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CHAPTER 22

Rights of Mental Health Patients

**SECTION 44‑22‑10.** Definitions.

 As used in this chapter:

 (1) [Reserved]

 (2) “Director” means the Director of the Department of Mental Health.

 (3) “Court” means probate court.

 (4) “Department” means the State Department of Mental Health.

 (5) “Facility” means a residential program operated by the department.

 (6) “Independent examination” means an examination of a patient by a qualified employee of the department.

 (7) “Individual plan of treatment” means a plan written by a multi‑disciplinary team setting forth measurable goals and objectives in prescribing an integrated program of individual designed activities or therapies necessary to achieve the goals and objectives.

 (8) “Major medical treatment” means a medical, surgical, or diagnostic intervention or procedure where a general anesthetic is used or which involves significant invasions of bodily integrity requiring an incision or producing substantial pain, discomfort, debilitation, or having a significant recovery period. It does not include a routine diagnosis or treatment such as the administration of medications or nutrition or the extraction of bodily fluids for analysis, dental care performed with local anesthetic, procedures which are provided under emergency circumstances, or the withdrawal or discontinuance of medical treatment which is sustaining life functions.

 (9) “Mental disability” means a medically diagnosable, abnormal condition which is expected to continue for a considerable length of time, whether correctable or uncorrectable, which reasonably is expected to limit the person’s functional ability.

 (10) “Multi‑disciplinary team” means persons drawn from or representing the professional disciplines or service areas included in the treatment plan.

 (11) “Patient” means an individual undergoing treatment in the department; however, the term does not include a person committed to the department pursuant to Chapter 48 of Title 44.

 (12) “Patient unable to consent” means a patient unable to appreciate the nature and implications of his condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner. This definition does not include a person under eighteen years of age, and this chapter does not affect the delivery of health care to that person unless he is married or has been determined judicially to be emancipated. A patient’s inability to consent must be certified by two licensed physicians, each of whom has examined the patient. However, in an emergency the patient’s inability to consent may be certified by a health care professional responsible for his care if the health care professional states in writing in the patient’s record that the delay occasioned by obtaining certification from two licensed physicians would be detrimental to his health. A certifying physician or other health care professional shall give an opinion regarding the cause and nature of the inability to consent, its extent, and its probable duration.

 (13) “Reasonably available” means that a person to be contacted may be contacted with diligent efforts by the attending physician or another person acting on behalf of the attending physician.

 (14) “Treatment” means the attempted correction or facilitation of a mental illness or alcohol and drug abuse.

HISTORY: 1991 Act No. 127, Section 1; 1992 Act No. 279, Section 1; 1993 Act No. 181, Section 1079; 1998 Act No. 321, Section 5.

**SECTION 44‑22‑20.** Right to writ of habeas corpus.

 Patients have the right to the writ of habeas corpus.

HISTORY: 1991 Act No. 127, Section 1.

**SECTION 44‑22‑30.** Right to counsel for involuntarily committed persons suffering from mental illness or chemical dependency.

 Persons suffering from mental illness or chemical dependency have the right to be represented by counsel when involuntarily committed to the department pursuant to Sections 44‑17‑530 and 44‑52‑110.

HISTORY: 1991 Act No. 127, Section 1.

**SECTION 44‑22‑40.** Consent to electro‑convulsive therapy or major medical treatment; determination of ability to give consent; who may give consent.

 (A) A patient in need of electro‑convulsive therapy or major medical treatment must be examined by a qualified physician to determine if the patient is able to consent to electro‑convulsive therapy or major medical treatment. Where a patient is determined unable to consent to surgery or electro‑convulsive therapy or major medical therapy or treatment, decisions concerning the need for treatment may be made by the following persons in the following order of priority:

 (1) a guardian appointed by the court pursuant to Article 5, Part 3 of the South Carolina Probate Code, if the decision is within the scope of the guardianship;

 (2) an attorney‑in‑fact appointed by the patient in a durable power of attorney executed pursuant to Section 62‑5‑501, if the decision is within the scope of his authority;

 (3) a person given priority to make health care decisions for the patient by another statutory provision;

 (4) a spouse of the patient unless the spouse and the patient are separated pursuant to one of the following:

 (a) entry of a pendente lite order in a divorce or separate maintenance action;

 (b) formal signing of a written property or marital settlement agreement;

 (c) entry of a permanent order of separate maintenance and support or of a permanent order approving a property or marital settlement agreement between the parties;

 (5) a parent of the patient or child eighteen years of age or older of the patient;

 (6) a sibling or grandchild eighteen years of age or older of the patient or grandparent of the patient;

 (7) other relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the patient;

 (8) a person given authority to make health care decisions for the patient by another statutory provision.

 (B) If persons of equal priority disagree on whether certain health care should be provided to a patient who is unable to consent, an authorized person, a health care provider involved in the care of the patient, or another person interested in the welfare of the patient may petition the probate court for an order determining what care is to be provided or for appointment of a temporary or permanent guardian.

 (C) Priority under this section must not be given to a person if a health care provider responsible for the care of a patient who is unable to consent determines that the person is not reasonably available, is not willing to make health care decisions for the patient, or is unable to consent as defined in Section 44‑22‑10(6).

 (D) An attending physician or other health care professional responsible for the care of a patient who is unable to consent may not give priority or authority under subsection (A)(5) through (8) to a person if the attending physician or health care professional has actual knowledge that, before becoming unable to consent, the patient did not want that person involved in decisions concerning his care.

 (E) This section does not authorize a person to make health care decisions on behalf of a patient who is unable to consent if, in the opinion of the certifying physicians, the patient’s inability to consent is temporary, and the attending physician or other health care professional responsible for the care of the patient determines that the delay occasioned by postponing treatment until the patient regains the ability to consent will not result in significant detriment to the patient’s health.

 (F) This section does not affect the application of the Adult Health Care Consent Act, Sections 44‑66‑10 through 44‑66‑80, to a patient in need of health care.

HISTORY: 1991 Act No. 127, Section 1.

**SECTION 44‑22‑50.** Treatment suited to needs; least restrictive care and treatment.

 (A) A patient receiving services for mental illness or alcohol and drug abuse shall receive care and treatment that is suited to his needs and which is the least restrictive appropriate care and treatment. The care and treatment must be administered skillfully, safely, and humanely with full respect for the patient’s dignity and personal integrity.

 (B) Persons who operate facilities of the department shall ensure that restrictions on a residential patient’s liberty are confined to those minimally necessary to establish the therapeutic objectives for the patient. The department and the Department of Alcohol and Other Drug Abuse Services shall make every effort to ensure that no patient is admitted to a facility unless a prior determination has been made that residence in the facility is the least restrictive setting feasible for the patient.

 (C) In cases of emergency admissions, when the least restrictive setting is not available, patients must be admitted to the nearest appropriate facility until the patient may be moved to the least restrictive setting.

 (D) No patient may remain at a level of care that is more expensive and restrictive than is warranted to meet his needs when the appropriate setting is available.

 (E) Patients have a right to the least restrictive conditions necessary to achieve the purposes of treatment. The facility shall make every attempt to move residents from:

 (1) more to less structured living;

 (2) larger to smaller facilities;

 (3) larger to smaller living units;

 (4) group to individual residences;

 (5) segregated from the community to integrated into the community living;

 (6) dependent to independent living.

HISTORY: 1991 Act No. 127, Section 1; 1993 Act No. 181, Section 1080.

**SECTION 44‑22‑60.** Explanation of rights with regard to admission to facility; individualized treatment plan.

 (A) Before or when admitted to a facility, a patient or his guardian or parent must be provided with an explanation, in terms and language appropriate to the person’s ability to understand, of the rights of the patient while under the care of the facility.

 (B) Within six hours of admission a patient must be examined by a physician. Within fourteen days of admission, a patient or his parent or guardian must be provided with a written individualized plan of treatment formulated by a multi‑disciplinary team and the patient’s attending physician. Each patient or his parent or guardian shall participate in an appropriate manner in the planning of services. An interim treatment program based on the preadmission evaluation of the patient must be implemented promptly upon admission. An individualized treatment plan must contain:

 (1) a statement of the nature and degree of the patient’s mental illness or chemical dependency and his needs;

 (2) if a physical examination has been conducted, the patient’s physical condition;

 (3) a description of intermediate and long‑range treatment goals and, if possible, future available services;

 (4) criteria for release to a less restrictive environment, including criteria for discharge and a description of services that may be needed after discharge;

 (5) a statement as to whether or not the patient may be permitted outdoors on a daily basis and, if not, the reasons why. Treatment plans must be updated upon periodic review as provided in Section 44‑22‑70.

HISTORY: 1991 Act No. 127, Section 1; 1992 Act No. 279, Section 2.

**SECTION 44‑22‑70.** Assessment of patient; establishment and review of individualized treatment plan; discharge plan; notice of discharge.

 (A) The individualized plan of treatment must be reviewed every thirty days by the multi‑disciplinary team during the first two months of inpatient treatment. After two months of inpatient treatment, the plan must be reviewed every sixty days, except in long‑term nursing care facilities the plan must be reviewed every ninety days. This section does not prohibit review of the plan on a more frequent basis.

 (B) After review by the attending physician or multi‑disciplinary team, if the results of the examination determine the conditions justifying confinement no longer exist, a notice of intent to discharge must be made immediately to the probate judge having jurisdiction. Notice must be given before discharge to a person who has made a written request to be notified.

 (C) For patients committed after a hearing by the probate court for the involuntary inpatient treatment for mental illness or chemical dependency, an appropriate and comprehensive discharge plan must be developed. Planning for a patient’s discharge must begin within seventy‑two hours of admission, must include input from the patient, and must address community treatment, financial resources, and housing. The facility and community treatment staff must be involved in developing the discharge plan. Representatives of all entities which provide services pursuant to the plan must be consulted and informed about the plan. Based on available resources, the department shall make every effort to implement the discharge plan when the patient, in the opinion of the multi‑disciplinary team, is ready for discharge.

HISTORY: 1991 Act No. 127, Section 1; 1992 Act No. 279, Section 3; 1992 Act No. 324, Section 1.

**SECTION 44‑22‑80.** Patients’ rights.

 Unless a patient has been adjudicated incompetent, no patient may be denied the right to:

 (1) dispose of property, real and personal;

 (2) execute instruments;

 (3) make purchases;

 (4) enter into contractual relationships;

 (5) hold a driver’s license;

 (6) marry or divorce;

 (7) be a qualified elector if otherwise qualified. The county board of voter registration in counties with department facilities reasonably shall assist patients who express a desire to vote to:

 (a) obtain voter registration forms, applications for absentee ballots, and absentee ballots;

 (b) comply with other requirements which are prerequisite for voting;

 (c) vote by absentee ballot if necessary.

HISTORY: 1991 Act No. 127, Section 1.

**SECTION 44‑22‑90.** Communications with mental health professionals privileged; exceptions.

 (A) Communications between patients and mental health professionals including general physicians, psychiatrists, psychologists, psychotherapists, nurses, social workers, or other staff members employed in a patient therapist capacity or employees under supervision of them are considered privileged. The patient may refuse to disclose and may prevent a witness from disclosing privileged information except as follows:

 (1) communications between facility staff so long as the information is provided on a “need‑to‑know” basis;

 (2) in involuntary commitment proceedings, when a patient is diagnosed by a qualified professional as in need of commitment to a mental health facility for care of the patient’s mental illness;

 (3) in an emergency where information about the patient is needed to prevent the patient from causing harm to himself or others;

 (4) information related through the course of a court‑ordered psychiatric examination if the information is admissible only on issues involving the patient’s mental condition;

 (5) in a civil proceeding in which the patient introduces his mental condition as an element of his claim or defense, or, after the patient’s death, when the condition is introduced by a party claiming or defending through or as a beneficiary of the patient, and the court finds that it is more important to the interests of justice that the communication be disclosed than the relationship between the patient and psychiatrist be protected;

 (6) when a competent patient gives consent or the guardian of a patient adjudicated as incompetent gives consent for disclosure;

 (7) as otherwise authorized or permitted to be disclosed by statute.

 (B) This does not preclude disclosure of information to the Governor’s ombudsman office or to the South Carolina Protection and Advocacy System for the Handicapped, Inc.

HISTORY: 1991 Act No. 127, Section 1.

**SECTION 44‑22‑100.** Confidentiality of records; exceptions; violations and penalties.

 (A) Certificates, applications, records, and reports made for the purpose of this chapter or Chapter 9, Chapter 11, Chapter 13, Chapter 15, Chapter 17, Chapter 20, Chapter 23, Chapter 24, Chapter 25, Chapter 27, or Chapter 52, and directly or indirectly identifying a mentally ill or alcohol and drug abuse patient or former patient or individual whose commitment has been sought, must be kept confidential, and must not be disclosed unless:

 (1) the individual identified or the individual’s guardian consents;

 (2) a court directs that disclosure is necessary for the conduct of proceedings before the court and that failure to make the disclosure is contrary to public interest;

 (3) disclosure is required for research conducted or authorized by the department or the Department of Alcohol and Other Drug Abuse Services and with the patient’s consent;

 (4) disclosure is necessary to cooperate with law enforcement, health, welfare, and other state or federal agencies, or when furthering the welfare of the patient or the patient’s family;

 (5) disclosure to a court of competent jurisdiction is necessary for the limited purpose of providing a court order to SLED in order to submit information to the federal National Instant Criminal Background Check System (NICS), established pursuant to the Brady Handgun Violence Prevention Act of 1993, Pub.L. 103‑159, and in accordance with Article 10, Chapter 31, Title 23; or

 (6) disclosure is necessary to carry out the provisions of this chapter or Chapter 9, Chapter 11, Chapter 13, Chapter 15, Chapter 17, Chapter 20, Chapter 23, Chapter 24, Chapter 25, Chapter 27, or Chapter 52.

 (B) Nothing in this section:

 (1) precludes disclosure, upon proper inquiry, of information as to a patient’s current medical condition to members of the patient’s family, or the Governor’s Office of Ombudsman; or

 (2) requires the release of records of which disclosure is prohibited or regulated by federal law.

 (C) A person who violates this section is guilty of a misdemeanor, and, upon conviction, must be fined not more than five hundred dollars or imprisoned not more than one year, or both.

HISTORY: 1991 Act No. 127, Section 1; 1992 Act No. 279, Section 4; 1993 Act No. 181, Section 1081; 2013 Act No. 22, Section 2, eff August 1, 2013.

**SECTION 44‑22‑110.** Access to medical records; appeal of denial of access.

 (A) A patient or the guardian of a patient has access to his medical records, and a person subject to a proceeding or receiving services pursuant to this chapter has complete access to his medical records relevant to this commitment if the access is allowed in the presence of professional mental health staff.

 (B) Patients or guardians of patients may be refused access to:

 (1) information in medical records provided by a third party under assurance that the information remains confidential;

 (2) information in medical records if the attending physician determines in writing that the information is detrimental to the patient’s treatment regimen. The determination must be placed in the patient’s records and must be considered part of the restricted information.

 (C) Patients and guardians denied access to medical records may appeal the refusal to the Director of the Department of Mental Health. The director of the residential program shall notify the patient or guardian of the right to appeal.

HISTORY: 1991 Act No. 127, Section 1; 1993 Act No. 181, Section 1082.

**SECTION 44‑22‑120.** Patients’ rights; communication with outside; visitors; personal belongings and effects; clothing; religious practice; limits on rights made part of record and valid no more than 30 days.

 (A) Except to the extent the director of the facility determines it is required by the medical needs or safety of the patient to impose restrictions, a patient may:

 (1) communicate by sealed mail, telephone, or otherwise with persons, including official agencies, inside or outside the institution. Reasonable access to writing materials, stamps, and envelopes must be provided. Reasonable access to telephones including funds or means in which to use telephones must be provided. The head of a residential program determines what constitutes reasonable access;

 (2) receive visitors including unrestricted visits by legal counsel, private physicians, or members of the clergy or an advocate of the South Carolina Protection and Advocacy System for the Handicapped, Inc., if the visits take place at reasonable hours or by appointment, or both. Each facility must have a designated area where patients and visitors may speak privately if they desire;

 (3) wear his own clothes, have access to personal hygiene articles, keep and spend a reasonable sum of his own money, and keep and use his own personal possessions including articles for personal grooming not provided for by the facility unless the clothes or personal possessions are determined by a mental health professional to be dangerous or otherwise inappropriate to the treatment regimen. If clothing is provided by the facility, patients may select from neat, clean, seasonal clothing that allows the patient to appear normal in the community. To the extent staff determines a patient is able and willing to care for and maintain the patient’s own clothing, the patient must be assisted in maintaining this clothing during the patient’s stay in the facility;

 (4) have access to secure individual storage space for his private use. Personal property of a patient brought into the hospital and placed in storage by the hospital must be inventoried. Receipts must be given to the patient and at least one other interested person. The personal property may be reclaimed only by the patient, his spouse, or his parent or guardian as long as he is living unless otherwise ordered by the court. If property belonging to a patient is not reclaimed within ninety days following the patient’s discharge or death, the property may be utilized by the department for the benefit of other patients or programs ten days after written notice is sent to the individual or the individual’s family at the last known address;

 (5) follow religious practices. Religious practices may be prohibited by the facility director if they lead to physical harm to the patient or to others, harassment of other patients, or damage to property.

 (B) All limitations imposed by the director of a residential program on the exercise of these rights by the patient and the reasons for the limitations must be made part of the clinical record of the patient. These limitations are valid for no more than thirty days.

HISTORY: 1991 Act No. 127, Section 1; 1992 Act No. 279, Sections 5, 6.

**SECTION 44‑22‑130.** Physical examination of involuntarily committed patient to rule out physical condition mimicking mental illness.

 Patients involuntarily committed to a facility may have a physical examination to rule out physical conditions which may mimic mental illness.

HISTORY: 1991 Act No. 127, Section 1.

**SECTION 44‑22‑140.** Authorization of, and responsibility for, treatment and medication; guidelines for medication; rights with respect to refusal of treatment.

 (A) The attending physician or the physician on call, or both, are responsible for and shall authorize medications and treatment given or administered to a patient. The attending physician’s authorization and the medical reasons for it must be entered into the patient’s clinical record. The authorization is not valid for more than ninety days. Medication must not be used as punishment, for the convenience of staff, or as a substitute to or in quantities that interfere with the patient’s treatment program. The patient or his legal guardian may refuse treatment not recognized as standard psychiatric treatment. He may refuse electro‑convulsive therapy, aversive reinforcement conditioning, or other unusual or hazardous treatment procedures. If the attending physician or the physician on call decides electro‑convulsive therapy is necessary and a statement of the reasons for electro‑convulsive therapy is entered in the treatment record of a patient who is considered unable to consent pursuant to Section 44‑22‑10(13), permission for the treatment may be given in writing by the persons in order of priority specified in Section 44‑22‑40(A)(1‑8).

 (B) Competent patients may not receive treatment or medication in the absence of their express and informed consent in writing except treatment:

 (1) during an emergency situation if the treatment is pursuant to or documented contemporaneously by written order of a physician; or

 (2) as permitted under applicable law for a person committed by a court to a treatment program or facility.

HISTORY: 1991 Act No. 127, Section 1.

**SECTION 44‑22‑150.** Restraint; seclusion; physical coercion.

 (A) No patient residing in a mental health or alcohol and drug abuse facility may be subjected to mechanical restraint, seclusion, or a form of physical coercion or restraint unless the action is authorized in writing by the attending or on‑call physician as being required by the medical needs of the patient and unless the use of the restraint is a last resort in treatment.

 (B) Each use of a restraint or seclusion and justification for it, including a reasonably specific description of the actions by the patient that warranted restraint or seclusion, must be entered into the clinical record of the patient. These authorizations are not valid for more than twenty‑four hours during which the patient’s condition must be charted at fifteen‑minute intervals. If the orders are extended beyond the twenty‑four hours, the extension must have written authorization and justification by the attending physician and then only after he has interviewed and evaluated the patient on an individual basis. Within twenty‑four hours a copy of the authorization and justification must be forwarded to the facility supervisor for review. Patients under mechanical restraint must have the restraints removed at least every two hours for motion and exercise. Mechanical restraint must be employed to lessen the possibility of physical injury and to ensure the least possible discomfort. In an emergency such as the occurrence of, or serious threat of, extreme violence, injury to others, personal injury, or attempted suicide, if the director of the facility or the attending physician is not available, designated staff may authorize, in writing, mechanical restraint, seclusion, or physical restraint as necessary. The use must be reported immediately to the director or attending physician who shall authorize its continuance or cessation and shall make a written record of the reasons for the use and of his review. The record and review must be entered into the patient’s record. The facility must have written policies and procedures governing the use of mechanical restraints, seclusion, and physical restraints and clearly delineate, in descending order, the personnel who may authorize the use of restraints in emergency situations. The authorization must be posted on each ward.

 (C) “Restraint” shall not include medical protective devices used as a regular part of medical, diagnostic, or surgical procedures, used to posturally support a patient, or used to obtain or maintain normative bodily functioning.

HISTORY: 1991 Act No. 127, Section 1; 1992 Act No. 279, Section 7; 2000 Act No. 253, Section 9.

**SECTION 44‑22‑160.** Employment within facility; compensation; right to refuse nontherapeutic employment.

 (A) Each patient may refuse nontherapeutic employment within the facility. The department shall establish policies and guidelines to determine what constitutes therapeutic employment. The record and justification of each patient’s employment must be sent immediately to the attending physician for review and entered into the patient’s record. Patient employment must be compensated in accordance with the Fair Labor Standards Act.

 (B) Personal living skills or household tasks not involving maintenance of the facility are not considered employment and are uncompensated.

HISTORY: 1991 Act No. 127, Section 1.

**SECTION 44‑22‑170.** Education of school‑aged residents.

 (A) The State Department of Education shall ensure that each school‑aged resident of a state‑owned, operated, or another designated facility shall receive an appropriate education geared toward the unique capabilities of that person.

 (B) If a school‑aged resident is unable to assemble in a public school setting, the Department of Education shall implement the appropriate course of instruction.

HISTORY: 1991 Act No. 127, Section 1.

**SECTION 44‑22‑180.** Exercise and exercise facilities; right to go outdoors.

 Resident patients must have the right to daily physical exercise. The facility shall provide indoor and outdoor facilities for the exercise. Patients determined able to be outdoors on a daily basis pursuant to Section 44‑22‑60 must be allowed outdoors on a daily basis in the absence of contrary medical considerations or during inclement weather.

HISTORY: 1991 Act No. 127, Section 1, eff June 5, 1991.

**SECTION 44‑22‑190.** Finding employment for mentally disabled citizens.

 The employment division of the South Carolina Department of Employment and Workforce and the Department of Vocational Rehabilitation shall work with the department in a coordinated effort to find employment for mentally disabled citizens. Services must include, but are not limited to, counseling, referral, timely notification of job listings, and other services of the employment division and the Department of Vocational Rehabilitation.

HISTORY: 1991 Act No. 127, Section 1.

**SECTION 44‑22‑200.** Move of patient to less restrictive setting; court approval required for move to more restrictive setting.

 The head of a treatment facility may move a patient to a less restrictive setting without court approval if the move is consistent with the goals and objectives of the individualized treatment plan. The head of the treatment facility may not move a patient to a more restrictive setting without court approval.

HISTORY: 1991 Act No. 127, Section 1.

**SECTION 44‑22‑210.** Temporary leaves of absence.

 (A) The head of a treatment facility or unit may permit the patient to leave the facility on a temporary leave of absence for no longer than ninety days.

 (B) The head of the treatment facility or unit upon releasing a patient on a temporary leave of absence may impose conditions on the patient while he is absent from the facility as are proper and in the best interest of the patient and public welfare.

HISTORY: 1991 Act No. 127, Section 1; 1992 Act No. 279, Section 8.

**SECTION 44‑22‑220.** Grievances concerning patient rights; penalties for denial of patient rights.

 (A) The department shall develop a system for documenting and addressing grievances concerning patient rights. Grievances concerning patient rights must be reviewed by the department and a determination made concerning whether or not corrective action is warranted. A copy of the written grievance must be forwarded to the Client Advocacy Program and Protection and Advocacy for People with Disabilities.

 (B) The department shall develop procedures with time lines to process the grievances in a timely manner. The procedures must be made known to patients.

 (C) A person who wilfully causes, or conspires with or assists another to cause, the denial to a patient of rights accorded to the patient under this chapter, upon conviction, must be fined not more than one thousand dollars or imprisoned not more than one year, or both. A person acting in good faith, either upon actual knowledge or information thought to be reliable, is immune from criminal liability under the provisions of this subsection.

HISTORY: 1991 Act No. 127, Section 1; 2008 Act No. 266, Section 6, eff June 4, 2008.