Title 64 Series 59
Department of Health and Human Resources
BEHAVORIAL HEALTH CLIENT RIGHTS

Summary of Public Comments:
The Department notes that the rule has not been amended since its adoption nearly 25 years ago. Many comments address the proposed deletion of antiquated language or requirements and the adoption of protocols consistent with the standard of care. The Department modified the rule in response to many comments and to attempt to enhance compliance with prevailing certification and accreditation standards for the two state hospitals, William R. Sharpe, Jr. Hospital and Mildred Mitchell-Bateman Hospital.

Title

Comment
The title change from "Behavioral Health Client Rights" to "Client Rights at State-Operated Mental Health Facilities" connotes negative stereotypes and does not reflect the service array at state hospitals.
Response
The Department has reviewed the comment and no change was made. The enabling statute defines the rights of persons at a "hospital" and at a "mental health facility." *See* W.Va. Code §27-5-9(b) and (f). State hospitals are defined by W.Va. Code §27-1-6 and §27-2-1. State psychiatric hospitals constitute "mental health facilities" as defined by W.Va. Code §27-1-9. State psychiatric hospitals are licensed as a "hospital" by the Office of Health Facility Licensure and Certification; certified as a "hospital" by the Centers for Medicare and Medicaid Services; and accredited as a "hospital" under The Joint Commission's Hospital Accreditation Program. The Joint Commission has distinct accreditation standards for behavioral health organizations that are inapplicable to state psychiatric hospitals. State psychiatric hospitals are not behavioral health organizations by statute, licensure, certification, or accreditation.

Section 1 — General

Comment
1.5 Sunset provision will repeal the rule without further action.
Response
The Department has reviewed the comment and no change was made. The sunset provision is required by W.Va. Code §29A-3-19(b) and consistent with W.Va. Code §29A-3-20.

Section 3 – Definitions

Comment
3.10 The definition of neglect permits subjectivity, inconsistent application, and fails to list examples of neglect.
Response

The Department has reviewed the comment and modified the definition of neglect. The definition of neglect in the current rule is internally inconsistent and includes a subjective and ambiguous negligence standard for identifying cases of purported neglect. The proposed rule specifically provides that neglect can arise in one of three ways: (a) violation of W. Va. Code §9-6-1(3); (b) violation of the CMS certification standard contained in 42 C.F.R § 482.13, or (c) breach of the applicable standard of care. These are the governing standards of state hospitals. To clarify the scope of the definition the Department added that neglect includes the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." Neglect is a fact-specific determination. Standard of care is an objective standard. The Department further amended the rule to provide that seclusion, chemical restraints, and/or mechanical restraints used solely as a means of coercion, discipline, convenience, or retaliation are prohibited and would thus constitute neglect.

Comment

3.11 The definition of physical abuse permits subjectivity, inconsistent application, and fails to list examples of physical abuse.

Response

The Department has reviewed the comment and modified the definition of physical abuse. The proposed rule specifically provides that physical abuse can arise in one of three ways: (a) violation of W. Va. Code §9-6-1(2); (b) violation of the CMS certification standard contained in 42 C.F.R § 482.13, or (c) breach of the applicable standard of care. To clarify the scope and broaden the application of the definition of physical abuse the Department added language consistent with certification standards. Physical abuse is a fact-specific determination. Standard of care is an objective standard that governs health care providers. The Department further amended the rule to provide that seclusion, chemical restraints, and/or mechanical restraints used solely as a means of coercion, discipline, convenience, or retaliation are prohibited and would thus constitute physical abuse.

Comment

3.15 The definition of verbal abuse permits subjectivity, inconsistent application, and fails to list examples of verbal abuse.

Response

The Department has reviewed the comment and modified the definition of verbal abuse. Because W.Va. Code §9-6-1 does not address verbal abuse, the proposed rule provides that verbal abuse can arise in one of two ways: (a) violation of the CMS certification standard contained in 42 C.F.R § 482.13 or (b) breach of the applicable standard of care. To clarify the scope and broaden the application of the definition of verbal abuse the Department added language consistent with certification standards. Verbal abuse is a fact-specific determination. Standard of care is an objective standard that governs health care providers.

Section 4 – Adoption of Other Standards

Comment

4 The citation to the "State Operations Manual Appendix A – Survey Protocol, Regulations, and Interpretative Guidelines for Hospitals" should be clarified.

Response

The Department agrees with the comment and it revised the reference to the citation.

Section 5 – Clients' Rights Generally

Comment

5.2 The word "disability" should replace the word "handicap."

Response

The Department agrees with the comment and made the requested change.

Comment

5.4 The change to the definitions of neglect (3.10); physical abuse (3.11); and verbal abuse (3.15) and other changes is contrary to the responsibilities of the state hospital administrator and will result in clients not being informed of their rights.

Response

The Department has reviewed the comment and believes no additional changes are necessary. The draft rule and corresponding changes must be read in their totality. The current rule contains antiquated language that in many respects is inconsistent with or less rigorous than the licensure, certification, and accreditation standards of the state psychiatric hospitals. The draft rule, and recent revisions, contain precise definitions consistent with the standard of care. The draft rule further requires a treatment plan with accelerated timeframes for treatment and assessment that are specifically targeted to "promote the discharge of a client" as defined in §3.6. These revisions expand client rights by hastening treatment and streamlining discharge consistent with CMS certification standards and Joint Commission accreditation standards. Further, the draft rule establishes legal standards and to the extent their application requires clarification the Department provides annual grant agreements to West Virginia Advocates, Inc., d/b/a Disability Rights of West Virginia ("DRWV"), the designated protection and advocacy system under the Protection and Advocacy for Individuals with Mental Illness Act, and Legal Aid of West Virginia, Inc. ("LAWV"), to assist clients and to promote and protect clients' interests. Each hospital and its administrator inform clients of their rights through various means and each client is informed of his or her right to consult with DRWV or LAWV for legal assistance or advocacy.

Section 6 – Clients' Right to Treatment

Comment

6.1 The citation to the "State Operations Manual Appendix A – Survey Protocol, Regulations, and Interpretative Guidelines for Hospitals" should be clarified.

Response

The Department agrees with the comment and it revised the reference to the citation.

Comment

6.2 The rule should provide that no person may be "detained" for the sole purpose of confinement.

Response

The Department reviewed the comment and added the word "detained" and the phrase "except as otherwise permitted by law."

Comment

6.5 and 6.6 The citation to the "State Operations Manual Appendix A – Survey Protocol, Regulations, and Interpretative Guidelines for Hospitals" should be clarified.

Response

The Department agrees with the comment and it revised the reference to the citation in these sections.

Comment

6.6 – 6.14 The elimination of language in the existing rule and reference to standards in the West Virginia Code, the Code of Federal Regulations, and the Joint Commission standards create confusion and are difficult to navigate.

Response

The Department has reviewed the comment and no additional changes were made. The draft rule and corresponding changes must be read in their totality. The licensure, certification, and accreditation standards govern state psychiatric hospitals. These objective standards provide clarity and not confusion and these standards govern the operation of and service delivery at the state hospitals. Most importantly, the revised rule further adopts an objective definition of an Individualized Program Plan and requires the completion of an IPP within 24 hours and not 72 hours as under §6.6 of the current rule. The proposed rule enhances patient rights and accelerates patient treatment that encourages discharge.

Section 10 – Seclusion and Restraints

Comment

We object to any change to Section 10.

Response

As a result of a collaborative discussion with DRWV, the Department modified the rule.

10.1 Added language to provide that "seclusion or mechanical or chemical restraints that are used solely as a means of coercion, discipline, convenience, or retaliation are prohibited."

10.2 Amended the reference to 42 C.F.R. § 482.13(e); clarified the citation to the "State Operations Manual Appendix A – Survey Protocol, Regulations, and Interpretative Guidelines for Hospitals;" clarified that neither seclusion nor restraint interventions are permitted for developmentally disabled clients; and added language to address training of personnel at state hospitals who administer or assist in the administration of seclusion and restraint interventions.

10.7.1 Preserved language that requires five-minute face checks and added language to require compliance with 42 C.F.R. § 482.13 for clients in seclusion.

10.13 Clarified the citation to the "State Operations Manual Appendix A – Survey Protocol, Regulations, and Interpretative Guidelines for Hospitals.

Comment

10.14 Mechanical restraint of individuals with intellectual or developmental disabilities is prohibited.

Response

The Department agrees with the comment and modified §§10.1 and 10.2.

Comment

10.2.; 10.6; 10.9; 10.13-10.16; 10.22-10.25 The elimination of language in the existing rule and reference to standards in the West Virginia Code, the Code of Federal Regulations, and the Joint Commission standards create confusion and are difficult to navigate.

Response

The Department has reviewed the comment and believes no additional changes are necessary. The draft rule and corresponding changes must be read in their totality. The licensure, certification, and accreditation standards govern state psychiatric hospitals. These objective standards provide clarity and not confusion. The modifications to the revised rule were prepared in collaboration with DRWV.

Section 11 – Confidentiality and Records

Comment

11.4.5-11.4.10 The elimination of language in the existing rule and reference to standards in the West Virginia Code, the Code of Federal Regulations, and the Joint Commission standards create confusion and are difficult to navigate.

Response

The Department has reviewed the comment and made no additional modifications. The current legislative rule was promulgated before the enactment of The Health Insurance Portability and Accountability Act of 1996 (HIPAA), the widespread development and use of electronic health care records, and the current protocols for Health Information Management Departments. The revisions are consistent with the standard of care and applicable certification and accreditation standards.

Section 12 – Right to Unrestricted Communication

Comment

12.2.1[sic] Language that permits visitors to take clients off grounds should not be deleted.

Response

The Department is unclear about the comment. Visitors taking clients off grounds is contained in §12.5.1. The Department made no modification. Clients are committed to a state hospital pursuant to a court order and placed in the custody of the Department. Allowing visitors to take clients from the hospital removes the client from the Department's custody, permits and/or potentially encourages elopements that violate applicable CMS certification standards, and creates unnecessary risk exposure for the client, the person removing the client, and the Department.

Comment

12.5 The rule should be clarified to incorporate patient visitation rights under 42 C.F.R. § 482.13(h).

Response

The Department agrees with the comment and modified the rule.

Section 14 – Outdoor Exercise and Other Recreational Programming

Comment

14.3.4 Language that defines social activities should not be deleted.

Response

The Department has reviewed the comment and made no additional modification. A client's social activities are determined by the client's clinical needs and abilities based on the treatment team's clinical discretion exercising sound professional judgment consistent with the standard of care to promote the discharge of a client consistent with the amendment of §3.6.

Comment

14.4 The language that permits a "reasonable opportunity" vague.

Response

The Department reviewed the comment and, in collaboration with DRWV, modified the rule to permit community integration as "determined by the client's treatment team in its clinical discretion and in the client's best interests."

Section 15 – Physical Environment

Comment
15.1.1 The phrase "handicapped individuals" should be amended to "individuals with a disability."
Response
The Department agrees with the request and made the requested modification.
Comment
15 The elimination of language in the existing rule and reference to standards in the West Virginia Code, the Code of Federal Regulations, and the Joint Commission standards create confusion and are difficult to navigate.
Response
The Department has reviewed the comment and made no additional modification. The draft rule and corresponding changes must be read in their totality. The licensure, certification, and accreditation standards govern state psychiatric hospitals. These objective standards provide clarity and not confusion and establish a consistent, uniform standard.

Section 16 – Food

Comment
The section should not be changed because dietetic service should have policies governing the sanitary handling and preparation of food and compliance with the FDA Food Code should be required.
Response
As a result of a collaborative discussion with DRWV, the Department modified the rule to affirm that state hospitals must comply with the CMS certification standards reflected in 42 C.F.R. §§ 482.28, 482.41, and 482.42; the applicable standards of the Joint Commission; the State Operations Manual – Survey Protocol, Regulations and Interpretative Guidelines for Hospitals; and the Food Code, as amended, that is promulgated by the U.S. Food and Drug Administration.
Comment
16 The elimination of language in the existing rule and reference to standards in the West Virginia Code, the Code of Federal Regulations, and the Joint Commission standards create confusion and are difficult to navigate.
Response
The Department has reviewed the comment and made no additional modification. The draft rule and corresponding changes must be read in their totality. The licensure, certification, and accreditation standards govern state psychiatric hospitals. These objective standards provide clarity and not confusion. The foregoing amendments provide further clarity and ensure adherence to applicable dietetic standards, as may be amended by responsible governing bodies.

Section 17 – Clients' Labor, Earnings and Funds

Comment

17.1 and 17.4 The phrase "non-handicapped workers" should be amended to "workers without a disability."

Response

The Department reviewed the comment and modified the rule by replacing the phrase with "workers with no disability."

Section 20 – Client Advocacy and Grievance Procedure

Comment

20.2 The elimination of an appeal process for patient grievances is inappropriate.

Response

As a result of a collaborative discussion with DRWV, the Department modified the rule to provide appeals to the "Office of the Court Monitor in accordance with an Agreed Amended Order entered on October 15, 2012, in the action *E.H., et al., v. Matin, et al.*, Civil Action No. 81-MISC-585 (Circuit Court of Kanawha County, West Virginia) or subsequent applicable order that may be entered by the court in such action."

Disability Rights WV

August 4, 2020

April L. Robertson
General Counsel
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By email: April.L.Robertson@wv.gov

Re: Comments on proposed revisions to WVCSR 64-59

Dear Ms. Robertson:

The following are comments from Disability Rights West Virginia regarding DHHR's proposed revisions to WVCSR 64-59 – Client Rights at State-Operated Behavioral Health Facilities. Thank you for agreeing to extend the time for comment.

§ 1.1 - Why is "behavioral health facility" changed to "mental health facility" throughout? Does this change indicate a philosophical shift that will impact the treatment provided to individuals with intellectual or developmental disability?

§ 1.5 – DRWV disagrees with the inclusion of a sunset provision that would repeal 64-59 without further action.

§ 3.10 – DRWV objects to any change to the definition of neglect.

§§ 3.11, 3.15 – DRWV objects to any change to the definition of abuse.

§ 4 – The proper citation to the interpretive guidelines is "State Operations Manual Appendix A – Survey Protocol, Regulations, and Interpretive Guidelines for Hospitals." On 2-21-2020, CMS merged the interpretive guidelines for hospitals and psychiatric hospitals into SOM Appendix A.

§ 5.2 – Change "handicap" to "disability."

§ 6.1 – "State Operations Manual Appendix A – Survey Protocol, Regulations, and Interpretive Guidelines for Hospitals" should be added to the last sentence.

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§ 6.2 – Proposed change – No individual shall be admitted to or detained in a mental health facility for the sole purpose of confinement. Adding "detained in" clarifies a court's duty to discharge a patient from hospitalization when clinically indicated.

§ 6.5 – Proper citation to CMS interpretive guidelines is "State Operations Manual Appendix A – Survey Protocol, Regulations, and Interpretive Guidelines for Hospitals."

§ 6.6 – SOM Appendix A should be included as a source for accepted standards.

§ 10 – DRWV objects to any change to these rules. All language from 42 C.F.R. §§ 482.13(e) and (f) should be merged into § 10 to add substance that is removed by the proposed deletions.

§ 10.2 - SOM Appendix A should be included as a source for accepted standards.

§ 10.14 – Mechanical restraint of individuals with intellectual or developmental disabilities [I/DD] is inconsistent with any accepted standard of care; and the ban on mechanical restraint of I/DD clients should not be eliminated.

§ 12.5 – For clarity, language from § 482.13(h) (patient visitation rights) should be merged into this rule.

§ 14.4 – A "reasonable opportunity" for community integration is too vague to be useful. This rule should specify who determines the reasonableness of the opportunities provided and relevant factors to be considered.

§ 15.1.1 – "[H]andicapped individuals" should be changed to "individuals with a disability."

§ 16.5.6 – This rule should not be changed. Dietetic service should have policies governing the sanitary handling and preparation of food; and compliance with the FDA Food Code should remain a requirement.

§§ 17.1.2.a, 17-1-2.b, 17.4.1.a – "[N]on-handicapped workers" should be changed to "workers without a disability."

§§ 20.2.12, 20.2.13, 20.2.16.e – DRWV disagrees with the elimination of an appeal process for patient grievances.

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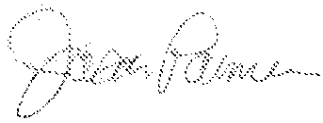
Disability Rights WV

I look forward to discussing these matters with you at our meeting on August 11, 2020. Thank you for your attention to this matter.

Sincerely,



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July 31, 2020

April L. Robertson, Esq.
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RE: TITLE 64-59 Behavioral Health Client Rights
Proposed Legislative Rule Change

PUBLIC COMMENT

submitted via email to april.l.robertson@wv.gov

Dear Ms. Robertson,

Thank you for the opportunity to comment on the Proposed Changes to Legislative Rule 64CSR59 Behavioral Health Client Rights. I am the Supervising Attorney for Legal Aid of West Virginia, Inc.'s Behavioral Health Project. We have behavioral health advocates located within Mildred Mitchell-Bateman Hospital and William R. Sharpe Jr. Hospital. Our facilities advocates respond to 100% of all patient grievances that are presented to them under 64CSR59. As such, the advocates use this document on a day to day basis and have practical knowledge and experience as to its impact, functionality, and application within the hospitals. Please accept and consider our comments to the proposed changes as outlined below.

MAJOR CONCERNS

1. Title Change. The proposed changes include changing the title of 64CSR59. Currently, this section is titled "Behavioral Health Client Rights." The proposed change is "Client Rights at State-Operated Mental Health

Facilities." The definitions section also changes "behavioral health" references to "mental health."

We believe that the terminology should not change from behavioral health to mental health for two main reasons. First, the usage of "mental health" and "mental health facility" elicits a negative stigma and stereotype. It also does not fully capture the care and services that the facilities provide to clients. While mental health generally focuses only on a person's mental or psychological state, behavioral health encompasses more about the person as a whole. Behavioral health involves habits, routines, and physical abilities along with a person's psychological state. The care and services that clients are entitled to and provided at the state-run facilities are more in line with behavioral health treatment and not merely mental health treatment.

Secondly, this change provides inconsistency across 64CSR as the current and proposed changes to 64CSR11, Behavioral Health Centers Licensure, maintain the "behavioral health" language throughout. Additionally, the advocates working within the facilities are behavioral health advocates. They take an inclusive approach to each client's behavioral health and associated services.

Keeping the behavioral health language maintains dignity in clients and maintains consistency throughout 64CSR and the programs that utilize it. We suggest maintaining the "behavioral health" terminology throughout 64CSR59 and not changing the language to "mental health." We recognize that the title as currently written could offer confusion as to whom it applies, since it does not specify where a client has such rights. As such, we offer the following as more appropriate change to the title: Client Rights at State-Operated Behavioral Health Facilities.

2. Abuse and Neglect Definitions. The change in the applicable definitions to abuse (3.11 and 3.15) and neglect (3.10) removes the list of specific behaviors, language, and actions that client advocates use to determine whether a client was subjected to abuse or neglect. The change opens the definition up to subjective interpretation and inconsistent results. Clients also

rely on the specific examples of what constitutes abuse or neglect. It helps them feel protected and to understand when an action, or inaction, may have violated their rights.

We recommend keeping the current definitions of abuse and neglect for four reasons. First, it provides protection to patients and helps them understand their rights and when their rights may have been violated. The advocates often provide clients with a copy of their rights in order for them to be educated and understand what treatment to expect and what is inappropriate. It also assists advocates in being able to quickly assess a client grievance for validity. Slowing down this process would result in delays in resolving grievances.

Second, it greatly assists advocates in being able to determine whether or not an abuse or neglect allegation should be substantiated. It is a concrete standard allowing advocates to point directly to a behavior within 64CSR59 that has been violated. The ambiguity caused by the proposed changes could result in a greater number of grievances, more lengthy investigations, and broader substantiations. Clarity of standards limits the scope of the grievance, investigation, and outcome. And provides for greater consistency.

Third, the language and examples set out in the current definition are objective. The proposed change to the definition is subjective, which can allow for differences in interpretation, implementation, and inconsistent results among clients and employees. The proposed definition sets out a willfulness standard of deliberate action (although not intentional injury). This, too, allows for subjective treatment and adds an analysis that must be done to determine whether the action was deliberate and not merely whether an action occurred that resulted in a client being abused.

Lastly, the proposed change removes the wording of the definitions from 64CSR59 and references to the West Virginia Code, the Code of Federal Regulations and the "applicable standard of care." Clients and staff working within the facility deserve to have a clear standard by which they are to follow. This allows clients to be protected and workers the ability to properly do their jobs. This would also

require changes to the client rights trainings and resources which are provided to clients and staff. Which could also result in the need to retrain all clients and staff on the new standards.

We oppose such a removal of language and the replacement of directing one to other sources to obtain the information as contrary to section 5.4-Responsibility of Administrator. This section states that "It is the responsibility of the facility's administrator to assure that each client is informed of his or her rights and to make all necessary arrangements to allow the client to exercise his or her rights." By removing the definition and examples of behaviors and action or inaction that constitute abuse or neglect, and providing a more subjective, less concrete definition that references three other sources, we believe clients will not be informed of their rights nor have the necessary arrangements (e.g. access to the sources referenced and clear standards) in order to exercise those rights.

3. Understanding Client Rights. Removing significant sections and providing reference to other documents denies clients the ability to have easy access to and ability to understand their rights. There are multiple sections that have been removed and replaced with language that refers to standards as set for in the West Virginia Code, the Code of Federal Regulations, and the standards of the Joint Commission[1]. We believe this will cause confusion with clients as to what their rights are and an inability to easily and successfully navigate the necessary documents in order to know their rights. We believe this will also cause a significant delay in the ability to process client grievances and resolve abuse and neglect allegations/investigations.

The State Operations Manual that is referenced for use is over 550 pages that has been changed at least three times since 2017. The document is burdensome and complex, and it is unreasonable to expect a client to be able to adequately utilize and understand its contents. Clients have a right to know and

[1] See §§6.6-6.14, regarding treatment planning and acceptable standards, generally; §§10.2-10.6, 10.9, 10.13-10.16, 10.22-10.25, regarding seclusion and restraint; §§11.4.5-11.4.10, relating to record maintenance; §15. Physical Environment; §16. Food.

understand their rights. The removal of easily understandable and clear standards contained within 64CSR59 denies them the ability to understand their rights and what behavior, action, or inaction violates these rights.

We urge that these rights remain written within the language of 64CSR59 allowing for basic client rights to be encompassed in one document that both clients and advocates can easily navigate, understand, and utilize. We believe this is consistent with protecting a client's right to be informed of and understand their rights.

These changes amount to a reduction of rights and protections, inconsistent with decades of prior practice and understanding. We, therefore, oppose any change that would reduce, negatively impact, or provide the opportunity or potential to negatively impact clients, their rights, and the services which they receive.

4. Subjective Language. The addition of the language "or as required by the applicable standard of care" allows for subjective evaluation and inconsistent outcomes. Nowhere is there a clear definition or guidance as to what the "applicable standard of care" is or may be and provides, at best, very minimal protection. Or how it is to be determined. The use of the term "or" in some of the proposed section changes allows for the option of application of what is actually stated in the section *or* the abstract concept of the standard of care.

5. Client Grievances and Right to Appeal. We oppose the removal of 20.2.12, 20.2.13 and 20.2.16e that provides client a right to appeal a grievance and lays out the process for the appeal and response from the facility administrator. Eliminating a client's right to appeal an initial grievance decision takes away a right that clients have been able to utilize for decades. The right to an appeal an adverse decision is a fundamental right found is nearly every legal arena. We believe clients should continue to be able to exercise a right to appeal a grievance.

6. Other Reductions in Client Rights. We generally oppose any changes that reduce or have the potential to cause of reduction in the rights that

clients currently enjoy, and we strongly suggest that the following changes are not made:

a. §12.2.1 eliminates language that permits visitors to take clients off grounds. We recommend that this clause not be eliminated. This provides clients an opportunity to spend meaningful time with family and friends outside of the facility. This is something that clients and visitors enjoy experiencing.

b. §14.3.4 is eliminated entirely. This section lists what type of social activities count as passive, moderate, and vigorous. While we recognize that it is not an exhaustive list, it provides examples within each category to better inform clients of expectations.

c. §14.4 removes a clear standard of minimum frequency for community integration and replaces it with a highly subjective standard of "reasonable" opportunity. As with other changes to subjective standards and for the same reasons, we oppose this change. We feel clients have a right to clear and objective standards. We oppose this change as it can lead to a reduction in the activities in which the clients are currently entitled to participate.

GENERAL COMMENTS

1. The Sunset Provision in 1.5 will prevent this section from becoming outdated with terminology and practices as we move further into the twenty first century. For example, the removal in 12.3.2 of reference to the use of coin operated phones recognizes the outdated use of technology aligns with what is actually being provided to clients. The same is true of 16.4.2 which strikes out "[m]eals should be served family style," as this is no longer the practice. The Sunset Provision will ensure that this type of alignment with modern practices is evaluated and we therefore are not opposed to its inclusion.

2. Neither of the state-run facilities currently accept juveniles as clients and we find the changes to 19.1 et seq to be appropriate. However, should this change and either the two current facilities begin accepting juvenile client or a state-run facility begins to operate that does accept juvenile clients, we encourage these provisions to be re-introduced quickly, without regard to timing in relation to the sunset provision, in order to adequately protect this very vulnerable population.

3. An incorrect statute is provided in 20.2.14. No Waiver (current section, proposed change to 20.2.12). West Virginia Code §29-6A-1 et seq appears to have been repealed in 2007. I believe the statute was relocated to West Virginia Code §6C-2-1 et seq. We suggest this be checked and corrected as necessary.

SUMMARY

In summary, we recommend the following:

1. Maintain the term "behavioral health" and do not change the language to "mental health."

2. Provide clients and advocate with the ability to access and understand client rights by keeping specific language within the document that clearly states each right of the client. While reference can be made to a *minimum* standard as to what is required by various sections of the Code of Federal Regulations, the West Virginia Code, and the standards of the Joint Commission, the language should be included within 64CSR59 and not require one to look to multiple other documents in an attempt to obtain the information.

3. We recommend removing subjective language that can lead to different interpretations, application, and results.

4. We oppose any change that would result in a decrease or negative change in client rights. Their current level of rights should be the minimum

that is maintained with any changes that occur. Rights should not be taken away from this vulnerable population.

Thank you for the opportunity to share these comments. We would be happy to discuss this matter in greater detail if that would be helpful.

Sincerely,

/s/ Jacqueline M. Schwaben

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