SB

8

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill 8

"An Act relating to a mental health patient's right to choose the gender of hospital staff providing intimate care to the mental health patient and to the duties of hospital staff in caring for patients receiving mental health treatment."

Sponsor Statement

SB 8 provides that a mental health patient 18 years of age or older who is receiving mental health treatment and being provided intimate care at a hospital shall have the right to have care provided by a staff member who is the gender that the patient requests. Many of these patients have been traumatized by sexual and/or physical abuse in the past and they are very sensitive to being touched or assisted by hospital staff who provide intimate care, because the experience may trigger from original abuse feelings of fear, helplessness, distress, humiliation, and loss of trust in staff. The supervisor or manager employed by a hospital shall post notice of this right in a conspicuous place, so patients know they may exercise this right when they are concerned about the gender of staff responsible for their personal intimate care.

While it is understandable that a hospital may not always be able to comply with the requirement of choice of gender in all situations and requests due to staffing schedules and shortages on particular shifts or duty units, the bill requires that the facility document the non-compliance in the patient record that the intimate care was provided by a licensed staff member of a gender opposite that requested by the patient. This information might otherwise be ignored or lost. The information is also useful not only for confirming the good faith effort on the part of the institution to comply with the wishes of the patient, but for medical purposes as well in evaluating the effect on patient outcome, because individuals re-traumatized in this way are subject to chronic stress which can worsen serious mental illness and result in symptomatic relapses and repeated re-hospitalizations. Lastly, this bill will preserve information for inquiry into grievance procedures at mental health facilities under Title 47, which have been described as unduly burdensome for patients, and easily circumvented or limited because the language is too broad.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 6, 2007

SUBJECT: Sectional Summary (SB 8)

TO: Senator Bettye Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Establishes a right to staff choice for the provision of intimate care for patients 18 years of age or older who are receiving mental health treatment and intimate care at a hospital. Also requires certain actions of hospital staff to provide privacy and to accommodate staff choice except as otherwise described.

JMM:med
07-078.med

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: CSSB014-DOC-A&O-4-1
Bill Version: CSSB 14
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Corrections
Title: An Act raising the compulsory school attendance age; relating to the crime of contributiong to the delinquency. . .
RDU: Office of the Commissioner
Component: Administration & Operations
Sponsor: Senator Davis
Requester: Senate Special Committee on Education
Component No. 694

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2007) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Passage of this legislation will not have a fiscal impact on the Department of Corrections.

Prepared by: Sharleen Griffin, Director
Phone (907) 465-3339
Division: Administrative Services
Date/Time 4/16/07 1:42 PM
Approved by: Dwayne Peeples, Deputy Commissioner
Date 4/16/2007
Agency: Department of Corrections

STATE OF ALASKA

Sarah Palin, GVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

Advisory Board on Alcoholism and Drug Abuse
Alaska Mental Health Board

P.O. BOX 110608
JUNEAU, AK 99811-0608
PHONE: (907) 465-8920
FAX: 465-4410

April 16, 2007

Senator Bettye Davis, Chair
Health, Education and Social Services Committee
Alaska State Legislature

Dear Representative Davis:

Thank you for introducing SB 8, Mental Health Patient Rights: Staff Gender.

The Alaska Mental Health Board (AMHB) strongly supports the notion that patients in psychiatric hospitals should have the right to choose the gender of the person providing them intimate care. This type of choice will allow the individual to retain their dignity during a time of extreme distress and vulnerability, and will afford a modicum of choice and control in a fundamentally uncontrollable situation.

This bill has been criticized as "unnecessary" because hospitals should be allowed to handle this issue administratively through internal policies and procedures. The AMHB was instrumental in convincing API to promulgate such a policy, and applauds their efforts. But the Board believes a single, isolated policy is not sufficient to safeguard the rights of all individuals who find themselves in an acute psychiatric facility. Placing this provision into statute will ensure that patients in API and the State of Alaska's Designated Evaluation and Treatment beds, as well as those in private psychiatric facilities, will be afforded this basic right.

The AMHB is also sensitive to the argument that the bill's provisions will create a financial burden on psychiatric hospitals by forcing them to staff so as to have both genders available for patient care at all times. But the language found in the CS clearly provides a method for dealing with this issue – if the patient cannot be served by someone of the gender they choose, the hospital must simply document that a request was made and that it was not able to be honored. As such, this bill will not impact the "bottom line" for hospitals.

Finally, the bill offers a balance between the rights of the patient for privacy and choice and the physician's duty to provide sound and responsible care. If the treating psychiatrist determines that the choice made by the patient is not in the best interest of the patient's treatment, he or she may override a patient's choice.

The AMHB believes that putting gender choice into statute is the correct and responsible way to ensure that all psychiatric patients retain their basic dignity while being treated for acute or ongoing psychiatric disabilities. The Board urges all members of the Senate Health and Social Services Committee to support the bill.

Sincerely,

Andrea Schmook

Andrea Schmook, Chair,
Alaska Mental Health Board

ALASKA COUNSELING INC.

March 1, 2005

Faith Myers,
Dorrance Collins
330 E. 14th Ave., Apt E
Anchorage, Alaska 99501

Re; Psychiatric Staff Gender Rights

Dear Ms Myers and Mr. Collins,

I would very much support your efforts to amend AS47.30.840 to include a section acknowledging the right of Psychiatric patients to choose the gender of staff providing intimate care.

This is a very important issue as my Psychiatric inpatients already have significant issues with both sexuality and trust.

I believe that as a Physician this would be a significant step forward in providing the best and most therapeutic care for psychiatric patients throughout the State of Alaska. Please contact me if I can be of further assistance.

Sincerely,

Aron S. Wolf MD, MMD
Distinguished Life Fellow American Psychiatry Association

Alaska Counseling, Inc.
Parkway Professional Building II
4120 Laurel St., Suite 102, Anchorage, Alaska 99508
907.569.8600

August 12, 2005

Faith Myers
Dorrance Collins
801 Airport Hts. #35
Anchorage, AK 99508

Dear Ms. Myers and Mr. Collins,

I wholeheartedly support your efforts to amend AS47.30.840 to include a section acknowledging the right of psychiatric patients to choose the gender of staff providing intimate care. How sad that you and others have to fight for something that simple human respect and common sense would dictate should be done.

Recent empirical studies provide evidence that many common practices in psychiatric settings - such as those at issue here, cause patients chronic stress and put them at risk for iatrogenic psychiatric morbidity such as PTSD and Depression. They also very likely increase avoidance of helpful treatments. [1] Yet, it is often difficult to influence change in professional practice, or in established procedures. The medical dictum to "do no harm" frequently does not guide decision making.

Legislators often have good common sense. It should be clear to them for example that no one in their circle of family or friends would accept routinely being bathed, touched intimately, toileted etc. by someone of the opposite sex that they did not know.

But with patients in a psychiatric setting, the issue is much more serious. First, many psychiatric patients (51% - 98%) have histories of sexual and/or physical abuse. [2,3,4] This makes them especially vulnerable to "re-traumatization" by procedures such as being stripped, bathed, touched, and toileted by a staff of the same gender as their childhood perpetrator. Such a practice replicates and "triggers" feelings from the original abuse experiences and engenders feelings of fear, helplessness, distress, humiliation and loss of trust in staff. [2] When individuals are continually re-traumatized in this way, they are subject to chronic stress [5] which in turn worsens serious mental illness and results in symptom relapses and repeated re-hospitalization [6,7,8,9].

Thank you for your efforts on behalf of persons with mental health issues. In this instance of unconscionable resistance to changing practices experienced as harmful by patients, the right to choose a preferred or same-sex provider must be legislatively mandated, and enforced.

Sincerely,

Ann Jennings

Ann F. Jennings, Ph.D.
Trauma-Informed Systems Consultant
The Anna Foundation
21 Ocean Street
Rockland, ME 04841

References:

1. Mueser, K.T., Rosenberg, S.D. (2003) Treating the trauma of first episode psychosis: A PTSD perspective. *Journal of Mental Health.* 12, 2, 103-108

2. Cusack, K.J., Frueh, B.C., Hiers, T., Suffoletta-Maierle, S., and Bennett, S. (2003). Trauma within the psychiatric setting: A preliminary empirical report. *Administration and Policy in Mental Health*, 30, 453-460.

3. Mueser, K., Goodman, L.A., Trumbetta, S.L., Rosenberg, S.D., Osher, F.C., Vidaver, R., Auciello, P., & Foy, E.W. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology, 66,* 493-499.

4. Switzer, G.E., Dew, M.A., Thompson, K., Goycoolea, J.M., Derricott, T., & Mullins, S.D. (1999). Posttraumatic stress disorder and service utilization among urban mental health center clients. *Journal of Traumatic Stress, 12,* 25-39.

5. Mueser, K.T., Rosenberg, S.D., Goodman, L A., Trumbetta, S.L. (2002). Trauma, PTSD, and the course of severe mental illness: an interactive model. *Schizophrenia Research 53,* 123-143

6. Bebbington, P., Kuipers, L. (1992) .Life events and social factors. In: Kavanagh, D.J. (Ed.). *Schizophrenia: An Overview and Practical Handbook.* Chapman and Hall, London. 126-144

7. Butzlaff, R.L., Hooley, J.M. (1998). Expressed emotion and psychiatric relapse. *Archives of General Psychiatry 55,* 547-552

8. Goodwin, F.K., Jamison, K.R. (1990) Manic-depressive Illness. Oxford University Press, New York.

ANCHORAGE
[redacted]
Suite 100
[redacted]
(907) 565-1002
FAX (907) 565-1000
1-800-478-1234

December 22, 2004

Faith Myers
Dorrance Collins
330 E. 14th Ave., Apt. E
Anchorage, Alaska 99501

Dear Faith and Dorrance:

I am in receipt of your letter wherein you request support from the Disability Law Center, Alaska's Protection and Advocacy agency for individuals with disabilities, in your efforts to secure "more rights" for patients at the Alaska Psychiatric Institute ["API"]. Specifically, you are advocating for a change in AS 47.30.840 that would, in effect, provide Alaskans undergoing mental health evaluation or treatment the right to choose the gender of the person providing them hands-on intimate care, such as toileting, bathing, diapering and dressing. You have asked the Disability Law Center to both confirm the legality of the requested statutory change and to voice support for your effort.

A review of statutory and judicial authority reveals a strong foundation of support for your legislative goal. In fact, securing the change in statute would not be bestowing 'more rights' onto patients, but would be a codification of an existing constitutional right that is not being acknowledged and protected. Based on this research, as well as common sense and decency, the Disability Law Center fully supports your effort.

It is clear that the State anticipates that some individuals admitted to API will require assistance with intimate care activities. The brief job description for a psychiatric nursing assistant that appears on the State's website describes the duties as follows:

> Assist patients in occupational, recreational, and industrial therapy and school programs. Assist patients with daily routine activities *such as oral hygiene, preparing for meals, toileting, or preparing for bed.* Help with feeding of patients unable to feed themselves.

(Emphasis supplied). Acknowledging the need by some patients for this intimate assistance during a hospitalization, must these individuals submit themselves to care by a staff member of API's choosing, or do they have the right to choose the gender of the person viewing and touching their bodies? Do patients at API have a right to privacy?

Article I, Section 22 of the Constitution of Alaska provides that: "The right of the people to privacy is recognized and shall not be infringed." The specific enumeration of this right in Alaska's Constitution has been interpreted to

mean that Alaska's right to privacy is broader than that afforded by the United States Constitution. *Messerli v. State*, 626 P.2d 81 (Alaska 1980).

Federal courts have clearly enunciated that encompassed within the right to privacy is the right to shield one's unclothed body from view. As the Ninth Circuit Court of Appeals held over forty years ago, "We cannot conceive of a more basic subject of privacy than the naked body. The desire to shield one's unclothed figure from view of strangers, and particularly strangers of the opposite sex, is impelled by elementary self-respect and personal dignity. *Story v. York*, 324 F.2d 450, 455 (9th Cir. 1963).

Many of the cases discussing this aspect of the right to privacy arose in the context of employment discrimination complaints against correctional facilities. These facilities were sued for restricting the gender of certain guard positions, in part, to protect the privacy rights of prisoners. The courts have held that this right is not destroyed simply because one is institutionalized. *Turner v. Safley*, 482 U.S. 78, 84. (1987) ("Prison walls do not form a barrier separating prison inmates from the protections of the Constitution."); *Robino v. Iranon*, 145 F.3d 1109, 1111 (9th Cir. 1998) ("[A] person's interest in not being viewed unclothed by members of the opposite sex survives incarceration.")

> Most people, however, have a special sense of privacy in their genitals, and involuntary exposure of them in the presence of people of the other sex may be especially demeaning and humiliating. When not reasonably necessary, that sort of degradation is not to be visited upon those confined in our prisons.

Lee v. Downs, 641 F.2d 1117, 1119 (4th Cir. 1981).

There are a few cases that address the employment of gender specific individuals in psychiatric hospitals. Courts have recognized that, unlike prison guards, hospital staff can infringe significantly on a patients privacy rights. "Treatment assistants at a state psychiatric hospital intrude on patients' privacy by performing duties involving intimate personal care such as 'assisting patients with toileting, disrobing, showering and cleaning their genitals,' as well as stripping patients before placing them into restraints and conducting bed checks of patients who sleep naked or whose nightwear comes off during sleep. *Olsen v. Marriott International., Inc.*, 75 F. Supp.2d 1052, 1062 (Ariz. 1999) *quoting Jennings v. New York State Office of Mental Health*, 786 F. Supp. 376, 382 (S.D.N.Y. 1992).

> Obviously most people would find it a greater intrusion of their dignity and privacy to have their naked bodies viewed (or any number of personal services performed) by a member of the opposite sex. Although there will be a certain relinquishment of privacy by necessity when anyone is admitted to a hospital or mental health facility, this is not to say that a patient has forfeited all rights to privacy.

Local 567 American Federation of State, County & Municipal Employees v. Michigan Council 25, American Federation of State, County & Municipal Employees, 635 F.Supp. 1010, 1013-14 (E.D. Mich. 1986) (footnote omitted).

The court in *Jennings* distinguished the privacy rights of patients from that of prisoners.

> The patients at OMH are not convicted criminals but instead are there as a result of civil commitments. Thus, their right to privacy may not be abrogated by virtue of their confinement in a state-run facility unlike a prison inmate who has forfeited some rights in repayment to society. The patients at OMH are just that, patients. They are vulnerable and mentally ill. Basic decency demands that their privacy be respected to whatever degree feasible.

Jennings v. New York State Office of Mental Health, 786 F. Supp. At 384. The federal district court in Michigan held that not only should the psychiatric hospital respect the privacy rights of their patients, but should assist in protecting those rights.

> It is obvious that the law recognizes the privacy rights of these patients or residents and that the defendants had the right to protect these rights, possibly even more so in the case of mental health patients who are far more reliant on the protection of the defendants than patients in hospitals. Moreover the failure to recognize their privacy rights is contrary to the concept of normalization which recognizes that mentally handicapped persons have a right to lives as close as possible to that which is typical for the general population.

Local 567 American Federation of State, County & Municipal Employees v. Michigan Council 25, American Federation of State, County & Municipal Employees, 635 F.Supp. at 1013. *See also Jennings v. New York State Office of Mental Health*, 786 F. Supp. at 383 ("[T]he fact that a person does not assert his or her constitutional right does not mean that state run facilities are still not obligated to respect these same rights.") "It would be a strange doctrine . . . that would decree that the sanctity of the right of privacy in the performance of the excretory functions, fully respected in a public restroom, is forfeited by the fact of falling ill and becoming hospitalized." *Local 567*, 635 F.Supp. at 1014.

Sensitivity towards the privacy rights of patients would also seem to further the treatment goals for many individuals. A large number of women and men have been sexually abused and live with the devastating aftermath of such experiences. Many with histories of maltreatment are extremely sensitive to issues of privacy and violation of their privacy. Early on in their lives their sense of body integrity was invaded by the behaviors of their perpetrators. Being exposed to the invasion of privacy while dressing, showering, or using the toilet can cause flashbacks in some individuals of prior abuse experiences. In others it can cause embarrassment and a sense of shame, even if they have no history of prior maltreatment. The need for a safe place where one is not exposed to the dominate

and submission process is imperative. The only way to make that possible is for people to have choices. Without choice there is a potential for the reenactment of trauma.

It is therefore possible that being viewed naked by staff of the opposite gender can cause significant harm to patients. A serious risk of harm violates the Eighth Amendment of the U.S. Constitution, even if no harm has yet occurred. *Farmer v. Brennan*, 511 U.S. 825 (1994); *Helling v. McKinney*, 509 U.S. 25 (1993).

For the reasons set forth above, the Disability Law Center of Alaska enthusiastically supports your efforts to protect the privacy rights of patients at API through the legislative process. Please do not hesitate to contact me if there is anything this agency can do to assist you with your advocacy.

Sincerely,

DISABILITY LAW CENTER OF ALASKA

David C. Fleurant
Executive Director

cc Ron Adler

NAMI Anchorage

Anchorage's Voice on Mental Illness

There is hope.

Trish McDonald
Executive Director

Yvonne Alni Evans
President

Eileen Davey
Vice President

Roger Branson
Secretary

Alina Blasiak
Treasurer

Geno Daly
Member at Large

Pat Kouris
Member at Large

Megan Wilts
Member at Large

907.272.0287

P.O. Box 240202
Anchorage, AK
99524

Yvonne Alni Evans
907.272.0952 direct

yvnn@gci.net

501 3 (c) non-profit
corporation in
Alaska since 1984

Faith Myers
Dorrance Collins
330 E. 14th Ave., Apt. E
Anchorage, Alaska 99501

27 February 2005

Dear Faith and Dorrance:

We here at the National Alliance for the Mentally Ill, Anchorage Affiliate (NAMI-Anch) have received and support your request for psychiatric patients to have the ability, through existing law and the most basic of privacy rights, to request gender specific intimate care. We further feel that these rights need to be clearly enunciated and that an addition to AS 47.30.840 reflecting such is in order.

We concur with and support the position Disability Law Center has taken in their letter to you dated December 22, 2004 and support their further involvement in resolving this matter of extreme importance.

It is telling to us that we rarely hear of this issue in private facilities where patients and their families have the freedom and ability to select other service providers. We understand that public institutions operate on limited resources, however this most basic of human rights, the right to personal dignity, is one that cannot carry a price tag but must be provided for in public as well as private facilities.

It is further troubling for us to realize that the staff making the majority of these decisions involving this most intimate of care are those who are the least trained. These staff members may well view their employment in the psychiatric care field as being transitory in nature and feel they have nothing or little to lose should a complaint regarding them be found to have merit. Our highest concern is that these individuals wield excessive physical and emotional power over these vulnerable persons and can too easily abuse the discretion given them to include suppressing complaints against them.

It is important to note that as State laws are currently being interpreted these basic rights to control who views and perhaps even touches our naked bodies may well be, and likely are being, violated without rising to the level of being a sexual assault or breaking any other laws. However, in this context, sexual assaults may well be, and quite possibly are being, committed with the vulnerable victim having little to no recourse, hope or even prayer of justice.

We urge our lawmakers to pass legislation which will protect individuals receiving this care.

Sincerely,

Yvonne Evans, President

Trish McDonald, Executive Director

Cc Ron Adler
David Fleurant

Alaska Mental Health Consumer Web

1248 Gambell St.
Anchorage, ALASKA 99501

Phone: 907.222.2000
Fax: 907.222.2001

March 2, 2005

Faith Myers
Dorrance Collins
330 E. 14th Ave., Apt. E
Anchorage, Alaska 99501

Dear Faith and Dorrance:

We at Alaska Mental Health Consumer Web would like to express our full support for your efforts to ensure the right of Alaskans undergoing mental health evaluation and treatment to choose the gender of their caregivers. Specifically, we wholeheartedly endorse the amendment of AS47.30.840 to include the right of Psychiatric patients to choose the gender of those that provide their care. It is our collective belief that this is not only a core human right, but also a matter of basic human dignity. For many years Alaskans have received care without regard to the gender of the provider. This practice has potentially violated the rights of thousands of Alaskan citizens and may have broached the boundaries of people who may have issues of sexuality and trust.

We again applaud your efforts and if I can be of further assistance please do not hesitate to contact me.

Sincerely,

Carl Ipock
Executive Director
Alaska Mental Health Consumer Web

PsychRights

LAW PROJECT FOR
PSYCHIATRIC RIGHTS, INC.
406 G Street, Suite 206, Anchorage, Alaska 99501
(907) 274-7686 Phone ~ (907) 274-9493 Fax
http://psychrights.org

January 3, 2005

Faith Myers
Dorrance Collins
330 E. 14th Ave., Apt. E
Anchorage, Alaska 99501

Re: Psychiatric Staff Gender Rights

Dear Ms. Myers and Mr. Collins:

The Law Project for Psychiatric Rights (PsychRights) unreservedly supports your efforts for legislative acknowledgment of the right for psychiatric patients to choose the gender of staff providing intimate care. We are outraged such a choice is not provided now. It is well known that many psychiatric patients (male as well as female) have been sexually assaulted or otherwise physically abused and that the failure to be sensitive to this issue is re-traumatizing and counter-therapeutic. Since the Alaska Psychiatric Institute is unwilling to recognize this and change its policy, a legislative directive is certainly in order.

PsychRights also concurs in the Disability Law Center's conclusion that Alaska patients already have such rights under the Alaska Constitution at least. If the 2005 Alaska Legislature fails to correct this outrage, I would encourage the Disability Law Center to pursue this through the courts.

Yours truly,

James B. (Jim) Gottstein, Esq.

cc: Ron Adler
David Fleurant

Testimony supporting Senate Bill 8 by Dorrance Collins—February 11, 2007

Madam Chair, Committee members,

My name is Dorrance Collins. I support the passing of Senate Bill 8 as written.

Post traumatic stress disorder is one of the most prevalent and costly mental illnesses in America. Not giving gender choice of staff for intimate care in inpatient settings is traumatic to many psychiatric patients and can add to the illness.

In other states some psychiatric facilities take providing gender choice of staff for intimate care seriously. These facilities have policies that require the facility to schedule a portion of their work force by gender. As an example, if there are 5 male staff on one unit and 5 female staff on another unit, policy would require the head nurse, when scheduling, to see to it that there are sufficient men and women staff on each shift to provide gender choice.

Also, in the larger hospitals with multiple units—if the required gender is not available for intimate care, facility policy would require staff to go to the next unit to try and find the requested gender. Units are often just separated by a door.

These are all policies that we have been informed that the Alaska psychiatric hospitals and facilities will not adopt, even when it is pointed out that adopting such policies does not cost money and it reduces trauma.

In a recent Alaska Supreme Court decision, the justices stated there is a clear, unavoidable tension between hospitals seeking convenience/ economics and patient rights, which can manifest itself in patient abuse.

The justices saw it as a given that psychiatric hospitals and units were going to take shortcuts and would without regulation deny psychiatric patients their rights. It is laws passed by the legislature and action taken by the courts that will force psychiatric hospitals to do the right thing.

Almost without exception those patients entering an acute care psychiatric facility have dementia and trauma in their background. And to a lesser extent those patients entering evaluation facilities. Many have been victimized, some from childhood through adulthood. The percentage that has been sexually abused and physically abused is much higher than the rate in general society. When psychiatric patients are not given gender choice, they feel they are being re-victimized all over again.

As a civilized society, we can't leave psychiatric patient's protection up to guesswork. We need to pass statutes.

Passing Senate Bill 8 will give back to psychiatric patients' a small amount of dignity and control they lost when entering a psychiatric facility.

Senate Bill 8 only asks that psychiatric institutions make a good faith effort at providing gender choice of staff for intimate care. Adding more loopholes for psychiatric facilities to utilize will make the Bill useless.

In closing, I am asking you to pass Senate Bill 8 as written.

Thank you,

Dorrance Collins
(907) 929-0532

Dorrance Collins

Sen. Bettye Davis
Chair — HESS Committee

Testimony supporting Senate Bill 8 by Dorrance Collins—February 11, 2007

Madam Chair, Committee members,

My name is Dorrance Collins. I support the passing of Senate Bill 8 as written.

In a recent Alaska Supreme Court decision, the justices stated there is a clear, unavoidable tension between hospitals seeking convenience/ economics and patient rights, which can manifest itself in patient abuse.

The justices saw it as a given that psychiatric hospitals and units were going to take shortcuts and would without regulation deny psychiatric patients their rights. It is laws passed by the legislature and action taken by the courts that will force psychiatric hospitals to do the right thing.

Almost without exception those patients entering an acute care psychiatric facility have dementia. And to a lesser extent those patients entering evaluation facilities. Many have been victimized, some from childhood through adulthood. The percentage that has been sexually abused and physically abused is much higher than the rate in general society. When psychiatric patients are not given gender choice, they feel they are being re-victimized all over again.

As a civilized society, we can't leave psychiatric patient's protection up to guesswork. We need to pass statutes.

Passing Senate Bill 8 will give back to psychiatric patients' a small amount of dignity and control they lost when entering a psychiatric facility.

Senate Bill 8 only asks that psychiatric institutions make a good faith effort at providing gender choice of staff for intimate care. Adding more loopholes for psychiatric facilities to utilize will make the Bill useless.

In closing, I am asking you to pass Senate Bill 8 as written.

Thank you,

Dorrance Collins
(907) 929-0532

Dorrance Collins

Testimony supporting Senate Bill 8 by Faith Myers **February 8, 2007**

Mr. Chair, Committee members,

My name is Faith Myers. I support the passing of Senate Bill 8 as written.

I have an avocation in Mental Health Advocacy. In the past I have been in acute care psychiatric facilities in Alaska, Washington and Nevada. Also, as an advocate, I have contacted psychiatric hospital administrators in Maine, Maryland, Nevada, Alaska and Washington looking for best practices.

There is such a thing as unnecessary traumatization of psychiatric patients in a psychiatric facility, especially in facilities in states that look for shortcuts. It is the rules and statutes of the state that reduce the amount of trauma and recidivism.

We fully understand the idea of a psychiatric emergency when gender choice may not be able to be provided—What we want to reduce is the unnecessary traumatization of a psychiatric patient who is reasonably cooperative.

The percentage of women in acute care psychiatric facilities who have a history of sexual abuse and/or physical abuse in their past is somewhere between 51% and 98% respectively. The figure for men is a little bit less. To a person with mental illness, it is certain he/she feels re-victimized when he / she is given intimate care against their will by the gender of the person who sexually abused him or her in the past.

There are 3 or 4 hospitals that do civil commitments, and there are numerous other ones that do 3 day evaluations that stretch out into 7 days. This issue cannot be dealt with by working to change each hospital's policy. Change needs to be done by state statute.

I would like to briefly explain the support letters in favor of a bill for gender choice of staff for intimate care. The following letters of support should have been provided to you.

1. Ann F. Jennings, PhD., Trauma-Informed Systems Consultant has background knowledge of trauma in acute-care psychiatric institutions. She also has a personal connection. Her daughter was in and out of psychiatric institutions from the age of 13 to 32 when her daughter committed suicide in a psychiatric institution.

2. Aron S. Wolf, MD, MMD. Dr. Wolf has over 30 years of experience in treating psychiatric patients from children to adults.

3. NAMI, Anchorage —Their Board members have personally been in psychiatric institutions and had family members in psychiatric institutions.

4. Alaska Mental Health Consumer Web-- Their Board members also have a wide range of experience with psychiatric facilities.

5. The Alaska Mental Health Board, whose Board members are appointed by the Governor—again, their Board members have a wide range of experience in advocating for better treatment in psychiatric facilities.

6. Disability Law Center submitted a 4 page legal opinion, stating that gender choice of staff is a right that should be given to a civilly committed psychiatric patient.

7. Psychiatric Rights—an organization dedicated to furthering the rights of psychiatric patients—Psychiatric Rights also concurs with Disability Law's legal opinion that gender choice is a right of civilly committed psychiatric patients.

All told there are probably 50 or more Board members that voted that a gender choice of staff for intimate care bill should be passed, many of them experts in the field.

Senate Bill 8 only requires psychiatric institutions to make a good faith effort at giving gender choice of staff.

In closing, I am asking you to pass Senate Bill 8.

Thank you,

Faith Myers
(907) 929-0532

Faith Myers

Letters

Dear Editor,

We would like to make readers aware of Senate Bill 8, which when passed would require inpatient psychiatric facilities to make a good faith effort at providing patients receiving intimate care their choice of gender of staff performing that care. We believe if the bill does pass it would eventually carry over into senior care facilities.

The Alaska facilities we have surveyed do not schedule for gender. For example, if there are five men working on one shift at a facility and five women working on the other shift, all of the facilities we have surveyed do not have policies that require the nurse making up the work schedule to make an attempt to see to it there is proper gender on each shift to provide gender choice of staff for intimate care.

We fully understand not hiring for gender, but in Alaska they refuse to schedule the work force for gender.

Also, in larger facilities where there is more than one unit, there is no policy that requires staff to go to the next unit to get the requested gender to give someone a bath.

These are things that they do in other states and it doesn't cost money, but Alaska facilities we surveyed refused to do it.

Providing gender choice of staff for intimate care reduces traumatization and passing Senate Bill 8 will force psychiatric institutions to write good gender choice policies.

Faith Myers and Dorrance Collins
Anchorage

We would like to hear from you

Send letters to the editor to Senior Voice, 325 E. Third Ave., Suite 300, Anchorage AK 99501. Maximum length is 250 words. Senior Voice reserves the right to edit for content and length.

Space may be made available for longer opinion piece essays up to 500 words. Please contact the managing editor at seniorvoice@gci.net to discuss this.

Copy deadline is the 15th of the month prior to publication.

PsychRights•
Law Project for
Psychiatric Rights, Inc.

Alaska Legislature
Alaska State Capitol
Juneau, Alaska 99801

January 30, 2006

Re: Psychiatric Rights Legislation

This is to support the proposals by Faith Myers and Dorrance Collins to amend Alaska law to enhance certain rights given to people diagnosed with serious mental illness and held at inpatient facilities.

For example, the wording "patients must be given reasonable opportunity" gives some facilities license to deny patients the rights the statute is intended to ensure. Some facilities turn these rights on their head and make them "privileges." To address this, it is recommended that something like the following be added to AS 47.30.840:

> At no time shall the rights set forth in this chapter be treated as privileges that the recipient must earn by meeting certain standards of behavior.

Of course these rights are meaningless if there is no effective enforcement process. It is therefore suggested that AS 47.30.847 be amended to specify a time limit in which grievances/complaints must be answered and that patients 18 and older have a right to appoint a representative of their choice to help them file and pursue grievances/complaints.[1] Such representatives should have the right to "reasonable access to all living and program areas and to staff involved in the treatment of the patient in order to assist the patient in the protection of his or her rights."

In addition the state Ombudsman or some other state oversight authority should have the right to go into any facility holding people because being diagnosed with mental illness. The Ombudsman's Office is presently excluded from all but state hospitals and would have to he granted a different authority to enter other facilities.

I have known Faith Myers and Dorrance Collins for a number of years and they are absolutely spot on with their suggestions. Alaska citizens deserve the type of consideration Faith and Dorrance are asking for and I urge you to act favorably upon their suggestions.

Yours truly,

James B. (Jim) Gottstein, Esq.

[1] For patients under 18, their guardian would retain that right.

406 G Street, Suite 206, Anchorage, Alaska 99501 ~ (907) 274-7686 Phone ~ (907) 274-9493 Fax
http://psychrights.org

DISABILITY LAW CENTER OF ALASKA

ANCHORAGE
3330 Arctic Boulevard
Suite 103
Anchorage, AK 99503
(907) 565-1002
FAX (907) 565-1000
1-800-478-1234

January 30, 2006

Faith Myers
Dorrance Collins
330 E. 14th Ave., Apt. E
Anchorage, Alaska 99501

Dear Faith and Dorrance:

You have requested a letter of support from the Disability Law Center of Alaska for your effort to revise the grievance rights of psychiatric patients in Alaska. In essence, your proposed revisions seek to ensure that psychiatric patients are afforded basic due process rights when filing a grievance.

The Disability Law Center of Alaska supports your efforts to ensure that psychiatric patients in Alaska are afforded basic due process rights. Your recommendations, including permitting psychiatric patients the right to obtain the assistance of a self-designated representative and establishing specific time frames for certain actions, are very appropriate means of assuring that rights can both be exercised and are protected.

Please let me know if there is anything we can do to assist you in this effort.

Sincerely,

DISABILITY LAW CENTER OF ALASKA

David C. Fleurant
Executive Director

Support For New Grievance Procedures

NAMI Anchorage
144 W. 5th Avenue
Anchorage, AK 99501

(907) 272-0227
(phone and fax)

February 17, 2007

Alaska State Legislature
Juneau, Alaska

RECEIVED
FEB 20 2007

Re: Request for Amendment to AS 47.30.847
Psychiatric Grievance Procedures

Honorable Senators and Representatives:

NAMI Anchorage provides support, education and advocacy to persons experiencing a mental illness and their families. This letter is about the grievance rights of patients in mental health facilities. Those rights are set out in broad terms in AS 4.30.847. See copy attached.

We have received reports that patients have been unduly burdened by hospital procedures in their efforts to bring grievances. For example, the facility may repeatedly require the patient to confer with members of the very same treatment team that have aggrieved the patient as a pre-condition to filing a formal grievance. It can be traumatizing to a patient to be required to seek redress from the same caregivers with whom the patient has a dispute.

It has also been reported to NAMI that patients are not always being provided a written statement of the grievance procedure upon admission to the facility. The ability of the patient or patient's representative to advocate for themselves requires knowledge of the "what" and "how" of the grievance procedure *prior* to treatment. NAMI believes that self-advocacy is one of the building blocks for real and lasting recovery.

These examples demonstrate that the due process rights of patients can be easily limited or circumvented because the language of AS 47.30.847 is too broad. The statute does not say precisely what the mental health facilities must do, giving them considerable latitude in interpreting the law and developing the grievance procedures as they wish. The statute needs to be amended to state the following specific requirements:

- the written grievance procedure will be provided to the patient at the time of admission.
- the patient's written complaint will be accepted and delivered to the "impartial body" required in subsection (a) without requirement of further consultation with or approval by the treatment team or other precondition.
- the patient will be allowed the assistance of a self-designated representative and will not be limited to a representative as defined by the facility.
- the complaint will be addressed and resolved within specific time frames to be set out in the amended statute.

Additional specific provisions may be required as investigation continues. NAMI Anchorage is prepared to assist in this important revision process as requested. In the meantime, we ask the legislators and the administrators of mental health facilities to bear in mind the trauma that hospitalization by itself causes a patient, on top of the underlying problem resulting in the hospitalization. In such a situation, the balancing of administrative inconvenience with the health and welfare of the patient should weigh in favor of the patient.

Thank you for this opportunity to comment.

NAMI Anchorage

Pat Kouris / by Harbour

Pat Kouris

President, NAMI Anchorage Board of Directors

attachment: AS 47.30.847

cc: Representative Sharon Cissna
James B. Gottstein, Esq.
Faith Myers and Dorrance Collins
David Fleurant, Disability Law Center

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB008-DHSS-DBH-02-13-07
Bill Version: SB 8
( ) Publish Date:
Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: RIGHT OF PATIENTS TO CHOOSE GENDER OF HOSPITAL STAFF IN PSYCHIATRIC HOSPITALS
RDU: Behavioral Health
Component: Alaska Psychiatric Institute
Sponsor: DAVIS
Requester: SENATE (HES)
Component No.: 311

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2007) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The purpose of this bill is to require hospitals providing psychiatric services to proffer gender choice to patients requiring intimate care to document in the patient record, after "reasonable and good faith efforts to comply", a) failure to meet the patient's request for gender choice, but provision of intimate care by a licensed professional or b) failure to meet the patient's request for gender choice, but provision of intimate care by a non-licensed professional. Further, the bill would require posting of the notice of the patient's right of gender choice in intimate care situations.

(Continued on page 2)

Prepared by: Stacy Toner, Acting Director — Phone 465-2817
Division: Behavioral Health — Date/Time 01/18/2007
Approved by: Karleen Jackson, Commissioner — Date 02/13/2007
Agency: Department of Health and Social Services

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION
(Continued from page 1)

The bill is congruent with the department's desire to accomodate the gender choice of patients, and to protect vulnerable populations from medically unnecessary invasions of privacy. Although, there may be an increase in staff workload due to an increase in documentation, the effect is believed to be negligible and no fiscal impact is expected.

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/16/07

FURTHER: Judiciary
Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: _____

Health, Education and Social Services Committee considered

SENATE BILL NO. 8

SB 8 MENTAL HEALTH PATIENT RIGHTS: STAFF GENDER

"An Act relating to a mental health patient's right to choose the gender of hospital staff providing intimate care to the mental health patient and to the duties of hospital staff in caring for patients receiving mental health treatment."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

PREVIOUS FISCAL NOTE(S):

[ ] **APPROPRIATION - no fiscal note**

	Ellis	✓			
	Thomas	✓			
	Duncan				
	Carona			✓	
CHAIR: Betty Davis	B. Davis	✓			

RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES

PART A

RULES OF GENERAL APPLICABILITY

MAINE DEPARTMENT OF BEHAVIORAL AND DEVELOPMENTAL SERVICES
DIVISION OF MENTAL HEALTH
AUGUSTA, MAINE

BASIS STATEMENT

These rules were initially promulgated on October 1, 1984, pursuant to 34-B M.R.S.A. § 3003, that directed the Division of Mental Health to promulgate rules pursuant to the Maine Administrative Procedure Act for the enhancement and protection of the rights of clients receiving services from the Department of Behavioral and Developmental Services, state and non-state mental health institutions or units, or from any program or facility administered or licensed by the Department. These rules were subsequently amended on October 1, 1986, October 1, 1989 and January 1, 1995.

On August 2, 1990, the Kennebec County Superior Court approved the terms of a Consent Decree in the case of Paul Bates, et al. v. Sue Davenport, et al., Docket No. CV-89-88. The Consent Decree incorporated the contents of a Settlement Agreement, the terms of which require the defendants to draft revisions to the "Rights of Recipients of Mental Health Services" as needed to incorporate the provisions governing grievances and complaints and to make these rules consistent with the terms of the Settlement Agreement.

INTRODUCTION

The 110th Maine Legislature enacted into law, 34 M.R.S.A. section 2004, now 34-B M.R.S.A. section 3003, entitled "An Act Authorizing and Directing the Bureau of Mental Health to Enhance and Protect the Rights of Recipients of Mental Health Services," that directed the Bureau to promulgate rules, under the Administrative Procedures Act, in a number of areas of patient/client rights.

The intent of the Legislature was to provide a process whereby the Division of Mental Health, as the lead administrative agency for institutional and community mental health services, would develop comprehensive rules in this complex area, taking into account clinical, social and administrative factors while promoting and safeguarding the rights of people receiving mental health services.

These rules apply to all agencies licensed by the Department of Behavioral and Developmental Services and all public or private inpatient psychiatric institutes and units, including the state operated mental health institutes.

These rules were developed by a task force made up of consumers, providers, regulators, professionals, family members, advocates and others, with the input of citizens throughout the State.

These rules were initially promulgated on October 1, 1984, were amended October 1, 1986, October 1, 1989 and January 1, 1995.

Questions regarding the applicability or interpretation of these rules should be directed to the Director, Division of Licensing, Department of Behavioral and Developmental Services, State House Station 40, Augusta, Maine 04333, Area Code (207) 287-4200 or 287-3000 (TTY).

RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES

TABLE OF CONTENTS

PART C

RIGHTS IN OUTPATIENT SETTINGS

PART A. RULES OF GENERAL APPLICABILITY

I. STATEMENT OF INTENT

The purpose of these rules is to articulate the rights of recipients of mental health services so that these rights may be enhanced and protected. Mental health service recipients should suffer no loss of basic human or civil rights. Because of the exceptional circumstances under which such patients are treated, however, the exercise of some rights may require special safeguards. These rules, therefore, are intended to keep recipients' rights paramount, to assure that individual rights will be both recognized and protected during the course of service delivery, and to ensure treatment consistent with ethical and professional standards. Procedural mechanisms that exist to ensure enforcement of these rules include the licensing authority of the Department of Behavioral and Developmental Services pursuant to 34-B M.R.S.A. § 1203-A, the grievance and complaint procedures set forth in these rules, and the Department's contracting authority.

Part A, Rules of General Applicability that apply to all recipients, regardless of the treatment setting, should be read in conjunction with either Part B (for inpatient or residential settings) or Part C (for outpatient settings).

II. DEFINITIONS

A. Advocacy Program means the Office of Advocacy of the Department and the rights protection and advocacy agencies or other governmental agencies authorized by law to investigate grievances and protect rights.

B. Complaint means an allegation by a person or agency charged with investigating violations of client rights or with delivering or monitoring mental health services of violation of basic rights of a recipient, including those enumerated in these rules and the Settlement Agreement in Bates, et al. v. Davenport, et al. or any other applicable law or regulation.

C. Conjoint Family Treatment Services means services jointly provided to more than one member of a family, in which all members in question are recipients.

D. Department means Department of Behavioral and Developmental Services.

E. Division means the Division of Mental Health.

F. Grievance means an allegation by a recipient of violation of basic rights, including those enumerated in these rules and the Settlement Agreement in Bates v. Duby or any other applicable law or regulation.

G. Individualized Support Plan (henceforth referred to as "ISP") means an approach to support planning that focuses on the development of a life plan that expresses, in the recipient's own words, his or her wants, needs and goals, as well as an action plan for meeting these goals.

H. Mental Health Facility, Agency, or Program means any facility that provides in-patient psychiatric services and any agency or facility providing in-patient, residential or outpatient mental health services that is licensed by, funded by or has a contract with either the Department of Behavioral and Developmental Services or the Department of Human Services,

Deleted: 1

I. Mental Health Institute means state-operated inpatient facilities.

J. Non-State Mental Health Institution means a public institution, a private institution or a mental health center, that is administered by an entity other than the State and that is equipped to provide in-patient care and treatment for people with mental illness.

K. Person with long-term mental illness means a person who suffers from certain mental or emotional disorders that erode or limit the capacities of daily life. For purposes of this definition, mental and emotional disorders include organic brain syndrome, schizophrenia, recurrent depressive and manic depressive disorders, paranoid and other psychoses, plus other disorders that may become chronic. For purposes of this definition, capacities of daily life include personal hygiene and self care, self direction, interpersonal relationships, social transactions, learning, recreation and economic self-sufficiency. While persons with long-term mental illness may be at risk of institutionalization, there is no requirement that these persons are or have been residents of institutions providing mental health services.

L. Program Area means any discrete part of a facility or agency, including any building, residential program, ward, unit or program site.

M. Recipient means any person over age 18 receiving mental health treatment from any mental health facility, agency or program.

N. Representative means any person who has been designated in writing by a recipient, or by his or her guardian to act to aid the recipient in upholding his or her rights under these rules. Such person shall not be a patient of an inpatient facility nor a staff person currently serving the recipient.

O. Rights Protection and Advocacy Agency means the protection and advocacy program established by 42 U.S.C. §§ 10801 et seq. and described in 5 M.R.S.A. §§ 19501 et seq.

P. Treatment means any activity meant to prevent, ameliorate, prevent deterioration of, or cure a recipient's mental health problem or mental illness and includes behavioral, psychological, medical, social, psychosocial and rehabilitative methods that meet usual and customary standards in the field of mental health treatment.

Q. Treatment Team means those persons, including the recipient, who plan, carry out and review treatment.

III. BASIC RIGHTS

A. Recipients have the same human, civil and legal rights accorded all citizens, including the right to live in a community of their choice without constraints upon their independence, except those constraints to which all citizens are subject. Recipients have the right to a humane psychological and physical environment within the facility or program. Recipients have the right to be treated with courtesy and dignity. Recipients are at all times entitled to respect for their individuality and to recognition that their personalities, abilities, needs, and aspirations are not determinable on the basis of a psychiatric diagnosis. Recipients have the right to have their privacy assured and protected to the greatest extent possible in light of their treatment needs. Recipients shall not be incapacitated nor denied any right, benefit, privilege, franchise, license, authority or capacity of whatever nature that they would otherwise have, simply due to their status as recipients of mental health services.

B. There shall be no limitation on the freedom of religious belief.

C. Discrimination in the provision of services due to race, creed, sex, age, national origin, political belief, or handicapping condition shall be prohibited.

D. All basic rights shall remain intact unless specifically limited through legal proceedings, as in the case of guardianship or in an emergency or when necessary to protect the rights or safety of the recipient or others, only as outlined in specific sections of these rules.

E. Services delivered to recipients shall be based on their identified individual needs and shall be delivered according to flexible models that accommodate changes in recipients' needs and the variations in the intensity of their needs. To the extent possible, recipients will not be required to move from one setting to another in order to receive the services appropriate to their changed needs.

F. Recipients have the right to refuse all or some of the services offered, subject to the exceptions noted below. A person's refusal of a particular mode or course of treatment shall not per se be grounds for refusing a recipient's access to other services that the recipient accepts. Only the following services may be imposed against a recipient's wishes:

1. Involuntary hospitalization pursuant to 34-B M.R.S.A. §§ 3863 et seq.;

2. Forensic services pursuant to 15 M.R.S.A. § 101-B in a residential or hospital setting;

3. Services permitted under applicable law in the case of a person under guardianship, upon the guardian's informed consent and within the limits of the guardian's authority;

4. Emergency treatment in a residential or hospital setting during a psychiatric emergency, pursuant to procedures set out in these rules; or

5. Treatment in a residential or hospital setting pursuant to the administrative hearing provisions of these rules for individuals who lack capacity to consent to services.

G. Recipients have the right to exercise their rights pursuant to these rules without reprisal, including reprisal in the form of denial of or termination of services.

H. Recipients with long term mental illnesses have the following additional rights, to the extent that state and community resources are available:

1. The right to a service system that employs culturally normative and valued methods and settings;

2. The right to coordination of the disparate components of the community service system;

3. The right to individualized developmental programming that recognizes that each recipient with long-term mental illness is capable of growth or slowing of deterioration;

4. The right to a comprehensive array of services to meet the recipient's needs; and

5. The right to the maintenance of natural support systems, such as family and friends of recipients with long-term mental illnesses, individual, formal and informal networks of mutual and self-help.

IV. LEAST RESTRICTIVE APPROPRIATE SETTING

A. Recipients have the right to be treated in the least restrictive appropriate setting to meet their needs.

B. Any restrictions or limitations in an inpatient setting shall be determined and imposed pursuant to the Right to Individualized Treatment and the Right to Informed Consent to Treatment.

C. No recipient shall be held in treatment against his or her will by policy, procedure or practice, except by order of court or by emergency hospitalization procedures.

D. Agencies or facilities proposing persons for commitment shall first fully consider less restrictive appropriate settings and treatment modalities pursuant to 34-B M.R.S.A. § 3864(5).

E. Involuntary hospitalization provisions shall not be utilized only as a means to accomplish admission, to obtain transportation, or for administrative reasons.

V. NOTIFICATION OF RIGHTS

A. Recipients have the right to be notified of all rights accorded them as recipients of services, by Maine statute, these rules, the Bates v. Duby Settlement Agreement, if applicable, and associated policies.

B. At the time of admission or intake, or as soon afterwards as is reasonably feasible, each recipient shall be informed, to the extent possible, of his or her rights under these rules in terms that he or she understands.

1. Such information shall be given by an employee of the facility or program in a manner designed to be comprehensible to the individual recipient.

2. In cases where the recipient does not understand English or is deaf, the notification of rights shall be conducted by an interpreter.

3. If the recipient's condition at admission or intake precludes understanding of his or her rights, additional attempts to provide information about rights shall occur and be documented.

4. Documentation of the results of the discussion about rights shall be noted in the recipient's permanent treatment record.

5. Recipients shall be advised of their right to name a designated representative or representatives to assist them to receive notices of meetings and to participate at meetings. Recipients shall additionally be given information regarding available advocacy and peer advocacy programs.

6. Recipients shall be further advised of their rights pursuant to these rules and the Settlement Agreement in Bates v Davenport, as applicable.

C. At the time of admission or intake, each recipient shall be given a summary of these recipient rights written in plain language. In instances in which the recipient is deaf, the summary of these recipient rights will be communicated in American Sign Language.

1. Copies of the summary shall be given to:

a. The recipient's guardian, if any; or

b. In the case of any recipient without a guardian, up to three individuals, if designated by the recipient.

2. Those persons, including the recipient, given copies of summaries shall be noted in the medical record.

3. Copies of the summaries shall be conspicuously posted in all agencies, facilities, and program areas.

4. The summaries shall contain instructions for viewing these rules, the Settlement Agreement in Bates v. Davenport, and associated policies developed to implement these two documents.

5. The summaries shall be made available in foreign languages or American Sign Language, if necessary.

D. At the time of the notification required above, recipients shall be notified that they, their guardians acting on their behalf, or their designated representatives may bring grievances claiming that the practices, procedures or policies of the Department, a non-State mental health institution, or any agency licensed by, funded by or under contract with the Department to provide mental health services, violate the terms of these rules, the terms of the Bates v. Duby Settlement Agreement, or any other applicable law or regulation. They shall additionally be notified of the process whereby grievances may be filed and of their right to be assisted throughout the grievance procedure by a representative of their choice. In the written notice required by section V(C) above, recipients shall additionally be notified of the advocacy services available through the Department's Office of Advocacy, the rights protection and advocacy agency, peer advocates, and the Ombudsman Program established pursuant to 22 M.R.S.A. § 5112(2).

E. Each program area shall have complete copies of these recipient rights rules, the Settlement Agreement in Bates v. Duby, and associated agency policies. Each recipient shall be offered a copy of these rules. Additional copies of these documents shall be available from the Department of Behavioral and Developmental Services, Station 40, State Office Building, Augusta, Maine 04333.

F. The Office of Advocacy shall have copies of all statutes referenced in these rules. These statutes shall be available for review during regular working hours at the Office of Advocacy, Station 60, State Office Building, Augusta, Maine 04333.

VI. ASSISTANCE IN THE PROTECTION OF RIGHTS

A. Recipients have the right to assistance in the protection of their rights.

B. Recipient Representative. Each agency, facility or program shall inform all recipients of their right to name a representative, including a peer representative, to aid them in the protection of their rights. Aid may include one or more of the following activities: assistance in the formulation and processing of a grievance; participation in the informal or formal development and revision of an ISP, individualized service or treatment plan or hospital treatment and discharge plan; or any other type of representative assistance activity referenced in these rules. The provision of aid by a designated representative shall be governed by this section and by other relevant sections of these rules.

1. Designation in writing. If the recipient or his or her guardian desires a representative for the recipient, the person desiring a representative for the recipient shall designate, in writing, a person to aid the recipient in upholding his or her rights.

2. Time for designation. The recipient or his or her guardian may designate a representative at any time.

3. Change in representative. Provision shall be made for change of representative should the recipient so desire, or if the recipient is placed under guardianship, should the guardian so desire.

4. Representative's physical access. The representative shall have reasonable access to all living and program areas and to staff involved in the treatment of the recipient in order to assist the recipient in the protection of his or her rights.

5. Confidentiality. The representative may obtain access to confidential information as defined under 34-B M.R.S.A. § 1207 concerning the recipient by obtaining the appropriate party's written informed consent to disclosure under Section IX of these rules.

6. Communication. A recipient shall have access, at any reasonable time, to a telephone to contact his or her representative.

7. Involvement in ISP and Service or Treatment and Discharge Planning.

a. The recipient representative shall be given 10 days written notice of ISP meetings unless the recipient directs that the representative not be invited. The recipient's involvement may include, without limitation, participation in service or treatment planning meetings, or discharge planning meetings. When the meeting is being convened to address an emergency, notice reasonable for the circumstances shall be given.

b. The representative shall be notified when the recipient is determined to lack clinical capacity pursuant to Section V, Part B (Inpatient and Residential Settings) or Section IV, Part C (Outpatient Settings) of these rules.

c. The representative shall receive, upon the recipient's authorization, a copy of prescribed medication, dosage levels, schedules and side-effects and a copy of the aftercare plan upon the discharge of the recipient.

C. Advocacy Programs. Each recipient shall be informed of advocacy programs available in the state. Recipients have the right to request assistance from the advocacy programs at any time. Advocacy services are available through:

1. The Office of Advocacy of the Department, which is mandated by State law to investigate the claims and grievances of recipients of mental health services provided by the Department or facilities or agencies administered, funded or licensed by the Department and to monitor the compliance of any facility or agency administered by the Department with all laws, rules, and policies relating to the rights and dignity of service recipients.

2. Other agencies including the rights protection and advocacy agency, and the Ombudsman program established pursuant to 22 M.R.S.A. § 5112(2).

D. Recipients may, at their request, be represented by a private advocate. In such cases the recipient shall bear the cost, if any, of such representation.

E. A report of complaints and grievances appealed to the Superintendent of AMHI and BMHI, the Director of the Division of Mental Health, and the Commissioner shall be compiled semi-annually and submitted to the Office of Advocacy, the Chief Administrative Officer of the agency or facility, the Office of the Master established pursuant to the terms of the Settlement Agreement in Bates v. Davenport, and plaintiffs' counsel in that action.

VII. RIGHT TO DUE PROCESS WITH REGARD TO GRIEVANCES

A. Recipients have the right to due process with regard to grievances.

B. Notwithstanding any other civil or criminal recourse that the person bringing the grievance may have, the facility, agency, and/or Department shall afford every reasonable opportunity for informal resolution of concerns or formal resolution of grievances.

C. Recipients or other persons may bring grievances regarding possible violations of basic rights, including any rights enumerated in these rules and the Settlement Agreement in Bates v. Duby or any other applicable law or regulation, any questionable or inappropriate treatment or method of treatment; or any policy or procedure or action, or lack thereof, of the mental health agency or facility.

D. Persons who may bring grievances include, but are not limited to:

1. The recipient;
2. The recipient's guardian;
3. The recipient's attorney, designated representative or representative of the Office of Advocacy or the rights protection or advocacy agency;
4. Other persons specifically aggrieved.

E. A grievant shall in no way be subject to disciplinary action, reprisal, including reprisal in the form of denial or termination of services, or loss of privileges or service as a result of filing a grievance.

F. Notice

1. Notices summarizing a recipient's right to due process in regard to grievances, including the process by which grievances may be filed, as well as copies of forms to be used for that purpose, shall be available within each program area.

2. An employee of the mental health facility, agency or program shall inform each recipient of this right and the right to be assisted throughout the grievance procedure by a representative of his or her choice, in a manner designed to be comprehensible to the individual recipient. In instances in which the recipient does not understand English or is deaf, this information shall be delivered by an interpreter.

G. Formal Grievances

1. A grievance may be undertaken by a recipient, or a guardian acting on his or her behalf, making a formal written claim that provisions of these rules, the Settlement Agreement in Bates v. Davenport or any other applicable law or regulation have been violated by any facility, agency or program.

Grievances regarding the actions of specific employees shall be handled in accordance with personnel rules and contract provisions. No disciplinary action may be taken nor facts found with regard to any alleged employee misconduct except in accordance with applicable personnel rules and labor contract provisions.

2. Formal grievances may be appealed through three sequential levels:

a. The supervisor of the program or unit or the agency employee designated to hear grievances as applicable;

b. For grievances arising in inpatient facilities, the Administrator of the facility; for grievances arising in the community, the Director of the Division of Mental Health; and

c. The Commissioner of the Department.

3. Additional levels of grievance resolution may be added by agency or facility policy, but in no case shall such additional levels add to the overall time allotted for grievance resolution.

4. At each level of the formal grievance procedure the recipient or other grievant shall have rights to the following:

a. Assistance by a representative of the recipient's own choice;

b. Representation by the Office of Advocacy or the rights protection and advocacy agency of the Maine mental health system;

c. Review of any information obtained in the processing of the grievance, except that which would violate the confidentiality of another person;

d. Presentation of evidence or witnesses pertinent to the grievance;

e. Receipt of complete findings and recommendation except those that would violate the confidentiality of another person.

5. An electronic or written record shall be made of all proceedings associated with formal grievances. An electronic recording shall be made of any hearing held pursuant to this section.

6. In all grievances the burden of proof shall be on the agency, facility or program to show compliance, or remedial action to comply with the policies and procedures established to assure the rights of recipients under these rules.

7. Findings shall include:

a. A finding of facts, consistent with the terms of the Maine Administrative Procedure Act;

b. A determination regarding the facility, agency, program or employee adherence, or failure to adhere, to specific policies or procedures designed to assure the rights of recipients under these rules; and,

c. Any specific remedial steps necessary to assure compliance with such policies and procedures.

8. Upon appeal, all pertinent information gathered regarding a formal grievance shall be forwarded, by the person to whom the grievance was addressed, to the next responsible official.

9. Steps of Formal Grievances:

a. Level One

i. Formal grievances shall be filed first with the supervisor of the service delivery unit in which the grievance arises.

ii. Copies of the grievances shall be forwarded by the supervisor to the administrative head of the mental health facility or agency and, upon the request of the grievant, to the Office of Advocacy. In the case of state operated facilities, all formal grievances shall be immediately forwarded to the Office of Advocacy.

iii. A formal written response shall be made within five days, excluding weekends and holidays.

iv. If the agency staff needs a longer period to investigate the circumstances of the grievance, a five day extension may be made and the grievant so notified.

v. If the grievant is unsatisfied with the findings at the first level, he or she may appeal the decision to the Chief Administrative Officer of the mental health facility or, for grievances arising in the community, the Director of the Division of Mental Health.

vi. Such an appeal must be made within ten days, excluding weekends and holidays.

vii. Copies of such an appeal shall be forwarded to the Office of Advocacy by the Chief Administrative Officer of the facility or the Director of the Division of Mental Health.

b. Level Two

i. The Chief Administrative Officer or the Director of the Division of Mental Health, as applicable, or designee shall respond to a Level Two grievance within five days, excluding weekends and holidays, of day of receipt of the appeal.

ii. If the Chief Administrative Officer or designee needs a longer period to investigate the circumstances of the grievance, a five day extension may be made with the permission of the parties to such a grievance.

iii. The Chief Administrative Officer or the Director of the Division of Mental Health, as applicable, or designee may, at his or her discretion, hold a hearing before an impartial hearing officer, who shall be an individual free of bias, personal or financial interest, with all parties involved.

iv. If the grievant is dissatisfied with the finding at Level Two, he or she may appeal the decision to Level Three to the Commissioner, Department of Behavioral and Developmental Services, Station 40, Augusta, Maine

04333. Appeals must be made within ten days, excluding weekends and holidays.

c. Level Three

i. The Commissioner or designee shall make a formal written reply within five days, excluding weekends and holidays.

ii. If no hearing was held at Level Two a hearing shall be held at Level Three.

iii. A five day continuance may occur if a hearing is to be held or if the parties to such a grievance concur.

iv. The Commissioner's or designee's finding shall constitute the final action by the Department regarding a grievance.

10. The decision at each level of the grievance procedure shall be final and binding unless the grievant appeals within the indicated time frames.

H. The Commissioner's decision shall constitute final agency action, and the grievant may appeal the decision to Superior Court pursuant to the Maine Administrative Procedure Act, 5 MRSA s 11001 et seq.

I. Under no circumstances shall the remedies requested in a grievance be denied nor shall the processing of a grievance be refused because of the availability of the complaint procedure.

J. Exceptions

1. Grievances regarding abuse, mistreatment, or exploitation.

a. Any allegation of abuse, mistreatment, or exploitation shall be immediately reported to the Office of Advocacy and to the Chief Administrative Officer of the mental health facility or agency. Any disciplinary actions or findings of fact in these instances shall be consistent with personnel rules and labor agreements.

b. Investigation of any such allegation shall be conducted pursuant to statutory and regulatory standards including those relating to the Child and Family Services and Child Protection Act (22 M.R.S.A. Chapter 1071 s 4001 et seq.) and the Adult Protective Act (22 M.R.S.A. Chapter 958-A) and facility policy approved by the Department.

2. Urgent Grievances.

a. Any grievance that the grievant considers urgent shall be forwarded by staff within one working day to the Chief Administrative Officer of the facility or for grievances arising in the community, to the Director of the Division of Mental Health, or designee, at Level Two, and the Office of Advocacy so notified.

Such grievances must be reviewed by the Chief Administrative Officer, the Director or designee, who shall either arrange to hear the grievance within three working days or immediately refer the grievance to Level 1 for response.

b. All grievances concerning the development, substantive terms, or implementation of ISP's or hospital treatment and discharge plans shall be considered urgent grievances.

3. Grievances Without Apparent Merit

a. A grievance may be found to be without apparent merit, upon Level Two review, upon the concurrence of the Chief Administrative Office or the Director of the Division of Mental Health, as applicable, and, when the grievance relates to a state mental health institute, the representative of the Office of Advocacy.

b. Any decision that a grievance is without merit and the justification for that decision shall be forwarded to the grievant in writing, and shall include notice of other avenues of redress.

c. Grievances without apparent merit may not be appealed administratively beyond Level Two. This dismissal constitutes final agency action for purposes of judicial review.

VIII. COMPLAINTS

A. A written complaint may be filed by any person or agency that is charged with investigating violations of client rights or with delivering or monitoring mental health services. The complaint procedure may be used when:

1. The person or agency knows or has reason to believe that the practices, procedures (including the development, substantive terms or implementation of ISP's or hospital treatment and discharge plans) or policies of the Department or of any agency licensed, funded or contracted by the Department to provide services elsewhere described in these rules, violate these rules, the terms of the Settlement Agreement in Bates v. Davenport or any other applicable law or regulation; and

2. The information was obtained during the general course of the person's or agency's performance of their responsibilities.

B. Complaints that include allegations of employee misconduct shall be processed, but no disciplinary action may be taken nor facts found with regard to the alleged misconduct except in accordance with applicable personnel rules and labor contract provisions.

C. Complaints arising in an in-patient setting shall be addressed to the chief administrative officer of the in-patient facility, who shall forthwith refer them to the supervisor of the service delivery unit in which the complaint arose.

D. Complaints arising in the community shall be addressed to the agency employee designated to receive complaints.

E. A formal written response shall be made .. 'hin five days of receipt by the persons listed in (C) and (D) above, excluding weekends and holidays. Upon appeal, all pertinent information gathered regarding a complaint shall be forwarded by the person to whom the complaint was addressed to the next responsible official.

F. Decisions about complaints described in (C) above shall be appealable within five working days to the Chief Administrative Officer of the facility, who shall respond within five working days. If the person assigned to investigate a complaint needs a longer period to investigate the circumstances of the complaint, a five-day extension may be made and the complainant so notified.

G. Decisions about complaints described in (D) above shall be appealable within five working days to the Director of the Division of Mental Health, who shall respond within five working days.

H. Decisions resulting from appeals described in (F) and (G) above shall be appealable within five working days to the Commissioner, who shall respond within five working days. If the person assigned to investigate a complaint needs a longer period to investigate the circumstances of the complaint, a five-day extension may be made and the complainant so notified.

I. Investigations shall be conducted at each level of the complaint and shall include, as needed, interviews, site visits, or other data collection activities. At the conclusion of each investigation, a written summary of the results of the investigation and a statement of the remedial action to be taken, if any, shall be provided to the complainant, subject to the limitations of 5 M.R.S.A. § 7070(2)(E).

IX. CONFIDENTIALITY AND ACCESS TO RECORDS

A. Recipients have the right to confidentiality and to access to their record.

B. All information regarding mental health care and treatment shall be confidential except as otherwise provided below.

C. A recipient or guardian shall be notified, upon admission or intake to any mental health facility or program of:

1. What records will be kept, including any duplicate records;

2. How the recipient may see those records;

3. The use to which the records will be put;

4. What will happen to the record after the recipient leaves the facility or program;

5. How to add information to records;

6. How to obtain copies of material in records; and

7. The limits of confidentiality, as provided in J. below.

D. The recipient or legal guardian shall be informed when the possibility exists that the costs of the recipient's care, treatment, education or support will be borne by a third party. That information shall indicate that clinical information may be used to substantiate charges. The recipient or guardian may indicate that he or she will bear such costs privately rather than allow the release of information.

E. The recipient or guardian shall have the right to written and informed consent prior to release of any information to any agency or individual, whether or not such agency or individual is directly involved in the recipient's treatment or supervision thereof, except as provided in J below. Informed consent shall include:

1. Identification of the specific information to be disclosed;

2. Notice of the right to review mental health records upon request at any reasonable time including prior to the authorized release of such records;

3. The name of persons or agencies to whom disclosure is to be made;

4. The purpose to which the information is to be put;

5. The length of time within that the information is to be disclosed not to exceed one year; and

6. Notice of the right to revoke consent to release at any time.

F. Recipients have the right to require written informed consent for release of case record material that discloses the recipient's identity to students when they temporarily become a part of

treatment team, except when the student is involved in a professional program that has a formal relationship with the facility or agency.

G. All personnel of agencies or programs, including students or trainees, shall be trained regarding confidentiality and shall be held to confidentiality statutes, rules and policies.

H. Duplication:

1. If the facility or agency duplicates a portion of, or the entire care record of a recipient pursuant to any exception contained in J(1)(a) through (e) below a recipient or his or her guardian shall be notified, if possible, as to the purpose of such duplication.

2. Copies of original records shall be noted as such.

I. Separate personalized records shall be maintained when group treatment methods are employed except that individualized record keeping for service or treatment shall not be required in instances in which conjoint family treatment services are provided, under the following conditions:

1. Informed consent must be obtained to the conjoint treatment record keeping, pursuant to B.III., and such consent shall be documented by using a Department- approved form. This form shall be made a permanent part of the treatment record.

2. If any family member previously received treatment other than conjoint family treatment services at the facility, agency or program, or received conjoint family treatment services as a member of a different family group at the facility, agency or program, an extracted individualized discharge summary shall be placed in that family member's individualized record.

3. If any family member refuses to have treatment records blended, separate records must be maintained for that family member.

4. If any family member requests the release of his or her records subsequent to the termination of conjoint family treatment services, the facility, agency or program shall respond to this request by providing an extracted individualized discharge summary. The facility, agency or program shall not release information concerning an individual family member without that family member's written consent.

5. Nothing in these regulations shall preclude individualized record keeping by any program, facility or agency. Intake data, evaluations or assessments collected or performed for the purposes of determining eligibility for conjoint family treatment services are not treatment records for the purposes of this exception.

6. This exception shall be reviewed no later than December 31, 1995 to assess the impact and effect of these rules. The review shall include representatives of the Bureau of Children with Special Needs, the Division of Mental Health, the Division of Licensing, the Office of Consumer Affairs, the Office of Advocacy and other interested parties as designated by the Commissioner of the Department of Behavioral and Developmental Services.

J. Exceptions:

1. Information may be released without written informed consent, as provided by Maine statute (34-B M.R.S.A., section 1207, sub-section 1) in the following circumstances:

a. Disclosure may occur as necessary to carry out the statutory functions of the department or statutory hospitalization provisions. This shall include obtaining the services of an interpreter in cases in which the recipient does not speak English or is deaf.

b. Disclosure may be made as necessary to allow investigation by the rights protection and advocacy agency, the Office of Advocacy, or, in the following circumstances, the Department of Human Services.

i. Disclosure may be made to the Department of Human Services to cooperate in a child protective investigation or other child protective activity pursuant to an interdepartmental agreement promulgated as a rule by the Department of Behavioral and Developmental Services.

ii. Disclosure may be made to the Adult Protective Services of the Department of Human Services in instances in which Adult Protective Services is acting as public guardian or conservator for the recipient.

c. Disclosure may be ordered by a court of record subject to any limitations contained within the Maine Rules of Evidence.

d. An oral or written statement relating to the physical condition or mental status of a recipient may be disclosed to the recipient's spouse or next of kin upon proper inquiry:

i. Outpatient setting. Before responding to a request for information the recipient or the recipient's guardian shall be asked whether release of confidential information is acceptable. If the recipient or his or her guardian authorizes disclosure, the information shall be disclosed in accordance with that authorization. In the instance where a recipient lacks capacity to authorize release of such information, repeated attempts shall be made to determine capacity to make such a decision and, if capacity exists, to obtain

a decision. Efforts to determine capacity and the rationale for termination of such efforts shall be documented.

ii. Inpatient setting. The physical presence, and physical and mental condition of a recipient shall be immediately disclosed to a recipient's spouse or next of kin upon proper inquiry.

e. Disclosure may be allowed of biographical or medical information concerning the recipient to commercial or governmental insurers of any other corporation, association or agency from which the Department or licensee of the Department may receive reimbursement for the care, treatment, education, training or support of the recipient. Such disclosure may be made only after determination by the Chief Administrative Officer of the facility or designee that the information to be disclosed is necessary and appropriate.

f. Disclosure of information, including recorded or transcribed diagnostic or therapeutic interviews concerning any recipient may be allowed in connection with any educational or training program established between a public hospital and any college, university, hospital, psychiatric counseling clinic or school of nursing, provided that in the disclosure or use of any such information as part of a course of instruction or training the recipient's identity shall remain undisclosed. Such disclosure shall be conducted according to uniform standards consistent with de-identification.

g. Disclosure may be made to persons involved in statistical compilation or research conducted in compliance with these rules pursuant to Section XV. In the case of such disclosure records shall not be removed from the facility and reports shall preserve the anonymity of the recipient. Data that do not identify the recipient, or coded data, may be removed from the facility, provided the key to such code shall remain at the facility.

2. Information regarding the status and medical care of a recipient may be released by a professional, upon inquiry by law enforcement officials or treatment personnel, if an emergency situation exists regarding the recipient's health or safety.

3. Confidentiality may be violated if there is clear and substantial reason to believe that there is imminent danger of serious physical harm inflicted by the recipient on him or herself or upon another. Information regarding such danger or harm shall be immediately given to supervisory personnel or clinical mental health professionals who, if they concur in the assessment of imminent danger, shall notify civil authorities and any specific person threatened by direct harm.

4. A licensed mental health professional providing care and treatment to an adult recipient may provide to certain family members or other persons, in accordance with rules

promulgated pursuant to 34-B M.R.S.A., section 1207, sub-section 5, information regarding diagnosis, admission to or discharge from a treatment facility, the name of any medication prescribed, side effects of that medication, the likely consequences of failure of the recipient to take the prescribed medication, treatment plans and goals, and behavioral strategies.

K. Recipient Access to Records

1. The recipient or the recipient's guardian has the right to review the recipient's record at any reasonable time upon request, including prior to its authorized release. Such records shall be made available within three working days of such request.

2. Review of the care record shall occur under the supervision of a designee of the Chief Administrative Officer of the facility or program.

3. In cases where there exists a reasonable concern of possible harmful effect to the recipient if the review of the record occurs, the Clinical Director or designee shall supervise the review.

a. In cases where access of the guardian to the recipient's record would create documented imminent danger to the physical or mental well being of the recipient, the professional may refuse to disclose a portion of or the entire record to the recipient or guardian.

b. Written documentation shall be placed in the recipient's record in the event that access to the record or any portion of it is denied based on the above and the reasons for denial.

4. In cases where a recipient is unable to review the record at the program site, a certified copy of the record shall be forwarded to a professional, designated by the recipient, in the recipient's area, who shall supervise review of the record.

5. In cases where the record is at the program site, a certified copy of the record shall be forwarded to a professional, designated by the recipient, in the recipient's area, who shall supervise review of the record.

6. In cases where the recipient, after review of his or her record, requests copies of the record, or parts of the record, such copies shall be made available to the recipient at the actual cost of reproduction.

7. A recipient may add written material to his or her record in order to clarify information that he or she feels is false, inaccurate or incomplete.

8. Material that was obtained from another individual or facility through assurance of confidentiality shall not be available to the recipient in reviewing his or her record. A summary description of that material shall be provided to the recipient, and the recipient shall be informed regarding the process of gaining access to that material and shall be offered aid in securing appropriate release of information.

X. FAIR COMPENSATION FOR WORK

A. Recipients have the right to be paid a fair wage for work done.

1. Each individual or agency subject to the provisions of these regulations shall pay at least the minimum wage to each recipient who performs work regardless of level of performance, regardless of whether the work is considered therapeutic, and regardless of whether the recipient replaces or would replace a non-recipient worker.

2. Agencies shall compensate any recipient performing any work that is similar or identical to that performed by a non-recipient employee at the rate at which the non-recipient employee is compensated.

B. For purposes of this section, the following definitions shall apply:

1. Work shall mean any work having consequential economic benefit to the mental health agency, including but not limited to sheltered workshop employment programs, or any activity involved in the care, maintenance, and operation of the mental health agency.

2. Work shall not mean those tasks performed by each recipient for his or her own basic care or hygiene or upkeep of personal living space.

3. Federal law shall mean the Fair Labor Standards Act that sets national labor standards.

4. Minimum wage shall mean that hourly rate of pay established by the United States Congress or by the State of Maine, whichever is higher, as the legal minimum.

C. Agencies shall not directly or indirectly compel a recipient to perform any work, or punish any recipient for declining to perform work. Agencies shall not make any privilege or agency service conditional upon a recipient's agreement to perform work or withdraw a recipient's privileges or services because of that recipient's failure to perform work.

D. Agencies shall not discriminate in the hiring of agency staff. Any recipient is eligible to apply for and occupy, if qualified, any job classification.

E. Exceptions:

1. Agencies and service providers subjected to these regulations may pay a sub-minimum wage to a recipient who performs work after proper certification has been made by the United States Department of Labor under Handicapped Worker provisions contained in federal law.

2. Payment for work shall not be required when a recipient is a participant in an independent living program that requires a fair division of labor among all participants, including community-based psychosocial clubs and transitional living facilities, or in community-based transitional employment programs.

XI. PROTECTION DURING EXPERIMENTATION AND RESEARCH

A. Recipients have the right to refuse to participate in experimentation and research without loss of services.

B. All participation in experimentation and research shall be voluntary with full written informed consent, except as provided in these rules.

C. A recipient's refusal to participate in a research project or an experimental activity shall not be cause for denying the provision of indicated services to that recipient.

D. Definitions

1. Experimentation and research

a. Experimentation and research means the use of any medical, behavioral, or environmental intervention involving practices not commonly accepted by the discipline involved.

b. Experimental drug use means:

i. the use of any Food and Drug Administration non-approved drug.

2. Informed consent means the agreement obtained from a subject, or from his or her authorized representative, to participate in an activity. Informed consent requires that subjects understand the purpose, benefits and risks of research in which they are asked to participate and are given the opportunity to consent to, reject, or withdraw from participation without penalty.

3. Minimal risk means that the risk of harm anticipated in the proposed research or experimentation is not greater, considering probability and magnitude, than that ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tasks.

4. Board means the Research and Experimentation Review Board.

E. Research and Experimentation Review Board Membership

1. A Research and Experimentation Review Board, selected by the administrative head of the particular facility or agency, shall have at least five members with varying backgrounds, in order to promote complete and adequate review of research and experimental activities proposed for consideration.

2. The Board shall be sufficiently qualified, through the experience and expertise of its members and the diversity of the members' backgrounds, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects.

3. In addition to possessing the professional competence necessary to review such activities, the Board shall be able to ascertain the acceptability of proposed research or experimentation in terms of institutional commitments, regulations, applicable law, and standards of professional conduct and practice.

4. The Board shall consist of interdisciplinary members of both sexes including at least one member whose primary concerns are in non-scientific areas, such as law, ethics or theology, at least one member who is not otherwise affiliated with the institution or agency proposing the research or experimentation and at least one member who is a peer of the research subject.

5. No Board member may participate in the Board's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the Board.

6. At the Board's discretion, individuals with competence in special areas may be invited to assist in the review of complex issues that require expertise beyond or in addition to that available on the Board. These individuals may not vote.

F. General Procedures

1. All experimentation and research shall commence only after review and approval by the Research and Experimentation Review Board.

2. The Research and Experimentation Review Board shall have the authority to approve, require modifications in, or disapprove, any proposed research or experimentation activities.

3. The Office of Advocacy shall be informed of any proposed experimentation or research involving more than minimal risk.

4. The Board shall maintain adequate documentation of its activities.

5. The Board shall provide written notification of its approval or disapproval of the proposed research or experimentation activity, or of any modifications required to secure research and experimentation review board approval of any activity in question.

6. If the Board decides to disapprove a research or experimentation activity, it shall include, in its written notification, a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing.

7. Investigators and others directly involved in the research or experimentation shall, both in obtaining the consent and in conducting research, adhere to the ethical and research standards of their respective professions concerning the conduct of research or experimentation and to the regulations for research involving human subjects required by the U.S. Department of Health and Human Services in effect at the time of the adoption of these rules.

8. Researchers must report substantial changes or unanticipated problems immediately to the Chairperson of the Board.

9. The Board shall conduct continuing review of research covered by these regulations at intervals appropriate to the degree of risk, but not less than once a year, and shall have authority to observe or have a third party observe the consent process and research.

10. The Board shall have the authority to suspend or terminate approval of research that is not being conducted in accordance with the Board's requirements, these rules, or that has been associated with unexpected harm to subjects. Any suspension or termination of approval shall include a statement of the reasons for the Board's action and shall be reported promptly to the investigator, appropriate institutional officials, and the secretary of the Department of Health and Human Services as required by federal regulations.

11. Upon completion of the research and/or experimentation procedures the principal investigator shall attempt to remove any confusion, stress, physical discomfort, or other harmful consequences that may have been inadvertently produced as a result of the research or experimentation procedures.

G. Criteria for Board Approval of Research and Experimentation. In order to approve research covered by these regulations the Board shall determine that all of the following requirements are satisfied:

1. Risks to subjects are minimized by using procedures that are consistent with sound research or experimentation design and that do not unnecessarily expose subjects to risk, by confidentiality protocols consistent with other record keeping and, wherever

appropriate, by using procedures already being performed on the subject for diagnostic or treatment purposes.

2. Risks to subjects are reasonable in relationship to anticipated benefits to subjects. In evaluating risks and benefits, the Board shall consider only those risks and benefits that may result from the research and experimentation, as distinguished from the risks and benefits of therapy these subjects would receive in not participating in the research, or possible long-range benefits of applying knowledge gained in the research.

3. Selection of subjects is equitable, taking into account the purposes of the research and the setting in which the research will be conducted.

4. Informed consent is sought and appropriately documented in accordance with these rules.

5. The research or experimentation plan makes adequate provisions for monitoring the data collected or the activities allowed to ensure the safety and confidentiality of the subjects.

6. There are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

7. Where some or all of the subjects are likely to be vulnerable to coercion or undue influence, appropriate additional safeguards have been included in the project to protect the rights and welfare of these subjects.

H. Special Procedures; Exceptions to Informed Consent

1. Research involving the Need for Non-disclosure

a. If the research or experimentation methodology requires that the purpose, nature, expected outcome and/or implications of the research not be disclosed to the participants before it begins, the researcher shall clearly and vigorously justify to the Research and Experimentation Review Board the need for non-disclosure.

b. The Board may approve research or experimentation procedures that do not include, or that alter, some or all of the elements of informed consent set forth in these rules, or waive the requirements to obtain informed consent provided the Board finds and documents that:

i. the research involves no more than minimal risks to the subjects;

ii. the waiver or alteration will not adversely affect the rights and welfare of the subjects;

iii. the research or experimentation could not practicably be carried out without the waiver or alteration; and

iv. whenever appropriate, the subjects will be provided with full disclosure or additional pertinent information after the research or experimentation project is completed.

2. Research Involving Archival Review, Statistical Compilation or Record Review.

a. Research that is limited to archival review, statistical compilation or record review may be carried out pursuant to Title 34-B, MRSA, section 1207(2). Such research may be carried out without informed consent provided that:

i. the research is reviewed and approved by a Research and Experimentation Review Board;

ii. all data involved in said research shall not be identifiable as to individual recipients of services;

iii. the research plan shall be submitted to, and approved by, the head of the mental health facility or his or her designee.

3. Research Involving Persons Unable to Give Informed Consent, and Involuntary Recipients.

a. No experimentation or research involving more than minimal risks shall be conducted with persons unable to give informed consent, or involuntary patients unless:

i. the experimentation or research poses a clearly expected benefit to the individual recipient involved; and

ii. the experimentation or research has been reviewed and approved by the Research and Experimentation Review Board.

b. In the case of recipients adjudicated incapacitated, consent must be obtained from the recipient's legal guardian, and such consent must be reviewed by the Office of Advocacy and the rights protection and advocacy agency.

4. Utilization of Approved Food and Drug Administration Drugs for unlabeled uses.

a. Any use of drugs approved by the Food and Drug Administration, when applied in an unlat led manner, shall receive prior approval from the Clinical Director or his or her designee.

I. Applicability

1. Questions regarding the applicability of this section to specific recipients or activities shall be referred in writing to the Chairperson of the Research & Experimentation Board who shall determine applicability.

2. Where disagreement continues to exist, questions may be presented through the Grievance Procedure, Section VI.

3. In issues regarding professional standards, referral of the question may be made to the appropriate national professional standards committee whose decision shall be final and binding.

RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES

PART B

RIGHTS IN INPATIENT AND RESIDENTIAL SETTINGS

DEPARTMENT OF BEHAVIORAL AND DEVELOPMENTAL SERVICES
DIVISION OF MENTAL HEALTH
AUGUSTA, MAINE

CONTENTS

STATEMENT OF INTENT:

These rules [Part B] are applicable to all inpatient psychiatric units and hospitals and to all residential facilities providing mental health treatment to recipients. Individualized support planning for recipients in residential settings shall be governed by Section C.III, Individualized Support Planning Process.

Part B should be read in conjunction with Part A, Rules of General Applicability.

II. PRIVACY AND HUMANE TREATMENT ENVIRONMENT

A. Recipients have the right to a humane psychological and physical environment within the treatment facility.

B. Each recipient has the right to be treated with courtesy and with full respect for his or her individuality and dignity, and to recognition that his or her personality, needs and aspirations are not determinable on the basis of a psychiatric diagnosis.

C. Recipients have the right to have their privacy assured and protected and to preserve the basic rhythm of their lives to the greatest extent possible in light of their treatment needs.

D. The treatment facility shall be designed to afford recipients comfort and safety, shall promote dignity and independence and shall be designed to make a positive contribution to the efficient attainment of treatment goals.

E. Each inpatient or residential facility shall provide at least:

1. nutritious food in adequate quantities;

2. access to or provision of adequate professional medical care;

3. a level of sanitation, ventilation and light that meets health standards;

4. a reasonable amount of space per person in sleeping areas;

5. a reasonable opportunity for physical exercise and recreation, including access to outdoor activities;

6. an area for private conversation with other recipients and family and friends; if all designated areas are in use, staff shall make other reasonable arrangements to assure the recipient's and visitor's comfort and privacy;

7. an area for private telephone conversations;

8. areas that assure privacy for personal hygiene, counseling and physical examinations;

9. a secure and accessible storage area of adequate size to accommodate the recipient's personal belongings;

10. opportunities for appropriate involvement in community activities, subject to the requirements of Section III, Individualized Treatment and Discharge Plan in Inpatient Settings;

11. common areas with space and equipment sufficient to permit patients comfortably to socialize, relax, or engage in leisure time activity. To reduce the chance that recipients engaged in activities will intrude upon others not similarly engaged, such areas shall be equipped so that intrinsically incompatible activities are not performed in the same areas; and

12. schedule of available therapeutic, rehabilitative and recreational activities to each recipient. The schedule shall be updated monthly or more frequently as necessary.

F. Recipients have the right to be free from abuse, exploitation, or neglect.

1. Recipients shall not be subjected to humiliation or verbal abuse.

2. Recipients shall not be subjected to physical abuse, and corporal punishment is expressly prohibited.

3. Recipients shall not be subjected to exploitation or neglect.

4. Any allegation of abuse, exploitation or neglect shall be immediately reported to the Chief Administrator of the facility or agency, to the Office of Advocacy and, in the case of an adult recipient who does not have mental retardation, to the Department of Human Services pursuant to the Adult Protective Act (22 M.R.S.A. Chapter 958-A).

G. Simple, understandable written rules setting the limits of recipients' behavior required for the protection of the group and individuals shall be established and made known to the recipients.

H. Personal Property

1. Except as provided below, recipients have the right to retain and use personal property.

2. The use of personal property may be limited or items held in safekeeping only when the number or use of such items infringes upon the rights of other recipients, or poses a safety risk.

3. Each recipient shall have the right to manage his or her own personal financial affairs. A recipient's funds and access to funds shall not be limited unless:

a. the restrictions are a part of a plan of treatment pursuant to informed consent to treatment;

b. a conservator, guardian or representative payee has been appointed;

c. court ordered restrictions exist;

d. the restriction is to safeguard a recipient's assets during the initiation and pendency of any protective proceedings.

4. Any limitations on personal property or financial affairs shall be documented by a physician and receipts for all money or material held in safekeeping shall be given to the recipient or his or her guardian.

5. The facility or agency shall bear responsibility for any money or material held in safekeeping.

I. Every recipient has the right to be free from unnecessary searches of the person, of personal space or of common areas. A search shall only be conducted when staff have a reasonable belief that misappropriated articles are present or that certain items that would endanger the health or safety of a particular recipient or other recipients are present. Every search and the reasons therefore shall be documented.

III. INDIVIDUALIZED TREATMENT AND DISCHARGE PLAN IN INPATIENT SETTINGS

A. Recipients admitted to a State psychiatric facility or community psychiatric facility or unit have the right to treatment according to a written individualized treatment and discharge plan that shall be incorporated into the recipient's ISP as a discrete sub-part.

B. Treatment and discharge plans shall be based upon consideration of the recipient's housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional, and psychiatric and/or psychological strengths and needs as well as his or her potential need for crisis intervention and resolution services following discharge. Assessments shall be conducted by hospital personnel with appropriate credentials. These assessments shall be updated as frequently as changed circumstances may require, but no less frequently than the standards of the individual professional discipline dictate in order to assure that the information is current and reliable. The treatment and discharge plan shall include a description of the manner of delivery of each service to be provided. The manner of delivery shall be one that maximizes the recipient's strengths, independence and integration into the community. The names of the service providers and their performance expectations will be included in the plan.

C. The plan shall be developed by an inter-disciplinary team that includes the recipient and hospital staff representing the disciplines of social work, psychiatry, psychology, and nursing, except that in community hospitals and units, psychology will be represented when clinically indicated. Other hospital personnel, and other individuals from the community with whom the recipient has authorized the exchange of information and who are needed to assure that the recipient's needs are adequately assessed and that appropriate recommendations are made, shall be included on the team. One of the hospital staff team members shall be designated as a recipient's team coordinator.

D. The team coordinator or designee shall notify the recipient of all treatment and discharge planning meetings and invite and actively encourage the recipient to attend. If a recipient does not attend the meeting, the team coordinator or designee shall relay the recipient's views on issues to other members of the team. A recipient's guardian, if any, shall also be notified of all treatment and discharge planning meetings and shall be invited to attend. The recipient may invite other persons to his or her treatment and discharge planning meeting, and the team coordinator or designee shall encourage him or her to do so. Notices required by this paragraph shall be given by the team coordinator or designee at least two days in advance of the meeting date, with the following exception: When a meeting is being convened to address an emergency, or is called to formulate a preliminary or initial treatment and discharge plan, notice reasonable for the circumstances shall be required.

E. All recipients shall have a preliminary treatment and discharge plan developed within three working days of admission and a treatment and discharge plan within seven days thereafter. This plan shall be reviewed and revised as frequently as necessary, but in no case less frequently than within 30 days of development, every 60 days thereafter for the first year, and every 90 days thereafter.

Deleted: 1

F. Complete histories shall be obtained from the recipient, community service providers, and to the extent possible, from other individuals in the community as authorized by the recipient or guardian. Upon learning that a recipient has had a prior psychiatric hospitalization, the team coordinator or designee shall request the recipient's consent to the release of the records of that hospitalization to the inpatient facility where the recipient is currently hospitalized. If consent is given, the team coordinator shall, within two working days, send for copies of the records. These records shall be reviewed upon arrival and, to the extent of their relevance, shall be considered in the review of the recipient's treatment and discharge plan.

G. In addition to the foregoing requirements, the treatment and discharge plan shall be based upon a comprehensive assessment of the recipient, and shall meet the following standards:

1. Goals that must be met in order for the recipient to meet discharge criteria shall be clearly noted.

2. At each review, the team shall assess whether the recipient may be safely discharged.

3. The treatment and discharge plan shall include a description of any physical handicap and any accommodations necessary to provide the same or equal services and benefits as those afforded non-disabled individuals.

4. A description of short-term and long-range treatment goals, with a projection of when such goals will be obtained;

5. A statement of the rationale or reason for utilizing a particular form of treatment will be included;

6. A specification of treatment responsibility, including both staff and recipient responsibility and involvement to attain treatment goals will be noted;

7. Criteria for discharge or release to a less restrictive treatment setting will be included; and

8. Documentation of current discharge planning will be included.

H. Limitations

1. Such a plan must describe any limitation of rights or liberties. Such a limitation shall be based upon professional judgment and may include a determination that the recipient is a danger to him or herself or to others absent such limitation. Any limitation shall meet criteria outlined for the limitation in other sections of these rules.

2. When any limitation is included, the treatment and discharge plan shall address the specific limitation, and the restriction shall be subject to periodic review. When possible, the limitation shall be time specific.

3. Whenever possible specific treatment shall be developed to address the basis of the limitation.

4. Documentation regarding the limitation shall include documentation as per H.1. through 3. above and shall include specific criteria for removal of the limitation.

I. A copy of the treatment and discharge plan shall be offered to each recipient, to a guardian, if any, and to a recipient's representative if confidentiality has been waived pursuant to Section A.IX.

J. All facilities or agencies shall maintain specific written guidelines describing their practices concerning development of treatment and discharge plans.

K. Discharge or termination

1. Each recipient has the right to be informed of and referred to appropriate resources upon discharge or termination from a facility or program.

2. Each recipient has the right to a treatment and discharge plan and to assisted referral to existing resources in such areas as transportation, housing, residential support services, crisis intervention and resolution services, vocational opportunities and training, family support, recreational/social/vocational opportunities, financial assistance, and treatment options. Recommendations made in treatment and discharge plans shall not require the facility or department to provide recommended goods or service.

3. Upon a recipient's discharge from an inpatient facility, the facility shall provide each recipient with a written list of his or her prescribed medication, dosage levels, schedules, and side-effects. A copy of the medication list and the aftercare plan shall be sent to the recipient's guardian and to the recipient's representative upon the recipient's request.

4. Notification

a. The recipient's representative, with the permission of the recipient, and the recipient's guardian, shall be notified of and, if the representative, or guardian is available, involved in any treatment and discharge planning. Involvement may include, but need not be limited to, participation in any discharge planning meeting. Invited persons who cannot attend shall be notified that they may submit information in writing for consideration at the meeting.

b. The recipient's guardian shall be given prior notification of the recipient's discharge from an inpatient facility, if possible. Upon the recipient's request, his or her representative shall be notified, if possible. At least twenty-four hour notice shall be given in planned discharges, if possible. In the case of other discharges, the notice shall be given as quickly as possible. Good faith efforts shall be made to notify guardians or representatives, and such efforts shall be documented.

c. A family member designated by the recipient shall, if possible, receive notification of the recipient's discharge from inpatient facilities, pursuant to subsection 4(b) above. The recipient shall be informed prior to the notification.

L. Exceptions

1. A recipient may choose not to be involved in developing his or her treatment and discharge plan and may refuse treatment and discharge planning or services. All such cases shall be documented in the recipient's permanent treatment record.

2. A guardian shall be actively involved in the treatment and discharge planning, to the maximum extent possible. A public guardian has an affirmative duty to be fully and actively involved in treatment discussions and discharge planning.

Deleted: ¶

IV. INDIVIDUALIZED TREATMENT OR SERVICE PLAN IN RESIDENTIAL SETTINGS

A. Recipients have the right to an individualized treatment or service plan. For recipients who have an ISP, the ISP process will provide the foundation of the development of the treatment or service plan.

B. Treatment or service plans shall, in instances in which the recipient has an ISP, be based upon the life plan, needs, targets and action plans developed in the ISP process. Treatment or service plans shall be based upon an individualized assessment of the recipient's housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional, and psychiatric and/or psychological strengths and needs as well as their potential need for crisis intervention and resolution services. Each facility or agency shall fully consider the least restrictive appropriate treatment and related services taking into account factors that are supportive of each recipient's exercise of his or her basic rights, consistent with each individual's strengths, needs and treatment requirements, pursuant to this section and sections III and IV of these rules. Such considerations shall include accommodation of particular needs involving communication and physical accessibility to all treatment programs.

C. The recipient or guardian, shall be fully and actively involved in the development or revision of the treatment or service plan. Upon the request of the recipient, the recipient's representative or family members designated by the recipient shall be included in the development or revision of the treatment or service plan. Each agency program or facility shall give 10 days' notice of any treatment or service planning meetings, to the recipient's guardian, and designated representatives. If the meeting is being convened to address an emergency, notice reasonable for the circumstances shall be required. Invited persons shall be notified that, if they are unable to attend a treatment or service planning meeting, they may submit information in writing for consideration at the meeting.

D. Treatment or service plans shall be developed within 20 days of initiation of service and shall thereafter be reviewed and revised no less frequently than every 90 days. Plans may be reviewed more frequently as necessary to address substantial changes in a recipient's life, such as hospitalization.

E. Treatment or service plans shall be developed by a team consisting of the recipient and others among whom the recipient has authorized the exchange of information and who are needed to ensure that the recipient's needs are adequately assessed and that appropriate recommendations are made, based upon a comprehensive assessment of the recipient. The plan shall contain but need not be limited to:

1. A statement of the recipient's specific strengths and needs. The treatment or service plan should include a description of any physical handicap and any accommodations necessary to provide the same or equal services and benefits as those afforded non-disabled individuals.

2. A description of services to assist the recipient in meeting identified needs. Goals shall be written for each service. Short-range objectives shall be stated such that their achievement leads to the attainment of overall goals. Objectives shall be stated in terms that allow objective measurement of progress and that the recipient, to the maximum extent possible, both understands and adopts.

3. A description of services based on the actual needs as expressed or approved by the recipient rather than on what services are currently available. If at the time of the meeting, team members know on the basis of reliable information that the needed services are unavailable, they shall note them as "unmet service needs" on the treatment or service plan and develop an interim plan based upon available services that meet, as nearly as possible, the actual needs of the recipient.

4. A description of the manner of delivery of each service to be provided. The manner of delivery shall be one that maximizes the recipient's strengths, independence and integration into the community.

5. A statement of the rationale or reason for utilizing the described treatment or services to meet such goals;

6. A specification of treatment or service responsibility, including both staff and recipient responsibility and involvement to attain treatment or service goals; and

7. Documentation of current discharge planning.

F. Within one week of the meeting, the recipient shall be offered a written copy of the treatment or service plan. The recipient shall also be notified, by means he or she shall most likely understand, of the process to pursue, up to and including the right to file a grievance if he or she disagrees with any aspect of the plan or the assessments upon which the plan is based, or is later dissatisfied with the plan's implementation.

G. Limitations

1. Such a plan must describe any limitation of rights or liberties. Such a limitation shall be based upon professional judgment and may include a determination that the recipient is a danger to him or herself or to others absent such limitation. Any limitation shall meet criteria outlined for the limitation in other sections of these rules.

2. When any limitation occurs, the treatment plan shall address the specific limitation, and the restriction shall be subject to periodic review. When possible, the limitation shall be time specific.

3. Whenever possible specific treatment shall be developed to address the basis of the limitation.

4. Documentation regarding the limitation shall include documentation as per G.1., 2. and 3. above and shall include specific criteria for removal of the limitation.

H. A copy of the treatment or service plan shall also be offered to the recipient's guardian, if any, and to recipient's representative, if confidentiality has been waived.

I. All agencies shall maintain specific written guidelines describing their practices concerning development of treatment or service plans.

J. Recipients who have had a community support worker assigned to them have the right to a variety of appropriate services from the community support worker, including the following, when pertinent to meeting a recipient's need for services:

1. assistance in locating services;

2. continuing monitoring of the services provided;

3. notification of ISP meetings and coordination of the ISP;

4. participation in the recipient's hospital discharge planning meeting; and

5. assistance in the exploration of lesser restrictive alternatives to hospitalization.

K. Discharge

1. Each recipient has the right to be referred to appropriate resources prior to discharge from a program.

2. Each recipient has the right to a comprehensive discharge plan and to assisted referral to existing resources in such areas such as transportation, housing, financial assistance, and mental health treatment. Recommendations made in discharge plans shall not require the agency or department to provide recommended goods or service.

3. Notification

a. The recipient's representative, upon request of the recipient, and the recipient's guardian, shall be notified of and, if the representative, or guardian is available, involved in any discharge planning. Involvement may include, but not be limited to, participation in a discharge planning meeting.

L. Exceptions

1. No treatment or service plan is required for recipients who solely received informal social support and recreation in drop-in mental health programs or social clubs.

2. A recipient may choose not to be involved in developing his or her treatment or service plan and may refuse planning.

3. A legally responsible guardian shall be actively involved in treatment or service planning, to the maximum extent possible. A public guardian has an affirmative duty to be fully and actively involved in treatment or service planning.

V. INFORMED CONSENT TO TREATMENT

A. Right to informed consent. Recipients have the right to informed consent for all treatment.

B. Statement of purpose. This rule has the following purposes:

1. To promote respect for individual autonomy and recipient participation in decision-making;

2. To ensure that, whenever possible, the informed consent of a recipient is obtained prior to treatment;

3. To avoid, whenever possible, forcible imposition of any treatment;

4. To provide reasonable standards and procedural mechanisms for determining when to treat a recipient absent his or her informed consent, consistent with applicable law; and

5. To ensure that the recipient is fully protected against the unwarranted exercise of the state's parens patriae power.

C. Treatment of recipients. All recipients with unimpaired capacity have the right to consent to or to refuse treatment, absent an emergency. Treatment may be provided to a recipient only when:

1. Informed consent for the treatment has been obtained from the recipient; or

2. The recipient has been judged by a court of competent jurisdiction to lack capacity to give informed consent to the particular treatment, and the informed consent of the recipient's guardian has been obtained; or

3. The recipient has been found to lack clinical capacity to give informed consent to the particular treatment pursuant to subsections D and E of this rule and:

a. in the case of an inpatient recipient willing to comply with treatment, approval of the treatment is being processed in a timely fashion or has been obtained in accordance with subsection E(2) of this rule; or

b. in the case of a recipient willing to comply with treatment in a residential facility or program, the provisions of E(3) have been followed; or

c. in the case of an involuntary inpatient recipient unwilling to consent to treatment, treatment may be provided in accordance with the procedures and standards provided in subsection F of this section; or

4. An emergency exists, as defined in subsection H of this rule, and the emergency procedures required by sub-section H are observed.

D. Informed consent to treatment. Informed consent to treatment is obtained only where the recipient possesses capacity to make a reasoned decision regarding the treatment, the recipient or the recipient's guardian is provided with adequate information concerning the treatment, and the recipient or guardian makes a voluntary choice in favor of the treatment. Informed consent must be documented in each case in accordance with this section.

1. Capacity. Capacity means sufficient understanding to comprehend the information outlined in section (D)(2) and to make a responsible decision concerning a particular treatment. Recipients are legally presumed to possess capacity to give informed consent to treatment unless the recipient has been judged by a court of competent jurisdiction to lack capacity generally, or to lack capacity to give informed consent to a particular treatment.

2. Adequate information. The licensed, certified or other qualified mental health professional recommending a particular treatment shall provide to the recipient, or guardian, all information relevant to the formulation of a reasoned decision concerning such treatment.

The recipient shall have the right to have a person of his or her choice present during the presentation of this information, provided that the nominee can be available within 48 hours, or within such other reasonable period as may be agreed upon; and the recipient, or guardian, shall be informed of this right. The information may be provided orally, in sign language or in writing, shall be communicated in terms designed to be comprehensible to a lay person, and shall include, without limitation:

a. An assessment of the recipient's condition and needs, including the specific signs, symptoms or behaviors that any proposed medication is intended to relieve;

b. The nature of the proposed treatment, and a statement of the reasons why the professional believes it to be indicated in the recipient's case;

c. The expected benefits of the treatment, and the known risks that it entails, including precautions, contraindications, and potential adverse effects of any proposed medication;

d. The anticipated duration of the treatment;

e. A statement of reasonable alternatives to the proposed treatment, if any;

f. Information as to where the recipient may obtain answers to further questions concerning the treatment; and

g. A clear statement that the recipient has the right to give or withhold consent to the proposed treatment.

3. Voluntary choice. Consent to treatment must be given willingly in all cases, and may not be obtained through coercion or dec ption. Special care shall be taken to assure that consent is voluntary where the recipient's status as an involuntary inpatient militates against truly voluntary consent.

A recipient or guardian's initial refusal of treatment shall not preclude renewed attempts to obtain the recipient's willing consent; and a recipient's initial willing consent shall not preclude the recipient from validly withdrawing such consent at any time before or during treatment.

4. Documentation. The informed consent of a recipient or his or her guardian to a particular treatment shall be documented to show:

a. From whom consent is obtained, whether recipient or guardian;

b. If consent is given by the recipient, a signed statement that the recipient possesses capacity to give informed consent;

c. That adequate information, including at a minimum all the elements listed in section D(2) of this rule, was provided;

d. The signature of the recipient or, where applicable, the signature of a guardian, indicating consent. In residential programs, a signature is necessary for psychotropic medication treatment only.

e. Exceptions to Written Consent

In cases of unanticipated treatment needs, the informed consent of a guardian may be obtained by telephone, but that oral consent shall be confirmed in writing in accordance with this section as soon as practicable.

E. Recipients with clinical incapacity.

1. Administrative finding. Where a licensed, certified or other qualified mental health professional recommending a particular treatment determines that, in his or her opinion, a recipient not having a guardian lacks clinical capacity to give informed consent to the treatment under subsection D, he or she shall, by means of a written statement to that effect, refer the recipient to a physician or licensed clinical psychologist not directly responsible for the recipient's treatment for an examination in regard to capacity. The physician or clinical psychologist to whom the recipient is referred shall conduct the examination, and shall make a documented finding that the recipient either possesses or lacks clinical capacity to give informed consent to the particular treatment.

a. Finding of capacity. Where the recipient is found to possess capacity to consent to treatment by the physician or licensed clinical psychologist, he shall be referred back to the licensed, certified or other qualified mental health professional recommending the treatment for the processing of his or her informed consent to or refusal of such treatment.

b. Finding of clinical incapacity. Where the recipient is found to lack clinical capacity to consent to treatment by the physician or licensed clinical psychologist, he shall be referred back to the licensed, certified or other qualified mental health professional recommending the treatment for a documented determination as to whether the recipient, notwithstanding lack of clinical capacity, is willing to comply with or refuses the proposed treatment.

Such determination must be based upon the provision to the recipient of adequate information as required by subsection D(2) of this rule.

If an inpatient recipient is willing to comply with treatment, the procedure outlined in subsection E(2) shall be followed. If a recipient in a residential program is willing to comply with treatment, the procedure outlined in subsection E(3) shall be followed. If any recipient refuses treatment, the procedure outlined in subsection E(4) and, in the case of inpatient recipients, if applicable, subsection (F) shall be followed.

c. Notice. Where the recipient is found to lack clinical capacity pursuant to this section, the licensed, certified or other qualified mental health professional recommending the treatment shall notify the following persons of such finding:

i. the Office of Advocacy and the rights protection and advocacy agency of the Maine mental health system;

ii. the recipient's next of kin, if the recipient does not object;

iii. the recipient's designated representative, if the recipient has waived his or her confidentiality with respect to such representative; and

iv. the head of the mental health facility.

Such notice shall include a copy of the documented administrative finding, and shall state that the recipient has been found to lack clinical capacity to give informed consent to a particular treatment; that notwithstanding such finding, the recipient may refuse treatment; and that in the case of involuntary, inpatient recipients, treatment shall not be administered unless authorized by a hearing officer following an administrative hearing held in accordance with subsection F of this rule.

2. Inpatient recipients with clinical incapacity, compliant. This subsection shall apply where it is determined pursuant to subsection E(1)(b) above that an inpatient recipient with clinical incapacity is willing to comply with the proposed treatment. In such case:

a. Treatment may be authorized by the licensed, certified or other qualified mental health professional for a period not to exceed 72 hours. Treatment may continue beyond such period only if approval of the head of the mental health facility is obtained prior to treatment in accordance with subsection E(2)(c) below. The professional shall document:

i. the nature of the proposed treatment, including expected benefits, known risks and any alternatives and a statement of the reasons why he believes the treatment to be a necessary part of the recipient's treatment plan;

ii. that the recipient lacks clinical capacity pursuant to the provisions of section E(1) above; and

iii. that the recipient is willing to comply with the proposed treatment.

Such documentation shall be immediately forwarded to the Clinical Director of a mental health institute or his or her equivalent in any other mental health facility and to the resident advocate in a state mental health institute.

b. Within 48 hours of any authorization to treat under section E(2)(a) above, the Clinical Director or his or her equivalent shall review the documentation required by that section and shall make a written report to the head of the mental health facility as to whether or not, in his or her opinion

i. the recommendation of the proposed treatment is based on an adequately substantiated exercise of professional judgment;

ii. the proposed treatment is the least intrusive appropriate treatment available under the circumstances; and shall include a brief statement of the reasons for his or her opinion. A copy of such report shall be immediately forwarded to the resident advocate in a state mental health institute.

c. If the Clinical Director or his or her equivalent reports an affirmative opinion as to both elements set forth in section E(2)(b)(i) and (ii) above, the head of the mental health facility may, following due consideration of the circumstances of the particular case, approve treatment on behalf of the recipient. Such approval shall authorize administration of the proposed treatment to the recipient for a period not to exceed sixty days. The recipient shall be monitored throughout such period for any change in regard to capacity, and at the latest upon expiration of such period, the recipient shall be re-examined in accordance with section E(1) above.

d. If the Clinical Director or his or her equivalent reports a negative opinion as to either element set forth in sections E(2)(b)(i) and (ii) above, the head of the mental health facility shall not approve treatment, and treatment shall not be continued beyond the 72 hour period authorized in accordance with section E(2)(a) above until informed consent for treatment can be obtained from a legal decision-maker.

3. Recipients in residential settings with clinical incapacity, compliant. This subsection shall apply where it is determined pursuant to subsection (E)(l)(b) that a recipient in a residential setting with clinical incapacity is willing to comply with the proposed treatment. In such case treatment may be provided only if:

a. Protective proceedings are initiated in accordance with law; and

b. A licensed, certified or other qualified mental health professional follows the procedures outlined in subsection (D) and, where applicable, subsection (E) on at least an annual basis.

4. Recipients with clinical incapacity, refusing. This subsection shall apply where it is determined pursuant to subsection E(1)(b) above that a recipient with clinical incapacity is refusing the proposed treatment.

a. Alternative treatment meeting. The licensed, certified or other qualified mental health professional recommending the treatment and a representative of the treatment team shall meet with the recipient to explore the reasons for the recipient's refusal and to discuss any appropriate alternatives to the proposed

treatment that may be available and that may include behavioral, psychological, medical, social, psychosocial or rehabilitative treatment methods.

The purpose of the meeting shall be to elaborate in an informal setting an alternative treatment that is both professionally justified and acceptable to the recipient. If agreement can be reached as to an alternative treatment, review by the Clinical Director or equivalent and approval by the head of the mental health facility, if appropriate, of such treatment shall be processed in accordance with subsection E(2) or E(3) above.

b. Voluntary or outpatient recipient, no agreement. Where no agreement can be reached as to an alternative treatment, and the recipient is a voluntary recipient at an inpatient facility or a recipient at an outpatient facility, the licensed, certified or other qualified mental health professional recommending the proposed treatment shall report in writing to the head of the facility concerning the outcome of the meeting held pursuant to subsection E(4)(a) above.

The head of the inpatient or residential facility or designee may discharge a voluntary recipient from the facility. Any such discharge shall be made in accordance with the section III, subsection J and section IV, subsection K of this part.

c. Involuntary recipient, no agreement; request for hearing. Where no agreement can be reached as to an alternative treatment in the case of a recipient who is an involuntary recipient at an inpatient facility and the licensed, certified or other qualified mental health professional recommending the proposed treatment continues to believe, in the exercise of his or her professional judgment, that the proposed treatment would be in the recipient's best interest, either the professional or the recipient may request that an administrative hearing be held for the purpose of deciding whether or not treatment may be administered, in accordance with subsection F of this rule. Such request shall be directed to the head of the mental health facility.

F. Administrative hearing.

1. When afforded. An administrative hearing for the purpose of deciding whether or not a proposed treatment may be administered shall be afforded in all cases where each of the following conditions is met:

a. Where an involuntary recipient at an inpatient facility lacks clinical capacity pursuant to subsection E(1) of this rule; and

b. Where it has been determined that the recipient is refusing a proposed treatment pursuant to subsection E(1)(b) of this rule; and

c. Where no agreement as to an alternative treatment has been reached following a meeting held pursuant to subsection E(4)(a) of this rule; and

d. Where the licensed, certified or other qualified mental health professional recommending the proposed treatment continues to believe, in the exercise of his or her professional judgment, that the proposed treatment would be in the recipient's best interest pursuant to subsection E(4)(c) of this rule; and

e. Where the licensed, certified or other qualified mental health professional recommending the proposed treatment or the recipient requests an administrative hearing pursuant to subsection E(4)(c) of this rule.

2. Time frame. An administrative hearing shall be held as soon as possible but in no event later than 10 working days from the date of the request. On motion by any party, the hearing may be continued for cause for a period not to exceed 10 additional working days.

3. Notice. Upon receipt of a request for an administrative hearing pursuant to subsection E(4)(c) of this rule, the head of a mental health facility or his or her designee shall provide adequate and timely notice of such request and of the date set for hearing at least 5 working days prior to the date set for hearing to:

a. the recipient;

b. the recipient's attorney, if any;

c. one person designated by the recipient; and

d. the Clinical Director of a mental health institute or his or her equivalent in any other mental health facility.

4. Parties. The mental health facility and the recipient shall be parties to the administrative hearing, and shall have the right to call and cross-examine witnesses and introduce relevant evidence.

5. Right to counsel. The recipient shall have the right to be represented by counsel at the administrative hearing. Upon receipt of a request for hearing pursuant to subsection E(4)(c) of this rule, the head of the mental health facility or designee shall inform the recipient of his or her right to counsel, and ascertain whether the recipient is already represented by counsel, or specifically desires to employ his or her own counsel. If the recipient is not already represented, does not specifically desire to employ his or her own counsel, and does not explicitly refuse representation by appointed counsel, the head of the mental health facility or designee shall appoint counsel to represent the recipient. The Bureau shall maintain a list of attorneys from which such appointed counsel shall be

selected. In cases where the recipient is not represented by counsel and refuses representation by appointed counsel, the head of the mental health facility or designee shall request that a representative of the rights protection and advocacy agency of the Maine mental health system contact the recipient in an effort to arrange to represent the recipient. If the recipient refuses such representation, the representative of the rights protection and advocacy agency shall nevertheless attend the hearing as an observer.

6. Medical Records. The recipient shall have access, upon request, to his or her medical records to prepare for the hearing within one working day of his or her request.

7. Hearing officer. An independent hearing officer shall preside at the administrative hearing.

8. Informal setting; mediation.

a. The hearing shall be conducted in an informal setting and atmosphere.

b. The hearing officer shall open the hearing by exploring with the parties the reasons why they were unable to agree to an alternative treatment pursuant to subsection E(3)(a) of this rule and shall attempt to mediate a solution. Where no mediated solution is reached, the hearing officer shall proceed with the hearing in accordance with subsections F(9) - (11) below.

9. Burden on facility. The hearing officer shall authorize treatment of the recipient over his or her objection and absent his or her informed consent only if the recipient fails to make the affirmative showing under subsection 10 below and the facility is able to make a clear and convincing showing on each of the following four factors:

a. That the recipient lacks capacity to make a decision in regard to the particular treatment as outlined in subsection D of these rules. For purposes of this showing, the administrative finding of clinical incapacity made pursuant to subsection E(1) of this rule is not conclusive, and the recipient's refusal of treatment is not evidence of incapacity; AND

b. That the proposed treatment is based on an adequately substantiated exercise of professional judgment; AND

c. That the benefits of the proposed treatment outweigh the risks and possible side-effects; AND

d. That the proposed treatment is the least intrusive appropriate treatment available under the circumstances.

10. Affirmative showing by recipient. The hearing officer shall not authorize treatment of the recipient over his or her objection and absent his or her informed consent if the recipient affirmatively shows that, if he possessed capacity, he would have refused the proposed treatment on religious grounds or on the basis of other previously expressed personal convictions or beliefs.

11. Decision

a. Ruling

i. Denial of treatment

Where the facility fails to carry its burden as required by subsection F(9) above in any respect, or where the recipient makes the affirmative showing pursuant to subsection F(10), the hearing officer shall rule that the proposed treatment shall not be administered to the recipient.

ii. Approval of treatment

Where the facility carries its burden in all respects, and the recipient fails to make the affirmative showing pursuant to subsection F(10), the hearing officer shall rule that the proposed treatment shall be administered to the recipient in the exercise of the state's parens patriae power.

b. The hearing officer may announce his or her decision at the conclusion of the hearing and shall, in any event, issue a written decision detailing his or her conclusions and reasoning within 3 working days of the hearing.

c. If the hearing officer decides that treatment may be administered, treatment may begin one full working day after the decision is announced, unless stayed by order of court. The hearing officer's decision shall be effective for a period not to exceed sixty days from the date on which treatment is begun. The recipient shall be monitored throughout such period for any change in regard to capacity, and, at the latest, upon expiration of such period, the recipient shall be re-examined in accordance with subsection E(1) of this rule.

d. The hearing officer's decision shall constitute final agency action and may be appealed to Superior Court pursuant to the Maine Administrative Procedure Act, 5 M.R.S.A. s 11001 et seq. If the issue of incapacity of the recipient is raised on appeal, the Superior Court may conduct a hearing de novo on such issue.

e. An electronic recording of the hearing shall be made, and an accurate transcription thereof shall constitute the administrative record for purposes of an appeal.

f. The hearing shall be confidential and no report of the proceedings may be released to the public or press, except by permission of the recipient, his or her counsel and with the approval of the presiding hearing officer.

G. Notice; protective proceedings. In all cases where an administrative finding of clinical incapacity is made, the head of the mental health facility shall be notified immediately. If treatment is authorized for a 60-day period pursuant to subsection E(2)(c) or subsection F(11) of this rule, the head of the mental health facility or designee shall, within such 60-day period, notify the family, public guardian or other appropriate party of the potential need for protective proceedings. No renewal of treatment pursuant to subsections E(2)(c) or F(11) shall be authorized unless and until the notice required by this subsection has been given and documented.

H. Emergency treatment

1. Definition. An emergency is defined as a situation where, as a result of a recipient's behavior due to mental illness, there exists a risk of imminent bodily injury to the recipient or to others.

2. Declaration of emergency. A licensed physician [or physician extender] may declare an emergency when he reasonably believes an emergency exists as defined in subsection G(1) above, and when

a. A recognized form of treatment is required immediately to ensure the physical safety of the recipient or of others; and

b. No-one legally entitled to consent on the recipient's behalf is available; and

c. A reasonable person concerned for the physical safety of the recipient or of others would consent under the circumstances.

3. At no time may a physician or physician extender declare an emergency merely because the recipient refuses treatment.

4. Documentation. When an emergency is declared, documentation of the emergency shall be immediately entered into the recipient's permanent treatment record and, if declared by a physician extender, endorsed within 24 hours by the physician. Such documentation by the physician or physician extender shall include the following:

a. A description of the behaviors that he has observed, and that created the emergency;

b. The period, not to exceed 72 hours, during which the medication may be administered;

c. The expected benefits of the order; and

d. The specific behaviors or physical responses that staff should monitor and record, and the means they should use.

5. Emergency treatment. Following a declaration of emergency pursuant to subsection H(2) above, a licensed physician or a person acting under his or her direction may administer a recognized form of treatment over the recipient's objection and absent his or her informed consent. Treatment imposed following a declaration of emergency may continue for a period not to exceed 72 consecutive hours.

6. Notice and review. The administrative head of the facility and the Clinical Director or his or her equivalent shall be notified, as soon as possible, of any emergency. Any renewal of emergency treatment requires review by and the written authorization of the Clinical Director of a mental health institute or his or her equivalent in any other mental health facility. Additionally, an order for continued medication may be entered only upon compliance with the foregoing provisions of this sub-section and, if the recipient lacks capacity, only upon consent of the guardian or initiation of administrative hearing proceedings described in sub-section (F) above.

I. Electroconvulsive Therapy (ECT). ECT treatment shall not be administered to a recipient except as provided in these rules. The authorized treating professional seeking to administer ECT treatment shall:

1. Obtain written informed consent for such procedure according to the procedures outlined in Section IV of this part from:

a. the recipient, or

b. from a court of competent jurisdiction, in the case of a clinically incapacitated recipient, or

c. from a guardian or other legal decision maker for an incapacitated recipient who has a guardian;

2. ECT treatment shall not be authorized pursuant to Section IV(E)-(H) of this part.

J. Psychosurgery. Psychosurgery shall only be performed on an adult recipient upon order of a court of competent jurisdiction.

K. Documentation. All documentation required by this rule shall be made a part of the recipient's clinical chart.

VI. BASIC RIGHTS

A. Recipients have the right to freedom of association and communication.

B. Recipient's Right to Visitors

1. Each facility shall establish the most liberal visiting policies that are administratively feasible.

a. Each facility shall establish regular daily visiting hours. Such hours shall be prominently posted in the facility. Visitation during these hours shall not require prior notification or request by either the recipient or the visitor except when such visits would conflict with regularly scheduled therapeutic activities of which the recipient has been notified.

b. Recipients have the right to refuse or terminate visitation from specific visitors or all visitors.

2. Suitable areas shall be provided by the facility for privacy during visitation.

3. The facility shall provide unrestricted visitation by a recipient's attorney, clergy, professional service provider or advocate of the rights protection or advocacy services of the Maine mental health system, accompanied by a sign language interpreter, if needed, at any reasonable time.

4. Exceptions

a. When a physician or licensed clinical psychologist treating a recipient determines, in consultation with the treatment team, that denial of access to a particular visitor or visitors, except those visitors listed in subsection 3 above, is necessary for treatment, or for security purposes in the case of forensic recipients, such professional may, for a specific limited and reasonable period of time, deny such access.

i. A written order denying such visitation including the reasons for the denial, shall be entered into the recipient's permanent treatment record.

ii. Any limitation of this right shall be explained to the recipient and to the specifically restricted visitor, and when appropriate to the recipient's family or any other regular visitors. Those same people shall be immediately notified, if possible, when the restrictions on visitation have been lifted.

iii. Any limitation on visitation may be appealed by the recipient or by the specifically restricted visitor, if aggrieved, through the grievance mechanism as outlined in Section V.

C. Recipient's Right to Communicate by Mail

1. No facility shall censor, delay or restrict incoming or outgoing letters or packages. Incoming letters and packages shall be delivered sealed and unopened to the recipient, and outgoing letters and packages shall be mailed in like manner.

2. Writing materials and postage funds adequate to mail at least one letter per day shall be provided to inpatient recipients who are unable to procure such items.

3. Exceptions

a. If staff of a facility reasonable believes that mail contains contraband, such mail may, upon the written order of a physician or Chief Administrative Officer, be subjected to physical examination in the recipient's presence if appropriate.

b. Any illegal it found during such an examination may be confiscated by the facility.

c. Any other contraband shall be held in safekeeping, and returned to the recipient upon discharge, except that no medication shall be released without the authorization of a physician.

d. Any exception to the right to communicate by mail under subsection (a) above must be explained to the recipient. The justification for any such exception, and an itemized list of any materials confiscated must be documented in the recipient's permanent trea ment record.

e. Additional procedures may be developed to assure security in the cases of forensic recipients.

D. Recipient's Right to Communicate by Telephone.

1. Each inpatient and residential treatment facility shall provide all recipients reasonable access to telephones for placing and receiving confidential calls, including access to telecommunication devices for the deaf, when necessary.

2. Each inpatient and residential treatment facility shall assure, at any reasonable time, a recipient's access to a telephone for contact with a particular designated family member, clergy, professional service provider, or personally designated representative. Reasonable time means from the hours of 7:00 a.m. - 10:00 p.m., daily. Telephone access to an

advocate of the rights protection and advocacy service or to an attorney shall be assured at all times.

3. Each inpatient facility shall provide use of telephones at no charge, or telephone usage funds in reasonable amounts, to recipients who would otherwise be unable to communicate with family or friends by telephone.

4. Exceptions

a. Upon the recommendation of a physician or licensed psychologist, the chief administrator of the facility may restrict a recipient's right to communicate by telephone when the facility is notified, by a person receiving calls, that the person is being harassed and wishes the calls to be curtailed or halted. Telephone restrictions shall apply only to those persons so notifying the facility.

b. Upon the recommendation of a physician or licensed psychologist, the chief administrator of the facility may restrict or monitor a recipient's right to communicate by telephone, if it is determined that the recipient has made obscene or threatening phone calls, or for other security reason in the case of forensic recipients.

c. If a physician or licensed psychologist determines, in consultation with the treatment team, that restrictions on asking or receiving telephone calls, except to those listed in 2 above, is necessary for treatment purposes, the physician or licensed clinical, psychologist may restrict the recipient's right to communicate for a specific limited and reasonable period of time, not to exceed one week without reauthorization.

i. Any such restrictions shall become incorporated in the recipient's treatment plan, and be a focus of treatment, pursuant to Section IX(F).

ii. An explanation of any such restrictions shall be given to the recipient's regular callers as designated by the recipient. The recipient's designated regular callers, so requesting, shall be immediately notified, if possible, when the restrictions on communication by telephone are lifted.

iii. Any limitation on telephone calling may be appealed by the recipient or specifically restricted caller, if aggrieved, through the grievance mechanism as outlined in Section V.

E. Recipients are entitled to receive individualized treatment, to have access to activities necessary to the achievement of their individualized treatment goals, to exercise daily, to recreate outdoors, and to exercise their religion.

F. At no time shall the entitlements or basic human rights set forth in this Section be treated as privileges that the recipient must earn by meeting certain standards of behavior.

VII. FREEDOM FROM UNNECESSARY SECLUSION AND RESTRAINT

A. Seclusion

1. Seclusion means the placement of a recipient alone in an isolation room from which exit is denied.

2. Seclusion may be employed only in the following instances:

a. when absolutely necessary to protect the recipient from causing physical harm to self or others; and

b. to prevent further serious disruption that significantly interferes with other recipients' treatment. Behaviors causing serious disruption that interferes with others' treatment may include uncontrollable screaming, public masturbation, indecent exposure and uncontrolled intrusiveness on other recipients. Use of seclusion may be appropriate in these circumstances if the behaviors cannot be controlled through lesser restrictive means than seclusion and if the behaviors will likely be controlled with the use of seclusion. Seclusion may not be used solely to address the comfort, convenience or anxiety of staff; to address factors related to ward or unit dynamics; to control a recipient's mild obnoxiousness, rudeness, obstinacy, use of profanity or other unpleasantness; nor as discipline for resolved behaviors.

Seclusion under these circumstances shall be employed in the following manner:

i. if the recipient is examined in person by a physician or physician extender prior to the implementation of seclusion; or

ii. by a registered nurse in telephone consultation with a physician or physician extender.

3. Seclusion may be used only if less restrictive measures are inappropriate or have proven to be ineffective.

4. The decision to place a recipient in seclusion shall be made by a physician or physician extender and shall be entered as a medical order in the recipient's records.

5. All recipients must be examined before being placed in seclusion in accordance with the following:

a. If the physician or physician extender is not immediately available to examine the recipient, the recipient may be placed in seclusion following an examination by a registered nurse if the registered nurse finds that the recipient poses a risk of imminent harm to self or others or following an examination by the nurse and with telephone consultation from the physician or physician extender in order to prevent further serious disruption that significantly interferes with other recipients' treatment. Any recipient placed in seclusion under these circumstances shall be kept under constant observation while awaiting an examination by a physician or physician extender.

b. The examination by the registered nurse shall be conducted in accordance with a protocol approved by the chief of psychiatry or medicine and by the Director of Nursing. The protocol must include the following:

i. A list of indicators for organic causes of changed behaviors.

ii. Elements for assessment including but not limited to:
known medical disorders;

a. the recipient's medications including PRN administrations;

b. mental status, with observation of behavior, speech, affect and suicidal/homicidal ideation;

c. brief neurological examination: pupil size and reactivity, gait, limb movement and strength;

d. vital signs; and

e. cognition using a standard tool.

iii. Provision for completion as soon as is clinically sound, those elements of assessment that require the recipient's cooperation and that the nurse may not be able to perform immediately due to the recipient's condition.

c. A physician or physician extender shall personally evaluate the recipient within 30 minutes after the recipient has been placed in seclusion. If the evaluation does not take place within 30 minutes, the reasons for the delay shall be documented in the recipient's record. This provision applies to all recipients, including those placed in seclusion during the night. Any recipient placed in seclusion shall be kept under constant observation while awaiting an examination by a physician or physician extender. The physician examination must be conducted as follows:

i. At Augusta Mental Health Institute the physician or physician extender examination shall be conducted in person in all instances.

ii. At all other facilities, the physician examination may be conducted via telephone consultation with the registered nurse and shall include consideration of the results of the nurse's formal assessment. The physician may order seclusion on the basis of this consultation and shall enter any additional orders for further assessments or treatment as appropriate. Thereafter a physician or physician extender shall examine the recipient in person:

a. within 1 hour when the registered nurse requests that a physician evaluate the recipient in person;

b. within 1 hour when the information is suggestive of organic causes that could lead to harm to the recipient;

c. within 1 hour if the recipient has not had a physical examination during the current hospital stay; and

d. within 12 hours in all other instances.

6. Documentation of the physician or physician extender's examination and, if applicable, the registered nurse's assessment must be entered in the recipient's file.

7. Staff who place recipients in seclusion shall have documented training in the proper techniques, in less restrictive alternatives to seclusion and in the detection of organic causes of behavioral disturbances.

8. As soon as possible, staff should make reasonable efforts to notify the recipient's parent, guardian or designated representative, if any, that the recipient has been placed in seclusion, and the reasons therefore.

9. Each order for initiation or extension of seclusion shall state the time of entry of the order. It shall state the number of hours the recipient may be secluded, not to exceed ten and the conditions under which the recipient may be sooner released.

10. No PRN orders for seclusion may be written and no treatment plan may include its use as a treatment approach.

11. The need for a recipient's continuation in seclusion shall be re-evaluated every 2 hours by a nurse. The nurse shall examine the recipient in person. This examination may be conducted outside the seclusion room. The nurse shall note the clinical reasons for selection of the examination site. The nurse shall assess the recipient to determine whether

he or she continues to pose a danger to self or others, or continues to cause serious disruption of other recipients' treatment (in cases in which an examining physician or physician extender has ordered seclusion for this reason). If the nurse finds danger and that the recipient continues to require seclusion, seclusion may be continued if the physician's or physician extender's order has not yet lapsed. Should the recipient not need continued seclusion, the nurse shall release the recipient even if the time frame of the original order has not yet elapsed.

12. A special progress record/check sheet shall be maintained for each use of seclusion and shall include the following documentation:

a. The indication for use of seclusion, i.e. whether a danger to self, others, or serious disruption of other recipients' treatment;

b. A description of the behaviors that constitute the recipient's danger to self, others, or serious disruption of other recipients' treatment;

c. A description of less restrictive alternatives used or considered, and a description of why these alternatives proved ineffective or why they were deemed inappropriate upon consideration.

13. All orders for the extension of seclusion shall include documentation as for an original order. If the recipient is examined outside of the seclusion room, progress notes shall additionally state where the recipient was examined and the clinical reasons for selecting the site.

14. Every recipient placed in seclusion shall be released, unless clinically contraindicated, at least every two hours to eat, drink, bathe, toilet and to meet any special medical orders.

15. Recipients placed in seclusion shall be given maximum observation and in no instance shall they be visually monitored less often than every 15 minutes.

16. A description of the recipient's behavior as observed shall be noted on the progress record/check sheet every 15 minutes.

17. The total amount of time that a recipient spends in seclusion may not exceed 24 hours unless:

a. The recipient is reassessed in accordance with the protocol described at 5(b) above;

b. The recipient is examined, at Augusta Mental Health Institute, by the director of psychiatry or clinical services and, in other hospitals, by a chief of

psychiatry or medicine or his or her physician designee. In cases where the chief or director is also th treating physician, he or she shall appoint another physician to conduct the required examination;

c. The order extending seclusion beyond a total of 24 hours is entered by the director of psychiatry or clinical services or by the chief of psychiatry or medicine following the examination of the recipient and consultation with the other examiners; and

d. The recipient's guardian or designated representative, if any, and if available, has been notified.

18. Records required by the above provisions shall be a part of the recipient's permanent record. At the mental health institutes, copies shall be forwarded to the medical director, the clinical services director and the recipient advocate. At all other facilities, copies shall be forwarded to the chief of psychiatry or medical services. For a period of one year following adoption of these regulations, these facilities shall submit summaries or copies of reports of each use of seclusion to the Division of Licensing of the Department of Behavioral and Developmental Services. Said reports to DMHMR shall be submitted on a quarterly basis, shall not contain information identifying the recipient by name but shall be reported in a manner to permit the reader to discern whether individual recipients have been secluded on repeat occasions.

19. Seclusion may be ordered on the basis of a recipient's self-report, provided the physician extender otherwise verified that the recipient meets the criteria of paragraph 2 above and provided the decision is otherwise clinically appropriate.

B. Restraint

1. Restraint is the immobilization of a recipient's arms, legs or entire body through the use of an apparatus that is not a protective device as described in sub-section VI.C below.

2. Restraint may be employed only when absolutely necessary to protect the recipient from serious physical injury to self or others and shall impose the least possible restriction consistent with its purpose.

3. Restraint may be used only after less restrictive measures have proven to be inappropriate or ineffective. The extent to which less restrictive measures are attempted at the time of the incident will be governed by the degree of risk of physical harm to the recipient or others.

4. The decision to place a recipient in restraint shall be made by a physician or a physician extender and shall be entered as a medical order in the recipient's records.

5. All recipients must be examined before being placed in restraint in accordance with the following:

a. If the physician or physician extender is not immediately available to examine the recipient, the recipient may be placed in restraint following examination by a registered nurse if the nurse finds that the recipient poses a risk of imminent harm to self or others.

b. The examination by the registered nurse shall be conducted in accordance with a protocol approved by the chief of psychiatry or medicine and by the Director of Nursing. The protocol must include the following:

i. A list of indicators for organic causes of changed behaviors.

ii. Elements for assessment, including but not limited to:
known medical disorders;

a. the recipient's medications including PRN medications;

b. mental status, with observation of behavior, speech, affect and suicidal/homicidal ideation;

c. brief neurological examination: pupil size and reactivity, gait, limb movement and strength;

d. vital signs; and

e. cognition using a standard tool.

iii. Provision for completion as soon as is clinically sound, those elements of assessment that require the recipient's cooperation and that the registered nurse may not be able to perform immediately due to the recipient's condition.

c. A physician or physician extender must thereafter examine the recipient within 30 minutes of the recipient's having been placed in restraint. If the evaluation does not take place within 30 minutes, the reasons for the delay shall be documented in the recipient's record. This provision applies to all recipients, including those placed in restraint during the night. The physician examination must be conducted as follows:

i. At Augusta Mental Health Institute the physician or physician extender examination shall be conducted in person in all instances.

ii. At all other facilities, the physician examination may be conducted via telephone consultation with the registered nurse and shall include consideration of the results of the registered nurse's formal assessment. The physician may order seclusion on the basis of this consultation and shall enter any additional orders for further assessments or treatment as appropriate. Thereafter a physician shall examine the recipient in person:

a. within 1 hour when the registered nurse requests that a physician evaluate the recipient in person;

b. within 1 hour when the information is suggestive of organic causes that could lead to harm to the recipient;

c. within 1 hour if the recipient has not had a physical examination during the current hospital stay; and

d. within six hours in all other instances.

6. Documentation of the physician or physician extender's examination and, if applicable, the registered nurse's assessment must be entered in the recipient's file.

7. Staff who place recipients in restraint shall have documented training in the proper techniques, in less restrictive alternatives to restraint and in the detection of organic causes of behavioral disturbances.

8. As soon as possible, staff should make reasonable efforts to notify the recipient's guardian, or designated representative, if any, that the recipient has been placed in restraint and the reasons therefore.

9. Each order for initiation or extension of restraint shall state the time of entry of the order. It shall state the number of hours the recipient may be restrained, not to exceed six, and the conditions under which the recipient may be sooner released.

10. No PRN orders for restraint may be written and no treatment plan may include its use as a treatment approach.

11. The need for a recipient's continuation in restraint shall be re-evaluated every two hours by a nurse. The nurse shall examine the recipient in person. This examination may be conducted with the recipient free of restraints. The nurse shall note the clinical reasons for selecting whether the recipient is examined in or free of restraints. The nurse shall assess the recipient to determine whether he or she continues to pose a danger of imminent injury to self or others. If the nurse finds such danger and that the recipient continues to require restraint, restraint use may be continued if the physician's or physician extender's

order has not yet lapsed. Should the recipient not need continued restraint, the nurse shall release the recipient even if the time frame of the original order has not yet elapsed.

12. A special progress/check sheet record shall be maintained for each use of restraint and shall include the following documentation:

a. The indication for use of restraint.

b. A description of the behaviors that constitute the recipient's danger to self or others.

c. A description of less restrictive alternatives used or considered, and a description of why these alternatives proved ineffective or why they were deemed inappropriate upon consideration.

13. In all facilities, the recipient shall be examined in person by a physician or physician extender before any order for restraint is extended. All orders for the extension of restraint shall include documentation as for an original order, but shall additionally state whether the recipient was examined in or free of restraints and the clinical reasons therefore.

14. Every recipient placed in restraint shall be frequently monitored and released as necessary to eat, drink, bathe, toilet, and to meet any special medical orders. Recipients in restraint shall have each extremity examined and the restraint loosened, sequentially, no less frequently than every 15 minutes. In instances in which blanket wraps are utilized for restraint, the recipient will be released and examined no less frequently than every hour.

15. Recipients in restraint shall be kept under constant observation.

16. A description of the recipient's behavior as observed shall be noted on the progress record/check sheet every 15 minutes.

17. The total amount of time that a recipient spends in restraint may not exceed 24 hours unless:

a. The recipient is reassessed in accordance with the protocol described at 5(b) above.

b. The recipient is examined, at Augusta Mental Health Institute, by the director of psychiatry or clinical services and in other hospitals, by a chief of psychiatry or medicine or his or her physician designee. In cases where the chief or director is also the treating physician, he or she shall appoint another physician to conduct the required examination.

c. The order extending restraint beyond a total of 24 hours is entered by the director of psychiatry or clinical services or by the chief of psychiatry or medicine following his or her examination of the recipient and consultation with the other examiners.

d. The recipient's guardian or designated representative, if any, has been notified.

18. Records required by the above provisions shall be made a part of the recipient's permanent record. At the mental health institutes, copies shall be forwarded to the medical director, the clinical services director and the recipient advocate. At all other facilities, copies shall be forwarded to the chief of psychiatry or medical services. For a period of one year following adoption of these regulations, these facilities shall submit summaries or copies of reports of each use of restraint to the Division of Licensing of the Department of Behavioral and Developmental Services. Said reports to DMHMR shall be submitted on a quarterly basis, shall not contain information identifying the recipient by name but shall be reported in a manner to permit the reader to discern whether individual patients have been restrained on repeat occasions.

19. If a recipient communicates via sign language, consideration will be given to restraining the recipient in such a manner as to permit the use of hands for communication purposes.

C. Protective Devices.

1. Protective devices that are used for medical reasons to ensure a recipient's safety and comfort, to provide recipient's stability during medical procedures, facilitate medical (non-psychiatric) treatment or safeguard health in the treatment of a health-related problem are exempt from the operation of the foregoing procedures governing the use of restraints. The following procedures for use of protective devices may never be used, however, as a substitute for those governing restraint or seclusion.

Examples of some protective devices are: bed-padding or bolsters to maintain a recipient's body alignment; devices for the immobilization of fractures; devices to permit the safe administration of intravenous solutions or to prevent their removal; protective equipment, such as mitts, to prevent the aggravation of the medical condition through scratching, rubbing or digging; helmets to protect the head from falls due to unsteadiness, seizures or self-injurious behavior; seat belts or vest restraints to prevent ambulation when it is medically contra-indicated or to permit a recipient, who for medical reasons could not do so unassisted, to remain in a seated position.

The use of protective devices shall be subject to the following:

a. The decision to use a protective device shall be made by a physician who has examined the recipient prior to its use. The decision shall be entered as a medical order in the recipient's record.

b. When ordering use of a protective device the physician shall select a device that interferes with the recipient's free movement and ability to interact with his or her environment to the least degree necessary to achieve the medical purpose for which the device is ordered.

c. Staff who use protective devices shall have the documented training in their application.

d. The need for the use of a protective device shall be re-evaluated bi-weekly by a physician who examines the recipient. Orders for devices that immobilize recipients shall be re-evaluated daily. If the physician determines that continued use of the protective device is clinically indicated, further use may be ordered. The order for extension of use shall be entered as a medical order in the recipient's record.

e. Protective devices that hamper a recipient's free movement, such as mitts or vest restraints, shall be removed every two hours, so that the recipient may be permitted free movement, unless the physician's order indicates that removal would interfere with the recipient's health care. The physician shall indicate in his or her order the level of staff supervision and assistance necessary during the recipient's periods of free movement. Where protective devices have been routinely used, the recipient's treatment plan will address ways of reducing or eliminating their use.

f. A special progress record/checksheet shall be maintained for each use of protective devices that hamper a recipient's free movement. These checksheets shall be used to document the recipient's relief from the device every two hours and shall include a description of the recipient's condition as observed during the period of free movement.

g. Every recipient to whom a protective device has been applied shall be frequently monitored and assisted as necessary to meet personal needs and to participate in treatment and activities.

RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES

PART C

RIGHTS IN OUTPATIENT SETTINGS

DEPARTMENT OF BEHAVIORAL AND DEVELOPMENTAL SERVICES
DIVISION OF MENTAL HEALTH
AUGUSTA, MAINE

CONTENTS

I. STATEMENT OF INTENT

These rules [Part C] are applicable to all outpatient agencies or programs that are licensed or funded by the Department of Mental Health & Mental Retardation to provide mental health services to recipients. Part C should be read in conjunction with Part A, Rules of General Applicability.

II. INDIVIDUALIZED SUPPORT PLANNING PROCESS

A. The individualized support planning (ISP) process will result in the development of a life plan based upon the wants and needs of the recipient.

B. All recipients with severe and prolonged mental illness have the right to an ISP presentation and, if they so choose, an ISP.

C. For those recipients who accept the ISP process, the following stages will occur:

1. A life plan will be developed with the recipient, based upon the recipient's vision of his or her future and will include consideration of all areas that the recipient deems relevant. The time frame of the life plan will be defined by the recipient.

2. A list of needs will be developed with the recipient, including those things that need to occur for the recipient to move toward his or her vision of the future. This list should include those needs that appear as unlikely to be met at the time the list is developed.

3. The recipient will select the areas that he or she wishes to target for immediate activity, in order to move toward his or her life plan.

4. Action plans will be developed in instances in which recipients and providers agree to work toward the achievement of a goal. The action plan will be consistent with the recipient's life plan, priority needs and targets. The action plan will contain the following:

a. Measurable outcomes;

b. Criteria for success;

c. Time frames; and

d. Assignment of responsibilities.

D. All unmet needs identified in the ISP process will be reported to the Division of Mental Health.

E. ISP's will be reviewed with the recipient no less frequently than every 90 days and revised as needed.

INDIVIDUALIZED TREATMENT OR SERVICE PLAN

A. Recipients have the right to an individualized treatment or service plan. For recipients who have an ISP, the ISP process will provide the foundation of the development of the treatment or service plan.

B. Treatment or service plans shall, in instances in which the recipient has an ISP, be based upon the life plan, needs, targets and action plans developed in the ISP process. Treatment or service plans shall be based upon an individualized assessment of the recipient's housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional, and psychiatric and/or psychological strengths and needs as well as their potential need for crisis intervention and resolution services. Each facility or agency shall fully consider the least restrictive appropriate treatment and related services taking into account factors that are supportive of each recipient's exercise of his or her basic rights, consistent with each individual's strengths, needs and treatment requirements, pursuant to this section and sections IV and V of these rules. Such considerations shall include accommodation of particular needs involving communication and physical accessibility to all treatment programs.

C. The recipient or guardian, shall be fully and actively involved in the development or revision of the treatment or service plan. Upon the request of the recipient, the recipient's representative or family members designated by the recipient shall be included in the development or revision of the treatment or service plan. Each agency program or facility shall give 10 days' notice of any treatment or service planning meetings, to the recipient's guardian, and designated representatives. If the meeting is being convened to address an emergency, notice reasonable for the circumstances shall be required. Invited persons shall be notified that, if they are unable to attend a treatment or service planning meeting, they may submit information in writing for consideration at the meeting.

D. Treatment or service plans shall be developed within 30 days of initiation of service and shall thereafter be reviewed and revised no less frequently than every 90 days. Plans may be reviewed more frequently as necessary to address substantial changes in a recipient's life, such as hospitalization.

E. Treatment or service plans shall be developed by a team consisting of the recipient and others among whom the recipient has authorized the exchange of information and who are needed to ensure that the recipient's needs are adequately assessed and that appropriate recommendations are made, based upon a comprehensive assessment of the recipient. The plan shall contain but need not be limited to:

1. A statement of the recipient's specific strengths and needs. The treatment or service plan should include a description of any physical handicap and any accommodations necessary to provide the same or equal services and benefits as those afforded non-disabled individuals.

2. A description of services to assist the recipient in meeting identified needs. Goals shall be written for each service. Short-range objectives shall be stated such that their achievement leads to the attainment of overall goals. Objectives shall be stated in terms that allow objective measurement of progress and that the recipient, to the maximum extent possible, both understands and adopts.

3. A description of services based on the actual needs as expressed or approved by the recipient rather than on what services are currently available. If at the time of the meeting, team members know on the basis of reliable information that the needed services are unavailable, they shall note them as "unmet service needs" on the treatment or service plan and develop an interim plan based upon available services that meet, as nearly as possible, the actual needs of the recipient.

4. A description of the manner of delivery of each service to be provided. The manner of delivery shall be one that maximizes the recipient's strengths, independence and integration into the community.

5. A statement of the rationale or reason for utilizing the described treatment or services to meet such goals;

6. A specification of treatment or service responsibility, including both staff and recipient responsibility and involvement to attain treatment or service goals; and

7. Documentation of current discharge planning.

F. Within one week of the meeting, the recipient shall be offered a written copy of the treatment or service plan. The recipient shall also be notified, by means he or she shall most likely understand, of the process to pursue, up to and including the right to file a grievance, if he or she disagrees with any aspect of the plan or the assessments upon which the plan is based, or is later dissatisfied with the plan's implementation.

G. Limitations

1. Such a plan must describe any limitation of rights or liberties. Such a limitation shall be based upon professional judgment and may include a determination that the recipient is a danger to self or to others absent such limitation. Any limitation shall meet criteria outlined for the limitation in other sections of these rules.

2. When any limitation occurs, the treatment plan shall address the specific limitation, and the restriction shall be subject to periodic review. When possible, the limitation shall be time specific.

3. Whenever possible specific treatment shall be developed to address the basis of the limitation.

4. Documentation regarding the limitation shall include documentation as per G.1., 2. and 3. above and shall include specific criteria for removal of the limitation.

H. A copy of the treatment or service plan shall also be offered to the recipient's guardian, if any, and to recipient's representative, if confidentiality has been waived.

I. All agencies shall maintain specific written guidelines describing their practices concerning development of treatment or service plans.

J. Recipients who have had a community support worker assigned to them have the right to a variety of appropriate services from the community support worker, including the following, when pertinent to meeting a recipient's need for services:

1. assistance in locating services;

2. continuing monitoring of the services provided;

3. notification of ISP meetings and coordination of the ISP;

4. participation in the recipient's hospital discharge planning meeting; and

5. assistance in the exploration of lesser restrictive alternatives to hospitalization.

K. Termination

1. Each recipient has the right to be informed of and referred to appropriate resources upon termination from a program.

2. Each recipient terminated from the outpatient agency after ten days or longer term of treatment has the right to a comprehensive termination plan, and to assisted referral to existing resources in such areas such as transportation, housing, financial assistance, and mental health treatment. Recommendations made in termination plans shall not require the agency or department to provide recommended goods or service.

3. Notification

a. The recipient's representative, upon request of the recipient, and the recipient's guardian, shall be notified of and, if the representative or guardian is available, involved in any termination planning. Involvement may include, but not be limited to, participation in a termination planning meeting.

K. Exceptions

1. No treatment or service plan is required for recipients who solely received informal social support and recreation in drop-in mental health programs or social clubs.

2. A recipient may choose not to be involved in developing his or her treatment or service plan and may refuse planning.

3. A legally responsible guardian shall be actively involved in treatment or service planning, to the maximum extent possible. A public guardian has an affirmative duty to be fully and actively involved in treatment or service planning.

IV. INFORMED CONSENT TO TREATMENT AND/OR SERVICES

A. Recipients have the right to informed consent for all treatment and/or services.

B. Statement of purpose. This rule has the following purposes:

1. To promote respect for the individual autonomy and recipient participation in decision-making;

2. To ensure that the informed consent of a recipient is obtained prior to treatment and/or services;

3. To avoid the forcible imposition of any treatment and/or services;

4. To provide reasonable standards and procedural mechanisms for determining when to treat and/or serve a recipient absent his or her informed consent, consistent with applicable law; and

5. To ensure that the recipient is fully protected against the unwarranted exercise of the state's parens patriae power.

C. Treatment and/or service of recipients. All recipients with unimpaired capacity have the right to consent to or to refuse treatment and/or services, absent an emergency. Treatment may be provided to a recipient only when:

1. Informed consent for such treatment and/or services has been obtained from the recipient; or

2. The recipient has been judged by a court of competent jurisdiction to lack capacity to give informed consent to the particular treatment and/or services, and the informed consent of the recipient's guardian has been obtained; or

3. The recipient has been found to lack clinical capacity to give informed consent to the particular treatment and/or services pursuant to subsections D and E of this rule, the recipient is willing to comply with treatment and/or services and the provisions of E(2) have been followed.

D. Informed consent to treatment and/or services. Informed consent to treatment and/or services is obtained only where the recipient or his or her guardian possesses capacity to make a reasoned decision regarding the treatment and/or services and the recipient or his or her guardian is provided with adequate information concerning the treatment and/or services; and the recipient or guardian makes a voluntary choice in favor of the treatment and/or services. Informed consent must be documented in each case in accordance with this section.

1. Capacity. Capacity means sufficient understanding to comprehend the information outlined in section (D)(2) and to make a responsible decision concerning a particular treatment and/or service. Recipients are legally presumed to possess capacity to give informed consent to treatment and/or services unless the recipient has been judged by a court to competent jurisdiction to lack capacity generally, or to lack capacity to give informed consent to a particular treatment and/or service.

2. Adequate information. The licensed, certified or other qualified mental health professional recommending a particular treatment and/or service shall provide to the recipient, or guardian, all information relevant to the formulation of a reasoned decision concerning such treatment and/or service. The recipient, or his or her guardian, shall have the right to have a person of his or her choice present during the presentation of this information, provided that the nominee can be available within time frames established for the service in question in the Licensing Standards, or within such other reasonable period as may be agreed upon; and the recipient, or guardian, shall be informed of this right. The information may be provided orally or in writing, shall be communicated in terms designed to be comprehensible to a lay person, and shall include, without limitation:

a. An assessment of the recipient's condition and needs, including the specific signs, symptoms or behaviors that any medication is intended to relieve;

b. The nature of the proposed treatment and/or service, and a statement of the reasons why the professional believes it to be indicated in the recipient's case;

c. The expected benefits of the treatment and/or service and the known risks that it entails, including precautions, contraindications, and potential adverse effects of any medication;

d. The anticipated duration of the treatment and/or service;

e. A statement of reasonable alternatives to the proposed treatment and/or service, if any;

f. Information as to where the recipient may obtain answers to further questions concerning the treatment and/or service; and

g. A clear statement that the recipient has the right to give or withhold consent to the proposed treatment and/or service.

3. Voluntary choice. Consent to treatment and/or services must be given willingly in all cases, and may not be obtained through coercion or deception.

A recipient or guardian's initial refusal of treatment and/or services shall not preclude renewed attempts to obtain the recipient's willing consent; and a recipient or guardian's initial willing consent shall not preclude the recipient from validly withdrawing such consent at any time before or during treatment and/or service.

4. Documentation. The informed consent of a recipient or guardian to a particular treatment and/or service shall be documented to show:

a. From whom consent is obtained, whether recipient, or guardian;

b. That adequate information, including at a minimum all the elements listed in section D(2) of this rule, was provided;

c. The signature of the recipient or, where applicable, the signature of a guardian, indicating consent, in the case of psychotropic medications only.

d. Exceptions. In cases of unanticipated treatment and/or service needs, the informed consent of a guardian may be obtained by telephone; but such oral consent shall be confirmed in writing in accordance with this section as soon as practicable.

E. Recipients with clinical incapacity.

1. Administrative finding. Where a licensed, certified or other qualified mental health professional recommending a particular treatment and/or service determines that, in his opinion, a recipient not having a guardian lacks clinical capacity to give informed consent to the treatment and/or service under subsection D of these rules, he or she shall, by means of a written statement to that effect, refer the recipient to a physician or licensed clinical psychologist not directly responsible for the recipient's treatment for an examination in regard to capacity.

The physician or clinical psychologist to whom the recipient is referred shall conduct the examination, and shall make a documented finding that the recipient either possesses or lacks clinical capacity to give informed consent to the particular treatment and/or service.

a. Finding of capacity. Where the recipient is found to possess capacity to consent to treatment and/or service by the physician or licensed clinical psychologist, he shall be referred back to the licensed, certified or other qualified mental health professional recommending the treatment for the processing of his or her informed consent to or refusal of such treatment and/or service.

b. Finding of clinical incapacity. Where the recipient is found to lack clinical capacity to consent to treatment and/or service by the physician or licensed clinical psychologist, he shall be referred back to the licensed, certified or other qualified mental health professional recommending the treatment for a documented determination as to whether the recipient, notwithstanding lack of clinical capacity, is willing to comply with or refuses the proposed treatment and/or service.

Such determination must be based upon the provision to the recipient of adequate information as required by subsection D(2) of this rule.

If recipient is willing to comply with treatment and/or services, the procedure outlined in subsection E(2) shall be followed. If any recipient refuses treatment and/or services, the procedure outlined in subsection E(3) shall be followed.

Nothing shall preclude the agency from pursuing guardianship in appropriate cases at any time after a determination of clinical incapacity.

c. Notice. Where the recipient is found to lack clinical capacity pursuant to this section, the licensed, certified or other qualified mental health professional recommending the treatment and/or service shall notify the following persons of such finding:

i. the rights protection and advocacy agency of the Maine mental health system;

ii. the recipient's next of kin, if the recipient does not object;

iii. the recipient's designated representative, if the recipient has waived his or her confidentiality with respect to such representative;

iv. the head of the mental health facility.

Such notice shall include a copy of the documented administrative finding, and shall state that the recipient has been found to lack clinical capacity to give informed consent to a particular treatment and/or service and that notwithstanding such finding, the recipient may refuse treatment and/or service, absent court adjudication of incapacitation.

2. Outpatient recipients with clinical incapacity, compliant. This subsection shall apply where it is determined pursuant to subsection (E)(1)(b) that an outpatient recipient with clinical incapacity is willing to comply with the proposed treatment and/or service. In such case treatment and/or service may be provided only if:

a. Protective proceedings are initiated in accordance with law;

b. A licensed, certified or other qualified mental health professional follows the procedures outlined in subsection (D) and, where applicable, subsection (E) on at least an annual basis.

3. Recipients with clinical incapacity, refusing. This subsection shall apply where it is determined pursuant to subsection E(1)(b) above that a recipient with clinical incapacity is refusing the proposed treatment and/or service.

a. Alternative treatment meeting. The licensed, certified or other qualified mental health professional recommending the treatment and/or service and a representative of the treatment team shall meet with the recipient to explore the reasons for the recipient's refusal and to discuss any appropriate alternatives to the proposed treatment and/or service that may be available and that may include behavioral, psychological, medical, social, psychosocial or rehabilitative methods. The purpose of the meeting shall be to elaborate in an informal setting an alternative treatment and/or service that is both professionally justified and acceptable to the recipient. If agreement can be reached as to an alternative treatment and/or service, review by the Clinical Director or equivalent and approval by the head of the mental health facility, if appropriate, of such treatment shall be processed in accordance with subsection E(2) above.

b. No agreement. Where no agreement can be reached as to an alternative treatment and/or service, the licensed, certified or other qualified mental health professional recommending the proposed treatment and/or service shall report in writing to the head of the program concerning the outcome of the meeting.

The head of the program may conclude that the recipient's termination from services is the only available option.

F. Electroconvulsive Therapy (ECT). ECT treatment shall not be administered to a recipient except as provided in these rules. The authorized treating professional seeking to administer ECT treatment shall:

1. Obtain written informed consent for such procedure according to the procedures outlined in Part C, Section IV.D.1., 2., 3., and 4.a.-d. of these rules from

a. the recipient, or

b. from a court of competent jurisdiction, in the case of a clinically incapacitated recipient, or

c. from a guardian or other legal decision maker, in the case of a minor recipient or an incapacitated recipient;

2. ECT treatment shall not be authorized pursuant to Section III.E.-H. of this part.

G. Documentation. All documentation required by this rule shall be made a part of the recipient's clinical chart.

H. Seclusion and restraint are under no circumstances to be utilized in outpatient settings.