedure provided in this Act.

(k) *Capacity to give consent.* — Means the physical and mental condition that allows a person to make any decision at a specific time.

(l) *Certificate.* — Means the document issued by a psychiatrist, a clinical doctor, clinical psychologist or person authorized therefor, which describes aspects of the mental health treatment of the person subject to treatment with a specific purpose, such as a court order, petition by an attorney or request from an insurance company.

(m) *Certificate for involuntary placement or mandatory treatment.* — Means the document issued to the court by the psychiatrist, in consultation with the inter- or multidisciplinary team, when the involuntary placement of a person in a mental healthcare service is requested, be it hospitalization or another level of care that accords greater autonomy, which shall contain the recommendation based on the warranted clinical need.

(n) *Acute condition.* — Means a clinical manifestation characterized by beginning very quickly and having an intense biological, psychological, social and behavioral conduct, which makes it necessary that the person receive treatment, recovery and rehabilitation mental health services. The person may or may not show evident or known triggering factors, which frequently cause that a person is put at risk of causing damage, injury or death to the self, others or property.

(ñ) *Confidentiality.* — Means the right that a person who receives mental health services has to communicate orally or in writing without it being disclosed to third parties when there is no express authorization from him/her, except when otherwise provided in this Act.

(o) *Professional counselor*. — Means the professional licensed by the Professional Counselors Examining Board of the Commonwealth of Puerto Rico pursuant to Act No. 147 of August 9, 2002, as amended [20 L.P.R.A. §§ 3241 et seq.], known as "An Act to Regulate the Practice of Professional Counselors in the Commonwealth of Puerto Rico", who is knowledgeable in the application of mental health, psychological or human-developmental principles through the employment of cognitive, affective, behavioral, or systemic intervention strategies to tend to the welfare, personal growth, or career development, as well as pathologies.

(p) *Informed consent*. — Means a determination made by an adult or his/her guardian, or by the father, mother or a legal guardian of a minor, to receive or reject a mental health service or any other procedure resulting from a dialogue in which the provider of mental health services informed the person subject to receive such services, or the parent with patria potestas, or legal guardian, the nature, need and scope of these mental health services.

(q) *Custody*. — Means the care and vigilance given to a person, and includes the following types of custody:

(1) Legal custody. — The one granted by a court, in addition to the one parents have over a minor.

(2) Provisional custody. — The one granted to a person temporarily by a government agency empowered to do so.

(3) Emergency custody. — The one carried out in cases when if not carried out immediately, the person represents a risk to his/her safety and welfare, that of other persons and to property.

(4) Custody in fact. — Is the custody delegated during his/her absence by the person with patria potestas or the legal guardian of the minor to a person over twenty-one (21) years of age.

(r) *Medical director*. — Means the mental healthcare professional responsible for directing, coordinating and implementing the best practices for mental healthcare treatment in the services offered by the institutional provider.

(s) *Medical emergency*. — Means the sudden and unexpected start of a mental or physical health condition that requires immediate medical attention and that if not provided, would result in the injury of an organ, part of the body or could put the person, another person or property at risk of damage or death.

(t) *Psychiatric emergency*. — Means the clinical symptoms characterized by an alteration of the thoughts, of the perception of reality, of the affects or feelings, or of the person's actions or conduct that needs immediate or emergency therapeutic intervention in which of the intensity of the symptoms and signs, and representing an immediate risk to the person, another person or property at risk of damage or death.

(u) *Severe mental disease*. — Means severe mental disorders in adults as specified in Federal Public Law 102-321, as amended, known as the "Alcohol, Drug Abuse and Mental Health Services Administration Reorganization Act".

(v) *Nurse*. — Means the person authorized by the Board of Female and Male Nurse Examiners to practice the nursing profession, as provided by Act No. 9 of October 11, 1987, as amended [20 L.P.R.A. §§ 203 et seq.], known as the "Act to Regulate the Practice of Nursing in the Commonwealth of Puerto Rico".

(w) *Interdisciplinary team*. — Means the team composed of three (3) or more mental healthcare professionals of different disciplines, among which there shall be one (1) psychiatrist or one (1)

psychologist, who provide mental healthcare services with the professional and legal capability and authority to diagnose and prescribe treatment in the different areas of human functionality and capabilities, and by those other professionals germane to the person's condition, all working in the same scenario. The interdisciplinary team is distinguished by its cooperative and consensual work, which is characterized by the interaction of all the professionals with the patient under treatment, a discussion of the case, full knowledge of the contributions of each profession or discipline, and the application of the best practices of the field, geared toward the recovery of the person. The team's composition and leadership shall vary in accordance with the scenario or the service to be rendered and the clinical needs of the person.

(x) *Multidisciplinary team.* — Means a work group composed of three (3) or more mental health professionals of different disciplines, who provide mental health services with the capacity, and the professional and legal faculty to diagnose and prescribe treatment in the different areas of human performance and capacities, and by other professionals related to the person's condition, all working in the same scenario. They serve the same population, within the same category in order to develop the treatment, recovery and rehabilitation for the person's best performance, according to his/her situation and diagnosis. This team works on consultation and may communicate through the clinical record and discussions of the case. A providing institution may use this team when, for any reason, is not able to gather an interdisciplinary team to diagnose and prescribe the corresponding treatment.

(y) *Therapeutic team.* — Means the group of health professionals that includes specialists in different behavioral areas that integrate into a single clinical task to implement the treatment, recovery and rehabilitation plan developed by the team of inter- or multidisciplinary professionals.

(z) *Evaluation.* — Means the procedure conducted by a psychiatrist, physician, psychologist or other professional within the professions related to mental healthcare, who is authorized to diagnose and prescribe treatment within his/her profession or specialty, certified and licensed to practice his/her profession in Puerto Rico. Said evaluation shall be the product of a direct clinical examination with instruments according to the corresponding level of care and setting when conducting the same, which shall contain the findings of the patient's medical history, his/her emotional, mental and physical condition at the time it is conducted, diagnostic impressions applicable to each situation in particular, and specific recommendations as to the immediate management and prognosis of the patient.

(aa) *Clinical record.* — Means the organized and detailed compilation of data and information related to the medical treatment and health care that a person receives from a mental health professional or provider.

(bb) *Family member.* — Means the spouse or relatives up to the fourth degree of consanguinity or affinity of a person who receives mental health services, such as his/her parents, children, grandparents, siblings, uncles and aunts, grandchildren, and nephews and nieces.

(cc) *Medical faculty.* — Means the group of mental healthcare professionals of the highest order in each of their specialties, who are duly certified by their respective examining boards and licensed to practice in the jurisdiction of Puerto Rico, hold the highest rank in the mental healthcare institutional providers, and supervise and support other health professionals who are legally authorized to practice their professions.

(dd) *Open source.* — Means the software that may be obtained, used, copied, studied, modified, and redistributed due to having access to the source code, which does not abridge the capability

of receiving services from a single source or electronic/computerized information system provider.

(ee) *Hospitalization*. — Means the highest level of psychiatric care, which is characterized by the continuous and frequent intervention of professional and technological resources twenty-four (24) hours a day, in order to achieve a prompt stabilization of the symptoms and signs that, due to their severity, make it necessary, so that the person may continue his/her recovery and treatment in another level of less intensive care and greater autonomy within the mental health care system.

(ff) *Involuntary placement*. — Means placement into a mental healthcare service ordered by the court after an evaluation by a psychiatrist in consultation with the inter- or multidisciplinary team certifying the need for this service, when there is no consent for such from the adult or the parent with legal or physical custody of the minor, or the person's legal guardian, insofar as he/she meets dangerousness standards as to the likelihood of inflicting harm upon him/herself or others or damaging property, or has engaged in acts that put his/her life in jeopardy, or has engaged in acts which indicate that he/she cannot manage everyday life without the supervision or assistance of other persons for being unable to feed, protect, or care for him/herself, thus increasing his/her chances of dying or experiencing physical weakening to the point of putting his/her life in jeopardy.

(gg) *Voluntary admission*. — Means the determination made by an adult capable of consent to go to or be admitted into a providing institution and receive a mental health service after an evaluating process so determines, or the determination made by the parent with patria potestas, or a minor's legal guardian, to be admitted into the providing institution, provided that the severity of the symptoms and signs so does justify. In both cases, this determination shall be made after having been duly informed of the conditions, rights and duties of the decision made.

(hh) *Institutionalization*. — Means the state that a patient reaches due to an excessive and improper use of the psychiatric hospitalization, as the only option of treatment or deficiency of the release plan without appropriate follow-up. It can also arise due to lack of services that are crucial for the person's recovery. This entails mental deterioration and habits of variable intensity due to disuse, dependence, and impeding the person from acquiring the autonomy needed to cope [outside] of the hospital's restrictive environment. The institutionalization usually happens in psychiatric hospitals, but it can also happen in any environment or level of therapeutic care that fosters and promotes dependence, and that does not stimulate the patient's autonomy.

(ii) *Institutional provider*. — Means any juridical person, public or private facility, or facility fully or partially engaged in planning, administering and providing mental healthcare treatment, recovery and rehabilitation services and that operates with professionals authorized to practice as such, pursuant to the laws of Puerto Rico. This definition also includes professionals in mental healthcare sciences and their private offices, insofar as they operate with the purpose of providing treatment, recovery, and rehabilitation services to address mental health issues, including drug and alcohol-related disorders and comorbid conditions. Likewise, the term "institutional provider" is deemed to include for-profit or non-profit community-based organizations devoted to offering therapeutic interventions to patients with disorders arising from drug or alcohol abuse or dependency or comorbid conditions.

(jj) *Case manager*. — Means a person holding a Bachelor's or higher degree in mental healthcare sciences, who, under the supervision of a mental healthcare professional duly licensed to practice his/her profession, discharges tasks, such as accessing all the comprehensive services needed for

the recovery and rehabilitation of a person with a mental disorder. In addition, he/she follows up on the implementation of the person's individual treatment, recovery and rehabilitation plan. Provided, That case managers presently working for nonprofit or for-profit organizations shall be certified by the Mental Health and Addiction Services Administration as such when credited proof is furnished to attest that they have rendered services for two (2) or more years prior to the approval of this act.

(kk) *Minor*. — Means any person less than eighteen (18) years of age. An emancipated minor shall be empowered to make decisions, provided he/she has the capacity to consent. For the purposes of this Act, an emancipated minor shall be considered an adolescent, with respect to the treatment services to be rendered.

(ll) *Justified clinical need for treatment*. — Means the clinical determination that arises from the evaluation [of] a person according to the standards accepted by the different mental health disciplines as clinical option for treatment, recovery and rehabilitation due to the severity of the symptoms and signs in order to stop the progress of the disease, improve the person's condition and keep him/her at a socially accepted performance level, according to the severity of the symptoms and signs. The purpose of this determination, which is included in the person's clinical record, is to inform and support the need for initiating or continuing to render mental health services.

(mm) *Levels of care*. — Means the different degrees of intensity and frequency in the medical, psychiatric, psychological, social and rehabilitation treatments that lead a person to perform at the most independent level possible.

(nn) *Psychotherapy notes*. — Means notes recorded in any medium by a mental healthcare professional in order to document or analyze the contents of a conversation during a psychotherapeutic intervention session or an individual or group therapy session, which are separate from all other contents in the clinical record. The definition of this term does not include the prescription, medication monitoring, the sheet to record when the session begins or ends, treatment modality and frequency, clinical test results, the diagnostic summary, functionality status, the treatment plan, symptoms, prognosis, and progress notes.

(ññ) *For-profit or nonprofit community-based organizations*. — Means any for-profit or nonprofit community-based organization duly organized and certified by the Department of State of Puerto Rico that develops programs and services consistent with its statement of mission, vision, and objectives, which may include guidance, counseling, assistance, support, and treatment, recovery and rehabilitation services for persons who need services to address mental health issues, including disorders relative to drug and/or alcohol abuse or dependency and comorbid conditions.

(oo) *Other level of care*. — For the purposes of this Act, it means all treatment, recovery and rehabilitation services or modalities that comprise the whole of ongoing mental healthcare services, excluding hospital and emergency services.

(pp) *Pass*. — Means the permit given to a person who receives mental health services to be absent from the providing institution for a determined period of time and based upon clinical reasons.

(qq) *Dangerousness*. — Means the state determined by the existence of an imminent risk of causing damage due to a mental disorder. For the purposes of this subsection, dangerousness shall be considered to be when:

(1) There exists a high probability of causing damage, or physical or psychological harm to another person as revealed by the patient's actions, intentions or threats, based on the opinion of a psychiatrist, clinical psychologist, or social worker with clinical experience;

(2) Within twenty-four (24) hours prior to the evaluation, the patient has made threats, attempted suicide or caused severe bodily injuries to the self; or has carried out actions putting his/her life at risk; or has carried out actions that indicate that he/she cannot handle his/her everyday life without supervision or help from other persons for not having the capacity to feed, protect or care for the self, thus increasing the probabilities of death, substantial bodily injury or physical weakness to a level that would put his/her life at risk.

(3) The person carries out, attempts or threatens to damage or destroy his/her property or that of another person due to a mental health disorder.

(rr) *Person who requires and receives mental healthcare services.* — Means any adult or minor who receives mental healthcare services, also commonly denominated as patient.

(ss) *Mental health support personnel.* — Means all the professionals in different disciplines and levels of academic preparation who are trained to give support to the performance and necessary operations of the mental health services system. It also includes any other person or group whose participation is necessary and pertinent for treating and handling the condition of the person who receives mental health services. All support personnel shall comply with the requisites of law to practice his/her profession in Puerto Rico.

(tt) *Discharge plan.* — Means the document produced by the inter- or multidisciplinary team which summarizes and records in writing the clinical picture, the results of the treatment, the level of recovery achieved by the person, and the recommendations and arrangements at the time of changing his/her level of care to another to suit his/her needs. The discharge plan shall be available for immediate use, not less than 24 hours before transferring or discharging the person into the corresponding level of care.

(uu) *Individualized treatment, recovery and rehabilitation plan.* — Means the design and implementation of a series of strategies directed to support strengths and to deter, counteract, limit or eliminate problems and difficulties identified by mental health professionals on the person evaluated, at the time and level of care he/she is at.

(vv) *Mental health professionals.* — Means those professionals in different disciplines and levels of mental health-related academic preparation who provide services and comply with the laws of Puerto Rico to practice their profession.

(ww) *Indirect health service provider.* — Means any public or private health service organization or insurer duly authorized in Puerto Rico to offer or bound to provide health services pursuant to the provisions of Act No. 77 of June 19, 1957, as amended [26 L.P.R.A. §§ 101 et seq.], known as the "Puerto Rico Insurance Code"; health maintenance organizations as defined in subsection (x) of Section 1 of Act No. 101 of June 26, 1965, as amended; and any plan organized and authorized by any special law, as well as all Managed Behavioral Healthcare Organizations (MBHOs).

(xx) *Proprietary provider of information systems.* — Means a person or entity that offers the services of an electronic/computerized information system for sale, to rent, etc.

(yy) *Psychologist.* — Means the professional licensed by the Psychologists' Examining Board of the Commonwealth of Puerto Rico, as defined in Act No. 96 of June 4, 1983, as amended [20 L.P.R.A. §§ 3201 et seq.], known as "An Act to Regulate the Practice of the Profession of Psychology", who has the training, knowledge, skills, and experience to offer services which

include, but are not limited to: prevention, behavioral description or diagnosis, psychological evaluation, therapeutic intervention to address psychological issues in the several levels of severity, and counseling in connection with the intellectual, emotional, behavioral, interpersonal, familial, social, and occupational functionality of individuals and groups.

(zz) *Psychiatrist*. — Means the medical doctor specialized in general psychiatry, of children or adolescents, or in other sub-specialties known and duly certified, who is authorized to practice as medical doctor in Puerto Rico and with authority to practice the specialty or sub-specialty, as certified by the Board of Medical Examiners of Puerto Rico.

(aaa) *Claim*. — Means the statement made verbally, behaviorally or by any other means of expression, by which a person states his/her dissatisfaction or displeasure with the treatment or service received or lack thereof, in his/her inter-relationship with an institution engaged in rendering mental health services that provides direct or indirect services.

(bbb) *Complaint*. — Means the written statement expressing dissatisfaction with the treatment or services received or lack thereof, by the person, in his/her inter-relationship with an institution engaged in rendering mental health services that provides direct or indirect services.

(ccc) *Recovery*. — Means the ability to improve and maintain functionality in one (1) or more of the following dimensions of life, such as work, living accommodations, community or family roles, so as to be able to lead a full and fulfilling life, even if there are limitations brought on by the disease. Furthermore, recovery means the remission of symptoms and signs, and the resolution of situations for each level of care corresponding to the severity and level of functionality the patient acquires as he/she improves his/her state, and acquires knowledge and autonomy to manage his/her condition, to prevent relapses and to manage them effectively. Among the most imminent resolution of situations, there is the acceptance of the condition and its treatment, as well as its limitations, alternatives, triggering factors and resistance factors, among others.

(ddd) *Referral*. — Means the document issued by any health professional authorized to practice his/her profession pursuant to the laws of the Government of Puerto Rico, which states the need for a person to be evaluated in order to determine if he/she needs or not mental health services.

(eee) *Rehabilitation*. — Means the acquisition, restoration or compensation of skills and capacities to a satisfactory level of functionality of a person, according to his/her condition, diagnosis and prognosis on the basic skills to achieve an autonomous life and an affective, intellectual, working, academic satisfaction that would allow him/her to perform in all the aspects mentioned above.

(fff) *Restriction*. — Means the therapeutic measure that makes use of physical and mechanical means to involuntarily limit movement of all or part of the body, in order to control physical activity and protect the person subject to the restriction, thus avoiding injury to the self or others, or damage to property. The use of means to protect the person, such as rails, helmets and/or mechanisms such as orthopedic equipment, braces, wheel chairs and other equipment or artifacts to support the person's posture or aid him/her in obtaining or maintaining the functions of the body, shall not be considered as a restriction.

(ggg) *Mental health*. — Means the whole of the state of wellness in the physical, mental and social orders, which enables persons to employ their intellectual, emotional, ethical and spiritual capabilities and their social resources in order to make rational and creative decisions, foresee the consequences of their actions, acknowledge their mistakes, feel comfortable with themselves, relate satisfactorily with other people and contribute to their welfare, strive to fulfill their own

potential and to reach their own goals, adapt to changes constructively, deal with daily demands or stress which are commonplace in life, work productively, and contribute to the welfare of their community and society in general.

(hhh) *Mental healthcare services.* — Means, among others, the preventive, diagnostic and therapeutic interventions and activities that help to manage, reduce, or eliminate symptoms, suffering and distress in persons showing to have a mental disorder or mental health issue, and to effectively manage the impairment that usually ensues from these conditions, so that the person may recover from his/her condition, attain an age-appropriate level of self-sufficiency, and lead a stable life together with their families or within their communities. This term includes preventive interventions and activities geared toward reducing the risk or delaying the onset of mental disorders. Mental healthcare services may be offered in a wide array of places or settings covered under this Act. These include the following kinds of services, among others:

(1) *Treatment services.* — Which include, but are not limited to: psychotherapy, counseling, pharmacotherapy, and support therapy geared toward curbing or lessening the symptoms or the suffering caused by severe mental disorders.

(2) *Rehabilitation services.* — Which are geared toward curbing or lessening the impairment associated with mental disorders or mental health issues. These services may include, but are not limited to: individual strength and personal goal evaluation, readiness or disposition, training in a specific skill, and assistance in designing settings which enable the person to enhance his/her ability to function and participate in the community.

(3) *Support services.* — Which include services geared toward assisting persons to lead their lives successfully within the settings of their choice. Such services may include financial income support, social support, housing support, vocational support, or accommodations to suit the symptoms or impairment associated with the mental disorder or mental health issue.

(4) *Case management services.* — Geared toward assisting persons in gaining access to formal and informal resources that they might need in order to successfully cope with the repercussions of their condition. These resources may include interventions for treatment, rehabilitation, or support, ministered by formal or informal service providers. Case management may include an evaluation of the needs of the patient or client; intervention planning together with the person, his/her family, and the providers; establishing the connection between the patient or client and the services; monitoring or following up on the services offered; evaluating the effect of the services and support provided; and advocate on behalf of the patient or client.

(iii) *Interdisciplinary treatment services within the community.* — Means those treatment, rehabilitation and recovery services rendered by a direct or indirect provider, to reach out to the person within his/her own community, in order for the person to remain integrated therein and to be able to remain functional with the support of his family and community groups, [especially] in cases at high risk.

(jjj) *Severity.* — Means the intensity of the symptoms and signs that result in a significant impediment as to the person's social, working and occupational functionality at the time it is diagnosed.

(kkk) *Collaborative system.* — Means the interagency and community system of joint and collaborative work. Said system is characterized by the identification of a common problem in a common population, which through the arrangement of integrated services receives comprehensive services, thus involving an allocation of economic, professional and

technological resources that correspond to the needs of said population. These agencies have the legal responsibility of handling different manifestations of the problem and its triggering factors.

(lll) *Quality assurance system.* — Means the systematic compilation of data and efficiency factors for executing and implementing mental health treatment services and procedures in each level of care according to the protocol by disorder, age, gender and severity. This system forms part of the normal standards and procedures of the institution providing mental health services as a mechanism that allows the faculty to assure their quality.

(mmm) *Petition for mental health services.* — Means the action to request mental health services for treatment, recovery and rehabilitation in a providing institution.

(nnn) *Social worker.* — Means the social work professional with a degree from an accredited institution, who has evidence of College of Social Workers membership, with license issued by the Board of Examiners of Social Workers, pursuant to Act No. 171 of May 11, 1940, as amended [20 L.P.R.A. §§ 821 et seq.].

(ñññ) *Transportation.* — Means the action of moving a person from one place to another in a vehicle appropriate for his/her condition, which in the case of a medical-psychiatric emergency, shall include an ambulance certified by the Public Service Commission and the Department of Health. In the event that the person has the financial resources, including coverage under a health plan, to defray transportation expenses, these shall be defrayed under the coverage of his/her plan. In the case of persons receiving mental healthcare services under the Health Reform, the entity contracted to manage and coordinate the health services shall be responsible for defraying transportation expenses. If necessary, and in the absence of other alternatives, transportation shall be provided by ambulances serving under the 911 Emergency Hotline. Transportation shall cover from the point where the person who needs emergency services is located to any institutional provider of the medical services needed, or transportation between institutional health service providers. Transportation by ambulance shall meet the requirements set forth in the Emergency Medical Treatment and Active Labor Act, (42 USC § 1395; 42 CFR § 489.24) and §§ 3111 et seq. of this title.

(ooo) *Transfer.* — Means the action by which an institution makes a change in the responsibility of treating a person within the same institution, from one unit to another, from one service to another, or from one therapist to another. The change in treatment responsibility is also considered as a transfer when the transfer is made from one health institution to another. The transfer shall be made in a coordinated manner in order to continue rendering the service and treatment, according to the level of care person requires.

(ppp) *Mental disorder.* — Means a psychological syndrome or behavior pattern of clinical significance, which is associated with discomfort (i.e., pain), an impairment (deterioration in one (1) or more areas of functionality), or the significantly increased risk of dying or experiencing pain, an impairment or the loss of freedom. This syndrome or pattern should not be merely a culturally acceptable response to a particular event (i.e., the death of a loved one). Whichever its cause, this syndrome or pattern should be regarded as the individual manifestation of a behavioral, psychological or biological dysfunction. Controlled substance or alcohol abuse or dependency is included in this definition for being regarded as a mental disorder, as established in the Manual of International Classification of Mental Diseases (DSM-IV-TR) in effect, in its fourth and subsequent editions. It is hereby provided, that any subsequent version of this definition shall be applied by reference of this Act, insofar as the same is contained in the Diagnostic and Statistical Manual in effect.

(qqq) *Substance-related disorders.* — Means the abuse of and/or dependency on alcohol, prescription drugs, solvents, illegal drugs, etc., as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), in its fourth and subsequently revised editions.

(rrr) *Acute treatment.* — Means the prompt and intense intervention by mental health professionals to attend a person with an acute clinical condition in order to avoid, stop or decrease the symptoms and signs of the condition and its consequences. Among others, it may include intervention during crisis, use of psychoactive drugs, hospitalization, restriction and isolation.

(sss) *Compulsory treatment.* — Means the treatment ordered by the court, under penalty of contempt, upon recommendation from the inter- or multidisciplinary team to be given to a person with a mental disorder who, although he/she does not meet the severity requisites, represents danger to the self to others, or to property, and meets the requirements for another level of care, such as ambulatory care, partial hospitalization or maintenance with medication.

(ttt) *Complementary treatment.* — Means the therapeutic services not included in the basic services of the mental health services system, which may help in the recovery process of a person with a mental disorder, as recommended by mental health professionals, such as art, sports and others.

(uuu) *Community or Community-based treatment.* — Means the strategies and efforts established by for-profit or nonprofit community-based organizations that develop service programs, which may include guidance, education, counseling, assistance, support, and treatment, recovery and rehabilitation services for persons who need services to address mental health issues, including disorders relative to drug and/or alcohol abuse or dependency.

(vvv) *Legal guardian.* — Means the person designated by the court to be in charge of the care and custody of a person and his/her property, upon the corresponding declaration of disability issued by the court.

(www) *Visit.* — Means any intervention conducted by a healthcare professional, as defined in this Act, on a person receiving services, with the purpose of evaluating, diagnosing, and providing treatment and counseling to manage a mental disorder. Visits include the whole range of visits established in the codes, diagnoses duly accepted by the medical community. This includes introductory visits, follow-up visits, and any collateral visit needed to effectively treat the person who receives mental healthcare services, as defined below:

(1) *Introductory visit.* — Refers to the first intervention of a mental healthcare practitioner, after the placement of a patient, whereby the plan of action to be followed is set forth.

(2) *Follow-up visit.* — Refers to subsequent visits made to ascertain compliance with the plan of action and the present condition of the patient.

(3) *Collateral visit.* — Refers to the visit made to a mental healthcare practitioner that requires the presence of a close relative, in the case of adults, or of a parent, legal guardian or custodian, in the case of minors. Said visit provides for information to be furnished and for guidance to be received as to the management of the person who receives mental healthcare services.

CHAPTER II — GENERAL RESPONSIBILITIES OF MENTAL HEALTH SERVICE PROVIDERS AND GENERAL PROVISIONS FOR ADULTS AND MINORS

Section 2.01. — Special Considerations for Persons with Severe Mental Disorders. (24 L.P.R.A. § 6153)

Populations with severe mental diseases, by level of intensity and multiple needs of their conditions, require particular and special attention regarding their mental health care systems in order to make the decision of participating in the treatment and continue with it, as well as to achieve and keep the stabilization of the symptoms and signs.

The considerations for persons with acute mental health disorders, that is adults, adolescents, children, by gender, according to the definitions established in mental diseases classification manuals in effect and federal regulations and structural criteria for services to these populations, are established in this Chapter pursuant to the provisions of Public Law 102-321 of June 10, 1992, as amended, known as the "Alcohol, Drug Abuse and Mental Health Services Administration Reorganization Act".

Section 2.02. — Criteria for Severe Mental Disorders in Children and Adolescents. (24 L.P.R.A. § 6153a)

The criteria that shall be considered for severe mental disorders in children and adolescents shall be the following:

- (a) That he/she is less than eighteen (18) year old.
- (b) That at the present time or during the past year, he/she has been diagnosed with a mental, emotional or behavioral disorder.
- (c) That he/she complies with the criteria specified for treatment, pursuant to the Diagnostic and Statistical Manual of Mental Disorders — Fourth Revision (DSM IV), the ICD-10, or the manuals in effect at the time.
- (d) That said disorder resulted from a functional disability that interferes or limits the child or minor's ability [to] function with his/her family, in school or in the community.

Section 2.03. — Prohibition of Hospitalization or Treatment Without Clinical Criteria. (24 L.P.R.A. § 6153b)

The lack of interest or the inability of the parent with legal or physical custody, the legal guardian or the person with physical custody or the duty to provide care and shelter to a person, shall not constitute grounds for having him/her placed in a mental healthcare hospital when he/she does not meet hospitalization criteria. If this should be the case, the director of the institution shall file a petition with the court to secure adequate care and shelter. The practice of hospitalizing a person when he/she does not meet adequate clinical criteria shall be penalized pursuant to the provisions of Article 168 of the Puerto Rico Penal Code [33 L.P.R.A. § 4796].

The criteria to be met by any person so that a court may order mandatory psychiatric treatment, be it on an outpatient basis or by hospitalization, are:

(a) Situations posing the imminent danger of the person inflicting harm upon him/herself or others or damaging property or whereby the person proves to be unable to make decisions or control his/her behavior.

In such a case, it shall be required to provide proof of the specific behavior within a time lapse that precedes the time of filing the petition; proof of the absence of less-intensive alternatives that could equally correct or improve the person's symptoms and signs; and proof of the fact that the treatment or measure requested shall yield beneficial clinical results.

No person shall be placed involuntarily or receive mandatory treatment unless there is clear and convincing proof, to the court's satisfaction, that there is a need for such placement or treatment, according to the criteria established in this section.

Section 2.04. — Certificate of Specialized Treatment in Isolation, Restriction and Electroconvulsive Therapy. (24 L.P.R.A. § 6153c)

Every mental health professional empowered by this Act to order restriction, isolation or electroconvulsive therapy shall complete training in the use and application of these therapeutic methods, credited by the applicable certificate. The provisions of this Section are subject to the regulations [that the Administration promulgates for these purposes].

Section 2.05. — Protocol Requisite for the Use of Isolation, Restriction and Electroconvulsive Therapy. (24 L.P.R.A. § 6153d)

Every entity that provides mental health hospital services that uses therapeutic isolation, restriction and electroconvulsive therapy procedures shall have a protocol that incorporates the best practices and standards in the treatment of persons with mental or emotional disorders, according to the parameters established by the medical organisms that regulate these therapeutic procedures, and pursuant to the requirements of the Administration.

Section 2.06. — Services Manual. (24 L.P.R.A. § 6153e)

Every institution that provides ambulatory health services shall have a descriptive services manual, which shall include, as a minimum, the following:

- (a) The criteria of admission that must be met any person who requests the services.
- (b) The age and level of care of the applicants.
- (c) The model of the individualized treatment, recovery and rehabilitation plan.
- (d) The composition of the personnel the institution shall have, as well as their qualifications; Provided, That this section shall not apply in those cases of private mental health professional offices.

Section 2.07. — Notice of Right to Confidentiality. (24 L.P.R.A. § 6153f)

Insofar as the person who receives mental healthcare services is able to communicate rationally, the mental healthcare service provider shall notify him/her in writing and orally, at the time of the initial evaluation or as soon as possible after the same, of his/her right to confidentiality. He/She shall be also informed that any violation of the provisions that protect

confidentiality is a crime, pursuant to the provisions of subsection (b) of Section 15.08 of this Act, and he/she shall receive a written notice of the proper procedures to notify any case of violation. The notification required in this section shall be made to the parent with legal or physical custody, or to the legal guardian, in all cases in which mental healthcare services are provided to a minor or a disabled person.

The mental healthcare professional assigned through institutional regulation to notify as provided in this section shall include the contents of said notice in the clinical record, as well as the date and time when said notice was delivered, in a form provided by the Administration, which shall be signed by the recipient so that the form is understood to be completed. The direct mental healthcare service provider, whether an individual or an institution, shall notify the patient, if he/she has a health plan, that the indirect provider may access his/her clinical record to ascertain services rendered in order to pay for the same. In examining the record, the indirect provider shall not have access to the notes of the psychotherapist.

Section 2.08. — Inspection of Clinical Record. (24 L.P.R.A. § 6153g)

Persons who receive mental healthcare services may inspect their clinical records inasmuch as the mental health science professionals who provide outpatient services at their private offices or the inter- or multidisciplinary team within an institution determines that the person who receives the services is capable of interpreting the information reasonably; Provided, That no information shall be provided when it may constitute a risk to the person who receives the services and/or to third parties. He/She may also have a copy of the complete record upon written request to that effect and payment of the corresponding fees; being the inclusion on clinical grounds of the psychotherapy notes, as these are defined in this Act, at the discretion of the mental healthcare professional and/or the interdisciplinary team. The institutional provider shall assign a mental healthcare professional to explain any matter relative to the information contained in the clinical record. If, in the judgment of the mental health science professionals that render services to the patient, the patient is not fit to receive his/her complete record, such a determination shall be notified to the patient or to his/her guardian or caregiver; in default thereof, a petition shall be filed before the Court of First Instance for an appointee. Furthermore, the Court of First Instance shall review the determination whereby the surrender of the complete record is denied and adopt the measures it deems pertinent. Provided, That the mental healthcare professionals who render services to the patient shall not be held civilly liable for their refusal to surrender the complete record in those cases in which the court has intervened.

Any other person expressly authorized, as provided in this Act, by the person who receives mental healthcare services, by the court or by his/her legal guardian, may inspect the clinical record at the institution, obtain a summary of the record and a copy of any document expressly authorized upon payment of the corresponding fees, insofar as the reproduction of the documents does not constitute the complete record or those documents expressly prohibited under this Act.

The right to confidentiality of the patient may only be forgone in those cases expressly contemplated under this Act.

The parent with legal or physical custody or the legal guardian of the minor who receives mental healthcare services, shall have the right to examine, at the institution, said minor's record exclusively in matters relative to the diagnosis, severity, prognosis, treatment plan, medications, recommendations to the family, and the amount and kinds of therapy offered. Any other

information requested by these persons shall have the express authorization of the minor if he/she is fourteen (14) years of age or older, or of the court when the minor does not authorize the inspection of the information requested, or if the minor is thirteen (13) years of age or younger. In addition, he/she may obtain a copy or a summary thereof upon written request to that effect and the payment of the corresponding fees.

When the person who received mental healthcare services dies, any request presented by a family member, up to the fourth degree of consanguinity or affinity, to inspect or obtain a copy of any part or the complete record, shall require a court order.

In all cases, and upon any inspection or copy of the record, the institutional provider shall offer guidance as to the possible consequences of disclosing the information contained in the record.

The corresponding payment for copies of any part or the complete record shall not exceed seventy-five cents (75 cent(s)) per page or twenty-five dollars (\$25) for the complete record. For those cases in which the person does not have the financial means to pay for the cost of the copies, the procedure to follow shall be established through regulations by the Administration.

Section 2.09. — Reports. (24 L.P.R.A. § 6153h)

Any report that does not constitute a clinical record and contains direct or indirect information about the person who receives or has received mental health services shall use codes to refer to the person, and shall not include in any of its parts, any name nor nickname. This section does not prohibit the disclosure of information in those cases in which federal and state laws apply for the protection of the person who receives mental health services.

Section 2.10. — Express Authorization; Requirements. (24 L.P.R.A. § 6153i)

The express authorization required pursuant to this Act shall meet the following requirements when the information is requested by third parties:

- (a) The specific name of the institutional provider authorized to disclose the information;
- (b) the name of the natural or juridical person authorized to receive the information;
- (c) the name of the person who consents to the disclosure. When other than the person who receives mental healthcare services, a sworn statement shall be included stating the source of his/her authority to give consent;
- (d) the specific information to be disclosed, which shall not include psychological testing protocols, information relative to other family members or to persons who have been involved in the treatment process, and/or notes containing the dialogue between the provider and the person who receives mental healthcare services during treatment sessions;
- (e) the specific purpose for which the information requested and authorized shall be used, and the signature;
- (f) the date when the consent is given;
- (g) the date of expiration of the consent given, and any condition or event that would invalidate the consent upon its occurrence;
- (h) notice of the fact that the participant may revoke the consent given at any time, and
- (i) the signature of the person giving the consent.

The express authorization shall be made in a written document, which shall expire not later than twelve (12) months after the signature and date of issuance, without impairment of having

the consent expiration date lapse at a shorter term or of the authorizer's right to revoke said consent at any time.

Section 2.11. — Quality Assurance System. (24 L.P.R.A. § 6153j)

Any institutional provider of mental healthcare system services shall have a quality assurance system for the services rendered, which shall assess and oversee that the quality of said services is maintained, as well as the adequate use of the procedures administered to patients pursuant to the best practices in the mental healthcare field and to that which is established in this Act. This system shall oversee, study and keep the medical director and the medical faculty of the institutions informed on all matters relative to the services and practices implemented therein. The Administration shall specify through regulations the scope of these quality systems, compatible with the federal regulations for these populations.

It shall be the responsibility of the mental healthcare service providers to keep a compilation of basic statistical data that provide indicators of the incidence of mental disorders and substance abuse, according to the characteristics of the population. Said statistical data shall be informed to the Administration.

Section 2.12. — Patient Guidance and Complaint Management Offices. (24 L.P.R.A. § 6153k)

All mental healthcare service providers shall have offices for people to be offered guidance about their services. As pertains to services offered under the Puerto Rico Government Health Plan and by indirect providers, said offices shall be seated in centrally located places in the area of greater concurrence of the region. These offices shall process any complaint lodged by persons on the services they receive. Complaints are to be managed until the person's need for services is satisfied. The offices established to provide guidance to patients and their families shall be the responsibility of the entities that administer, coordinate, and plan mental healthcare services for the Puerto Rico Government Health Plan and of indirect providers, and the Health Insurance Administration shall be responsible for overseeing compliance with this provision. As pertains to all other indirect providers, the Insurance Commissioner shall be responsible for overseeing compliance with this provision.

Section 2.13-A — Electronic or Computerized Clinical Records. (24 L.P.R.A. § 6153k-1)

Vis-a-vis the worldwide trends and the federal initiatives as regards to the management of healthcare information by electronic means, all mental healthcare service providers shall record the clinical records for their patients on electronic or computerized media as of January 1, 2010. Such electronic or computerized clinical records shall meet the following requirements:

- (a) They shall include all the information required for clinical records on paper.
- (b) The information on the electronic/computerized clinical record shall be the property of the person who receives mental healthcare services and shall be under the custody of the institutional provider and shall not be shared with third parties, except for the purpose of paying for services, or by means a written express authorization by the person who receives mental healthcare

services in compliance with the provisions of law or by means of a order from the court or from a regulatory agency or a public or private agency with custody over said person.

(c) *[Note: blank in the original act]*

(d) Said records shall be under the custody of the director of the institution or the personnel designated by him/her or under the direct custody of the mental healthcare service provider.

(e) Said records shall meet all electronic security provisions required under the HIPAA and/or any other federal or Commonwealth legislation whose requirements are more stringent than those of this Act.

(f) The electronic or computerized clinical record to be used shall be certified by the Certification Commission for Healthcare Information Technology (CCHIT) appointed by the federal government.

(g) In order to prevent patients from being constricted as to their access to their mental health information for treatment or for other valid purpose under the law, in the event of a change in the proprietary provider of electronic/computerized information systems-mental healthcare service provider relationship and to keep the costs of the electronic or computerized mental health clinical record as low as possible, it is necessary to use, to the extent practicable, open source or open source-based solutions.

(h) The institutional or individual provider of mental healthcare services that uses electronic or computerized clinical records shall give priority to considering using electronic or computerized clinical record solutions which are free of charge and are offered and used by the federal government.

(i) The programming for electronic or computerized clinical records to be used shall separate and restrict access to mental healthcare information from access to the patient's general healthcare information.

(j) Electronic or computerized clinical records must adopt the interoperability standards established by the federal initiative known as the National Healthcare Information Infrastructure/Network--NHII.

(k) Electronic or computerized clinical records must be [able to be integrated] into the regional healthcare information initiatives which are a part of the National Healthcare Information Infrastructure/Network--NHII, directed by the private sector.

Section 2.13-B. — Clinical Record. (24 L.P.R.A. § 6153l)

All institutional providers shall keep and conserve a precise, clear, and legible record on each person who receives mental healthcare services. Such record shall contain all the requirements established under the laws and regulations approved by the Secretary of Health, in addition to the following information:

(a) The circumstances under which the person was evaluated or admitted, depending on the case.

(b) The documentation required for the patient's placement.

(c) The clinical findings made by a qualified professional who renders mental health services.

(d) The diagnosis and diagnostic impression.

(e) The individualized treatment, recovery and rehabilitation plan.

(f) The prognosis and estimated release date.

(g) Any change that may arise in his/her state.

(h) Notations to record any situation relative to the person's treatment and management, contemporaneous with the date on which the service was rendered.

(i) Psychotherapy notes shall be deemed not to be a part of the clinical record.

The clinical record shall be the property of the person who receives mental healthcare services, and as provided in Section 2.08, he/she may receive a copy of the complete clinical record pursuant to the conditions set forth in said Section 2.08. The clinical record shall be held under the custody of the institutional provider, and shall not be removed from the same, except otherwise provided by a court order, or by written request and payment of the corresponding fees by the person who receives mental healthcare services. The director of the institution shall oversee its confidentiality. To that effect, the institution shall provide all the necessary resources to establish mechanisms to protect the confidentiality, disclosure, and the clinical information contained in the record against unlawful use, unauthorized access, and alteration.

In the event that the patient needs his/her record because he/she is moving to another place outside of Puerto Rico, or decides to change to another health providing service, the institution shall furnish said record to the new service provider by means of the express authorization mechanism provided for under this Act.

Section 2.14. — Duty to Safeguard Confidentiality. (24 L.P.R.A. § 6153m)

Unauthorized disclosure of information related to a person who receives mental healthcare services is hereby prohibited, including any third party who has received this information, be it verbally or in writing, upon express authorization, whether or not said information is contained in the record.

The person who receives mental healthcare services shall offer his/her express authorization, as defined in this Act, for sending the information by fax. If accessibility of the information is through computerized or electronic systems, it shall be protected by security codes or any other acceptable security system, as provided for under Section 2.13-A of this Act.. The Administrator shall adopt regulations for said purposes. The person sending the information, as well as its recipient, shall comply with the regulations. It is furthermore prohibited to disclose information about the person with a mental disorder that has been supplied by a third party, and that may cause bodily injury or put at risk said party or another person.

The duty to safeguard the confidentiality of the information related to a person who receives mental healthcare services from any institutional provider shall apply to all those professionals that render said services, and to the support personnel, including indirect healthcare service providers. This duty shall extend to any person who is receiving or shall receive mental healthcare services, even after his/her death.

Section 2.15. — Prohibition to Disclose to Third Party for All Those Who Receive Confidential Information. (24 L.P.R.A. § 6153n)

Any person who receives confidential information is hereby prohibited from its disclosure to any third party if no express authorization has been given by the person who receives mental healthcare services.

Any confidential information disclosed under the terms of this Act shall be accompanied by a document stating that the information disclosed is protected by the applicable federal and

Commonwealth laws and regulations of confidentiality, and that the same prohibit the person who receives the information from its disclosure to a third party.

Section 2.16. — Disclosure to Authorized Personnel of the Juvenile and Criminal Justice System. (24 L.P.R.A. § 6153o)

When the person receives mental health treatment services as a condition established by a court for his/her probation, conditional release, etc., the providing institution may disclose to the personnel so authorized by the Criminal or Juvenile Justice System, as the case may be, only the information needed to carry out the supervision required to comply with the condition imposed by the court. The person who receives the information may only disclose it to comply with his/her official rights in relation to the condition imposed by the court.

Section 2.17. — Prohibition as to the Use of Identification Cards. (24 L.P.R.A. § 6153p)

No mental health service provider shall require to the person who receives said services to carry an identification card or any other object that would identify him/her as a person who receives mental health services while outside the institution that provides said services.

Section 2.18. — Duty to Warn Third Parties at Risk or Under Threat of Harm. (24 L.P.R.A. § 6153q)

(1) When a person informs a physician, psychiatrist, psychologist, social worker, professional counselor, or any other healthcare professional of a threat to physically harm a third party, the physician, psychiatrist, psychologist, social worker, professional counselor, or healthcare professional shall have the duty to warn said third party of the possibility of a threat, when he/she may be reasonably identified, after complying with the provisions of this section.

(2) In the event that the threat to harm a third party is informed to any other person rendering services to a mental health patient, he/she shall immediately so notify the physician, psychiatrist, psychologist, social worker, professional counselor, or any other healthcare professional in charge of rendering mental healthcare services to the person, and shall so state in detail in the clinical record.

(3) In order for the duty to warn to arise, the physician, psychiatrist, psychologist, social worker, professional counselor, or other healthcare professional must:

(a) Have identified, evaluated, and verified the existence of a threat to harm a third party in particular, and

(b) have established that, upon taking into consideration the risk factors associated with violence, there is a great probability that said threat could be carried out.

(4) Once the threat is notified, the physician, psychiatrist, psychologist, social worker, professional counselor, or other healthcare professional shall warn the person under threat, and carry out the following actions:

(a) Provided it is therapeutically indicated, he/she shall inform the person who proffers the threat of the duty to warn that he/she has pursuant to this Act;

(b) notify the threat to the police station closest to the residence of the third party put at risk;

- (c) notify the third party of the threat to harm him/her, handling this situation with tact and caution, and
- (d) if he/she has reasonable basis to believe that the third party is not able to understand or is a minor, he/she shall notify a family member of the existence of the threat.
- (5) In those situations in which the professional believes that the person issuing the threat meets the criteria needed for hospitalization, such professional shall initiate the procedures for voluntary or involuntary hospitalization.
- (6) In those situations in which the risk is informed while the person is hospitalized, the physician, psychiatrist, psychologist, social worker, professional counselor, or other healthcare professional, shall notify the medical director, and shall so state in detail in the clinical record.
- (7) Any information entered in the clinical record as per the requirements of this section shall be included in a separate section within the clinical record. This information shall be deemed to be privileged and confidential for disclosure purposes.
- (8) When a psychiatrist, physician, psychologist, social worker, professional counselor, or any other healthcare professional determines that a particular situation requires carrying out the duty to warn, he/she shall be held harmless from any civil liability, insofar as there is no gross negligence involved in the discharge of his/her duty. Moreover, mental healthcare professionals who, in good faith, carry out their duty to warn shall not be breaching the physician-patient privilege, pursuant to the provisions of Rule 26 of the Rules of Evidence of 1979, as amended.
- (9) Any law enforcement officer (from both the Commonwealth and the municipal police) who has been notified by a mental healthcare professional, a relative, or any citizen, as to the risk or threat posed by a mental health patient to harm him/herself or others or to damage property, shall respond as soon as practicable to protect the persons or the property involved.

Section 2.19. — Duty to Warn of Suicide or Self-mutilation Risk. (24 L.P.R.A. § 6153r)

- (1) When a person communicates to a physician, psychiatrist, psychologist, social worker, professional counselor, or other healthcare professional his/her intention to commit suicide or self-mutilation, or when such professional believes, based on the person's behavior, that said person might attempt to conduct such actions, the physician, psychiatrist, psychologist, social worker, professional counselor, or other healthcare professional shall have the duty to warn a family member of the possibility of an attempt to carry out said act. Provided, That in the case of inmates, notice shall be given to the director of the institution where the person in question is confined.
- (2) In the event that the intention to commit suicide or self-mutilation is communicated to another mental healthcare professional, said professional shall immediately so notify to the psychiatrist, psychologist, social worker, professional counselor, or any other healthcare professional in charge of rendering mental healthcare services to the person, and shall so state in detail in the clinical record.
- (3) In order for the duty to warn to arise, the physician, psychiatrist, psychologist, social worker, professional counselor, or any other healthcare professional must:
 - (a) Having identified and evaluated the existence of an intention to commit suicide or self-mutilation, and
 - (b) having stated that after taking into consideration the risk factors associated with suicide and self-mutilation, there is a great probability that said intention could be carried out.

(4) Once the intention to commit suicide or self-mutilation is communicated, the physician, psychiatrist, psychologist, social worker, professional counselor, or any other healthcare professional shall be charged with the duty to warn, and shall carry out the following actions:

(a) Provided it is therapeutically indicated, he/she shall inform the person who states his/her intention to commit suicide or self-mutilation of the duty to warn that he/she has pursuant to this Act.

(b) Notify a family member of the threat, handling this situation with tact and caution.

(5) In those situations in which the professional believes that the person communicating his/her intention to commit suicide or self-mutilation meets the criteria needed for hospitalization, such professional shall initiate the procedures for voluntary or involuntary hospitalization.

(6) In the event that the intention to commit suicide or self-mutilation is communicated while the person is hospitalized, the physician, psychiatrist, psychologist, social worker, professional counselor, or any other healthcare professional shall notify the medical director, and shall so state in detail in the clinical record.

(7) Any information entered in the clinical record as per the requirements of this section shall be included in a separate section within the clinical record. This information shall be deemed to be privileged and confidential for disclosure purposes.

(8) When a physician, psychiatrist, psychologist, social worker, professional counselor, or any other healthcare professional determines that a particular situation requires carrying out the duty to warn, he/she shall be held harmless from any civil liability, insofar as there is no gross negligence involved in the discharge of his/her duty. Moreover, mental healthcare professionals who, in good faith, carry out their duty to warn shall not be breaching the physician-patient privilege, pursuant to the provisions of Rule 26 of the Rules of Evidence of 1979, as amended.

(9) Any law enforcement officer (from both the Commonwealth and the municipal police) who has been notified by a mental healthcare professional, a relative, or any citizen, as to the risk or threat posed by a person to harm him/herself or others or to damage property, shall respond as soon as practicable to protect the persons or the property involved.

Section 2.20. — Carrying Weapons Inside the Institution. (24 L.P.R.A. § 6153s)

It is hereby prohibited to carry weapons inside any mental healthcare institution. This prohibition excludes Commonwealth police officers and armed security officers in extraordinary public safety conditions, as well as in methadone treatment centers and their mobile or in-house units. If no extraordinary public safety issues should arise so as to warrant the carrying of weapons inside a mental healthcare institution, Commonwealth police officers and other security officers shall be under the obligation to surrender their weapons to the administrator of the institution, who shall see to their safekeeping and return the same to such officers, once they have completed their business within the institution.

Section 2.21. — Adoption of Norms and Procedures. (24 L.P.R.A. § 6153t)

The director of each institutional provider shall adopt norms, regulations, and procedures as necessary within his/her institution to assure compliance with all the provisions of this Act, and the same may broaden or extend, but they may neither restrict nor constrict the rights guaranteed to persons who receive mental healthcare services.

All norms and procedures relative to the implementation of this Act shall be revised annually. Said process shall be documented and shall form part of the licensing requirements for all institutional providers.

Section 2.22. — Reconsideration of Determination of Admission, Transfer, Release or Change of Status. (24 L.P.R.A. § 6153u)

All providing institutions shall develop and implement a procedure for reconsidering and revising all clinical determinations.

When a person is denied entrance or admission, or is notified that he/she shall be transferred or released, or that his/her condition shall change and opposes to it, the director of the institution shall inform the person of the procedure to follow. This procedure shall include the following:

- (a) Once the person is notified of the determination, or in the case of a minor, his/her parent with patria potestas or custody or the legal guardian, he/she shall have the right to request from the director, or his/her representative, a written reconsideration of the same, within the next twenty-four (24) hours.
- (b) The director or his/her representative shall evaluate and make a determination within twelve (12) hours after the written reconsideration is received and shall inform his/her decision to the petitioner.
- (c) If the person is not satisfied with the determination made by the director or his/her representative, he/she may file a request for review before the Review Committee of the institution that offers mental health services.

In case of an indirect mental health service provider, the procedures established for said entities shall apply.

Section 2.23. — Review Committee (24 L.P.R.A. § 6153v)

The review committee shall be constituted by a psychiatrist and an inter- or multidisciplinary team different from that which tends to the person, as defined in this Act, to be appointed by the director of the institution. As part of this committee, a representative from an independent community-based organization shall be designated to represent the public interest. Said committee shall be empowered to review the determinations made by the medical director or his/her representative, when the reconsideration procedure has been followed pursuant to the provisions of the preceding Section. Once the request for review is received, the committee shall open a record of the proceedings, which shall form part of the person's clinical record. The committee shall have two (2) working days to conduct a review hearing. The petitioner or his/her representative shall have the right to be heard and to present evidence in said hearing. Within forty-eight (48) hours after the hearing is held, the committee shall submit its findings of facts and conclusions in writing to the petitioner or his/her representative, and to the director of the institution. If the petitioner does not agree, he/she may file an injunction with the Court of First Instance.

When any of the members of the review committee is related with the situation to be considered, he/she shall disqualify him/herself from reviewing the case.

The committee shall conduct its proceedings so as to guarantee an impartial hearing and due process of law.

Section 2.24. — Responsibility Towards the Family. (24 L.P.R.A. § 6153w)

Family members of the adult who receives mental health services shall be treated with respect and dignity. Family members shall have the opportunity to provide information to the professionals in charge of the treatment. They shall also receive educational information related to the nature of the disorders, medications and their side effects, support services available and support groups, as well as assistance in crisis management strategies. All providing institutions shall furnish this information.

Section 2.25. — Presence of a Family Member. (24 L.P.R.A. § 6153x)

When a mental healthcare professional requires the presence of a family member or the legal guardian of an adult, or the parent with physical or legal custody or the legal guardian of a minor who receives mental healthcare services, the family member shall respond immediately. When the family member or legal guardian refuses to respond without any justified reason, after having been duly summoned on two (2) consecutive occasions, and such summons are so entered in the clinical record, the director of the institutional provider, by petition of the mental healthcare professional, may resort to the Court of First Instance to request that an order to appear be issued under penalty of contempt. Said order shall be served by a [courts] marshal not later than twenty-four (24) hours after its date of issue. The institutional provider shall notify the court whether or not the person so ordered appeared. If the person thus summoned should not appear, the court may impose a contempt order, as well as any other applicable measure.

Section 2.26. — Duty to Publish. (24 L.P.R.A. § 6153y)

The rights stated in this Act shall be posted in a visible place at all institutions that provide mental health services, and [a] copy of these rights shall be delivered to the persons who receive services by virtue thereof. In addition, the responsibilities of the persons who receive mental health services shall be posted in a visible place.

CHAPTER III — BILL OF RIGHTS OF ADULTS WHO RECEIVE MENTAL HEALTH SERVICES

Section 3.01. — Bill of Rights. (24 L.P.R.A. § 6154)

The provisions of this Chapter shall be interpreted so as to protect and promote the dignity of the human being through recognition of the essential rights for his/her treatment and rehabilitation.

Section 3.02. — Protection of Constitutional Rights. (24 L.P.R.A. § 6154a)

Any adult who receives mental health services shall continue to enjoy his/her rights, benefits and privileges pursuant to the Constitution of the United States of America and the Constitution of Puerto Rico, as well as state and Federal laws, while receiving evaluation or treatment and

rehabilitation, and during the process of admission, transfer or release in any providing institution.

Section 3.03. — Presumption of Mental Competency. (24 L.P.R.A. § 6154b)

It is presumed that all persons are mentally competent, except otherwise determined by a court. The judicial determination of disability under Section 703 of the Civil Code of Puerto Rico, as amended, shall be distinct and separate from the judicial proceeding to determine if an adult should be subject to involuntary admission.

It shall be presumed that any person with a mental or emotional disorders has the potential to recover and rehabilitate upon receiving mental health services adequate to his/her diagnosis and the severity of his/her symptoms and signs.

Section 3.04. — Limitation of Rights. (24 L.P.R.A. § 6154c)

The rights established by this Act for adults who receive mental health services are applicable to those adults serving a sentence or confined in penal or forensic-psychiatric institutions, as long as they are not in conflict with the security measures established in the institution.

Section 3.05. — General Rights. (24 L.P.R.A. § 6154d)

Any adult who needs, requires and/or receives mental health services shall have the following rights:

- (a) To receive medical, psychiatric and psychological attention in its preventive, clinical, recovery and rehabilitation phases for the protection of his/her health and general well-being.
- (b) To practice a profession, occupation or trade, according to his/her knowledge and capacity, taking into consideration his/her mental disorder and level of functionality.
- (c) To request employment and be employed within existing employment opportunities available, without being discriminated against for reason of mental disorder, and to participate in workshops and receive the technical or professional orientation and help that shall allow him/her to develop his/her potential.
- (d) To have access to public services and benefits of housing, social welfare, health, food, transportation, education and employment.
- (e) To act [individually] or collectively while searching for solutions to his/her problems and grievances.
- (f) To be heard, listened to and consulted in all matters that affect his/her condition and progress.
- (g) To receive ambulatory medical-hospital services without being discriminated for having a mental disorder.

Section 3.06. — Specific Rights. (24 L.P.R.A. § 6154e)

All adults who need, require, or receive mental healthcare services shall be entitled to the following specific rights:

(a) *Access to services.* —

All adults shall have access to mental healthcare services in accordance with the specialties and sub-specialties by stage of life, gender, disorder, age, and level of care, as per their diagnosis and the severity of symptoms and signs. Treatment services shall be rendered on an ongoing basis, in accordance with the level of intensity and the severity of the symptoms and signs, in order to achieve recovery in a reasonable level of functionality. To that effect, adults who receive mental healthcare services shall not be subject to discrimination or prejudice, and shall have access to said services, without distinction of diagnosis and severity of their mental disorder, except as provided for in this Act. This right may not be constricted due to the existence of any physical condition or disability. There shall be no distinction between a mental disorder and any other medical condition in terms of the access that persons shall have to the services they need, except as provided for in this Act.

No direct or indirect provider may establish distinctions as to the rendering, access, administration, or planning of mental healthcare services which might be discriminatory against this population.

The use of mental healthcare services at all levels of intensity, shall be determined by the inter- or multidisciplinary team, on the basis of the justified clinical need, which, in turn, shall be based on the diagnosis and the severity of symptoms and signs of the mental disorder, as defined in the disorder classification manual in effect at the time.

No direct or indirect provider may impose its medical criteria in the payment for mental healthcare services which have been found to be necessary by mental healthcare professionals, medical psychiatrists, and other practitioners duly qualified for such purposes, who are in charge of providing healthcare to the patient.

They shall also be entitled to receive pharmacotherapy services, as well as all kinds of therapy within the standards acceptable in the practice of psychiatry and psychology, including, but not limited to psychotherapy, support services, and others befitting their diagnosis and the severity of symptoms and signs, pursuant to optimal clinical parameters.

It is hereby provided that access to ambulance services shall be accorded by means of the 911 System and/or Medical Emergencies, whether this is a service under Commonwealth and/or health plan coverage, when an emergency arises which involves a person suffering from a mental disorder. Such services shall be rendered without discrimination or prejudice against persons suffering from mental disorders. These services shall be rendered upon the request of a mental healthcare professional or the person him/herself or any citizen who believes that the situation is potentially dangerous to a person's life or to property.

All direct or indirect mental healthcare service providers shall be under the obligation to render services within the first fifteen (15) working days as of the date of being so requested, insofar as such a request does not issue from a psychiatric emergency. Direct or indirect mental healthcare service providers are hereby prohibited from keeping waiting lists to offer services to people who so request, which exceed the fifteen (15)-working-day limit established in this section. In the event that a direct or indirect provider is unable to provide services within such term, such provider shall be under the obligation to refer and to coordinate the services to be rendered.

(b) *Right not to be identified as a mental health patient.* —

Any adult who receives mental healthcare services shall have the right not to be identified as a patient, or as a former patient, except when the person so requests or authorizes pursuant to the procedure established in this Act for such purpose.

(c) Notification of rights; limitations. —

Any adult who requests mental health services has the right to receive notification at the time of being admitted or hospitalized in the providing institution, or as soon as possible after the same, of the rights guaranteed pursuant to this Act.

To that effect and in accordance with Section 2.07 of this Act, the director of the institution or his/her representative shall advise the adult receiving the mental health services, the person designated by him/her, or his/her legal guardian in the case of those legally declared as mentally disabled. In the case of adults who request services voluntarily, the director of the institution or his/her representative shall expressly inform him/her of the right to be released from the institution within the shortest term possible. If the adult has been admitted voluntarily, he/she, or his/her legal guardian, family member or any other person so designated by the adult who receives mental health services shall receive a petition for release form.

Moreover, he/she shall receive a written document of the operating norms of the institution, which shall include, among others, the procedures to decide placement, to review said placement, and the claims and complaints procedures. In addition, during the process of admission or hospitalization, the person shall receive a detailed explanation of any limitations he/she may suffer while hospitalized, and the obligation that they result from a justified medical determination made by the inter or multidisciplinary team and are included in the clinical record. Admissible limitations shall also be notified to the closest family member, the legal guardian or the attorney, if any.

No limitation shall apply when the communication is between an adult, his/her representative, legal tutor, attorney or the court, or between the adult and another individual on matters related to administrative or legal procedures.

(d) Individualized treatment, recovery and rehabilitation plan. —

Every adult shall have the right to have an inter or multidisciplinary, safe and human individualized treatment, recovery and rehabilitation plan designed for him/her, within the least restrictive environment possible, according to his/her condition.

Any adult who receives the services shall participate in the preparation and revision of the plan to the degree to which said participation is possible. In addition, the participation from his/her closest family member shall be required. The case handler shall be responsible for giving follow-up to the implementation of the inter or multidisciplinary individualized treatment, recovery and rehabilitation plan. The clinical record shall contain the signature of all the professionals participating in the elaboration of the plan, and that of the adult or family member who represents him/her during its preparation.

(e) Informed consent. —

Every adult shall have the right to know everything related to the services or treatments proposed by his/her inter or multidisciplinary individualized treatment, recovery and rehabilitation plan, for mental health services, before consenting to it. Every time an adult receives mental health services, regardless of the level of care, his/her informed consent shall be obtained, or that of his/her legal guardian, in the case of an adult who has not been legally declared disabled. The information and orientation shall be offered in a language and tone that the person can understand.

The minimum required information that the adult shall receive for his/her consent to be considered as being duly informed, shall be the following:

- (1) The diagnosis and clinical description of his/her health condition.

- (2) The recommended treatment.
- (3) The risks and consequences of accepting or rejecting the treatment.
- (4) Other alternatives for treatment available, even though they are less indicated.
- (5) Benefits, risks and consequences of the alternatives for treatment.
- (6) The corresponding prognosis.
- (7) The possibility of side effects and irreversible damages caused by the treatments or use of certain recommended medications.

As an exception, in case of a medical, psychiatric or dental emergency, the treatments necessary to stabilize the emergency situation may be offered without prior informed consent from the adult. The reason and determination of an emergency shall be included in the adult's clinical record, and shall be notified as soon as possible to the closest family member or his/her legal guardian, as the case may be.

(f) Refusal to receive treatment. —

Any adult who receives services at an institutional provider may, pro se or through his/her legal guardian, exercise the right to refuse any kind of service within his/her treatment, recovery and rehabilitation plan. This refusal applies to medications and to any other kind of service within his/her treatment, recovery and rehabilitation plan. If the adult refuses to receive such services, these shall not be rendered; however, this shall be so entered in the clinical record.

The director or his/her representative shall inform the adult or legal guardian of alternate services and treatments available, the risks and consequences that said adult may suffer when refusing to receive said services, and the prognosis of receiving or refusing to receive the same. However, if the services or treatments required by the adult's treatment and rehabilitation plan are necessary to handle a psychiatric emergency situation, these shall be provided. The psychiatrist shall enter in the clinical record the emergency circumstances in which it was necessary to order said service or treatment. The adult shall be notified of said decision as soon as he/she can understand the information, or his/her legal guardian. This notification shall be entered in the clinical record.

Under no circumstance shall an order be issued to receive or refuse a service or to administer medications as a punishment or as a condition for the adult's discharge.

(g) Freedom of communication. —

Every adult who receives services at an institutional provider shall, after being institutionalized, have the right to communicate in private, with no censorship or impairment, with any person he/she chooses. This communication may be accomplished by telephone, mail or visits, as described below:

- (1) Correspondence. — The director of the providing institution shall make sure that the correspondence is received and deposited in the mail. He/She shall also provide writing materials and stamps when the adult who receives mental health services does not have the means to obtain them. All the letters, regardless of the addressee, shall be sent to thereto, without being examined by the authorities of the institution that provides mental health services. [The responses to the adult's letters shall be handed over, regardless of the addressee and without being examined by the authorities of the mental health institution. In case that the adult does not know how to read or write and upon the adults request, he/she shall be assisted when desiring to exercise his/her right to communicate in writing.]
- (2) Telephone. — The director of the institution that provides mental health services shall make sure that telephones are accessible and shall establish in writing the places and times

for their reasonable use. Any adult who does not have the means to obtain one, shall receive funds for the reasonable use of the telephone, be it for local calls or long distance.

(3) Visits. — The director of the providing institution shall be responsible for guaranteeing the existence of an adequate place so that adults subject to hospitalization may receive visitors. To that effect, he/she shall make public the schedule and place for said visits.

The institutional provider shall establish the rules for communication through other media, such as fax machines, email or courier service.

The foregoing notwithstanding, written communication, use of the telephone and visits to adults shall be reasonably constricted by the director of the institutional provider or his/her representative when there exists a clinical determination that so warrants, insofar as said constriction has the purpose of protecting the adult or third parties from being harmed, persecuted, harassed or intimidated. The decision to constrict this right shall be taken into consideration by the inter- or multidisciplinary team, and entered in the clinical record, duly warranted and notified to the adult. The person's family member, legal guardian or attorney, if any, shall be also notified. As to forensic psychiatric institutions, the appropriate restrictions shall apply to conform to the nature of the services being rendered.

No constriction whatsoever shall apply between the adult and his/her representative, legal guardian, or attorney, or the court, or between the adult and another person, when the communication is about matters associated with administrative or judicial proceedings.

(h) *Personal effects.* —

Every adult who receives mental health services in a providing institution may possess, use and keep his/her personal effects in an assigned and safe place provided for such purposes.

Possession and use of certain types of personal property may be limited by the director of the providing institution or his/her representative when necessary in order to protect the adult or others from any physical injury. When the adult is released, all of his/her personal property shall be returned.

(i) *Money and deposits.* —

Every adult shall have the right to manage his/her own assets, including his/her valuable belongings while receiving services in a mental health institution. The hospital or residential providing institution shall establish the necessary rules and procedures according to the regulations promulgated to that effect by the Administration to ensure that the money of the adults who receive services therein are protected against theft, loss or illegal appropriation. To that effect, the rules and procedures shall include the following:

(1) Any person who receives services in these institutions may use his/her money as he/she wishes. However, no adult who has been prohibited from using his/her money by court order may do so;

(2) no personnel of the hospital or residential institution shall be designated to receive money from social security, pensions, annuities, trusts or any other direct form of payment or assistance of the adults hospitalized in institutions that provide mental health services, except in those cases in which a court order designates the personnel as custodian of said money. In addition, a designation may occur by virtue of a law or regulation related to the disposition of rights from social security, pension or any other benefit, and

(3) any adult in a hospital or residential institution that provides mental health services may request the deposit of any funds pertaining to it in any financial institution in Puerto Rico.

(j) *Labor or work.* —

Any adult under treatment at an institutional provider may voluntarily agree to engage in labor or work for the institution. However, the adult may not be forced to engage in such labor or work. It is hereby provided that when the work or labor is not a part of the treatment, recovery and rehabilitation plan at the institution and the same yields financial benefits for said institution, the adult shall receive wages and benefits in proportion with the work carried out, pursuant to the applicable federal and Commonwealth laws. In those cases in which adults are confined at an institutional provider by a court order, such adults shall be subject to the terms of the sentence imposed by the court.

It is hereby provided as an exception that it may be required that the adult carry out maintenance duties or tasks in his/her room, and any other duty or task as part of his/her treatment, recovery and rehabilitation plan with no compensation. The assignment of these tasks or duties shall be entered in the clinical record as part of the treatment, recovery and rehabilitation plan.

Such duties may not infringe upon the dignity and physical integrity of program participants, nor be contrary to the constitutional clause that prohibits involuntary servitude.

The foregoing notwithstanding, under no circumstance may any adult be required to carry out duties or tasks of any kind as retaliation or punishment.

(k) *Claims and complaints.* —

Any adult may, per se or through his/her legal guardian, exercise his/her right to present claims or complaints in relation to any violation to the rights described in this Act. The providing institution shall have the obligation to warn the adult who receives mental health services and his legal guardian of the right he/she has for his/her claim or complaint to be solved in an impartial proceeding, in a fair and timely manner. When the petitioner does not agree with the determination made, he/she may seek remedy at the Court of First Instance.

Every providing institution shall establish a system to handle claims and complaints related to the treatment and service being offered pursuant to this Act. The proceeding established to present claims and complaints shall be informed to the adult who receives mental health services, his/her legal guardian, family members, visitors and personnel who work in the institution.

Every claim and complaint shall be handled and solved within a term of thirty (30) days after having been duly presented. The adult or his/her legal guardian shall be notified in writing of the final determination made on his/her claim even after having been released.

The services manuals stipulated in Sections 6.03 and 10.04, respectively, shall include a section titled Proceedings for the Presentation and Solution of Claims and Complaints, which shall consist of a description, in simple words, of the steps to be followed by adults, minors and their families who need to use these mechanisms.

(l) Experimental or exploratory procedures. No adult shall be submitted to experimental or exploratory procedures that are not approved by the corresponding federal and state organisms. To participate in the same, the adult or his/her legal guardian, as the case may be, shall give written and legally effective informed consent.

The minimum information that shall be offered to a participant of these procedures shall be made in comprehensible and non-coercive language, and shall consist of:

- (1) A document stating that the procedure constitutes a scientific experiment or investigation; its purposes, the duration of the patient's participation in the procedure; a description of the procedures to be used and which parts of them are experimental;

- (2) the risks and nuisances that may be reasonably foreseen;
- (3) a description of the benefits that may be reasonably expected by the participant or others;
- (4) disclosure of alternate procedures or treatments that may benefit or have more advantageous results for the participant than the experimental or exploratory procedure;
- (5) a document stating the scope and degree of confidentiality under which the adult's identity shall be kept;
- (6) in investigations that involve risks, it shall be informed if compensation or medical treatment shall be offered for damages resulting from the procedure, and the full extent of the treatments, in addition to the place in which to obtain additional information about them;
- (7) an explanation with respect to the persons to be notified, in case the participant has any questions or suspects to any damages related to the procedure;
- (8) a document stating that participation in the procedure is voluntary and refusal to participate or to discontinue at any moment does not involve penalty or loss of any benefit to which the participant may be entitled. The adult subject to any experimental or exploratory procedure shall be notified in writing at least seventy-two (72) hours before beginning the procedure, excluding Saturdays, Sundays and holidays, and
- (9) any other criteria established through regulation by the Administrator.

The adult has the right to end his/her participation in the experimental procedure, before or during the procedure.

(m) *Scientific research.* —

Any petition to conduct scientific research related to an adult who receives mental health services in public or private institutions shall be directed to the Administrator or the director of the institution that provides these services, respectively, who shall request the approval from the evaluating committee of the requesting institution, in order to evaluate the proposals submitted for investigation according to its recommendations. The preceding shall be carried out pursuant to the standards established by the federal and State Government for scientific investigation processes. The committee shall issue its recommendation within fifteen (15) days after its receipt. Afterwards, the Administrator or the director of the providing institution shall notify to the interested party its determination on the investigation.

No adult shall be submitted to any scientific investigation without having first obtained his/her authorization or that of his/her legal guardian, as the case may be, through a written and legally effective informed consent.

The basic information that shall be offered to the person or his/her legal guardian in a comprehensible and non-coercive language and shall consist of:

- (1) A document stating that the procedure constitutes a scientific investigation; its purposes, the duration of the patient's participation in the procedure; a description of the procedures to be used and which parts of them are experimental;
- (2) the risks and nuisances that may be reasonably foreseen;
- (3) a description of the benefits that may be reasonably expected by the participant or others;
- (4) disclosure of alternate procedures or treatments that may benefit or have more advantageous results for the participant than the scientific investigation procedure;
- (5) a document stating that adult's identity shall be kept in strict confidentiality;
- (6) in investigations that involve risks, it shall be informed if compensation or medical treatment shall be offered for damages resulting from the procedure, and the full extent of the treatments, in addition to the place in which to obtain additional information about them;

- (7) an explanation with respect to the persons to be notified, in case the participant or his/her legal guardian has any question or suspects any damages related to the procedure;
- (8) a document stating that participation in the procedure is voluntary and that refusal to participate, or to discontinue it at any time does not involve a penalty or loss of benefits of any kind to which the participant may be entitled, and
- (9) any other criteria established through regulation by the Administrator.

The persons in charge of conducting the investigation shall comply with the rules of confidentiality established in this Act. The director of the institution shall safeguard the confidentiality of the information of the adult who receives mental health services in relation to any type of scientific or exploratory investigations.

(n) *Language.* —

Every adult who receives mental health services has the right to know and be informed about everything related to his/her evaluation, treatment, recovery and rehabilitation, and therefore, when there is a need to give an explanation to the adult who receives mental health services and he/she does not know or understand the language in which it is offered, the institution shall be bound to provide to the adult, or his/her legal guardian, the translator or interpreter necessary to achieve an effective communication. This provision includes those cases in which the nature of the limitation is auditory or of speech. For the purposes of this provision, family members of the person who receives mental health services are not banned from serving as interpreters, provided the adult so determines it.

All written documentation furnished to the adult shall be issued in the language he/she understands. Everything possible shall be done for an effective communication. In those cases in which the adult has visual limitations, the institution shall be bound to advise him/her of the right to have the documents read out loud by the person of his/her choice, who shall also sign each and all the documents that have been read, pursuant to the adult's petition and determination. The provisions of this section shall be included in the clinical record of the adult who receives mental health services.

(ñ) *Right to request participation of support groups or persons.* —

Upon designation of the inter- or multidisciplinary team, the patient shall have the right to request the participation of any support person or group. Any persons who serve in such a capacity shall be under the obligation to keep the clinical information of the person receiving mental healthcare services confidential, pursuant to the provisions on this matter contained in this Act. Noncompliance with this provision shall entail the imposition of penalties, as provided for in this Act.

(o) *Right to receive support from the patient's mother, father, guardian and protection or assistance agencies for the person at the time of release.* —

Every person admitted to a facility shall have the right to receive support from his/her parents, family members, significant others and agencies with protection services and the obligation to provide shelter and the adequate level of care, as well as the personnel trained to adequately serve persons with mental disorders in a less restrictive environment with greater autonomy.

(p) *Transportation.* —

All persons on a state of psychiatric emergency shall have the right to transportation in an adequate vehicle, including ambulances certified by the Public Service Commission and the Department of Health, to take them to the facility where they will receive treatment.

In they should have the financial means, such as health coverage to pay for transportation expenses in cases of medical emergency, such expenses shall be paid by such coverage. In the case of persons who receive mental healthcare services or interventions under the Health Reform, the entity contracted to manage and coordinate healthcare services shall be responsible for covering the transportation expenses in cases of medical emergency. No mental health patient may be transported in a vehicle of the Puerto Rico Police, unless the situation involves the commission of a crime, in which case, the police officer who intervenes shall respond pursuant to the law. When placement of a patient is ordered by a court, the court shall make the necessary arrangements for the patient's transportation as provided.

(q) *Right to support when there is a moral responsibility.* —

Any adult person who, for reason of consanguinity or moral obligation, be it because he/she has benefited financially or received any other benefit from the person who [suffers from mental disorders], or that needs or receives mental health services, shall be bound to provide the necessary support and shall make sure that the person with a mental disorder can participate in the services directed toward his/her recovery, according to his/her level of capacity.

(r) *Legal representation upon involuntary admission.* —

Any adult involuntarily admitted shall have the right to be represented by an attorney. If the person is indigent and has not been able to hire an attorney, the court shall appoint one to represent him/her during the hearing.

(s) *Less intensive level of care with greater autonomy.* —

Every person has the right to receive adequate treatment, according to his/her diagnosis and level of care, and therefore his/her hospitalization shall be for the shortest period possible, until he/she can be transferred to a less intensive level of care.

(t) *Responsibility of persons who receive mental healthcare services in Puerto Rico.* —

It is hereby established that persons who receive mental healthcare services shall discharge the following responsibilities:

- (1) Assume responsibility for his/her recovery according to his/her abilities;
- (2) participate in self-sufficiency and community support activities and programs, and
- (3) The guardians or caregivers of the person who receives mental healthcare services shall have the responsibility of taking the person to his/her treatment sessions and participating in activities, counseling and family therapy sessions recommended for the progress of the person with mental disorders.

CHAPTER IV. — MENTAL HEALTH CARE SYSTEM FOR ADULTS

Section 4.01. — Levels of Care. (24 L.P.R.A. § 6155)

Mental healthcare services shall be rendered in the level of care affording the greatest autonomy and therapeutically more effective within the mental healthcare system concept, as per the diagnosis and the severity of symptoms and signs at the time the person is evaluated. At any level of treatment, the use of medications may be required, as per the diagnosis and the severity of symptoms and signs at the time the person is evaluated.

Mental healthcare levels include services that range from the most intensive, such as the psychiatric hospital, to those according the greatest autonomy, such as outpatient services.

Levels of care in order of greatest intensity or greatest autonomy are:

- (1) Psychiatric hospitals.
- (2) Psychiatric quarters or wards in general hospitals, or psychiatric addiction or addictive medicine quarters or wards in general hospitals.
- (3) Emergencies.
- (4) Transitional and live-in services.
- (5) Partial hospitalization.
- (6) Intensive outpatient services.
- (7) Outpatient services.
- (8) Maintenance treatment, with or without medication.

Section 4.02. — Adults Who Require Mental Healthcare Hospital Services. (24 L.P.R.A. § 6155a)

Any adult with a mental disorder of which the severity of symptoms and signs at the time of the evaluation indicates that he/she may inflict physical harm to him or herself or others or damage property; or any such adult who has made significant threats that substantiate the same outcome; or any such adult requesting services whose condition could substantially deteriorate if not provided with adequate treatment on time, shall require mental healthcare hospital services pursuant to the proceedings established in this Act.

Controlled substance and/or alcohol abuse or dependency, due to being considered a mental disorder, is hereby included in this provision, insofar as the conditions provided for in this section are present.

Section 4.03. — Initial Evaluation; Adults Placed in Institutional Providers of Mental Healthcare Services. (24 L.P.R.A. § 6155b)

(1) Any adult who, voluntarily or involuntarily, begins to receive mental healthcare services at an institutional provider at an emergency room, shall receive, among others, the following services within twenty-four (24) hours:

- (a) Medical record;
- (b) a physical examination;
- (c) laboratory tests when necessary to rule out physiological or organic conditions as part of a differential diagnosis;
- (d) a psychiatric evaluation by a psychiatrist, or in default thereof, by a physician after having consulted a psychiatrist by telephone; in the latter case, the psychiatrist shall have twenty-four (24) hours to enter in the clinical record his/her decision and to fill out the corresponding certification for the court in involuntary placement cases;
- (e) a psychological evaluation, if clinically indicated;
- (f) a social evaluation;
- (g) a psychiatric diagnosis in its five (5) axes as per the DSM-IV-TR or the clinical manual in effect at the time;
- (h) an initial treatment plan;
- (i) final destination, that is, after the patient has been stabilized, the referral to the corresponding level of care befitting the diagnosis and the severity of the clinical picture that

the patient presents at the time; if the patient cannot be stabilized, then hospitalization shall be in order;

(2) Provided, That any adult who is hospitalized, whether voluntarily or involuntarily, in a psychiatric hospital, or psychiatric hospitalization quarters or wards in general hospitals, or addiction psychiatric or addictive medicine quarters or wards in general hospitals, shall receive within twenty-four (24) hours the following services:

- (a) A medical record;
- (b) a physical examination;
- (c) laboratory tests, when clinically necessary;
- (d) a psychiatric evaluation; in the event that the institution does not have an in-house psychiatrist, this evaluation may be made by a physician legally authorized to practice in Puerto Rico;
- (e) a psychological screening, when clinically indicated;
- (f) a psychological evaluation, when clinically indicated;
- (g) an initial social evaluation, if clinically indicated, and
- (h) a substance screening by a professional counselor, when clinically indicated to rule out or assess substance abuse and/or dependency.

(3) The results of the evaluations, analyses, and examinations shall be used to determine the individualized treatment plan, an depending on the clinical response, to determine the level of care that corresponds to the severity of symptoms and signs, in order to determine the discharge plan which accords the adult the greatest autonomy. This plan shall be formulated in writing, within the first twenty-four (24) hours following the date of hospitalization of an adult, to be reviewed weekly by the interdisciplinary team until the person is discharged from the hospital. If the person is hospitalized over the weekend or a legal holiday, the twenty-four (24) hour period shall begin as of the next workday.

Section 4.04. — Therapeutic Restraints. (24 L.P.R.A. § 6155c)

Restraints shall be employed only at hospitals and centers with acute care wards or emergency rooms, and the same is to be employed abiding by the protocols of standards in the good practice of mental healthcare and pursuant to the provisions of this Act. Restraints shall be used for therapeutic purposes, without infringing upon human dignity. Application thereof shall be reserved as an extreme resort, to be used when the adult is in immediate danger of inflicting harm upon him/herself or others or damaging property. Before restraining any adult, his/her physical condition shall be taken into account; Provided, That under no circumstance shall restraints be used as punishment, as a disciplinary measure, or for the convenience of the personnel of the institution.

Any mental healthcare professional qualified to order, administer and observe restraints shall complete training on the use and application of this therapeutic procedure in adults. The provisions of this section are subject to the regulations that the Administration shall promulgate for these purposes. Restraints shall be applied when there is a written order issued by a psychiatrist to that effect, who after having observed the adult, is clinically convinced that restraints are necessary. The examination shall include an evaluation of the physical condition and the mental state of the adult. It is required to enter the restraint order in the clinical record,

which shall also include specific data, observations, purposes for its use, time used, and any other pertinent evidence that supports its employment.

The closest family member or legal guardian, as the case may be, shall be notified as soon as practicable, of the kind of restraints used. It shall be mandatory to conduct a review of the use of restraints as soon as practicable. The medical faculty and the medical director shall keep minutes of said review stating the reasons that support the use of this measure, in order to establish the medical-professional accountability of team members.

No restraint order shall be valid for more than twelve (12) hours after its issue. Restraints applied by virtue of said order shall not exceed more than four (4) hours, after which the psychiatrist shall conduct a new evaluation. If the results of the evaluations show that continuation of the use of restraints is necessary, the psychiatrist shall issue a new order, which shall be entered in the clinical record.

In case of emergencies that require the immediate use of this measure, when the psychiatrist is not available, restraints may be temporarily instituted by a physician or registered nurse, or a member of the inter- or multidisciplinary team duly trained and certified on this modality, who after consulting a psychiatrist by phone and having personally observed the patient, is clinically convinced that the use of restraints is indicated in order to keep the adult from inflicting harm upon him or herself or others or from damaging property. Once the psychiatrist is available, he/she shall conduct an evaluation to enter the written order in the clinical record as soon as practicable, but by no means shall it be after four (4) hours of the initial use of the emergency restraints. The need for a restraint order shall be entered in the clinical record. If after locating the psychiatrist, he/she does not authorize the use of restraints to continue, the use of restraints shall be immediately ceased. The psychiatrist who orders the use of restraints shall immediately notify so in writing to the medical director and the inter- or multidisciplinary team. A registered nurse trained and certified on this modality shall be assigned to observe the adult, at least every fifteen (15) minutes, without infringing upon the patient's right to privacy, and enter his/her observations in the clinical record in a legible, clear, and precise manner.

Restraint orders of up to four (4) hours may be employed during all or part of a twelve (12)-hour period. Said period shall be counted as of the moment the restraint order was issued. Once employed, it shall be ceased as soon as it is clinically unnecessary. Restraints shall be removed every two (2) hours for not less than fifteen (15) minutes, unless said removal is clinically contraindicated.

Once restraints are used over a twelve (12)-hour period, these shall not be used again on the same adult for the next two (2) calendar days, unless there is an order justified by a psychiatric re-evaluation and the prior authorization from the medical director of the hospital institution.

The medical director shall review all restraint orders on a daily basis and investigate the reasons recorded for the same. Furthermore, he/she shall keep a register of the restraints used and render a yearly report to the Administration.

The institution shall establish in writing a protocol for the use of therapeutic restraints according to the provisions contained in this section. Said document shall include information about the mental healthcare professionals who are qualified to begin the use of restraints in case of an emergency, pursuant to the provisions of this Act. Any healthcare professional qualified to begin, order, and observe the use of restraints must have completed a training course and be certified in the use and application of this therapeutic procedure. The provisions of this section

shall be subject to the regulations and licensing requirements for institutional providers of mental healthcare services that the Administration shall promulgate for these purposes.

Section 4.05. — Therapeutic Seclusion. (24 L.P.R.A. § 6155d)

Seclusion shall only be employed as a therapeutic measure to keep the adult from inflicting harm upon him or herself or others or from damaging property. Its use shall be circumscribed to hospital institutions and mental healthcare centers that have acute care wards. Under no circumstance shall seclusion be used as punishment, as a disciplinary measure, or for the convenience of the personnel of the institution.

Seclusion shall only be employed when there is a written order issued by a psychiatrist to that effect, who after having observed the adult, is clinically convinced that the employment of seclusion is the indicated alternative. The examination shall include an evaluation of the mental state and the physical condition of the adult.

In case of emergencies that require the immediate use of this measure, when the psychiatrist is not available, seclusion may be temporarily instituted by a physician or registered nurse, or a member of the inter- or multidisciplinary team duly trained and certified on this modality, who after consulting a psychiatrist by phone and having personally observed the patient, is clinically convinced that instituting seclusion is indicated in order to keep the adult from inflicting harm upon him or herself or others or from damaging property. Once the psychiatrist is available, he/she shall conduct an evaluation to enter the written order in the clinical record as soon as practicable, but by no means shall it be after twelve (12) hours from instituting the emergency seclusion.

The seclusion order shall be entered in the clinical record, which shall also include the reasons for which it was issued, and the closest family member or legal guardian shall be notified of the use of seclusion as soon as practicable. The order shall also include the duration of such seclusion and the aspects to be observed. A seclusion order shall be valid for twelve (12) hours. Each seclusion period shall require that the psychiatrist issue a new order after having conducted a direct evaluation of the person. The psychiatrist who orders seclusion shall immediately notify its use in writing to the institution's director and the inter- or multidisciplinary team.

Seclusion shall be used during a period of not more than eight (8) hours, counted as of the time of its institution. Once seclusion has been used over said period, it shall not be used again on the same adult for the following two (2) calendar days. The provisions of this section shall be subject to the regulations and licensing requirements for institutional providers of mental healthcare services that the Administration shall promulgate for these purposes.

The psychiatrist who orders seclusion shall designate a registered nurse trained and certified on this modality to observe the adult, at least every fifteen (15) minutes, without infringing upon the patient's right to privacy, and to enter his/her observations in the clinical record in a legible, clear and precise manner.

Seclusion rooms shall be duly prepared pursuant to the federal and Commonwealth protocols in effect in order to keep the adult from harm.

It shall be mandatory to conduct, as soon as practicable, a review of the use of therapeutic seclusion, to be recorded in the form of minutes by the medical faculty and the medical director stating the reasons that support the use of this modality in order to establish the professional accountability of team members.

The director of the hospital institution shall notify or review all seclusion orders on a daily basis and render a yearly report to the Administration.

The institution shall establish in writing a protocol for therapeutic seclusion pursuant to the provisions contained in this section.

Section 4.06. — Electroconvulsive Therapy. (24 L.P.R.A. § 6155e)

No adult shall receive electroconvulsive therapy treatment without having provided his or her informed consent and express authorization in writing.

In the event that this treatment is indicated for the adult, but that due to his/her condition, he/she is unable to give consent and does not have a designated legal guardian, it shall be necessary to hold a hearing for the court to determine whether the treatment is appropriate or not and issue an order to that effect. Said hearing shall be held summarily in the court closest to the institution, within eight (8) hours after the petition, when it is established under oath that if this modality of treatment is not employed, the person who receives mental healthcare services could be placed under danger of imminent harm.

The adult for whom electroconvulsive therapy treatment is considered and his/her legal guardian, if any, shall be notified of such intention at least forty-eight (48) hours prior to the treatment. Upon completion of all pertinent evaluations, the intervening therapeutic inter- or multidisciplinary team shall discuss the case and report its recommendations to the medical director. Every adult shall have the right to refuse this treatment in writing at any time, even after having accepted such treatment.

Every institutional provider of mental healthcare services that offers electroconvulsive therapy treatment shall have a protocol that includes the accepted standards of the American Psychiatric Association (APA) and the entities that regulate the administration of said therapy, in addition to the regulations that the Administration shall promulgate for these purposes. Said protocol shall be revised to conform to and to be contemporaneous with the revision of the American Psychiatric Association (APA). The institutional provider of mental healthcare services shall be responsible for keeping abreast of scientific advancements that might alter the procedures or the administration of this modality of treatment.

Section 4.07. — Voluntary Admission. (24 L.P.R.A. § 6155f)

Every person of eighteen (18) years of age or more may request voluntary admission to a mental health service with a written petition signed by him/her and a psychiatrist, after an evaluation and discussion of the case with the inter- or multidisciplinary team determines that said adult should be admitted.

The written request for admission shall also contain a simple statement without technicalities stating that the adult understands he/she has the right to be released within the shortest term possible, except in those cases when during said term a petition is filed in court accompanied by a certificate stating that the adult shall be subject to involuntary admission.

Section 4.08. — Petition for Release; Change of Status; Hearing. (24 L.P.R.A. § 6155g)

Within twenty-four (24) hours after the petition for release, the adult shall be evaluated by a psychiatrist in consultation with the inter or multidisciplinary team, who shall determine if the adult represents a danger to the self or others, or to property, as an indicator of a mental disorder. If there is no evaluation, the adult shall be released immediately. If as a result of the petition for release, and after the evaluation, the psychiatrist, in consultation with the inter- or multidisciplinary team, determines that the adult represents danger, an order for involuntary admission shall be requested, which shall not exceed fifteen (15) days and the change of status from voluntary to involuntary, within the following twenty-four (24) hours. During this process, the adult shall remain hospitalized. The procedures of involuntary admission provided by this Act shall be continued.

Section 4.09. — Renewal of Consent; Revision of Record. (24 L.P.R.A. § 6155h)

The psychiatrist, along with the inter- or multidisciplinary team, in charge of the care and treatment of the adult shall have up to ten (10) days, after the involuntary admission, to conduct a re-evaluation in order to determine the need to continue with the hospital treatment, recovery and rehabilitation services or in another level of care. The result of said evaluation shall be notified to the adult and included in the clinical record. A written confirmation shall be requested from the adult in order to confirm the hospital service. This procedure shall continue every ten (10) days after the first revision is conducted while hospitalization lasts.

In those cases in which in the psychiatrist's best judgment, and in consultation with the inter- or multidisciplinary team, it is determined that the adult represents immediate danger to the self or others, or to property and he/she does not give consent to continue receiving treatment services, a petition to order involuntary admission shall be requested from court, which shall exceed fifteen (15) days, and the change of status from voluntary to involuntary.

Section 4.10. — Other Levels of Care. (24 L.P.R.A. § 6155i)

The court, before determining whether the adult should be institutionalized involuntarily, shall consider other indicated levels of care according to the diagnosis and severity of symptoms and signs at the time. The court may order that the adult be submitted to treatment in any other level of care of the basic and complementary treatment, recovery and rehabilitation services at an institutional provider of mental healthcare services or a for-profit or nonprofit community-based organization, as defined in this Act. Furthermore, the court shall consider the recommendations presented by the psychiatrist and the inter- or multidisciplinary team responsible for the adult's initial evaluation. Said recommendations shall be detailed in the report, which in turn, shall include a comprehensive evaluation together with a preliminary individualized treatment, recovery and rehabilitation plan applicable to the level of care recommended, and any other information that the court may deem necessary. The regulations established by the Administration shall include specifications as to the contents and form of the individualized treatment, recovery and rehabilitation plan by level of care.

The court shall, however, have authority to modify an order for treatment in another level of care if the adult under such order does not observe the same or if the mental healthcare

professionals determine that the response to treatment is not adequate, according to the condition. Before modifying the order, the court must receive a report from the director of the service or level of care specifying the reasons why the order should be modified. The court shall schedule a hearing, about which the adult shall be duly notified, and in which he/she shall have the opportunity to express his/her opinion when the order for mandatory treatment is reconsidered. The adult shall be accompanied by a legal representative during the hearing.

If the court revokes the order for mandatory treatment or orders that the adult be hospitalized, a marshal shall take all the necessary steps to coordinate transportation for the adult.

Section 4.11. — Compulsory Treatment. (24 L.P.R.A. § 6155j)

Any person who, as a result of the initial evaluation, does not require the level of care of hospitalization intensity, but represents a risk to the self or others, and to property, and requires a level of care of greater autonomy, the psychiatrist, along with the inter- or multidisciplinary team of professionals, shall recommend to the court to order compulsory participation in a level of care with less intensity and greater autonomy, under penalty of contempt if he/she does not attend. The institution in charge of the administration of the compulsory treatment shall be bound to notify the court of the patient's attendance and the progress of the treatment, or the evolution of the clinical condition. The reports shall be submitted to the court quarterly, until the person's situation, by the symptoms and signs so justify it, and this report may move the court to determine that the person does not represent a risk to the self or others, or to property.

Section 4.12. — Involuntary Admission; Hospitalization. (24 L.P.R.A. § 6155k)

Any adult who meets the necessary requirements to receive mental health services, but does not allow it or is not able to allow it, shall be evaluated to determine involuntary admission to a providing institution. Said evaluation shall require the court's intervention. The court shall order a direct evaluation by a psychiatrist in consultation with the inter or multidisciplinary team, who shall determine if the adult should receive treatment, recovery and rehabilitation for his/her mental disorder.

No person shall be admitted involuntarily, unless there exists clear and convincing evidence to the court's satisfaction that he/she represents a risk to the self or others, or to property, and needs to be admitted.

Section 4.13. — Twenty-four Hour (24) Temporary Detention. (24 L.P.R.A. § 6155l)

If as a result of a personal observation, a security agent or any other citizen has reason to believe that a person of eighteen (18) years of age or more requires immediate treatment in order to protect him/her from physical damage to the self or others, or to property, he/she may present to the Court of First Instance with venue, a sworn petition for a twenty-four hour (24) temporary detention so that an inter- or multidisciplinary team may conduct an evaluation of the adult. Said petition may be filed in the court closest to the residence of the person who is understood to need mental health services or in the court closest to the place where that person is located.

The court may grant said petition, provided the sworn petition contains and supports the following:

(a) Detailed reasons that are grounds to state that the adult should be admitted involuntarily, including a description of the acts or significant dangers that support said statement, as well as the place and date they occurred, with names, exact address, telephone number and personal data of the persons who witnessed the acts, if any;

(b) the name and address of the spouse, legal guardian or closest family member; and if there are none of these, the name or address of any other person, entity or institution with interest in the adult subject to evaluation for involuntary admission. If the petitioner is unable to supply the corresponding names and addresses, he/she shall state the steps that were taken to obtain this information and the specific measures followed, even if they were unsuccessful, and

(c) the relationship between the petitioner and the adult subject to evaluation for involuntary admission, as well as a statement by the petitioner as to having or not any type of interest with said adult, as the case may be, but not limited to any economic or litigious interest, be it civil or criminal.

Once the abovementioned requisites have been presented and the merits of the petition evaluated, the court may issue an order for temporary detention, for a term of not more than twenty-four (24) hours.

Once the adult arrives at the providing institution, he/she shall be kept in observation. He/She shall be evaluated and given the pertinent treatment, according to the severity of the symptoms and signs at the time, for a period not to exceed than twenty-four (24) hours. This order expires within three (3) calendar days after its issuance date.

If based on the results of the evaluation and observation made, the psychiatrist, in consultation with the inter or multidisciplinary team, determines that the adult does not meet the hospitalization criteria, he/she shall be released immediately or be referred to another level of care, if necessary. The court shall be notified of said determination and of the pertinent recommendations within a term not more than seventy-two (72) hours.

If, on the contrary, the psychiatrist, in consultation with the inter- or multidisciplinary team, determines that hospitalization is the indicated level of care, he/she shall render a certification of said determination so that the closest family member, legal guardian, or a representative of the institution, as may apply, may try to request an involuntary admission.

Section 4.14. — Petition for a Fifteen (15)-day Involuntary Admission. (24 L.P.R.A. § 6155m)

Every petition for involuntary admission for a maximum term of fifteen (15) days shall be filed in court within the twenty-four (24) hours provided by the order for temporary detention previously issued by the court. The same shall be accompanied by a certification from the psychiatrist, which shall be known, as the first certification, and shall establish that the adult meets the criteria for involuntary admission and immediate hospitalization in a hospital institution or any other providing institution in order to receive treatment. Said first certification shall establish the following:

(a) That the psychiatrist, in consultation with the inter- or multidisciplinary team, evaluated the adult within the twenty-four (24) hours prior to filing the first request for admission;

(b) the observations and determination of the psychiatrist, in consultation with the inter- or multidisciplinary team, to the effect that the adult meets the admission criteria as established in this Act;

(c) evidence that the adult has received a copy of the rights established in this Act, and

(d) the names and professional data of the members of the intervening inter- or multidisciplinary team.

Once the first certification is received, the court shall issue an order for involuntary admission for a term not to exceed fifteen (15) days, which shall be subject to the provisions stated hereinafter, which shall be known as "Fifteen (15)-Day Involuntary Admission". Upon issuing the order, the court shall schedule a follow-up hearing that shall be held within the next five (5) working days in order to evaluate the extension or suspension of the involuntary admission. The court shall notify to the adult, as well as to his/her closest family member or legal guardian, if any, the date, time and place of the hearing.

If during the hearing, the court finds that the adult should continue receiving involuntary treatment services, the first order for admission shall remain in effect until the end of the original established term of fifteen (15) days, or until the person is able to continue the ambulatory recovery and rehabilitation process, whichever happens first. When the court, based on the recommendations presented by the psychiatrist in consultation with the inter or multidisciplinary team and the evidence presented, determines that the involuntary admission should not continue, it shall order the immediate release of the adult. However, it may order that the person participate in another, less restrictive level of care and with greater autonomy, if recommended to keep the adult from causing immediate harm to the self or others, or damage to property.

Within twenty-four (24) hours of the issuance of the first order for involuntary admission, the adult, his/her family member in charge, legal guardian, attorney or representative, as the case may be, shall receive a copy of the first certification and of the order issued by the court.

Section 4.15. — Petition for Order to Extend Involuntary Admission. (24 L.P.R.A. § 6155n)

When necessary, the court may order an extension for hospitalization, which shall not exceed fifteen (15) additional days. To that effect, the director of the mental health institution or his/her representative, per ser or by request from the person's family member or legal guardian, shall file in court a petition for order to extend involuntary admission. Said petition shall be accompanied by a second certification issued by a psychiatrist along with the inter or multidisciplinary team. In those cases in which the adult is receiving detoxification services, this second certification may be issued by a physician, along with an inter- or multidisciplinary team. The petition shall be filed in court up to three (3) days before the end of the initial period of fifteen (15) days. Within forty-eight (48) hours upon filing the petition for order to extend involuntary admission, the court, after holding hearings, shall determine if the second hospitalization period requested is appropriate. While this process is in progress, the adult shall remain hospitalized.

This certification shall include the following:

(a) Evidence of the design and implementation of the individualized treatment, recovery and rehabilitation plan of the inter- or multidisciplinary team.

(b) A statement that the psychiatrist or the physician, as applicable, along with the inter- or multidisciplinary team, re-evaluated the adult according to the plan and determined the need for the adult to continue receiving involuntary services.

(c) A detailed description of the revised individualized treatment, recovery and rehabilitation plan, that includes a reasonable prognosis of the benefits it is expected for the adult receive during the continuation of the involuntary admission.

(d) Identification and processing by the case handler of the resources used to place the patient in the level of care necessary and convenient for his/her condition, once he/she has fulfilled the purposes of the treatment in the hospital.

(e) A release plan prepared by the psychiatrist in consultation with the inter- or multidisciplinary team, for the case handler to follow-up, a copy of which shall be given to the patient or to his/her legal guardian, if any.

(f) Name and professional circumstances of the inter- or multidisciplinary team that intervenes in the certification.

If upon expiration of the initial fifteen (15)-day term the petition for order to extend involuntary admission and its corresponding certification are not filed in court on time, the institution shall then proceed to immediately release the adult and it shall so notify to the court.

If in the hearing, the court finds that the adult shall continue to receive involuntary treatment services, it may order an extension of the involuntary hospitalization for a term not to exceed fifteen (15) days.

Within twenty-four (24) hours after the issuance of the petition for order to extend involuntary admission, a copy of the second certification and of the order issued by the court shall be given to the adult, his/her family member in charge, legal guardian, attorney or representative, as the case may be.

Section 4.16. — Petition for Release of Involuntary Admission. (24 L.P.R.A. § 6155o)

Any adult who has been admitted involuntarily in a providing institution through a court order may file a petition to the court requesting his/her release. The adult subject of involuntary admission, or a family member, legal guardian or representative, may file the petition for release. The petition shall include:

(a) Name of the person.

(b) A copy of the order(s) for involuntary admission issued by the court.

(c) An explanation or justification for petitioning to be released.

When a petition for release is filed, the court shall schedule a hearing within the next five (5) days as of the date the petition was filed. The court shall state the date, time and place the hearing shall be held, sending a copy to the adult-petitioner, his/her attorney, legal guardian and director of the providing institution.

If the court determines that the adult must not continue involuntarily admitted, he/she shall be released and said determination shall be notified to the adult, his/her attorney, legal guardian and the director of the institution.

If the court determines that the adult must continue involuntarily admitted, the original order may continue pursuant to the provisions of this Act.

In those cases in which the court deems necessary, it may order to transfer the adult to the hospital institution in a vehicle adequate for his/her condition, depending on the severity of the symptoms and signs at the time, in a state, municipal, or private ambulance. The health insurance shall assume the cost for said services in the case of those persons who receive mental health services under the Health Reform.

Section 4.17. — Change of Status. (24 L.P.R.A. § 6155p)

Before adjudicating the case in which involuntary admission is being discussed, the adult who receives mental health services who has been so admitted may request a change of status to a voluntary admission. The petition shall be accompanied by a certification by the psychiatrist or physician, as may apply, stating that the adult who receives mental health services and requests this change is capable of giving consent and has done so in a well-informed manner, as required by this Act. If the court accepts this change of status, it shall then close the proceedings. The institution that provides mental health services, in turn, shall proceed pursuant to Section 4.09 of this Act [24 L.P.R.A. § 6155h].

Section 4.18-A. — Petition to change from voluntary to involuntary placement status for a maximum term of fifteen (15) days. (24 L.P.R.A. § 6155q-1)

Whenever necessary, if within twenty-four (24) hours following the petition for the discharge of an adult voluntarily institutionalized, the psychiatrist, in consultation with the interdisciplinary team, determines that the adult poses danger, the director of the mental healthcare institution or his/her representative, pro se or by petition of a family member or the person's legal guardian, shall file with the court a petition to change from voluntary to involuntary placement status, which shall not exceed fifteen (15) days.

Such petition shall be accompanied by a change of status certification issued by the psychiatrist, together with the interdisciplinary team, which shall establish whether the adult meets the criteria for such change of status. Within forty-eight (48) hours following the filing of the petition to change from voluntary to involuntary status, the court shall determine whether such petition is in order. During the course of this process, the adult shall be kept in the hospital.

This change of status certification shall contain the following:

- (a) Evidence of the design and implementation of the individualized treatment, recovery and rehabilitation plan of the inter- or multidisciplinary team.
- (b) An attesting statement whereby it is established that the psychiatrist, together with the interdisciplinary team, reevaluated the adult pursuant to the individualized treatment plan, and that they found that it was necessary for the adult to continue receiving services under involuntary status.
- (c) A detailed account of the reviewed individualized treatment, recovery and rehabilitation plan that includes a reasonable prognosis of the benefits that the adult is expected to receive during the continuation of the involuntary placement.
- (d) The identification and prompting by the case manager of the resources to place the patient in the level of care necessary and convenient for his/her condition, once the treatment at the hospital has met its purpose.
- (e) A discharge plan prepared by a psychiatrist, in consultation with the therapeutic team, to be followed-up by the case manager, a copy of which shall be handed to the patient and his/her legal guardian, if any.
- (f) The name and professional standing of the interdisciplinary team intervening in the certification.

If the initial fifteen (15)-day term should have lapsed and a petition to extend the order for involuntary placement has not been filed on time before the court together with the

corresponding certification, the institution shall then immediately discharge the adult and notify the court of such discharge. If during the hearing, the court should find that the adult should continue receiving treatment services under an involuntary status, the court may order the extension of the involuntary placement for a term not greater than fifteen (15) days.

Within twenty-four (24) hours following the issue of the order to change from voluntary to involuntary status, a copy of the certification and the order issued by the court shall be furnished to the adult, to the caregiving family member, to the legal guardian, or to the attorney or representative of such adult, as the case may be.

Section 4.18-B. — Hearings. (24 L.P.R.A. § 6155q)

(a) Hearings shall be held before a court with venue, pursuant to the provisions of the Rules of Civil Procedure in effect.

(b) The adult shall be present at the hearing, except when he/she has expressly waived to do so, or when he/she has agreed to waive his/her right and expressed so through his/her attorney.

(c) If the court, *motu proprio*, or upon petition from one of the parties with just force majeure, postpones the case, the adult shall remain hospitalized pending a subsequent order from the court. The postponement of the hearing shall not be extended for more than five (5) calendar days.

(d) The adult shall have the right to present all the evidence he/she deems convenient to contest the continuation of his/her involuntary admission. Said evidence may be oral or written. To that effect, the adult shall have the right to be examined by an independent mental health professional of his/her choice, or by one designated by the court, who shall conduct an evaluation and issue his/her recommendations to the court. The services of said professional shall be paid by the adult object of the petition for involuntary admission or change of status, by a close relative, if any, or by the state, if the adult is indigent.

Section 4.19. — Right to Legal Representation. (24 L.P.R.A. § 6155r)

Every adult object of a petition to order involuntary admission shall have the right to be represented by an attorney or family advocate, whoever is available. If the adult is indigent and has not been able to hire an attorney, the court shall appoint a public attorney. The attorney appointed by the court and the defendant should have reasonable time to prepare for the hearing.

Section 4.20. — Transfer Protocols. (24 L.P.R.A. § 6155s)

When a mental health patient receiving at an institutional provider is in imminent danger due to a physical condition, such patient shall be transferred to a general hospital and notice shall be given to the closest family member or legal guardian not later than twenty-four (24) hours thereafter.

Likewise, hospital institutions shall adopt a "Patient Transfer Protocol", which shall predicate, at the very least, on the following management guidelines:

(a) If a patient that is hospitalized in a psychiatric institution should experience a complication in his/her health condition due to a physical condition that might place his/her life in jeopardy:

- (1) A call shall be placed to the physician of the emergency room of the general hospital selected for transfer.
 - (2) Such physician shall be briefed on the case and the details of the patient's condition.
 - (3) The patient's transfer shall be coordinated with the emergency room of the general hospital.
 - (4) A record containing relevant information on the condition, treatment offered during the emergency situation, and recommendations to manage the psychiatric condition shall be sent together with the patient, pursuant to the provisions of Act No. 35 of 1994 [24 L.P.R.A. 3111 et seq.] and the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395; 42 C.F.R. § 489.24, EMTALA). Furthermore, the name and information of the physician to be contacted at the facility for the corresponding clinical follow-up shall be forwarded in writing.
 - (5) Upon reaching the general hospital, a screening and an evaluation shall be conducted on the patient pursuant to the provisions of Act No. 35 of 1994 and the EMTALA, including the pertinent studies to establish diagnosis.
 - (6) The patient shall be stabilized as per his/her physical condition.
 - (7) If the patient is not placed in the general hospital and upon having controlled his/her physical issue, such patient shall be referred to a psychiatric hospital by presenting his/her medical case for the evaluation of the latter. Such referral shall include the progress notes, the transfer notes, a summary of results, and clear instructions for follow-up after discharge, as the case may dictate.
 - (8) The transfer of the patient shall be coordinated with the psychiatric hospital, which shall be responsible for reevaluating the recommendations remitted by the personnel of the emergency room that serviced the patient.
- (b) If a patient that is hospitalized at a general institution or at an emergency room should present an emotional disturbance:
- (1) A screening and an evaluation shall be conducted on the patient pursuant to the provisions of Act No. 35 of 1994 and the EMTALA,, including the pertinent studies to establish diagnosis.
 - (2) Organic origins shall be ruled out from the patient's picture before remitting the psychiatric diagnosis.
 - (3) During the evaluation, the general hospital shall resolve to take into account and rule out an organic-based etiology of the symptoms present in the occurrence of the emergency which may be causing agitation in the patient.
 - (4) The general hospital personnel shall consult with a mental healthcare professional in seeking to establish an ongoing care plan and to obtain the authorization from relatives or the person authorized for the transfer.
 - (5) The patient shall be stabilized as per his/her physical condition or disturbance. The waiting time required shall depend on the evaluation for organic conditions conducted in connection with the patient's overall health. In cases of poisoning, the general hospital shall be responsible for contacting the Poisoning Center to obtain information from this dependency as to the time it takes to eliminate the potentially toxic agent ingested from the body. Such lapse shall be the minimum period of retention for the patient at the emergency room before being transferred to the psychiatric hospital.

(6) Upon stabilization of the physical condition of the patient, such patient shall be transferred to the psychiatric hospital and a record remitted which shall provide a summary of the measures taken, a summary of the results in the form of clear follow-up instructions befitting the case, and the information of the physician that serviced the patient.

(7) The general hospital's physician shall be responsible for contacting the psychiatric hospital chosen for transfer over the phone in seeking to provide a briefing on the case and the symptoms of the condition afflicting the patient. Likewise, coordination shall be established for the transfer of the patient to the psychiatric hospital.

(8) The psychiatric hospital shall commit itself to accepting the patient's transfer and to service such patient.

In the event that the person has financial resources, including coverage under a health insurance plan to defray transportation expenses, such expenses shall be defrayed by the patient or by his/her health plan coverage. In such cases, the health insurance plan shall be responsible for making the payment to refund the hospital directly if such hospital institution paid for these services. In the case of persons receiving mental healthcare services under the Health Reform, the entity contracted to manage and coordinate healthcare services shall be responsible for defraying transportation expenses. If necessary, and in default of any other options, transportation shall be provided by ambulances serving under the 911 Emergency Hotline. Transportation shall cover from the place where the person who needs services is located to any other institutional provider of the hospital services needed. Ambulance transportation shall meet the requirements set forth under Act No. 35 of 1994 and the EMTALA.

Both the general hospital and the psychiatric hospital shall comply with all EMTALA regulations as to procedures established for the drafting and preparation of the Patient Transfer Protocol hereby mandated and required.

Section 4.21. — Passes. (24 L.P.R.A. § 6155t)

In those mental health cases in which is it clinically necessary or beneficial, the psychiatrist may, jointly with the inter- or multidisciplinary team, grant [a] pass to the adult admitted voluntarily or involuntarily, even if he/she is not fit to be released. In these cases, the court shall not need to be notified, but the closest family member or the legal guardian shall be notified of the pass granted as soon as possible.

Section 4.22. — Releases. (24 L.P.R.A. § 6155u)

The psychiatrist in charge of treatment, recovery and rehabilitation may, at any time, release any adult admitted voluntarily or involuntarily, after having notified the inter- or multidisciplinary team.

The psychiatrist and the inter- or multidisciplinary team of the adult to be released shall explain to him/her, his/her family or legal guardian, his/her release plan and the options for recovery, notifying the court of the findings made in those cases where the court orders an involuntary admission.

Section 4.23. — Unauthorized Abandonment of the Institution; Notices. (24 L.P.R.A. § 6155v)

When an adult subject to involuntary admission abandons the institution without having been released, the director shall immediately notify a police officer so that he/she may be apprehended and returned to the institution. In addition, he/she shall notify the adult's family, legal guardian and the person who requested his/her admission.

When an adult subject to voluntary admission abandons the institution without having been released, the director shall immediately notify the adult's family member or legal guardian.

CHAPTER V — TRANSITIONAL SERVICES FOR ADULTS

Section 5.01. — Purposes of the Transitional Services. (24 L.P.R.A. § 6156)

Transitional services shall be designed to provide experiences that are structured, consistent and specialized in different levels of supervision according to the severity of the symptoms and signs of the disorder that apply, by age and gender, and to achieve that the adult becomes adapted to his/her environment and is able to participate in another level of care of greater autonomy, until he/she can reach his/her eventual independence within the community. Their main function shall be to render treatment, recovery and rehabilitation services emphasizing the adequate development of the person's handling of daily life, in addition to offering care and custody in a safe and humane manner.

Section 5.02. — Transitional Services. (24 L.P.R.A. § 6156a)

Institutions that provide transitional services shall, as a minimum, provide the following:

- (a) Safe and humane care and custody within an environment with the greatest autonomy possible according to the adult's treatment, recovery and rehabilitation needs.
- (b) The corresponding individualized treatment, recovery and rehabilitation, emphasizing the skills that are necessary for everyday life given his/her clinical condition, the severity of the symptoms and signs, the stage of life where the person is, and his/her potential for recovery and rehabilitation to achieve greater autonomy in his/her environment.
- (c) An adequate coordination with government and private agencies to achieve comprehensive services for the person and his/her family, in order to reach a greater self-sufficiency.
- (d) Attention to the mental and physical health condition of the adults admitted, as well as of their families.
- (e) The promotion of family participation in the adult's individualized treatment, recovery and rehabilitation plan, as well as orientation thereof.
- (f) A balanced diet, according to the special needs of the participants of the programs.
- (g) A rehabilitation, recreational, vocational and occupational plan, as may apply, to be implemented on the program or service in charge of specialized personnel.

Section 5.03. — Services Manuals. (24 L.P.R.A. § 6156b)

Every institution that provides transitional services shall have a services manual, which shall contain, as a minimum, the following:

- (a) The admission criteria to be met by adults who request the services.
- (b) The age, sex, disorder, diagnosis and level of functionality.
- (c) An individualized treatment, recovery and rehabilitation plan prepared by an inter- or multidisciplinary team.
- (d) The staffing pattern that the institution shall have, as well as the qualifications thereof.
- (e) The program's philosophy and a description of the institution's environment.
- (f) The corresponding therapeutic method or activity program.
- (g) The evaluation protocol for suicide risks with its corresponding contingency provisions.
- (h) The procedure for filing and processing claims and complaints describing in simple words the steps adults and their families shall take if they need to use these mechanisms.

Section 5.04. — Levels, Stages of Services. (24 L.P.R.A. § 6156c)

Transitional services shall be developed by levels or stages of services, according to the needs, in the environment with the greatest autonomy possible, as it has been therapeutically indicated.

The levels or stages of service adopted by the institution that provide transitional services shall be designed in accordance with the severity of the symptoms and signs, the diagnosis and the degree of supervision required by the adult, with greater supervision, services with moderate supervision, services with minimum supervision and home services or independent being understood as such services.

It shall be permitted for adults to be directly referred to the level most appropriate for their condition, without having to go through all the levels or stages.

Section 5.05. — Outpatient Mental Healthcare Services for Adults. (24 L.P.R.A. § 6156d)

Any adult who resorts to an institutional provider of indirect mental healthcare services in order to start receiving outpatient services at the various levels of care and in the various modalities of treatment, rehabilitation, and recovery, shall receive, among others, the following services during the first seventy-two (72) hours:

- (a) A physical examination, when clinically necessary to rule out physiological or organic conditions or as part of the outpatient clinical follow-up;
- (b) a laboratory test, when clinically necessary to rule out physiological or organic conditions or as part of the outpatient clinical follow-up;
- (c) a psychiatric evaluation conducted by a psychiatrist;
- (d) a psychological screening conducted by a psychologist;
- (e) an initial social evaluation conducted by a social worker, when clinically indicated;
- (f) a psychiatric diagnosis in its five (5) axes, as per the DSM-IV-TR or the clinical manual in effect at the time;
- [(g)] a substance screening conducted by an addiction counselor, when clinically indicated, to rule out or assess substance abuse and/or dependency;
- [(h)] a clinical record.

The results of the tests, analyses, and evaluations shall form part of the adult's clinical record and be used to establish the individualized treatment, recovery and rehabilitation plan at the corresponding greater-autonomy level of care. This plan shall be devised by an inter- or a multidisciplinary team not later than fifteen (15) days following the beginning of treatment and be reviewed every thirty (30) days pursuant to the standards for each level of care or when a substantial change occurs. These procedures shall be recorded as part of the regulations to be promulgated for these purposes.

The provisions of this section shall not apply in the case of private offices of mental healthcare professionals. In such cases, the mental healthcare professionals shall make sure to comply with the standards applicable to their respective professions, based on the clinical protocols and treatment guidelines recommended by the Administration.

CHAPTER VI — OUTPATIENT MENTAL HEALTH SERVICES FOR ADULTS

Section 6.01. — Outpatient Mental Healthcare Services for Adults. (24 L.P.R.A. § 6157)

Any adult who resorts to an institutional provider of indirect mental healthcare services in order to start receiving outpatient services at the various levels of care and in the various modalities of treatment, rehabilitation, and recovery, shall receive, among others, the following services during the first seventy-two (72) hours:

- (a) A physical examination, when clinically necessary to rule out physiological or organic conditions or as part of the outpatient clinical follow-up;
- (b) a laboratory test, when clinically necessary to rule out physiological or organic conditions or as part of the outpatient clinical follow-up;
- (c) a psychiatric evaluation conducted by a psychiatrist;
- (d) a psychological screening conducted by a psychologist;
- (e) an initial social evaluation conducted by a social worker, when clinically indicated;
- (f) a psychiatric diagnosis in its five (5) axes, as per the DSM-IV-TR or the clinical manual in effect at the time;
- [(g)] a substance screening conducted by an addiction counselor, when clinically indicated, to rule out or assess substance abuse and/or dependency;
- [(h)] a clinical record.

The results of the tests, analyses, and evaluations shall form part of the adult's clinical record and be used to establish the individualized treatment, recovery and rehabilitation plan at the corresponding greater-autonomy level of care. This plan shall be devised by an inter- or a multidisciplinary team not later than fifteen (15) days following the beginning of treatment and be reviewed every thirty (30) days pursuant to the standards for each level of care or when a substantial change occurs. These procedures shall be recorded as part of the regulations to be promulgated for these purposes.

The provisions of this section shall not apply in the case of private offices of mental healthcare professionals. In such cases, the mental healthcare professionals shall make sure to comply with the standards applicable to their respective professions, based on the clinical protocols and treatment guidelines recommended by the Administration.

Section 6.02-A. — Outpatient Visits. (24 L.P.R.A. § 6157-1)

The number of outpatient visits to mental healthcare services may not be limited by a direct or an indirect mental healthcare service provider, except as provided for in this Act. The need for outpatient services on an ongoing basis shall be assessed by the inter- or multidisciplinary team or by the mental healthcare professional responsible for the care of the person receiving mental healthcare services. Outpatient visits include, among others, but are not limited to introductory visits, follow-up visits, and collateral visits.

Section 6.02-B. — Initial Evaluation; Treatment, Recovery and Rehabilitation Plan at Another Level of Care. (24 L.P.R.A. § 6157a)

In the case of adults who have been hospitalized or who received services at a level of care, when by recommendations of the psychiatrist and the inter- or multidisciplinary team of the service making the referral, it is found that such adults need treatment at another level of care with greater or lesser autonomy, the review of the discharge plan of such adults or of the recommendations ensuing from their evaluation shall be in order and the same shall be instituted within twenty-four (24) hours following placement, insofar as they are clinically qualified for such level of care.

The evaluation, the recommendations, or the discharge plan shall form part of the adult's clinical record at the applicable level of care. Such results shall be used to establish the individualized treatment, recovery and rehabilitation plan, which shall be reviewed in light of the diagnosis and the severity of symptoms and signs for each level of care pursuant to the best practices of mental healthcare professionals and the treatment protocols and guidelines recommended by the Administration. This plan shall be devised by an inter- or a multidisciplinary team not later than fifteen (15) days following commencement of services and reviewed every thirty (30) days pursuant to the standards for each level of care or when a substantial change occurs. Once patients have achieved the objectives of their individualized treatment, recovery and rehabilitation plan, they shall continue to the next level of care that accords them greater autonomy, as their condition allows.

Section 6.03. — Service Manuals. (24 L.P.R.A. § 6157b)

Every institutional provider of greater-autonomy services shall issue a service manual, which shall contain, at the least, the following:

- (a) The admission criteria to be met by adults who request the services.
- (b) The age, sex, disorder, diagnosis and level of functionality.
- (c) An individualized treatment, recovery and rehabilitation plan prepared by an inter- or multidisciplinary team.
- (d) The staffing pattern that the institution shall have, as well as the qualifications thereof.
- (e) The program's philosophy and a description of the institution's environment.
- (f) The corresponding therapeutic modality or activity program.
- (g) The evaluation protocol for suicide risks with its corresponding contingency provisions.
- (h) The procedure for filing and processing claims and complaints describing in simple words the steps adults and their families shall take if they need to use these mechanisms.

The provisions of this section shall not apply to mental healthcare professionals in the private practice. However, said professionals shall advise patients on the treatment options for their condition, the ones they recommend, which ones they can provide according to the patients' symptoms and signs, and the diagnostic impression at the time of the initial evaluation.

CHAPTER VII — BILL OF RIGHTS OF MINORS WHO RECEIVE MENTAL HEALTH SERVICES

Section 7.01. — Bill of Rights. (24 L.P.R.A. § 6158)

The provisions of this Chapter shall be interpreted so as to protect and promote the dignity of the human being through recognition of the essential rights for his/her treatment, recovery and rehabilitation.

Section 7.02. — Protection of Constitutional Rights. (24 L.P.R.A. § 6158a)

Any minor who receives mental health services shall continue to enjoy all his/her rights, benefits and privileges pursuant to the Constitution of the United States of America and the Constitution of Puerto Rico, as well as state and federal laws, while he/she is receiving treatment, recovery and rehabilitation, and during the process of admission, transfer or release in any providing institution.

Section 7.03. — Presumption of Rehabilitative Potential; Obligation to Provide Mental Healthcare Services to Minors Who so Require. (24 L.P.R.A. § 6158b)

It is presumed that all minors are mentally competent, except when otherwise found by the court. The judicial finding of disability under Section 703 of the Civil Code [31 L.P.R.A. § 2342], shall be distinct and separate from the judicial proceeding to determine whether a minor should be subject to involuntary placement. It shall be presumed that all minors with mental disorders have the potential to recover and be rehabilitated by receiving mental healthcare services befitting their diagnosis and severity of their symptoms and signs. In order to accomplish the foregoing, all direct or indirect mental healthcare service providers are hereby placed under the obligation to promptly address any claim for services regarding this population.

Section 7.04. — Limitation of Rights. (24 L.P.R.A. § 6158c)

The rights established by this Act for minors who receive mental health services may apply to minors liable for offenses or held in juvenile institutions, and to minor offenders in detention, provided they are not in conflict with the security measures imposed by the court.

Section 7.05. — General Rights. (24 L.P.R.A. § 6158d)

Any minor who receives mental health services shall have the right to:

(a) Receive medical, psychiatric and psychological attention in its preventive, clinical, recovery and rehabilitation phases for the protection of his/her health and general well being.

(b) Receive education and training, when his/her condition permits, that fosters full development of his/her personality and that his/her human rights be acknowledged and respected. This shall be done in connection with government agencies having these responsibilities.

(c) Obtain preparation (pre-vocational readiness) or training to receive vocational, occupational or job education according to his/her general functional capacity in order to develop his/her potential, as may apply, without being discriminated against for reason of mental disorder.

(d) Act individually or collectively while searching for solutions to his/her problems and grievances.

(e) Respect his/her autonomy in everything related to matters affecting his/her life, progress, treatment, recovery and rehabilitation, according to his/her general degree of functionality.

Section 7.06. — Specific Rights. (24 L.P.R.A. § 6158e)

Any minor who receives mental healthcare services shall be entitled to the following specific rights:

(a) Access to Services. —

Every minor shall have access to mental healthcare services in accordance with the specialties and sub-specialties by stage of life, gender, age, and level of care, depending on his/her diagnosis and on the severity of his/her symptoms and signs. Services shall be rendered on an ongoing basis and befitting the level of intensity, in order to achieve recovery in a reasonable level of functionality.

No provider may establish distinctions in the rendering, access, administration, or planning of mental healthcare services which might be discriminatory against this population, except as provided for in this Act.

The use of mental healthcare services shall be determined according to the justified clinical basis, which, in turn, shall be based upon the diagnosis and severity of symptoms and signs of the mental disorder, as defined in the classification manual in effect.

Minors shall also have the right to receive pharmacotherapy, psychotherapy, all kinds of therapy pursuant to standards in the practice of psychiatry and psychology, including, but not limited to psychotherapy, support and other services befitting their diagnosis and severity of symptoms and signs, pursuant to the best clinical parameters.

To that effect, minors who receive mental healthcare services shall not be subject to discrimination or prejudice, and shall have access to said services, regardless of their diagnosis and the severity of their mental disorders. This right may not be constricted due to the existence of any physical condition or disability. There shall be no distinction between a mental condition and a physical condition in terms of the access to the necessary services, except as provided for in this Act.

In turn, all mental healthcare service providers shall address all requests for services not relative to an emergency within the first fifteen (15) calendar days as of the date of such request.

(b) Notification of right. —

All minors identified as in need of mental healthcare services, as well as those who request and receive mental healthcare services, shall be offered guidance as to the rights set forth herein while being evaluated or at the time of intervention, when mentally capable of completing the information. The minor's parent with legal or physical custody or legal guardian, as well as the

minor if his/her mental capability so allows, shall be offered guidance and be given a copy of such minor's rights.

No constriction shall apply between a minor and his/her attorney or the court, or between the former and another individual, when the communication addresses matters relative to administrative or judicial proceedings.

(c) Contingent Autonomy to Request Counseling and Treatment. —

Every minor of fourteen (14) years of age or more, has the right to request counseling or psychotherapy and to receive mental healthcare treatment, up to a maximum of six (6) sessions, without his/her parents' consent, pursuant to the provisions of Section 10.01 of this Act [24 L.P.R.A. § 6161]. In those cases of counseling and treatment for substance-related disorders, the initial term shall not exceed seven (7) sessions.

(d) Individualized Treatment, Recovery and Rehabilitation Plan. —

Every minor shall have the right to have a safe and humane individualized treatment, recovery and rehabilitation plan designed for him/her, within the less restrictive environment possible according to his/her condition.

The plan shall be based on a clinical evaluation of the strengths and needs of the minor and his/her family. In addition, the plan shall consider and, if needed, extend to home, school and community situations.

Any minor who receives the services shall participate in the preparation and revision of the plan to the degree said participation is possible. In addition, participation from his/her closest family member shall always be required, be it the parent with patria potestas or custody, his/her legal guardian or the person with provisional custody, for the design and revision of the individualized treatment, recovery and rehabilitation plan.

A mental health professional acting as case handler shall be responsible for giving follow-up to the implementation of the individualized treatment, recovery and rehabilitation plan, and for accessing all the services needed for the minor's recovery. The name of said professional shall form part of the plan, which, in turn, shall form part of the minor's clinical record. The clinical record shall contain the signature of all the professionals participating in the preparation of the plan, and that of the adult or family member who represent him/her during its preparation.

(e) Special Considerations; Minors. —

All healthcare service providers shall address the special needs of children from birth up to twelve (12) years of age and of adolescents from thirteen (13) to eighteen (18) years of age, and the interconnection of signs and symptoms with the normal growing process and the development of mental disorders. Minors who receive mental healthcare services shall be serviced and treated at a different ward separate from adults who receive mental healthcare services.

(f) Lesser-intensity, Greater-autonomy Level of Care. —

All mental healthcare service providers shall consider as most beneficial to keep children and adolescents with severe mental disorders together with their families, or in similar settings, or in the community, before considering hospitalization, which leads to separation from the family unit.

(g) Hospitalization Services and Segregated Care for Children and Adolescents. —

Children from zero (0) to twelve (12) years of age shall be provided with services befitting their age and gender, with individualized therapy separate from the treatment provided to adolescents and adults.

Hospital services may be shared between the child and the adolescent population, contingent upon strict supervision. Treatment services for children and adolescents shall never be intermingled with services for adults.

(h) Informed consent of the minor or parent with patria potestas or custody, the legal guardian or the person with provisional custody. —

Every minor admitted, his/her parent with patria potestas or custody, legal guardian or person with provisional custody shall have the right to know everything related to the services and treatment proposed in the individualized treatment, recovery and rehabilitation plan, inter- or multidisciplinary, designed by an institution that provides mental health services, before consenting to it.

Every service offered to the minor shall be explained in such a way, that all related information may be understood. The clinical record shall include a summary of the explanation and, that according to the judgment of the professional in charge, the explanation given was understood.

When a minor receives mental health services, it shall be required that his/her parent with patria potestas or custody, or legal guardian or person with provisional custody, give a written and informed consent so that the minor may receive said service with the exceptions established in this Act.

The minimum information required for consent to be considered as duly informed shall be the following:

- (1) The diagnosis and clinical description of the health condition.
- (2) The recommended treatment.
- (3) The risks and consequences of accepting or rejecting the treatment.
- (4) Other available alternatives for treatment, even if they are less indicated.
- (5) Benefits, risks and consequences of the alternatives for treatment.
- (6) The corresponding prognosis.
- (7) The possibility of side effects and irreversible damages caused by the treatment or the use of certain medications recommended.

As an exception, in case of a medical, psychiatric or dental emergency, the treatments necessary to stabilize the emergency situation may be offered without prior informed consent from the minor or his/her parent with patria potestas or custody, legal guardian or person with provisional custody. The reason and determination of an emergency shall be included in the minor's clinical record. It is herein provided that consent from parent with patria potestas or custody, legal guardian or person with provisional custody shall be obtained as soon as possible.

(i) Refusal of treatment. —

The minor's parent with legal or physical custody, legal guardian, or surrogate parent may refuse services for such minor from an institutional provider. This refusal includes medications and any other kind of service or therapeutic modality. Such refusal shall be stated and entered in the clinical record. However, the healthcare professional may use the procedures established in this Act to provide medical treatment to the minor if he/she deems it to be clinically compelling to prevent such minor from inflicting harm upon him or herself or others or from damaging property.

The director or his/her representative shall inform the parent with legal or physical custody, the legal guardian or the surrogate parent of alternate services and treatments available, the risks and consequences that said minor may suffer by refusing such services, and the prognosis of receiving or refusing such services. However, in the event that the services or treatment required

under the minor's inter- or multidisciplinary treatment, recovery and rehabilitation plan are necessary in order to prevent a psychiatric or medical emergency situation whereby such minor may inflict immediate harm upon him/herself or others or damage property, or when such services have been ordered by the court, these shall be administered. The psychiatrist shall enter in the clinical record the emergency circumstances under which it was necessary to order said service or treatment. The minor shall be notified of said decision as soon as he/she is able to understand the information, as well as his/her parent with legal or physical custody or his/her legal guardian. This notification shall be entered in the clinical record.

Under no circumstance shall an order to provide or refuse to provide services or to administer medications shall be issued as punishment or as a condition to discharge the minor.

(j) Freedom of Communication. —

Every minor who receives services at an institutional provider shall have the right to communicate in private, with no censorship or impairment, with any person he/she chooses, save for persons who are the inflictors of physical, psychological, or sexual abuse upon the minor, and when it is determined by the intervening therapeutic team that said communication would bring about a declension in the minor's condition.

(1) Correspondence. — The director of the providing institution shall make sure that the correspondence is received and deposited in the mail. Minors shall receive writing materials and stamps when they do not have the means to obtain them. All the letters regardless of the addressee shall be sent thereto without being examined by the authorities of the institution that provides mental health services. Minors shall receive answers to said letters, regardless of the sender and without being examined by the authorities of the institution that provides mental health services. If the minor does not know how to read or write, and upon his/her request, he/she shall be assisted whenever he/she wishes to exercise the right to communicate in writing.

(2) Telephone. — The director of the institution that provides mental health services shall make sure that telephones are accessible and shall establish in writing the places and times for their reasonable use. Any minor who does not have the means to obtain one, shall receive funds for the reasonable use of the telephone, be it for local calls or long distance.

(3) Visits. — The director of the providing institution shall be responsible for guaranteeing the existence of an adequate place so that minors subject to hospitalization may receive visitors. To that effect, he/she shall make public the schedule and place for said visits.

Institutions shall establish the rules for communication through other media, such as fax machines, email or courier service.

As pertains to forensic psychiatric institutions or institutions relative with the criminal justice system which provide mental healthcare services, the appropriate restrictions shall apply to conform to the nature of the services provided.

The foregoing notwithstanding, written communication, the use of the telephone, and visits to minors may be reasonably constricted by the director of the institution or his/her representative when there is a clinical finding that so warrants, insofar as said constriction has the purpose of protecting the minor or third parties from being harmed, persecuted, harassed, or intimidated. The decision to constrict this right shall be taken into consideration by the inter- or multidisciplinary team, entered in the clinical record, duly justified, and notified to the minor, his/her parent with legal or physical custody or legal guardian, and his/her attorney, if any.

No constriction whatsoever shall apply between the minor and his/her father or mother, representative, legal guardian, or attorney, or the court, or between the minor and another person, when the communication is about matters relative to administrative or judicial proceedings.

(k) Personal effects. —

Every minor who receives mental health services in a providing institution may possess, use and keep his/her personal effects in an assigned and safe place provided for such purposes. Possession and use of certain types of personal property may be limited by the director of the providing institution or his/her representative when necessary in order to protect the minor or others from any physical injury. When the minor is released, all of his/her personal property shall be returned.

(l) Money and deposits. —

Every minor, his/her father or mother, representative or legal guardian, shall have the right to manage his/her assets, including his/her valuable belongings while receiving services in a mental health institution. The hospital or residential providing institution shall establish the necessary rules and procedures according to the regulations promulgated to that effect by the Administration ensure that the money of the minors who receive services therein are protected against theft, loss or illegal appropriation. To that effect, the rules and procedures shall include the following:

- (1) Any minor who receives services in these institutions may use his/her money as the parent with patria potestas, legal guardian or authorized representative wishes him/her to do so;
- (2) no personnel of the hospital or residential institution shall be designated to receive money from social security, pensions, annuities, trusts or any other direct form of payment or assistance of the minors hospitalized in institutions that provide mental health services, except in those cases in which a court order designates the personnel as custodian of said money. In addition, a designation may occur by virtue of a law or regulation related to the disposition of rights from Social Security, pension or any other benefit, and
- (3) any parent with patria potestas, legal guardian or representative of a minor in a hospital or residential institution that provides mental health services may request the deposit of any funds pertaining to it in any financial institution in Puerto Rico.

(m) Labor or work. —

Any minor under treatment at an institutional provider may voluntarily agree to engage in labor or work for the institution. However, the minor may not be forced to engage in such labor or work.

It is hereby provided that the minor may be required to carry out maintenance duties or tasks in his/her room, or any other duty or task that is a part of his/her treatment, recovery, and rehabilitation plan, insofar as it inures to the minor's benefit. The assignment of said tasks or duties shall be entered in the clinical record as part of the treatment, recovery and rehabilitation plan.

For-profit or nonprofit community-based organizations may request, as part of their community treatment and rehabilitation methodology, that participants of said programs carry out duties with no financial compensation, insofar as these are part of their treatment, recovery and rehabilitation plan and inure to the benefit of the minor. The assignment of such tasks or duties shall be entered in the clinical record as part of the treatment, recovery and rehabilitation plan, insofar as participants and their guardians have voluntarily agreed. However, said duties

may not infringe upon the dignity and physical integrity of participants of any program, nor be contrary to the constitutional clause that prohibits involuntary servitude.

The foregoing notwithstanding, under no circumstance may any minor be required to carry out any duty or task as retaliation or punishment, or for the institution's exclusive benefit.

(n) Grievances and complaints. —

Any minor may, pro se or through his/her parent with legal or physical custody, legal guardian or surrogate parent, exercise his/her right to lodge grievances or complaints in relation to any violation of the rights described in this Act. Furthermore, notice shall be given of the right to an impartial proceeding whereby such grievances or complaints are to be considered and elucidated fairly and expediently. When the petitioner does not agree with the determination made, he/she may resort to the Court of First Instance.

All institutional providers institution shall establish a system to manage grievances and complaints relative to the treatment and services being offered pursuant to this Act. The procedure established to lodge grievances and complaints shall be disclosed to the minor who receives mental healthcare services, his/her father or mother, legal guardian, family members, visitors and the personnel that works at the institution.

All grievances and complaints shall be addressed and elucidated within a term of twenty (20) days. The minor, his/her parent with patria potestas, and/or legal guardian shall be notified in writing of the final determination made on the minor's complaint even after having been discharged.

(ñ) Experimental or exploratory procedures. —

No minor shall be submitted to experimental or exploratory procedures that are not approved by the corresponding federal and state organisms. To participate in the same, the minor's parent with patria potestas or legal guardian, as the case may be, shall give written and legally effective informed consent.

The minimum information that shall be offered to the minor's parent with patria potestas or custody, or legal guardian shall be made in comprehensible and non-coercive language, and shall consist of:

- (1) A document stating that the procedure constitutes a scientific experiment or investigation; its purposes, the duration the minor's participation in the procedure; a description of the procedures to be used and which parts of them are experimental;
- (2) the risks and nuisances that may be reasonably foreseen;
- (3) a description of the benefits that may be reasonably expected by the participant or others;
- (4) disclosure of alternate procedures or treatments that may benefit or have more advantageous result for the participant than the experimental or exploratory procedure;
- (5) a document stating that the minor's identity shall be kept in strict confidentiality;
- (6) in investigations that involve risks, it shall be informed if compensation or medical treatment shall be offered for damages resulting from the procedure, and the full extent of the treatments, in addition to the place in which to obtain additional information about them;
- (7) an explanation with respect to the persons to be notified, in case the minor or his/her parent with patria potestas or custody, or legal guardian has any questions or suspects any damages related to the procedure;
- (8) a document stating that participation in the procedure is voluntary and refusal to participate or to discontinue at any moment does not involve penalty or loss of any benefit to which the participant may be entitled. The minor subject to any experimental or exploratory

procedure shall be notified in writing, though his/her parent with patria potestas or custody, legal guardian or person with provisional custody, at least seventy-two (72) hours before beginning the procedure, excluding Saturdays, Sundays and holidays, and

(9) any other criteria established through regulation by the Administrator.

The minor, as well as his/her parent with patria potestas or custody, legal guardian or person with provisional custody, has the right to end his/her participation in the experimental procedure, before or during the procedure.

(o) Scientific Research. —

Any petition to conduct scientific research related to the minor who receives mental health services in public or private institutions shall be directed to the Administrator or the director of the institution that provides these services, respectively, who shall request the approval from the evaluating committee of the requesting institution, in order to evaluate the proposals submitted for investigation according to its recommendations. The preceding shall be carried out pursuant to the standards established by the federal and State Governments for scientific investigation processes. The committee shall issue its recommendation within fifteen (15) days after its receipt. Afterwards, the Administrator or the director of the providing institution shall notify to the interested party its determination on the investigation.

No minor shall be submitted to any scientific investigation without having first obtained from his/her parent with patria potestas or custody, legal guardian, as the case may be, a written and legally effective informed consent.

The minimum information that shall be offered to the minor's parent with patria potestas or custody, or legal guardian shall be made in comprehensible and non-coercive language, and shall consist of:

- (1) A document stating that the procedure constitutes a scientific investigation; its purposes, the duration of the minor's participation in the procedure; a description of the procedures to be used and which parts of them are experimental;
- (2) the risks and nuisances that may be reasonably foreseen;
- (3) a description of the benefits that may be reasonably expected by the participant or others;
- (4) disclosure of alternate procedures or treatments that may benefit or have more advantageous results for the participant than the scientific investigation procedure;
- (5) a document stating describing that minor's identity shall be kept in strict confidentiality;
- (6) in investigations that involve risks, it shall be informed if compensation or medical treatment shall be offered for damages resulting from the procedure, and the full extent of the treatments, in addition to the place in which to obtain additional information about them;
- (7) an explanation with respect to the persons to be notified, in case the minor or his/her parent with patria potestas or custody, or legal guardian has any question or suspects any damages related to the procedure;
- (8) a document stating that participation in the procedure is voluntary and that refusal to participate, or to discontinue it at any time does not involve a penalty or loss of benefits of any kind to which the participant may be entitled, and
- (9) any other criteria established through regulation by the Administrator.

The persons in charge of conducting the investigation shall comply with the rules of confidentiality established in this Act. The director of the institution shall safeguard confidentiality of the information of the minors who receive mental health services in relation to any type of scientific or exploratory investigations.

(p) Language. —

Every minor who receives mental health services has the right to know and be informed about everything related to his/her evaluation, treatment, recovery and rehabilitation, and therefore, when there is a need to give an explanation to the [minor] who receives mental health services and he/she does not know or understand the language in which it is offered, the institution shall be bound to provide to the [minor], or his/her legal guardian, the translator or interpreter necessary to achieve an effective communication. This provision includes those cases in which the nature of the limitation is auditory or of speech. For the purposes of this provision, family members of the person who receives mental health services are not banned from serving as interpreters provided the [minor] so determines it.

All written documentation furnished to the minor, the parent with patria potesta or custody, legal guardian or person with provisional custody, shall be issued in the language he/she understands. In those cases in which any of them has visual limitations, the institution shall be bound to advise him/her of the right to have the documents read out loud by the person of his/her choice, who shall also sign each and all the documents that he/she was asked to read. The provisions of this section shall be included in the clinical record of the minor.

In these cases, the facts that generate the report or entry and the name of the issuer shall be clearly written into the record.

(q) Right to Request Participation of Support Groups or Persons. —

Upon designation of the inter- or multidisciplinary team, the patient shall have the right to request the participation of any support group or person. Any persons who serve in such a capacity shall be under the obligation to keep the clinical information of the person receiving mental healthcare services confidential, pursuant to the provisions on this matter contained in this Act. Noncompliance with this provision shall entail the imposition of penalties, as provided for in this Act.

(r) Right to Support from Father, Mother, Guardian, and Minors' Protective or Assistance Agencies upon Discharge. —

All minors institutionalized in a facility shall have the right to receive support from their parents, family members, and significant persons. Protective agencies with the obligation to provide shelter and care at the proper level shall provide these services as well as personnel trained to adequately serve minors with mental disorders at the lesser intensity setting with the greatest autonomy.

(s) Transportation. —

Every minor shall have the right to transportation in an adequate vehicle, including ambulances certified by the Public Service Commission and the Department of Health when the severity of the symptoms and signs so requires it, to transport him/her to the facility where he/she will receive treatment.

If the minor, his/her parent with patria potestas or custody, legal guardian or person with provisional custody has the economic means, such as health coverage to pay for transportation expenses, these shall be paid by said coverage. In the case of persons who receive mental health services or interventions under the Health Reform, the entity contracted to handle and coordinate health services shall be responsible for covering the transportation expenses.

(t) Responsibility of the Parent with Patria Potestas or Custody, Legal Guardian or Provisional Guardian of the Minor who Receives Mental Health Services. —

It is hereby established that the above-mentioned persons who have a minor receiving mental health services shall comply with the following responsibilities:

- (1) Assume responsibility for his/her recovery and promote that the minor assumes this responsibility according to his/her capacities.
- (2) Participate in the self-sufficiency and community support activities and programs.
- (3) Assume the responsibility of taking the minor to his/her treatments, participating in activities recommended, counseling and family therapies.
- (4) As their income allows and whenever possible, contribute toward the payment for the services, according to the criteria established by Medicaid or the co-payment amounts established by medical health plans.

(u) Right to Receive Support When There is a Moral Responsibility. —

Any adult person who, for reason of consanguinity or moral obligation, be it because he/she has benefited financially or received any other benefit from the minor who [suffers from mental disorders], or that needs or receives mental health services, shall be bound to provide the necessary support and shall make sure that the minor with a mental disorder can participate in the services directed toward his/her recovery, according to his/her level of capacity.

(v) Legal Representation Upon Involuntary Admission. —

Any minor involuntarily admitted shall have the right to be represented by an attorney. If the minor is indigent, his/her parent with patria potestas or custody, legal guardian or provisional guardian has not been able to hire an attorney, the court shall designate one to represent him/her during the hearing.

(w) Less Intensive Level of Care with Greater Autonomy. —

Every minor has the right to receive adequate treatment, according to his/her diagnosis and level of care, and therefore his/her hospitalization shall be for the shortest period possible, until he/she can be transferred to a less intensive level of care.

CHAPTER VIII. — MENTAL HEALTH CARE SYSTEM FOR MINORS

Section 8.01. — Levels of Care. (24 L.P.R.A. § 6159)

Mental healthcare services for minors shall be rendered in a therapeutically adequate setting according the greatest autonomy, pursuant to the mental healthcare system concept and befitting the diagnosis and severity of symptoms and signs at the time the person is evaluated. The levels of mental healthcare shall be organized by different levels of intensity, and integrated and articulated in order to ensure ongoing treatment. Levels of ongoing mental healthcare include services that range from the most intensive, such psychiatric hospitalization, to those which accord the greatest autonomy, such as outpatient services. At any level of treatment, the use of medications may be required, as per the diagnosis and the severity of symptoms and signs at the time the minor is evaluated.

Levels of care in order of greatest intensity and lesser autonomy are:

- (1) Psychiatric hospitalization for children and adolescents.
- (2) Psychiatric quarters or wards at general hospitals for children and/or adolescents and psychiatric addiction or addictive medicine quarters or wards at general hospitals for children and/or adolescents.
- (3) Emergency rooms for minors.

- (4) Live-in treatments for children or adolescents.
- (5) Partial or day hospitalizations for children or adolescents.
- (6) Intensive outpatient services for minors.
- (7) Outpatient services for minors.
- (8) Maintenance for minors with or without medications.

All institutional providers shall establish the mechanisms, norms and procedures to give access to comprehensive services through collaborative partnerships between the various mental healthcare agencies and providers, in order to facilitate the minor's progression through the mental healthcare system as his/her changing needs dictate and until it is clinically indicated to transfer him/her to alternatives that accord greater autonomy, or in default thereof, to alternatives which, albeit more intensive, are clinically necessary. [In the case of minors receiving special education services for mental disorders and mental health services, the coordination of those should be evident in the individualized education plan.]

Those circumstances which require the minor to be transferred to another level which requires greater intensity, the review of the inter- or multidisciplinary individualized treatment, recovery and rehabilitation plan shall be mandatory in order to determine the modifications, if any, that should be made, to maintain the progress of the recovery. The determination of placing the minor in a greater-autonomy level of care shall be based on the recommendation made by a child and adolescent psychiatrist, in consultation with the inter- or multidisciplinary team.

This provision shall apply to cases in which the parent with legal or physical custody, the legal guardian or the surrogate parent consent to the treatment, and to cases in which the court has ordered the minor to be institutionalized in an institutional provider.

The lack of interest or the inability of the parent with legal or physical custody, the legal guardian, or the person with physical custody or the duty to provide care or shelter, shall not constitute grounds for having a minor institutionalized in a mental healthcare institution serving minors, unless the services thereof are designed to fulfill such a purpose. If this should be the case, the director of the institution shall file a petition with the court to secure care and shelter for such minor. The court may order the Department of the Family to give the minor proper placement.

Section 8.02. — Minors Who Require Mental Healthcare Hospital Services. (24 L.P.R.A. § 6159a)

Any minor with a mental disorder with a severity of symptoms and signs at the time of the evaluation indicating that he/she might inflict physical harm upon him/herself or others or damage property, or when he/she has issued significant threats that might yield the same outcome, or when the condition of the minor for whom the services are requested by the parent with legal or physical custody, or the legal guardian, could substantially deteriorate if not provided with adequate treatment on time, shall require mental healthcare hospital services pursuant to the proceedings established in this Act.

Controlled substance and/or alcohol abuse or dependency, due to being considered a mental disorder, shall be subject to the application of all the conditions set forth in this section.

A minor may be institutionalized to an institutional provider of mental healthcare hospital services for evaluation, treatment, recovery and rehabilitation from a mental disorder, as provided in this Act, and shall receive specialized services in a specialized ward for children and

adolescents, to be segregated by age, stage of life, and gender. This segregation answers to purposes of the specialized services provided to children and adolescents, and are not to be construed at any time that separate physical facilities must exist.

Section 8.03. — Purposes of the Petition for Mental Health Services for Minors. (24 L.P.R.A. § 6159b)

Mental health services for minors shall be requested with one (1) or more of the following purposes:

- (a) Carry out a process of screening, comprehensive evaluation and disposition.
- (b) Receive treatment, recovery and rehabilitation modalities.
- (c) Obtain orientation, education and to be placed in support or transitional services.

Section 8.04. — Mental Healthcare Services Requested for Minors. (24 L.P.R.A. § 6159c)

A request for services for a minor may be lodged with an institutional provider or with a direct or an indirect mental healthcare service provider by:

- (a) The minor him/herself, if fourteen (14) years of age or older, if he/she requests outpatient services as provided for in Section 10.01 of this Act, and if, in the judgment of the mental healthcare professional, he/she is capable of understanding the effect of his/her request.
- (b) The parent with patria potestas, the legal guardian, or the surrogate parent.
- (c) Persons who have been professionally related to the minor and who, as a result of this relationship, have reasonable grounds to believe that the minor needs to receive mental healthcare services.
- (d) Public or private agencies with custody over the minor, or the court.

The request shall be made in writing and obtain a clear and simple statement, with no technical terms, of the grounds for requesting such services.

Section 8.05. — Screening, Comprehensive Evaluation and Treatment. (24 L.P.R.A. § 6159d)

Every petition or request for a level of mental health services with greater autonomy shall be initially handled with a screening process to determine the nature of the minor's problem and the need for mental health services. The screening process shall consist of, among others:

- (a) Advising the minor and his/her parent with patria potestas, legal guardian or person with provisional custody, of the process to be carried out, the findings and the recommendations.
- (b) Making a determination based upon the capacity shown by the minor as information transmitter and receptor.
- (c) Conducting an initial social evaluation to identify the areas of conflict and relevant information related to factors and resources that affect the minor's condition.

If through this screening, it is determined that the nature of the problem requires a kind of care unrelated to mental health services, then the situation shall be referred to the corresponding agency, if necessary, and the parents, legal guardian or legal representative shall be advised of other services. This information shall be documented and shall be included in the clinical record. The screening shall be conducted by a mental health professional so authorized by law. If

through the screening it is determined that the minor meets the criteria to receive mental health services, the mental health professional shall be required to initiate the comprehensive evaluation process and refer the minor to another type of mental health service according to minor's symptoms and signs. The comprehensive evaluation shall determine the diagnosis and level of care the minor needs to receive treatment. Here, the professional shall determine the individual and family nature of recurring or existing problems and the factors that contribute or have contributed to it. He/she shall also identify and evaluate the resources of the minor, his/her family and community for dealing with the problem(s). The comprehensive evaluation shall include, among others:

- (1) Substantial information as to, or in relation to, services that have been offered to the minor by other agencies. The consent of the parent with patria potestas or custody, or the legal guardian shall be obtained for this.
- (2) Evaluation of the minor in the areas of functioning, among which are.
- (3) The minor's identification.
- (4) The minor's developmental history, including educational and occupational development and social adjustment.
- (5) Family medical records, including the presence or absence of mental disorders.
- (6) Family profile, as well as physical and economic resources.
- (7) Presence or absence of special situations, such as abuse, mistreatment or learning problems.
- (8) Substance use and abuse, or dependency.
- (9) Laboratory and toxicology tests that help diagnose mental disorders or other medical conditions.
- (10) The mental, affective and physical state, and the minor's behavior at the time of receiving the service.
- (11) Any other information that must to be obtained from other sources, such as other professionals, document analysis or previous clinical records.
- (12) Conclusions and recommendations made by the mental health professional or the inter- or multidisciplinary team, diagnosis and preliminary individualized treatment, recovery and rehabilitation plan.

The information described above shall be included in the minor's clinical record. Participation of the minor's family, custodian or legal representative shall be essential in this comprehensive evaluation process. All appropriate measurements and evaluative instruments shall be used. They shall be valid, reliable, clinically useful and culturally competent for the population being served because they shall be useful when programming the services to be offered.

Section 8.06. — Initial evaluation of minors institutionalized. (24 L.P.R.A. § 6159d)

Any minor who, voluntarily or involuntarily, begins to receive mental healthcare services at an emergency room shall receive the following services, among others, within twenty-four (24) hours:

- (a) Medical record.
- (b) A physical examination.
- (c) Laboratory tests, when necessary to rule out physiological or organic conditions as part of a differential diagnosis.

(d) A psychiatric evaluation conducted by a psychiatric or in default thereof, by a physician, after consulting a psychiatrist by telephone; in the latter case, the psychiatrist shall have twenty-four (24) hours to enter in the clinical record his/her decision and to fill out the corresponding certification for the court, in cases of involuntary placement.

(e) A psychological evaluation, when clinically indicated.

(f) An initial social evaluation, when clinically indicated.

(g) A psychiatric diagnosis in its five (5) axes as per the DSM-IV-TR, or pursuant to the manual in effect.

(h) An initial treatment plan.

(i) [A] final destination, that is, after the minor has been stabilized, the referral to the corresponding level of care befitting the diagnosis and the severity of the clinical picture that the minor presents at the time; if the minor cannot be stabilized, then hospitalization shall be in order.

Provided, That all minors hospitalized voluntarily or involuntarily in a psychiatric hospital or in psychiatric quarters or wards at general hospitals, or in psychiatric addictive or addictive medicine quarters or wards at general hospitals for minors, shall receive the following services within twenty-four (24) hours:

(1) A medical record;

(2) a physical examination;

(3) laboratory tests;

(4) a psychiatric evaluation conducted by a child and adolescent psychiatrist, as may correspond;

(5) a psychological evaluation conducted by a psychologist, when clinically indicated;

(6) a psychological screening conducted by a psychologist, when clinically indicated;

(7) a substance screening conducted by a professional counselor, when clinically indicated to rule out or assess substance and alcohol abuse and/or dependency, and

(8) a psychiatric diagnosis in its five (5) axes as per the DSM-IV-TR or pursuant to the clinical manual in effect at the time.

The results of the evaluations, analyses, and tests shall be used to establish the individualized treatment plan, and depending on the clinical response, to establish the discharge plan which accords the minor the greatest autonomy. This plan shall be devised in writing within the first twenty-four (24) hours following the minor's admission into the hospital, and the same shall be reviewed weekly by the interdisciplinary team until the person is discharged from the hospital. If the minor is hospitalized over the weekend or on a legal holiday, the twenty-four (24) hour shall begin to lapse as of the next workday.

Section 8.07. — Certification of Acceptance of Custody. (24 L.P.R.A. § 6159f)

When a minor is admitted or hospitalized in a providing institution, its director or its representative shall sign a certification accepting custody of the minor and guaranteeing that the minor shall be subject to humanitarian, responsible and adequate treatment, in accordance with his/her needs. Said certification shall be given to the parent with patria potestas or custody, legal guardian or person with provisional custody. A copy of the same shall be included in the clinical record.

Section 8.08. — Therapeutic Restraints for Minors. (24 L.P.R.A. § 6159g)

Restraints shall be applied only at hospital institutions, live-in treatment institutions for minors, and centers that have emergency acute care wards, and be used as established in the protocols of standards of the best practices of mental healthcare and pursuant to the provisions of this Act. Restraints shall be used in a therapeutic manner without infringing upon human dignity. Their application shall be reserved as an extreme recourse, to be used when the minor is in immediate danger of inflicting harm upon him/herself or others or damaging property. Before restraining any minor, his/her physical condition shall be taken into consideration; Provided, That under no circumstance shall restraints be used as punishment, as a disciplinary action, or for the convenience of the personnel of the institution. The examination shall include an evaluation of the physical condition and the mental state of the minor.

Any mental healthcare professional qualified to order, administer or observe the use of restraints shall complete training in the use and application of this therapeutic procedure on minors, children and adolescents. The provisions of this section shall be subject to the regulations that the Administration shall promulgate for these purposes. If restraints should be necessary, their use may be temporarily instituted by a physician, a healthcare professional, or a member of the inter- or multidisciplinary team who has been duly trained and certified in such modality, after consulting a child and adolescent psychiatrist. Restraints shall be in order after having personally observed the minor and being clinically convinced that the employment of restraints is indicated to prevent the minor from inflicting harm upon him/herself or others or from damaging property.

The need for a restraint order shall be entered in the clinical record of the minor and notice shall be given as soon as practicable to the closest family member or the legal guardian of the minor. Once the child and adolescent psychiatrist consulted is available, such psychiatrist shall conduct the evaluation to make a written entry of the order in the record as soon as practicable, within the hour following the institution of their use for minors who are ten (10) years of age or older, and within the half hour for minors between the ages of seven (7) and nine (9) years. If after contacting the child and adolescent psychiatrist, such psychiatrist does not authorize continuation of the use of restraints, such use of restraints shall be ceased immediately; Provided, That restraints may never be employed on children under the age of seven (7) years as a therapeutic measure. It shall be mandatory to hold a discussion as soon as practicable about the use of medication and to enter the restraint order in the clinical record, which order shall contain specific data, observations, purpose of use, time of use, and any other pertinent evidence supporting the employment thereof.

No restraint order shall be valid for more than eight (8) hours after its issue. The restraints applied by virtue of said order shall not be extended beyond two (2) hours for minors who are ten (10) years of age or older, or beyond one (1) hour for minors between seven (7) and nine (9) years of age, after which the child and adolescent psychiatrist, or in default thereof, a general psychiatrist, after consultation with the former, shall conduct a new evaluation after having personally observed the minor. If the results of the evaluation show that continuation of the use of restraints is necessary, the child and adolescent psychiatrist, or in default thereof, a general psychiatrist, after consultation with the former, shall issue a new order, which shall be entered in the clinical record.

In no case shall the initial period exceed two (2) hours for minors who are ten (10) years of age or older, or one (1) hour for minors between seven (7) and nine (9) years of age. In the event that the clinical condition that led to the use of restraints continues, the child and adolescent psychiatrist, in consultation with the inter- or multidisciplinary team, shall evaluate the minor and may provide for the use of other therapeutic modalities. Restraints shall be removed every half hour for not less than fifteen (15) minutes, unless said removal is clinically contraindicated, or entirely when it is no longer necessary to achieve the objectives that prompted this therapeutic measure.

The mental healthcare professional, as authorized under this section, who institutes the use of restraints, shall require that a nurse practitioner trained and certified on this modality be assigned to observe the minor, at least every fifteen (15) minutes, without infringing upon the minor's right to privacy, and enter his/her observations in the clinical record in a legible, detailed, clear and precise manner.

The psychiatrist ordering the use of restraints shall immediately give written notice thereof to the medical director and the inter- or multidisciplinary team. The medical director and the medical faculty shall review all restraint orders and investigate the reasons recorded therefor in order to establish the professional accountability of team members. The director of the institution shall keep a register of the restraints employed and render a yearly report to the Administration. The minor's closest family member or his/her guardian shall be notified of any restraint orders as soon as practicable.

The institution shall establish in writing a protocol for the use of therapeutic restraints, pursuant to the provisions set forth in this section. Said document shall include information about the mental healthcare professionals who are qualified to institute the use of restraints in case of an emergency, pursuant to the provisions of this Act. Any healthcare professional qualified to institute, order and observe the use of restraints, must have completed a training course and be certified in the employment and application of this therapeutic measure. The provisions of this section shall be subject to the regulations and the licensing requirements for institutional providers of mental healthcare that the Administration shall promulgate for these purposes.

Section 8.09. — Therapeutic Seclusion. (24 L.P.R.A. § 6159h)

Seclusion shall only be employed as a therapeutic measure to keep the minor from inflicting harm upon him or herself or others or from damaging property. Its use shall be circumscribed to hospital institutions, live-in treatment institutions for minors, and centers that have emergency acute care wards. Before secluding a minor, his/her physical condition shall be taken into account. Under no circumstance shall seclusion be used as punishment, as a disciplinary measure, or for the convenience of the personnel of the hospital institutional provider of mental healthcare services.

Seclusion shall only be employed when there is a written order issued by a child and adolescent psychiatrist, or in default thereof, a general psychiatrist who, after consulting with the former and having personally examined the minor, is clinically convinced that the employment of seclusion is the indicated alternative. The examination shall include an evaluation of the physical condition and the mental state of the minor.

The seclusion order shall be entered in the clinical record, which shall include the grounds for such issue, and the minor's closest family member or his/her guardian shall be notified of the

employment of seclusion measures as soon as practicable. A seclusion order shall be valid for eight (8) hours as of its issue. Each seclusion order shall require that the child and adolescent psychiatrist, or in default thereof, that a general psychiatrist, after consulting with the former, issue a new order after having conducted a direct evaluation of the minor. The psychiatrist who orders seclusion shall immediately give written notice to the medical director and the inter- or multidisciplinary team of the grounds for the employment thereof, in order for its justification and results to be evaluated.

It is further provided that the initial seclusion period shall last one (1) hour for minors who are ten (10) years of age or older. No seclusion order shall be issued for minors under ten (10) years of age. If additional seclusion periods are necessary, the child and adolescent psychiatrist shall issue a new order. Upon expiration of said period, the minor shall be reevaluated by the child and adolescent psychiatrist and if he/she deems that the minor poses a danger to him/herself or others or to property, a second seclusion period may be instituted, which shall not exceed one (1) hour.

The child and adolescent psychiatrist, or in default thereof, a general psychiatrist, after consulting with the former, who orders seclusion, shall immediately designate a registered nurse trained and certified in this modality to personally and constantly observe the minor, and enter his/her observations in the clinical record every fifteen (15) minutes. The person so designated shall keep communication and direct visual contact with the secluded minor, without infringing upon the minor's right to privacy. Such observations shall be legible, detailed, clear and precise, and drafted so as to describe the minor's behavior.

Seclusion rooms shall be properly prepared, pursuant to federal and Commonwealth protocols in effect, in order to keep the minor from harm.

The medical director shall review all seclusion orders on a daily basis and investigate the reasons the psychiatrist had to issue such orders. With the purpose of assuring the professional accountability of team members and safeguarding the civil rights of the minor, the medical director and the inter- or multidisciplinary mental healthcare team shall formally review all seclusion cases as soon as practicable.

The institution shall establish in writing a protocol for the employment of seclusion pursuant to the provisions set forth in this section. All mental healthcare professionals qualified to order and observe a minor in seclusion shall complete a training course in the use and application of this therapeutic modality. The provisions of this section shall be subject to the regulations that the Administration shall promulgate for these purposes, and to the licensing requirements for institutional providers of mental healthcare services.

Section 8.10. — Electroconvulsive Therapy. (24 L.P.R.A. § 6159i)

No minor shall receive electroconvulsive therapy treatment without the previous informed consent and express authorization from one of the following:

- (a) The minor's parent with patria potestas or custody, or legal guardian, upon the opinion of one (1) child and adolescent psychiatrist, in consensus with the inter- or multidisciplinary team, who evaluates and recommends the use of this treatment and so entered in the minor's clinical record.
- (b) In the case this treatment is favorable to the minor, and after making reasonable efforts, if the persons authorized to consent could not be located or denied their consent, a petition shall be filed with the court. In this case, evidence shall be presented of the need for treatment, as well as

the unsuccessful attempts to locate the persons authorized by law to give consent, so that the court may be convinced and order the use of this treatment.

The medical director and the inter- or multidisciplinary team shall review all orders for electroconvulsive therapy under the established criteria and the grounds for the use of this measure in order to establish the professional accountability of team members, and render a yearly report to the Administration.

The parent with legal or physical custody of the minor for whom electroconvulsive therapy treatment is considered, and the legal guardian, if any, shall be notified within a period not greater than forty-eight (48) hours prior to the treatment. The parent with legal or physical custody, or the legal guardian, shall have the right to refuse this treatment at any time after having accepted the same. However, if there should be any discrepancy as to having accepted or refused the treatment, a hearing must be held for the court to determine whether or not the treatment shall be in order and to issue an order to that effect.

All institutional providers of mental healthcare services that offer the electroconvulsive therapy modality shall institute a protocol that includes the accepted standards of the American Psychiatric Association (APA) and the entities that regulate the application of said therapy, in addition to the regulations that the Administration shall promulgate for these purposes. Said protocol shall be revised annually. It shall be the responsibility of the institutional provider of mental healthcare services to keep abreast of scientific advancements that may alter the procedure or administration of this modality of treatment.

Section 8.11. — Request for Placement. (24 L.P.R.A. § 6159j)

Any minor, through his/her parent with legal or physical custody, his/her legal guardian, or surrogate parent, may tender a request for placement at an institutional provider for treatment, recovery and rehabilitation as pertains to a mental disorder. The request shall be made in writing and may be accompanied by a referral from a child and adolescent psychiatrist, psychiatrist, physician, psychologist, social worker, professional counselor, or any healthcare professional with experience in the mental healthcare field.

This referral shall be issued insofar as a preliminary evaluation has been conducted by a mental healthcare professional. In the event that the request is made for detoxification services, the preliminary evaluation and the referral shall be made by a physician or a psychiatrist. Professionals responsible for this referral shall make a written assessment as to whether the minor meets the criteria for placement for this service modality as established by this Act. Within twenty-four (24) hours after the request for hospital services is tendered, an inter- or multidisciplinary team shall be assigned to the minor, including a child and adolescent psychiatrist, to evaluate such minor so as to determine whether or not placement is in order.

If the need for hospitalization should be ascertained, the inter- or multidisciplinary team shall be responsible for drafting a treatment plan for the minor. Said plan shall establish the strategies to be followed to manage the immediate cause that gave rise to the hospitalization. If it should be found that the minor meets the criteria to receive services in a level of care with autonomy greater than that accorded by hospitalization, the minor shall be referred to the mental health level of care that best suits his/her individual needs.

The lack of interest or the inability of the parent with legal or physical custody, the legal guardian, or the person with physical custody or the duty to provide care or shelter, shall not

constitute grounds for having a minor institutionalized in a mental healthcare hospital. If this should be the case, the director of the institution shall file a petition with the court to secure care and protection at other public or private institutions, as the case may be.

Within twenty-four (24) hours after a minor has been institutionalized in a hospital institutional provider, the director or his/her representative shall furnish a copy of the request for services and prepare a clear and concise report explaining the minor's condition to his/her parent with legal or physical custody, legal guardian, or surrogate parent, as well as provide information regarding:

- (a) The preliminary diagnosis determined by the inter- or multidisciplinary team;
- (b) the right they have to request that the minor be released within the shortest term possible, except in those cases in which during said term, a petition is filed with the court accompanied by a certification that establishes that minor should be subject to involuntary admission, and
- (c) the treatment, recovery and rehabilitation plan to be followed, and the right to receive counseling and a hearing held in court.

After being institutionalized, any change in status shall be explained in detail to the minor and to his/her parent with legal or physical custody or legal guardian.

Section 8.12. — Review of the Clinical Status. (24 L.P.R.A. § 6159k)

Within seventy-two (72) hours of [the] minor's admission, the child and adolescent psychiatrist, jointly with the inter- or multidisciplinary team, shall review the minor's clinical status and clinical record in order to determine the need to continue the treatment at the current level. If [an] extension is necessary, the person or entity that gave consent for admission shall be notified to obtain their consent to said extension. Authorization for extension of admission shall be included in [the] minor's clinical record.

Whenever there is a substantial change and, as a maximum, every ten (10) days, the child and adolescent psychiatrist, along with the inter- or multidisciplinary team, shall conduct an evaluation of minor's clinical status, and authorization for the extension of the hospitalization shall be renewed, while it lasts. If extension for treatment, recovery and rehabilitation is not authorized, it shall be understood as a petition for the minor to be released.

In the case that it has been impossible to stabilize the severity of the symptoms and signs, and the minor could still be in danger of harming the self or others, or damaging property, a petition shall be requested to the court to obtain an order for extension of the admission into the hospital institution, or the level of care recommended by the child and adolescent psychiatrist with the inter- or multidisciplinary team, when there is no authorization from the father, mother with patria potestas or custody, or the legal guardian or entity that approved the minor's admission, changing the status from an involuntary to voluntary.

No minor shall be admitted to hospital services, unless he/she meets the clinical criteria for hospitalization and there exists clear and convincing evidence, to the satisfaction of the person authorized to give consent that shows the need for said admission.

Section 8.13. — Emergency Placement. (24 L.P.R.A. § 6159l)

In case of emergency, any person over the age of eighteen (18) may seek forwarding the request for placement of a minor, after making all the necessary efforts to locate the minor's parent with legal or physical custody or legal guardian. The minor shall be evaluated

immediately by the child and adolescent psychiatrist, or in default thereof, by the general psychiatrist, after consulting with the child and adolescent psychiatrist, together with the inter- or multidisciplinary team of the institutional provider, in order to establish the diagnosis and to determine the level of care that corresponds to the severity of symptoms and signs at the time.

Live-in treatments and transitional services for minors shall not be deemed to be emergency placements. Minors referred to receive these services shall meet the specific criteria set for such services, as defined in this Act.

The director of the institutional provider shall continue to make efforts to locate the parent with legal or physical custody or the legal guardian. If the person is located and gives written consent for placement, the minor shall continue in the indicated and recommended level of care. If the parent with legal or physical custody or the legal guardian cannot be located within the next twenty-four (24) hours, or if after being located, he/she refuses to give consent for the minor's placement, or requests the minor's discharge, a petition shall be filed with the court together with a report stating the minor's condition and the recommendations from the child and adolescent psychiatrist, in consultation with the inter- or multidisciplinary team. The court shall determine whether continuing the care or discharging the minor is in order, for which it shall schedule a hearing to be held within seven (7) calendar days. The court shall notify the minor, his/her attorney or the person representing him/her, and the director of the institution or his/her representative, and state the place, date, and time of the hearing. Hospitalization of the minor shall continue until the court provides otherwise.

The court may order the discharge of the minor if the assessment reports show that he/she may benefit from mental healthcare services in a therapeutically indicated level of care that accords him/her greater autonomy.

If necessary, the court shall order the Department of the Family to give the minor proper placement.

The lack of interest or the remissness or the inability of the parent with legal or physical custody, the legal guardian, or the person with physical custody or the duty to provide care or shelter, shall not constitute grounds for having a minor institutionalized or for continuing the placement of a minor in a mental healthcare institution. If this should be the case, and if failing to meet the clinical requirements for placement, the court shall order the Department of the Family to assume legal custody and to give the minor proper placement.

Likewise, in the event that the minor has been placed and such minor is able to benefit from a lesser-intensity, greater-autonomy level of treatment on an ongoing basis, and the remissness or the lack of interest or the inability of the parent with legal or physical custody, the legal guardian, or the person with physical custody or the duty to provide care or shelter disallows the coordination of the discharge, the director of the institutional provider of mental healthcare services shall file a petition with the court to secure shelter and care for such minor. The court shall order the Department of the Family to give the minor proper placement and to collaborate with the institutional provider of mental healthcare services as pertains to the discharge of the minor, and subsequently, the Department of the Family shall ascertain that the minor is able to remain in an ongoing-care setting that allows him/her to continue his/her treatment, recovery, and/or rehabilitation.

In the event that the court has authorized the continuation of placement, the court shall carry on with the proceedings for involuntary placement as provided by this Act.

Section 8.14. — Request for Admission by Public or Private Agencies. (24 L.P.R.A. § 6159m)

The authorized representative of a government or private agency may process a request for an evaluation for admission to a mental health hospital institution in behalf of a minor who is in its custody, provided the minor meets the criteria of admission to the institution and complies with the requisites established in this Act.

The child and adolescent psychiatrist, or a member of the inter- or multidisciplinary team of the providing institution shall notify in writing to the entity that referred the minor, the results of the evaluation performed and the therapeutically indicated level of care with greater autonomy that, [in] their best professional judgment, shall satisfy the minor's needs.

The report shall contain specific recommendations on how to handle the mental health disorder, within the institutional scenario that holds custody of the minor.

Once the minor has been clinically stabilized and released, the agency that requested the admission shall be responsible for receiving the minor immediately.

Section 8.15. — Treatment, Recovery, and Rehabilitation at another Level of Care. (24 L.P.R.A. § 6159n)

The court may consider other levels of care which accord greater autonomy if the child and adolescent psychiatrist, jointly with the inter- or multidisciplinary team, so recommends, as per the diagnosis and the severity of symptoms and signs at the time, as these are therapeutically indicated, before determining whether the minor should be involuntarily institutionalized.

The court may order that the minor submit to treatment, recovery and rehabilitation services at another level of care which accords greater autonomy at an institutional provider of mental healthcare services; as pertains to conditions related to controlled substance or alcohol use and abuse, one of the alternatives may be to order placement in services offered by nonprofit or for-profit community-based organizations that conduct evaluations and provide treatment for mental disorders, including substance and/or alcohol abuse or dependency and comorbid conditions. The court shall consider the recommendations that the psychiatrist or the physician, as may apply, and the inter- or multidisciplinary team responsible for the minor's initial evaluation, present as appropriate. Said recommendations shall be clearly conceptualized and specified in a report on the comprehensive evaluation conducted, including the individualized treatment, recovery and rehabilitation plan recommended, as well as any other information that the court deems convenient. The individualized treatment, recovery and rehabilitation plan shall be consistent with the minor's issues and needs and contain a timetable as to progression. Based on the recommendations, the court shall order the greatest-autonomy level of care that is most adequate for the minor.

Nevertheless, the court shall have the authority to modify an order for treatment at a greater-autonomy level of care if the minor subject to the order does not comply therewith, or if the mental healthcare professionals determine that the treatment is not adequate for his/her condition. Before modifying the order, the court shall receive a report from the director of the level of care program at which the minor is, specifying the reasons why the order should be modified. The court shall schedule a hearing, of which the minor's parent with legal or physical custody or legal guardian shall be duly notified and in which such parent or guardian shall have

the opportunity to express his/her opinion when the order for an alternate treatment is reconsidered. The minor shall be present at the hearing, together with his/her parent with legal or physical custody or legal guardian, who may be accompanied by a legal representative when the hearing is held.

If the court should revoke the order for treatment at a greater-autonomy level of care and order that the minor be hospitalized, a marshal or mental healthcare service support personnel shall make all provisions necessary to coordinate transportation for the minor.

Section 8.16. — Involuntary Admission. (24 L.P.R.A. § 6159o)

Any minor who meets the necessary clinical criteria to receive mental health services, but his/her parent with patria potestas or custody, or legal guardian does not consent to it or is not capable of consenting to it, shall be evaluated to determine if he/she qualifies for involuntary admission or compulsory treatment in a providing institution. Said evaluation shall require the court's intervention. The court shall order an evaluation by the inter- or multidisciplinary team, in order to determine if the minor should receive hospital treatment and rehabilitation for his/her mental disorder.

No minor shall be admitted involuntarily, unless there exists clear and convincing evidence to the court's satisfaction that shows the need for said admission.

Section 8.17. — Petition for a Fifteen (15)-day Involuntary Admission. (24 L.P.R.A. § 6159p)

(a) Every petition for involuntary admission for a maximum of fifteen (15) days, shall be accompanied by a certification from the child and adolescent psychiatrist, or if unavailable, a general psychiatrist after consulting with the former, which shall be known as the first certification. This first certification shall establish that the minor meets the criteria for immediate involuntary admission in a hospital institution or any other providing institution in order to receive treatment, recovery and rehabilitation.

Said first certification shall establish the following:

- (1) That the child and adolescent psychiatrist, or if unavailable, a general psychiatrist, after consultation with the former, and the inter- or multidisciplinary team, evaluated the minor within a term not greater than two (2) days prior to presenting the request for involuntary admission;
- (2) the observations and criteria that gave rise to the determination, to the effect that the minor meets the admission criteria as established in this Act, and
- (3) evidence that the minor, and his/her parent with patria potestas or custody, or legal guardian have received copy of the rights established in this Act.

(b) Once the first certification is received, the court shall issue an order for involuntary admission for a term not longer than fifteen (15) days, which shall be known as a fifteen (15)-day involuntary admission. Upon issuing the order, the court shall schedule a follow-up hearing that shall be held within the next seven (7) working days in order to evaluate the extension or suspension of the involuntary admission. The court shall notify the date, time and place of the hearing to the minor, his/her parent with patria potestas or custody, or legal guardian or the person with provisional custody.

If during the hearing, the court finds that the minor should continue receiving involuntary treatment services, the first order for admission shall continue in effect until the original established term of fifteen (15) days concludes. When the child and adolescent psychiatrist, in consultation with the inter- or multidisciplinary team, recommends the release, the court, if it accepts the recommendation, shall order the immediate release of the minor in that level of care. It may also order compulsory treatment in another level of care with greater autonomy, if recommended by the child and adolescent psychiatrist and the inter-or multidisciplinary team, because the minor represent an immediate risk of harm to the self or others, or damage to property.

Within not more than twenty-four (24) hours of the issuance of the first order for involuntary admission, the minor, his/her parent with patria potestas or custody, legal guardian or the person with provisional custody and his/her attorney, as the case may be, shall receive a copy of the first certification and of the order issued to the minor by the court.

Section 8.18. — Petition for Extension of Involuntary Admission Order. (24 L.P.R.A. § 6159q)

When deemed necessary, the court may order an extension for hospitalization, which shall not exceed fifteen (15) additional days. To that effect, the director of the mental health institution or his/her representative, per ser or by request from the minor's parent with patria potestas or custody, or legal guardian, shall file in court a petition to extend an involuntary admission order. Said petition shall be accompanied by a second certification issued by the child and adolescent psychiatrist along with the inter- or multidisciplinary team in charge of the minor's treatment, provided that in cases in which the minor is receiving treatment, recovery and rehabilitation services in a detoxification center, this second certification may be issued by a physician and the inter- or multidisciplinary team. The petition shall be filed in court up to three (3) days before the end of the initial period of fifteen (15) days. Within forty-eight (48) hours after filing the petition to extend an involuntary admission order, the court shall determine if the extension of the hospitalization period so requested shall proceed. While this process is in progress, the minor shall remain hospitalized.

This certification shall include the following:

- (a) Evidence of the plan and implementation of the individualized treatment, recovery and rehabilitation plan of the inter or multidisciplinary team.
- (b) A document stating that the child and adolescent psychiatrist or the physician of the detoxification center, as may apply, along jointly with the inter- or multidisciplinary team, re-evaluated the minor according to the plan reviewed the medical record, evaluated his/her progress and determined the need for the minor to continue receiving involuntary services.
- (c) Detailed preparation of the revised individualized treatment, recovery and rehabilitation plan that includes a reasonable prognosis of the benefits the minor is expected to receive during the continuation of the involuntary admission.
- (d) Identification and processing by the case handler of the resources used to place the minor in the necessary and convenient level of care for his/her condition, once the purposes of the treatment, recovery and rehabilitation plan of the hospital are fulfilled.

(e) Release plan worked by the child and adolescent psychiatrist in consultation with the inter- or multidisciplinary team for the case handler to follow-up, a copy of which shall be given to the parent with patria potestas or custody, or the legal guardian, if any.

(f) Name and professional circumstances of the inter- or multidisciplinary team that intervenes in the certification.

If the initial fifteen (15)-day term elapses, and the petition for extension of involuntary admission order and the corresponding certification are not filed in court on time, the institution shall then proceed to grant immediate release to the minor and it shall so notify to the court.

If in the hearing, the court finds that the minor shall continue to receive involuntary treatment services, it may order an extension of the involuntary hospitalization for a term not to exceed fifteen (15) days.

Within twenty-four (24) hours after the issuance of the petition for extension of involuntary admission order, a copy of the certification and of the order issued by the court shall be given to the parent with patria potestas or custody, legal guardian, attorney or representative, as the case may be.

Section 8.19. — Petition for Release by Parent with Patria Potestas or Legal Guardian. (24 L.P.R.A. § 6159r)

When the parent with patria potestas or custody, legal guardian or person with provisional custody requests that the minor involuntarily admitted be released, he/she shall be released within twenty-four (24) hours after the petition.

If the director of the institution has well-founded motives to object to the petition for release of the minor, he/she shall file a petition with the court stating the need for said services.

Lack of interest or inability of the parent with patria potestas or custody, the legal guardian or the person with provisional custody to provide care and shelter shall not be a reason for the court to deny issuing an order for the release of the minor. If this is the case, the court may order the intervention of the Department of the Family in order to assure that the necessary shelter and care shall be provided to the minor, in which case the Department of the Family shall assume custody of the minor.

Section 8.20. — Request for Discharge; Change in Status; Hearing. (24 L.P.R.A. § 6159s)

Within twenty-four (24) hours after the request for discharge, the minor shall be evaluated by a child and adolescent psychiatrist together with the inter- or multidisciplinary team, in order to find whether the minor poses immediate danger to him/herself, to others, or to any property as shown by violent or consistent acts that denote the presence of a mental disorder. If no such finding is made, the minor shall be discharged immediately. If as a result of the request for discharge, and after the evaluation set forth in this section, it is found that the minor poses immediate danger, an order for placement shall be petitioned from the court, which shall not exceed fifteen (15) days and the change of status from voluntary to involuntary placement. The court shall schedule a hearing within the following twenty-four (24) hours. During the course of this process, the minor shall remain hospitalized. The proceedings for voluntary-to-involuntary placement shall be continued, whereby the court shall schedule a hearing pursuant to the provisions of this Act.

Section 8.21. — Hearings. (24 L.P.R.A. § 6159t)

(a) Hearings shall be held before a court with jurisdiction, pursuant to the provisions of the Rules of Civil Procedure in effect.

(b) The minor shall be present at the hearing together with his/her parent with legal custody or his/her legal guardian, and represented by his/her attorney.

(c) If the court, *motu proprio* or by request of one of the parties, when justified by force majeure, defers the case's hearing, the minor shall remain hospitalized pending a subsequent order from the court. The deferral of such hearing shall not be extended for more than five (5) workdays.

(d) The minor, the parent with legal custody or the legal guardian shall have the right to present all the evidence he/she deems convenient to rebut the continuation of the minor's involuntary placement. Such evidence may consist of testimonies or documents. To that effect, the minor shall have the right to be examined by an independent mental healthcare professional of his/her choice or appointed by the court, who shall conduct an evaluation and issue his/her recommendations to the court. The services of said professional shall be paid by the parent with legal custody or the legal guardian of the minor for whom a request for involuntary placement or a change of status is sought, or by a close relative, if any, or by the Commonwealth, in the event that the minor is indigent.

When deemed necessary, the court may request the intervention of the Department of the Family in order to protect the minor's interests.

Section 8.22. — Right to Legal Representation. (24 L.P.R.A. § 6159u)

Every minor object of a petition to order involuntary admission shall have the right to be represented by an attorney or family advocate, according to availability. If the minor is indigent and has not been able to hire an attorney, the court shall appoint an attorney. The attorney appointed by the court and his/her client shall have reasonable time to prepare for the hearing.

Section 8.23. — Transfer of Minor. (24 L.P.R.A. § 6159v)

Any minor who receives mental health services and is in a providing institution, may request to be transferred if said transfer is necessary and without detriment to the minor, provided he/she and the receiving institution accept the transfer. The minor, closest family member or legal guardian shall be notified of the transfer at least three (3) days in advance. If the minor's life is in imminent danger, the transfer shall take place and his/her father, mother with patria potestas or legal guardian shall be notified within twenty-four (24) hours of said transfer.

If the minor, his/her father, mother with patria potestas or legal guardian has any objection to it, the institution shall give him/her the opportunity to reconsider said transfer, pursuant to Section 2.23 of this Act [24 L.P.R.A. § 6153v]. During the process of reconsidering the transfer, the minor shall remain in the original institution that provides mental health services.

Section 8.24. — Passes. (24 L.P.R.A. § 6159w)

In those cases in which is it clinically necessary or beneficial, the child and adolescent psychiatrist, jointly with the inter- or multidisciplinary team, may grant [a] pass to the minor

admitted voluntarily or involuntarily, even when he/she is not fit to be released. In these cases, the court shall not need to be notified, but his/her parent with patria potestas or custody or legal guardian shall be notified.

Section 8.25. — Releases. (24 L.P.R.A. § 6159x)

The child and adolescent psychiatrist in charge of the treatment, recovery and rehabilitation may release any minor admitted voluntarily or involuntarily, at any time after having consulted with the inter- or multidisciplinary team. The psychiatrist shall notify the parent with patria potestas or custody, or the legal guardian of the minor to be released, but his/her parent with patria potestas or custody or the legal guardian shall be notified [sic].

The child and adolescent psychiatrist, and the inter- or multidisciplinary team of the minor to be released, shall explain to him/her, his/her family or legal guardian, of his/her release plan and the options for recovery, notifying the court of the findings made in those cases where the court ordered an involuntary admission.

Section 8.26. — Leaving of the Institution Without Being Released; Notices. (24 L.P.R.A. § 6159y)

When the minor subject to involuntary admission leaves the institution without having been released, the director shall immediately notify a police officer so that he/she may be apprehended and returned to the institution. In addition, he/she shall notify the parent with patria potestas, or the legal guardian and the person who requested his/her admission.

When a minor subject to voluntary admission leaves the institution without having been released, the director shall immediately notify the minor's parent with patria potestas or the legal guardian.

CHAPTER IX — TRANSITIONAL SERVICES FOR MINORS

Section 9.01-A. — Live-in Treatment Programs for Minors. (24 L.P.R.A. § 6159z)

(a) *Purposes.* — Live-in treatment for minors is a treatment modality sub-specialized in the area of child and adolescent mental healthcare, designed specifically for minors with mental health conditions which are difficult to manage at their homes or in their communities, who, despite adequate management by parents or legal guardians, have failed to respond to less restrictive levels of treatment provided by child and adolescent mental healthcare professionals. This treatment modality integrates clinical and therapeutic services organized and supervised by an interdisciplinary team within an ongoing structured setting, day and night, twenty-four (24) hours a day, seven (7) days a week. The main function thereof is to promote, strengthen, and restore adaptive functioning in youths and their families, at their homes and their communities, so that they may come back home and to their communities and continue their treatment at a less intensive and less restrictive level. This treatment modality shall be covered by health plans in the event such treatment applies.

(b) *Objectives.* — Vis-a-vis the restrictive nature of this treatment modality, such treatment modality shall not be employed as a first-instance therapeutic intervention on minors who have

not received previous mental healthcare treatment or when such treatment has not been administered correctly by the minors' parents or legal guardians, unless a psychiatric evaluation conducted by a child and adolescent psychiatrist shows and such psychiatrist believes and recommends that the best treatment alternative for such minors is this service, and such minors meet the criteria for being placed in such treatment.

The objectives of live-in treatment programs for minors are:

- (1) To strengthen the family's functionality so as to improve effective communication skills and interaction styles between and among its members.
- (2) To develop adaptive and functionality skills of youths in their way of relating to their family, their community, and the various social institutions.
- (3) To foster the development of vocational or occupational skills in order for youths to function to the best of their ability within their environment.
- (4) To foster the development of skills to manage and curb mental and emotional condition-related symptoms.
- (5) To foster the development of adaptive behavior skills, as well as problem management and solving skills.
- (6) To foster the development of social skill management so as to allow their reintegration into society.
- (7) To coordinate services with other community agencies which suit the needs of youths and their families.
- (8) To develop training and workshops that focus on the prevention, management, and treatment of mental disorders in youths.

(c) *Treatment.* — Institutional providers of transitional services shall provide, at the very least, the following:

- (1) Individualized treatment, recovery and rehabilitation, focusing on the objectives set forth in subsection (b) of this section.
- (2) An adequate coordination with government and private agencies in order to successfully implement comprehensive services for minors and their families, conducive to the return of such minors to their homes and their communities.
- (3) Proper care of the physical and mental health conditions of minors placed therein.
- (4) Integration of families into the minors' individualized treatment, recovery and rehabilitation plan and guidance on the matter.
- (5) A balanced diet that suits the physiological needs of minors.
- (6) A recreational, educational or vocational rehabilitation plan, whichever modality applies, to be instituted within the program by the interdisciplinary team.

(d) *Levels or stages.* — Live-in treatment programs for minors shall be developed by progress levels or stages, in order to enable the minor's evaluation, classification, and reclassification as per his/her clinical progress, within the therapeutically indicated setting that accords the greatest autonomy possible.

The levels or stages adopted by the institution that offers the live-in treatment program for minors shall be designed to conform to the severity of symptoms and signs, the diagnosis, and the degree of supervision required by the minor, to wit, the greatest supervision, the moderate supervision, and the minimal supervision level or stage.

(e) *Service manuals.* — All institutional providers of live-in treatment programs for minors shall issue a service manual, which shall state, at the very least, the following:

- (1) The philosophy, mission, and objectives of the Program.
- (2) A description of the Program and its stages or levels.
- (3) The criteria for placement to be met by minors when placed in the Program.
- (4) Criteria for preclusion from the Program.
- (5) The composition of the institution's personnel and their qualifications.
- (6) The treatment and ancillary service modalities provided by the Program.
- (7) The age, gender, diagnosis, and functionality level.
- (8) An individualized treatment, recovery and rehabilitation plan prepared by an interdisciplinary team.

Section 9.01-B. — Purposes of Transitional Services for Minors. (24 L.P.R.A. § 6160)

Transitional services for minors shall be designed to provide experiences that are structured, consistent and specialized at different levels of supervision, befitting the severity of symptoms and signs of the disorder in question by age and gender, while successfully enabling the minor to adapt to his/her environment and to become able to participate at another level of care which accords him/her greater autonomy, until he/she can reach his/her eventual independence within the community. Their main function shall be to render treatment, recovery and rehabilitation services focusing on the adequate development of the minor's management of everyday life, in addition to providing care and custody in a safe and humane manner. An example of these services for the child and adolescent age bracket may [be] therapeutic homes or therapeutic communities provided by for-profit or nonprofit community-based organizations, among others.

Section 9.02. — Obligations of Transitional Service Institutions. (24 L.P.R.A. § 6160a)

Institutional providers of live-in treatment for minors shall provide, at the very least, the following:

- (a) The individualized treatment, recovery and rehabilitation, emphasizing the skills that are necessary for everyday life given his/her clinical condition, the severity of the symptoms and signs, his/her stage of life, and his/her potential for recovery and rehabilitation to achieve greater autonomy in his/her environment;
- (b) Adequate coordination with government and private agencies to achieve comprehensive services for the minor and his/her family, in order to reach a greater self-sufficiency;
- (c) The promotion as well as orientation of family participation in the minor's individualized treatment, recovery and rehabilitation plan;
- (d) A balanced diet, according to the special needs of the minors participating in the program, and

Vis-a-vis the restrictive nature of this treatment modality, such treatment modality shall not be employed as a first-instance therapeutic intervention on minors who have not received previous mental healthcare treatment or when such treatment has not been administered correctly by the minors' parents or legal guardians, unless a psychiatric evaluation conducted by a child and adolescent psychiatrist shows and such psychiatrist believes and recommends that the best treatment alternative for such minors is this service, and such minors meet the criteria for being placed in such treatment.

The objectives of transitional treatment for minors are:

- (1) To strengthen the family's functionality so as to improve effective communication skills and interaction styles between and among its members.
- (2) To develop adaptive and functionality skills of youths in their way of relating to their family, their community, and the various social institutions.
- (3) To foster the development of vocational or occupational skills in order for youths to function to the best of their ability within their environment.
- (4) To foster the development of skills to manage and curb mental and emotional condition-related symptoms.
- (5) To foster the development of adaptive behavior skills, as well as problem management and solving skills.
- (6) To foster the development of social skill management so as to allow their reintegration into society.
- (7) To coordinate services with other community agencies which suit the needs of youths and their families.
- (8) To develop training and workshops that focus on the prevention, management, and treatment of mental disorders in youths.

Section 9.03. — Service Manuals. (24 L.P.R.A. § 6160b)

Institutional providers of transitional services shall provide, at the very least, the following:

- (a) Safe and humane care and custody, within the setting that accords the greatest autonomy possible, befitting the treatment, recovery and rehabilitation needs of the minor.
- (b) Individualized treatment, recovery and rehabilitation, focusing on the objectives set forth in § 6160a of this title.
- (c) An adequate coordination with government and private agencies in order to successfully implement comprehensive services for minors and their families, conducive to the return of such minors to their homes and their communities.
- (d) Proper care of the physical and mental health conditions of the minors placed therein.
- (e) Integration of families into the minors' individualized treatment, recovery and rehabilitation plan and guidance on the matter.
- (f) A balanced diet that suits the physiological needs of minors.
- (g) A recreational, educational or vocational rehabilitation plan, whichever modality applies, to be instituted within the program by the interdisciplinary team.

Section 9.04. — Levels, Stages, or Services. (24 L.P.R.A. § 6160c)

Transitional services for minors shall be developed by levels, progress stages, or services, in order to enable the minor's evaluation and classification as his/her needs dictate and the placement of such minor in the therapeutically indicated setting that accords the greatest autonomy possible.

The levels, stages, or services adopted by the institutional provider of transitional services shall be designed to conform to the severity of symptoms and signs, the diagnosis, and the degree of supervision required by the minor, to wit, the greatest supervision service, the moderate supervision service, the minimal supervision service, and independent or in-home service.

The system shall allow for minors to be directly referred to the level most suitable for their condition, without having to course through all the levels or stages.

Section 9.05. — Involuntary Placement; Mandatory Treatment. (24 L.P.R.A. § 6160d)

All minors who meet the necessary criteria to receive transitional services for minors as per the evaluations and the recommendations by the child and adolescent psychiatrist and the inter- or multidisciplinary team, but whose parents with legal or physical custody, legal guardian, or surrogate parent does not give consent for such services, shall be subject to a petition for mandatory treatment or involuntary placement before the court, pursuant to the proceedings provided for in this Act to that effect.

CHAPTER X — MENTAL HEALTH SERVICES WITH GREATER AUTONOMY FOR MINORS

Section 10.01. — Conditioned Right to Request Counseling and Treatment. (24 L.P.R.A. § 6161)

Any minor between fourteen (14) and eighteen (18) years of age may request and receive counseling or psychotherapy and, if necessary, receive outpatient mental healthcare treatment for a maximum period of six (6) sessions if the child and adolescent psychiatrist, physician, psychiatrist, psychologist, social worker, or professional counselor determines that such minor is capable of making such a decision. Services shall not be denied to the minor due to lack of financial resources. During the course of the process, the child and adolescent psychiatrist, psychiatrist, physician, psychologists, social worker, or professional counselor shall determine the kind of mental health services, if any, that the minor needs and give his/her recommendations. If the minor should need more than six (6) sessions or require treatment at another level, the professional shall advise and help him/her to acknowledge the advantage of obtaining authorization from his/her parent with legal or physical custody or his/her legal guardian.

However, consent by the minor's parent with legal or physical custody, legal guardian, or surrogate parent, shall not be necessary to authorize counseling or psychotherapy for, or if necessary, the treatment of such minor, and the former shall not be notified of said intervention without the minor's consent, except in those cases in which the child and adolescent psychiatrist, physician, psychiatrist, psychologist, social worker, professional counselor, or any other healthcare professional finds that the minor is at risk of inflicting harm upon him/herself or others or damaging property. In cases in which notice to the minor's parent with legal or physical custody, legal guardian, or surrogate parent is necessary, the minor shall be immediately informed of such notice. Once the parent with legal or physical custody, the legal guardian, or the surrogate parent has been notified, the mental healthcare professional shall obtain consent to conduct the applicable intervention.

As pertains to counseling or treatment for substance-related disorders, the initial term shall not exceed seven (7) sessions if the physician, psychiatrist, psychologist, social worker, or professional counselor finds that the minor is capable of making such decision. During the course of the process, the psychiatrist, psychologist, physician, social worker, or professional

counselor shall determine the kind of mental healthcare services that the minor needs, if any, and give his/her recommendations. If the minor should need more than seven (7) sessions or require treatment at another level, the professional shall advise and help him/her to acknowledge the advantage of obtaining authorization from his/her parent with legal or physical custody or his/her legal guardian. As pertains to substance dependency-related cases, the pertinent laboratory or drug screening tests may be administered if the properly licensed healthcare professional believes these to be necessary.

Counseling or treatment shall be kept confidential, and no document shall be remitted between the mental healthcare service provider and the minor's parent with legal or physical custody or legal guardian, until the sessions have been completed as established in this section. Consent by the minor's parent with legal or physical custody, legal guardian, or surrogate parent shall not be necessary to authorize counseling or psychotherapy for, or if necessary, the mental healthcare treatment of the minor, and the former shall not be notified of said intervention without the minor's consent, except in those cases in which the child and adolescent psychiatrist, psychiatrist, physician, psychologist, social worker, professional counselor, or any other healthcare professional finds that the minor is at risk of inflicting harm upon him/herself or others or damaging property. In cases in which notice to the minor's parent with legal or physical custody, legal guardian, or surrogate parent is necessary, the minor shall be immediately informed of such notice. Once the parent with legal or physical custody, the legal guardian, or the surrogate parent has been notified, the mental healthcare professional shall obtain consent to conduct the applicable intervention.

Services shall not be denied to the minor due to lack of financial resources. Costs arising from counseling, psychotherapy, or outpatient treatment services for minors may be billed to the minor's health insurance, if applicable. In this Act, a session is equal to an outpatient treatment visit without medication. Services may also be terminated if the minor fails to attend or if services are concluded by mutual consent.

Section 10.02. — Greater-autonomy Services for Minors. (24 L.P.R.A. § 6161a)

Any minor who begins to receive direct outpatient services in mental healthcare at the various levels of care and treatment, rehabilitation and recovery modalities, or any such minor for whom such services are requested, shall receive, among others, the following services within the first seventy-two (72) hours:

- (a) A physical examination, when clinically necessary to rule out physiological or organic conditions or as part of the clinical outpatient follow-up.
- (b) Laboratory tests, when clinically necessary to rule out physiological or organic conditions or as part of the clinical outpatient follow-up.
- (c) A psychiatric evaluation conducted by a psychiatrist, when a child and adolescent psychiatrist is not available due to fully justified reasons. If the evaluation is conducted by a general psychiatrist or a primary-care physician, consultation with a child and adolescent psychiatrist shall be made as soon as practicable.
- (d) A psychological screening conducted by a psychologist, when clinically necessary.
- (e) A psychological evaluation conducted by a psychologist, when clinically indicated.

(f) A social evaluation conducted by a social worker, when pertinent due to the existence of social situations or circumstances which might affect the ongoing nature of the person's mental healthcare services.

(g) A psychiatric evaluation conducted by a psychiatrist; in the event that the institution does not have a psychiatrist, this evaluation may be conducted by a properly licensed physician.

(h) A substance screening conducted by a professional counselor knowledgeable in addiction issues, when clinically indicated to rule out or assess substance abuse and/or dependency.

The results of the tests, analyses and evaluations shall form part of the minor's clinical record, and shall be used to establish the individualized treatment, recovery and rehabilitation plan at the corresponding level of care which accords the greatest autonomy. This plan shall be devised by an inter- or a multidisciplinary team not later than fifteen (15) days following commencement of treatment and such plan shall be reviewed every thirty (30) days to conform to the standards for each level of care or when a substantial change occurs. The procedures shall be included in the regulations to be promulgated for these purposes.

The provisions of this section shall not apply to mental healthcare professionals with private offices. In this case, such professionals shall make sure to comply with the standards applicable to their respective professions, based on the clinical protocols and the treatment guidelines recommended by the Administration.

Section 10.03. — Initial Evaluation; Treatment, Recovery and Rehabilitation Plan at Another Greater Autonomy Level. (24 L.P.R.A. § 6161b)

Any minor who has been hospitalized or who received services at a level of care, when by recommendations of the child and adolescent psychiatrist and the inter- or multidisciplinary team of the service making the referral, it is found that such minor needs treatment at another level of care which accords greater or lesser autonomy, the review of the discharge plan of such minor or of the recommendations ensuing from their evaluation shall be in order and the same shall be instituted within twenty-four (24) hours following placement, insofar as he/she is clinically qualified for such level of care.

The evaluation, the recommendations, or the discharge plan shall form part of the minor's clinical record at the applicable level of care. Such results shall be used to establish the individualized treatment, recovery and rehabilitation plan, which shall be reviewed in light of the diagnosis and the severity of symptoms and signs for each level or modality of care pursuant to the best practices of mental healthcare professionals and the treatment protocols and guidelines recommended by the Administration. This plan shall be devised by an inter- or a multidisciplinary team not later than fifteen (15) days following placement in the new level of care and reviewed every ninety (90) days pursuant to the standards for each level of care or when a substantial change occurs. Once patients have achieved the objectives of their individualized treatment, recovery and rehabilitation plan, they shall continue to the next level of care that accords them greater autonomy, as their condition allows.

Section 10.4. — Services Manuals. (24 L.P.R.A. § 6161c)

Every institution that provides services with greater autonomy shall have a services manual, which shall contain, as a minimum, the following:

- (a) The admission criteria to be met by minors who request the services.
- (b) The age, sex, disorder, diagnosis and level of functionality.
- (c) An individualized treatment, recovery and rehabilitation plan prepared by an inter- or multidisciplinary team.
- (d) The staffing pattern that the institution shall have, as well as the qualifications thereof.
- (e) The program's philosophy and a description of the institution's environment.
- (f) The corresponding therapeutic modality or activity program.

The provisions of this section shall not apply to private offices of mental health professionals. However, said professionals shall advise the minor, his/her father, mother with patria potestas or custody, legal guardian or person with provisional custody on the treatment options for his/her condition, the ones they recommend and which ones they can provide according to his/her symptoms and signs, and to the diagnostic impression at the time of the initial evaluation.

CHAPTER XI — EVALUATION OF MINORS UNDER THE COURT’S JURISDICTION IN INSTITUTIONS THAT PROVIDE MENTAL HEALTH SERVICES TO MINORS.

Section 11.01. — Order to Evaluate Minors under the Court’s Jurisdiction. (24 L.P.R.A. § 6162)

The court shall order, *motu proprio* or by petition of party, that those minors who have been accused of offenses or who have been found liable for offenses be evaluated at institutional providers of mental healthcare services for minors, insofar as the presence of [a mental] disorder needs to be confirmed or ruled out.

The child and adolescent psychiatrist, together with the inter- or multidisciplinary team of the institutional provider of services for minors, shall give the court written notice of the results of said evaluation. These results shall include the specific recommendations for managing the minor and guidance to the family, as well as placement in the corresponding level of care.

Section 11.02. — Placement in Institution for Children and Adolescents. (24 L.P.R.A. § 6162a)

If after the evaluation, it should be found that the minor under court jurisdiction suffers from a mental disorder, the court shall order that an inter- or multidisciplinary individualized treatment, recovery and rehabilitation plan be prepared and implemented, which shall include all specialized services needed. Each and every service program shall be provided at special institutions for minors which are age- and gender-appropriate and which suit their clinical needs.

The minor shall meet the placement criteria of such institution. Upon placement, he/she shall be evaluated pursuant to the provisions of this Act, and the court shall be informed every three (3) months or before, if so required by the court or if a significant change has occurred in the minor's condition, in order to assess the progress of his/her treatment, recovery and rehabilitation and to issue the corresponding recommendations. A copy of the evaluation shall be remitted to the Court of First Instance, Minors' Affairs Part, to the Minors' Advocate, and to the parties, as indicated by the court.

Section 11.03. — Request to Place Minors with Mental Disorders Found Prosecutable and Chargeable. (24 L.P.R.A. § 6162b)

If as a result of the court-ordered evaluation, the child and adolescent psychiatrist, in consultation with the inter- or multidisciplinary team, finds that the minor is chargeable or prosecutable and that he/she has a mental disorder, the court, upon finding the minor liable for an offense and ordering his/her placement, shall order that the minor be transferred to a ward at the Administration of Juvenile Institutions specialized in the treatment, care, and custody of this population. While the minor is in the custody of the Administration of Juvenile Institutions, it shall be responsible for having the minor receive the treatment, recovery and rehabilitation mental healthcare services he/she requires. Chargeable or prosecutable minors, as provided for in this section, may not be placed in institutions that do not meet the required criteria to provide specialized care to this population.

In the event that the court grants probation benefits, the court shall maintain jurisdiction over the minor and demand as a condition, among others, that the minor receive mental healthcare services.

The director of the specialized ward shall notify the court as soon as the minor is discharged from the ward, and send a copy of such notice, together with the discharge plan, to the Administration of Juvenile Institutions. After such discharge, the court shall order as it sees fit and send a copy of the order to that effect to the Administration of Juvenile Institutions.

Once the court finds that discharge is in order, the minor shall be immediately discharged.

Section 11.04. — Minor Acquitted from Offense; Order to Refer to Mental Healthcare Service. (24 L.P.R.A. § 6162c)

When the court has acquitted a minor from the commission of an offense, but the evaluation shows that he/she has a mental disorder, the minor shall be referred to the mental healthcare service recommended in said evaluation. The court shall issue a fifteen (15) -day involuntary placement order. If the fifteen (15)-day term should be found not to be sufficient, the proceedings established in this Act shall be in order.

Section 11.05. — Report Prior to any Disposition on the Case. (24 L.P.R.A. § 6162d)

Before the court makes a final decision on the case, the inter- or multidisciplinary team responsible for minor's treatment, recovery and rehabilitation shall prepare a report including the level of care, bearing in mind that it is therapeutically indicated and with greater autonomy, including the interagency coordination, a social evaluation, a preliminary treatment, recovery and rehabilitation plan, and any other information that the court may deem convenient before the disposition of the case. The inter- or multidisciplinary individualized treatment, recovery and rehabilitation plan, shall be developed in accordance with the requirements of this Act. If [the] minor is admitted, the court shall consider the report to determine the disposition of the case.

Section 11.06. — Final orders, Copy to the Minor; Review. (24 L.P.R.A. § 6162e)

Every court order shall be in writing, duly sealed and signed, and shall be accompanied by a clear and precise determination made by the court with respect to the minor's situation.

Copy of the order shall be given to the parent with patria potestas, or legal guardian, or the person with provisional custody of the minor who receives mental health services, or his/her attorney, and to the director of the mental health institution or the director of the level of care service where the minor was admitted. The court shall notify any of the aforementioned of their right to request reconsideration and in case of being indigent, of their right to receive a free transcript of the legal file and to be assisted by an attorney. If the parent with patria potestas, or the legal guardian wishes [an appeal] and does have the economic means to do so, the court shall appoint an attorney.

CHAPTER XII — COLLABORATIVE SYSTEM

Section 12.01. — Manifestations of the Mental Health Problem. (24 L.P.R.A. § 6163)

It is hereby acknowledged that the different manifestations of mental problems and disorders, such as domestic violence, crime, delinquency, child abuse, truancy, and the homeless population fall within the responsibility of different government service agencies, which [results in] fragmented attention to the problem. Based on this premise, we establish the importance and urgency to develop interagency collaborative systems to provide integrated and comprehensive services to populations with mental disorders, which, one way or another, are also served or have the right to receive services from other agencies. Profit and non-profit private entities and corporations may collaborate in this effort.

Section 12.02. — Principles of the Collaborative System. (24 L.P.R.A. § 6163a)

The principles that govern this system are:

- (a) Avoid duplication of service efforts.
- (b) Provide long term and cost-effective services.
- (c) Keep a system to improve the quality of the services.
- (d) Provide the most comprehensive services possible close to their communities [of the] populations who need them.

Section 12.03. — Work Plan. (24 L.P.R.A. § 6163b)

This system shall develop a master work plan which shall specify its stages, purposes, objectives, activities, and achievements, execution and result indicators, as well as the implementation dates by agencies and the populations to be served (children, adolescents, women, mothers, homeless and others), and the agencies and services corresponding to each. It shall also include the contribution from each agency in proportion to the needs identified for each population and each collaborative project, the implementation of a formative and summative evaluation for this system, and the integrated budget for the complete collaborative system and its projects. It is worth mentioning that the collaboration is a group effort.

Section 12.04. — Types of Collaborations. (24 L.P.R.A. § 6163c)

It is hereby established that this system may use several types and models of interagency collaborations, such as the integration of physical and professional resources, the blended budget for a project or creation and access to a service, collaborative planning, and complementary planning.

It is worth mentioning that the collaboration is a group effort to achieve joint planning and implementation.

Section 12.05. — Reports. (24 L.P.R.A. § 6163d)

This system shall render [semi-annual and annual] reports to the Office of Management and Budget and to the Legislature, with the evaluations that according to the field, are designated as formative and summative, pursuant to this section.

Section 12.06. — Effectiveness. (24 L.P.R.A. § 6163e)

The effectiveness for the implementation of this system shall begin ninety (90) days after approval of this act, to begin interagency collaborative efforts.

CHAPTER XIII — TREATMENTS RELATED TO THE ABUSE AND DEPENDENCE ON ALCOHOL AND CONTROLLED SUBSTANCES

Section 13.01. — Therapeutic Alternatives for Treating Disorders Related to Alcohol and Controlled Substance Abuse. (24 L.P.R.A. § 6164)

The treatment of persons with substance-related disorders, including comorbid conditions diagnosed, who suffer from substance or alcohol dependency, shall require the intervention of an interdisciplinary team constituted by mental healthcare professionals, as determined by the study of the individual case conducted initially by the primary-care physician and the psychologist, in consultation with the psychiatrist, if the diagnosis so indicates. All interdisciplinary team physicians and clinicians shall have completed a specialty or continuing education in addiction issues. The therapeutic value of the intra-hospital detoxification process shall be assessed by the psychiatrist and the interdisciplinary team, vis-a-vis the first intoxication episodes, the physical condition, and the mental state of the person at the time of requesting such service.

Such treatment may include, but is not limited to the following:

- (1) The adequate matching of the level of treatment with the patient's individual needs.
- (2) Such treatment shall be readily accessible, assure integration and continuity as to the various levels of treatment, and be reasonably located in each municipality of the Island.
- (3) Such treatment shall accord flexibility and be based on ongoing assessments of the patients' needs, which might change during the course of treatment.
- (4) Treatment shall be integrated into one (1) or more levels, and may last no less than six (6) months of treatment, after a follow-up and lastly, an indefinite maintenance. Premature abandonment of the treatment shall be avoided.

(5) The multiple kinds of individual, family and group psychotherapy may be combined with pharmacotherapy, strategies to prevent relapses, and spiritual guidance, among others.

(6) Treatment shall have scientific foundations and shall include periodic evaluations of its effectiveness. The adequate use of medications prescribed by a psychiatrist shall not be limited.

(7) The rule-rather than the exception-shall be that persons who present two (2) or more psychiatric diagnoses, including substance and/or alcohol dependency, shall have all of their conditions treated concurrently.

(8) Detoxification shall be seen as the first stage in the treatment for the disease and shall be followed by an intensive treatment to avoid relapses.

(9) Drug use shall be monitored on an ongoing and periodical basis, including the use of alcohol and other controlled substances, as per the clinical history of the person.

(10) The pharmacological treatment modality, whether or not with agonist medications, shall be understood to be only one among various therapeutic interventions integrated into the treatment of substance- and alcohol-related disorders. Such modality shall not preclude the use of other treatment modalities, such as psychotherapy (whether cognitive, behavioral modification, introspective, or group or family therapy) and other community sustenance interventions, such as spiritual counseling, motivational counseling, vocational counseling, peer supervision, and support groups.

(11) Coordination and referral shall be provided for the evaluation and treatment of related diseases, such as HIV/AIDS, hepatitis, and tuberculosis, and guidance shall be offered to patients so as to prevent their physical deterioration and to prevent other persons from becoming infected.

(12) As pertains to long-term rehabilitation treatment, patients with controlled substance- or alcohol-related disorders shall be separated from other patients who suffer only from psychiatric disorders. Groups shall also be separated according to age and gender, as set forth in this Act. Persons who present comorbid disorders relative to controlled substance and/or alcohol abuse or dependency, as well as any other psychiatric diagnoses, shall have all their conditions treated concurrently.

(13) As to for-profit or nonprofit community-based organizations that provide treatment to persons with substance- and/or alcohol-related disorders, spiritual-pastoral guides and/or counselors, among others, may be constituents of the inter- or multidisciplinary team.

(14) The cases of children and adolescents with substance- and/or alcohol-related disorders shall be evaluated and treated by a child and adolescent psychiatrist with up-to-date continuing medical education or a psychiatric specialty in addiction issues, in consultation with an interdisciplinary team, whose members shall also keep abreast of the continuing education pertaining to their professions. In the absence of these professionals, a psychiatrist or a physician may carry on to conduct the evaluation and treatment until consultation with a sub-specialist is practicable.

(15) Care for pregnant women with substance- or alcohol-related disorders shall include special measures as their condition dictates, taking into account the welfare of the unborn baby and the foreseeable medical needs in relation to the birthing.

(16) Care for persons under placement (whether in correctional institutions of any level, hospitals, service or treatment or live-in centers, for-profit or nonprofit community-based organizations, or through any other restrictive treatment or confinement) shall take into

account the planning and coordination of ongoing services to be offered in the community in the course of deinstitutionalization or in the discharge plan.

Provided, That cases strictly about controlled substance and/or alcohol dependency or abuse, the indirect mental healthcare service provider shall be under the obligation to cover the following benefits, insofar as medically warranted:

- (1) Hospitalization for thirty (30) days during the policy year.
- (2) A maximum of fifteen (15) visits to the psychiatrist.
- (3) A maximum of fifteen (15) therapy sessions facilitated by a psychologist.

Health plans shall cover live-in treatments at a rate of ninety (90) days per policy year, insofar as medically warranted and as the services are available in Puerto Rico.

Section 13.02. — Applicability of provisions of this Act to for-profit or nonprofit community-based organizations. (24 L.P.R.A. § 6164a)

For-profit or nonprofit community-based organizations, as this term is defined in this Act, and spiritual-pastoral guidance and social work, shall be subject to the precepts of this Act. Provided, That such organizations shall continue to offer community services, pursuant to their historic, traditional and ordinary practice, and always subject to the precepts of the Constitution and the laws of the Commonwealth of Puerto Rico.

The approval of this Act shall not represent, in any way, a variation of the rights, prerogatives and benefits that for-profit or nonprofit community-based organizations receive pursuant to the development of the community efforts described herein.

CHAPTER XIV — GENERAL RESPONSIBILITIES OF THE MENTAL HEALTH AND ADDICTION SERVICES ADMINISTRATION

Section 14.01. — Licensing. (24 L.P.R.A. § 6165)

The Administrator, as authorized by Act No. 67 of August 7, 1993, as amended, known as “The Mental Health and Addiction Services Administration Act” (ASSMCA, for its Spanish acronym), shall establish all the necessary regulations in order to license, supervise and maintain a public registry of all the institutions and facilities, public or private, engaged in providing services to prevent or treat mental disorders, alcoholism, and drug addiction; and to formulate and implement prevention and treatment programs, and establish their quality controls in order to comply with the purposes of this Act.

The authority to grant licenses established in this section shall be the Administration's full competence; license that it shall issue through its Licensing Division, exclusively for mental health services and facilities. Said license shall be known as the "Mental Health Services License". The Administrator shall establish through regulation the fees that institutions shall pay when requesting or renewing the license, and establish categories between the profit and non-profit institutions. The regulation adopted to such effect shall provide, among other requisites, those for granting and renewing the license, that the applicant shall describe the mechanisms to implement and comply with this Act, as well as the indicators used to ensure that said implementation be effective and continuous.

Section 14.02. — Regulations. (24 L.P.R.A. § 6165a)

The Administrator is hereby authorized to prepare all regulations that may be necessary to facilitate the implementation of this Act, within a term of six (6) months after the approval of this Act, and pursuant to Act No. 170 of August 12, 1988, as amended, known as the “Uniform Administrative Procedures Act of the Commonwealth of Puerto Rico.”

Section 14.03. — Forms and Complaints. (24 L.P.R.A. § 6165b)

The Mental Health and Addiction Services Administration and the Puerto Rico Health Insurance Administration shall prepare all the forms that may be necessary to fully comply with their obligations and responsibilities. They shall oversee the implementation of these provisions as pertains to users and public and private institutions that offer services. They shall conduct investigations and establish procedures to manage complaints lodged by persons who receive mental healthcare services, their legal guardians or their legal representatives.

The Administration and the Puerto Rico Health Insurance Administration shall provide a liaison between persons who receive mental healthcare services and public and private institutions, in order to:

- (a) Ensure that persons receive the services to which they are entitled;
- (b) intercede in case there is no access to the services that correspond to the disorder and severity of the symptoms and signs, age and characteristics of the patient;
- (c) provide persons with severe mental disorders with case management and access to comprehensive services that suit their needs;
- (d) outreach chronic and recurring populations to [provider] networks so they may participate and receive the treatment they need for their condition, and
- (e) aid in the Health Reform transitional process until the same is completed.

Section 14.04. — Review and Annual Technical Assistance System. (24 L.P.R.A. § 6165c)

The Administrator shall establish and implement a review and technical assistance system of the providing institutions to assure quality and effectiveness of the services rendered, and to protect the best interest of the persons who receive mental health services. He/She shall design and implement a service, technical assistance and annual evaluation system. The results from the technical reviews shall be analyzed by the Administration to identify the needs in relation to the compliance with the provisions contained in this Act. The same shall be used to submit to the Administrator the recommendations that proceed, as for trainings, as well as amendments to this Act and other laws in effect related to mental health services.

To assure the quality and effectiveness of the services rendered, and protect the best interests of the persons who receive mental health services, the Administrator, after a hearing to that effect, may impose fines, deny, suspend or revoke said licenses, at any time, upon finding that an institution does not comply with the [requirements] established by this Act. In the case of institutions that provide treatment, recovery and rehabilitation services, and transitional services, the license granted by virtue of this Act shall be in effect for a period of two (2) years. The request for renewal shall be made in accordance with the rules and regulations the Administration promulgates to that effect.

Section 14.05. — Appropriation of Funds. (24 L.P.R.A. § 6165d)

The Administrator, as authorized by Act No. 67 of August 7, 1993, as amended, known as the “The Mental Health and Addiction Services Administration Act,” shall be responsible for procuring and assuring the appropriation of the budgetary funds necessary to facilitate the implementation of and compliance with this Act. It shall be the responsibility of the Legislature and the Office of Management and Budget to allocate funds to implement this Act.

CHAPTER XV — ADDITIONAL PROVISIONS

Section 15.01. — Claim of Abuse. (24 L.P.R.A. § 6166)

Any person who receives direct or indirect mental health services and who, per se, through his/her legal guardian or any other person, has well-founded motive to believe that abuse has been committed, may resort to the Court of First Instance to request to cease and desist of any act that violates the provisions of this Act.

Section 15.02. — Abuse; Notice to the Examining Board or Regulating Agencies. (24 L.P.R.A. § 6166a)

If [it is] determined that a mental health professional has incurred in abuse or negligence, the court shall notify said determination to the corresponding Examining Board or the Board of Examiners.

Presentation of an action pursuant to this section is independent from any other civil criminal or administrative action provided in the current legislation and shall not impede the exercise of said actions, rights or remedies.

Section 15.03. — Institutionalization Prohibited. (24 L.P.R.A. § 6166b)

Any institutional mental healthcare provider facility which is found to have institutionalized a person, whether an adult or a minor, who does not meet the clinical criteria nor present the severity that warrants his/her placement at the level of care where he/she has been kept, after symptoms and signs have been stabilized for the level of care in which he/she remained, thus being deprived from a greater autonomy, less intensive and less restrictive level of care, shall be guilty of a crime, as provided for in Article 168 of the Puerto Rico Penal Code [33 L.P.R.A. § 4796].

Section 15.04. — Habeas corpus. (24 L.P.R.A. § 6166c)

Nothing in this Act shall prevent a person from filing a writ of habeas corpus. The court that grants said remedy shall send a copy of the same to the court that ordered the admission. The clerk of the court shall include the same in the record of the case.

Section 15.05. — Petition to the Court. (24 L.P.R.A. § 6166d)

Any petition filed before the court, pursuant to the provisions of this Act, shall be subscribed under oath, under penalty of perjury. If there is well-founded motive to believe that the petitioner has offered false information to admit a person in a providing institution, a prosecutor shall be notified immediately, who shall then proceed to investigate the facts to establish if there exists cause of action against the petitioner.

Section 15.06. — Petition for Restoration to Competency. (24 L.P.R.A. § 6166e)

Any person who has been declared incompetent by any court, may file a petition at any time to amend guardianship or to have his legal competency restored. The petition may be filed in the court that resolved that the person was incompetent, or in the court in whose jurisdiction the person resides. The petition shall be accompanied by a certification from the psychiatrist and by the notice of release from the institution. The psychiatrist's certification shall include the extent of the patient's ability to manage him/herself and his/her property. If said certification is not attached, the court may appoint a psychiatrist to examine the patient and file the certification of his/her competency.

Section 15.07. — Notice of Death of Persons in the Institution. (24 L.P.R.A. § 6166f)

When a patient who was admitted to an institution dies within the same, the director shall be obliged to notify the corresponding prosecuting office so that an autopsy is ordered. The proceedings shall be carried out pursuant to Act No. 13 of June 24, 1985, as amended [34 L.P.R.A. §§ 3001 et seq.], known as the "Puerto Rico Institute of Forensic Sciences Act". In those cases in which the person was admitted by a court order, the director shall notify the court that issued the admission order.

Section 15.08. — Penalties. (24 L.P.R.A. § 6166g)

- (a) Any person who violates any of the provisions of this Act shall incur in a misdemeanor and if convicted, shall be sanctioned with a fine not to exceed five thousand dollars (\$5,000).
- (b) Any person, natural or juridical, who discriminates in relation to any aspect relative to the access to necessary services for a person who requires mental health services, who abuses or violates the duty to protect confidentiality of information, or uses isolation, restriction or electroconvulsive therapy contrary to the provisions of this act, shall incur in a felony and shall be sanctioned with a fine of not less than five thousand dollars (\$5,000) or more than fifteen thousand dollars (\$15,000), or imprisonment for a fixed term of three (3) years, or both penalties, at the discretion of the court.
- (c) [Upon initiating an action under subsections (a) and (b) of this section, the filing of any type of administrative action is not impeded].

Section 15.09. — Repeal. — Act No. 116 of June 2, 1980, known as the “Mental Health Code of Puerto Rico,” is hereby repealed.

Section 15.10. — Severability. (24 L.P.R.A. § 6152 note)

If any clause, paragraph, section, subsection, Act or part of this Act is declared unconstitutional by a court with jurisdiction, said ruling shall not affect the validity of any of the remaining provisions. The effect of said judgment shall be limited to the clause, paragraph, section, subsection, Act or part declared unconstitutional.

Section 15.11. — Effectiveness. (24 L.P.R.A. § 6152 note)

This Act shall take effect ninety (90) days after its approval, except for Chapter XIV, Responsibilities of the Administration, which shall take effect sixty (60) days after the approval of this Act, and with regard to health plans and the renewal thereof, which shall apply to those that take effect upon said approval.

Note. This compilation was prepared by the Puerto Rico OMB staff who have striven to ensure it is complete and accurate. However, this is not an official compilation and may not be completely free of error. It contains all amendments incorporated for reading purposes only. For accuracy and exactitude please refer to the act original text. Compiled by the Office of Management and Budget Library.