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.

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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.

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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.