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SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #3

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NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: Division of Health Department of Health and Human Resources TITLE NUMBER: 64

CITE AUTHORITY W. Va. Code § 27-5-9(g)

AMENDMENT TO AN EXISTING RULE: YES ______ NO X

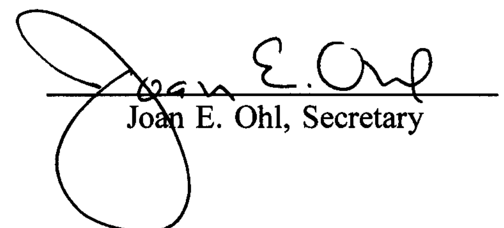
IF YES, SERIES NUMBER OF RULE BEING AMENDED: ______

TITLE OF RULE BEING AMENDED: ______

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 74

TITLE OF RULE BEING PROPOSED: Behavioral Health Consumer Rights

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.



Joan E. Ohl, Secretary

$13.00

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period, Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: July 27, 1998

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: (Agency name, Address & Phone No.) Division of Health
Department of Health and Human Resources

State Capitol Complex, Building 3, Room 265, Charleston, WV 25305

Telephone: (304) 558-3223

LEGISLATIVE RULE TITLE: Behavioral Health Consumer Rights, 64 CSR 74

1. Authorizing statute(s) citation: WV Code Section 27-5-9(g)

2. a. Date filed in State Register with Notice of Hearing or Public Comment Period:

   June 29, 1998

   b. What other notice, including advertising, did you give of the hearing?

   Notice of the proposed rule was sent to all licensed providers, hospitals with psychiatric inpatient programs, the Office of Health Facilities Certification and Licensure, provider representative organizations, consumer representative organizations, and family member representatives.

   c. Date of Public Hearing(s) or Public Comment Period ended:

   July 30, 1998

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached __X___ No comments received _____

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing (be exact):

August 3, 1998

f. Name, title, address and phone/fax/e-mail numbers of agency person(s) to receive all written correspondence regarding this rule (please type):

Marsha Dadisman, Acting Director

Regulatory Development/Department of Health and Human Resources

Room 265, Capitol Complex

Charleston, West Virginia 25305

(304) 558-3223 FAX: (304) 558-1130 MDadisman@WVDHHR.ORG

g. IF DIFFERENT FROM ITEM 'f', please give Name, title, address and phone number(s) of agency person(s) who wrote and/or has responsibility for the contents of this rule (please type):

Ted J. Johnson, Director

Division of Mental Health and Community Rehabilitation Services

Department of Health and Human Resources

1900 Kanawha Blvd. East Building 6, Room B -717

Charleston, West Virginia 25305 (304) 558-0627

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the

time and place a hearing for the taking of evidence and a general description of the issues to be decided.

N/A

b. Date of hearing or comment period:

N/A

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefore?

N/A

d. Attach findings and determinations and reasons:

Attached N/A

BRIEF SUMMARY OF THE RULE

This proposed rule defines the rights of individuals served in community-based behavioral health facilities. It provides for procedures for informing consumers of their rights and outlines grievance procedures when an individual believes his or her rights have been violated.

Statement of Circumstances Which Require the Proposed Rule

This proposed Rule was developed in response to a Request for Resolution discussed and agreed to by the parties to the consent decree resulting from the case of E.H. v. Matin, 168 W.Va. 248, 284 S.E.2d 232 (1981). This proposed Rule builds on a similar rights rule for persons who are committed or admitted to State-operated psychiatric hospitals or residential treatment centers for substance abuse.

The rule was developed by a task group composed of providers, family members, consumers, and Department personnel, which was formed by the Behavioral Health Work Group chaired by the Commissioner of the Bureau for Behavioral Health and Health Facilities. The task group obtained and reviewed the highest standards for rights of persons with mental illness, mental retardation, or addiction and prepared this proposed rule based on those standards.

TITLE 64
LEGISLATIVE RULES
DIVISION OF HEALTH
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

SERIES 74
BEHAVIORAL HEALTH CONSUMER RIGHTS

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SERIES 74
BEHAVIORAL HEALTH CONSUMER RIGHTS

§ 64-74-1. General.

1.1. Scope. -- This legislative rule establishes the rights of consumers of State-licensed behavioral health services.

1.2. Authority. -- WV Code § 27-5-9(g).

1.3. Filing Date. --

1.4. Effective Date. --

1.5. Construction. -- This rule shall be liberally construed to effectuate the rehabilitative goals of Chapter 27 of the West Virginia Code, consistent with the protection of consumer rights and dignity.

1.6. Applicability - This rule applies to behavioral health services licensed by the division of health, department of health and human resources.

§ 64-74-2. Definitions.

2.1. Administrator. -- The chief executive officer of a behavioral health service.

2.2. Advance Directive. -- Any directive written and signed by a consumer, describing preferences in health care, behavioral health care, or the conduct of business.

2.3. Aggrieved. -- An individual, guardian or legal representative who believes rights accorded by this rule have been violated by a service or employee of the service.

2.4. Behavioral Health. -- Mental health, developmental disabilities, or substance abuse.

2.5. Behavioral Health Service. -- Any inpatient, residential or outpatient service for the care and treatment of persons with mental illness, developmental disability or addiction which is licensed by the department of health and human resources.

2.6. Chemical Restraint. -- The use of drugs or medication as a behavior control mechanism to substitute for seclusion or mechanical restraint.

2.7. Consumer. -- Any individual receiving treatment or services in or from a behavioral health service licensed by the department of health and human resources.

2.8. Clinical Director or Chief Medical Officer. -- The person who has the responsibility for decisions involving clinical and medical treatment of consumers in a behavioral health service.

2.9. Designated Grievance Representative. -- An individual employed by the service who has been appointed by the administrator of the service to assist any consumer wishing to file a grievance.

2.10. Individualized Program Plan (IPP). -- A master plan which is a written, individualized plan specifically tailored to individual needs, including a complete, thorough review of the consumer's needs, strengths, weaknesses, response to initial interventions and prognosis for resolution of acute symptoms, and other components as indicated in this rule.

2.11. Legal Representative.

2.11.a. A conservator, temporary conservator or limited conservator appointed pursuant to the West Virginia Guardianship and Conservatorship Act, WV Code, § 44-1-1-et seq., within the limits set by the order;

2.11.b. A guardian, temporary guardian or limited guardian appointed pursuant to the West Virginia Guardianship and Conservatorship Act, WV Code, § 44-1-1-et seq., within the limits set by the order;

2.11.c. An individual appointed as committee or guardian prior to June 9, 1994, within the limits set by the appointing order and WV Code 44A-1-2(d);

2.11.d. A person having a medical power of attorney pursuant to the West Virginia Medical Power of Attorney Act, WV Code §16-30A-1 et seq., within the limits set by the law and the appointment;

2.11.e. A representative payee under the U.S. Social Security Act, Title 42 US Code § 301 et seq., within the limits of the payee's legal authority;

2.11.f. A surrogate decision-maker appointed pursuant to the West Virginia Health Care Surrogate Act, WV Code §16-30B-1 et seq., or the West Virginia Do Not Resuscitate Act, §16-30C-1 et seq., within the limits set by the appointment;

2.11.g. An individual having a durable power of attorney pursuant to WV Code § 39-4-1, or a power of attorney under common law, within the limits of the appointment; or

2.11.h. An individual lawfully appointed in a similar or like relationship of responsibility for a consumer under the laws of this State, or another State or legal jurisdiction, within the limits of the applicable statute and appointing authority;

2.11.i. If a legal representative has been appointed for or designated by any consumer as

having the authority to exercise on behalf of the consumer one or more of the consumer's rights under this rule, the service shall permit the individual's legal representative to act on behalf of the individual and to exercise the authority to the extent granted to the legal representative in the order or other document naming the legal representative or pursuant to the statute authorizing the legal representative and to the extent that the legal representative's acts are not hostile or adverse to the best interests of the consumer. This provision does not relieve the service of the responsibility of informing the individual consumer as required by this rule, to the extent that the individual is capable of understanding the matter, nor does it in any way deprive the consumer of his or her legal rights granted under this rule or state or federal law or rules and regulations. If the consumer has a legal representative, the name, address and telephone number of the legal representative shall be recorded in the consumer's financial and clinical records, as applicable, along with the nature and scope of the authority granted to the legal representative by order, appointment or law. The service shall also maintain a copy of the document documenting or designating the legal representative. The service administrator and staff should note that the various types of legal representatives do not necessarily have the lawful authority to act on behalf of the resident in all matters which may require action by a legal representative. For example, a conservator may have responsibility for financial affairs, but not personal affairs, such as medical care.

2.12. Mechanical Restraints. -- Handcuffs, straight-jackets or "sleeves", or other restraining devices or variations of these devices which are designed and applied for the purpose of preventing an individual from engaging in assaultive or self-abusive behavior.

2.13. Mediation. -- Private, informal dispute resolution process in which a neutral third person, the mediator, helps disputing parties to reach an agreement.

2.14. Neglect. -- A negligent act or omission by an individual responsible for providing services in a behavioral health service rendering care or treatment which caused or may have caused injury or death to an individual or which placed an individual at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for an individual, the failure to provide adequate nutrition, clothing, or health care to an individual, or the failure to provide a safe environment for an individual, including failure to maintain adequate numbers of appropriately trained staff.

2.15. Physical Abuse. -- Any act or failure to act by an employee of a behavioral health service which was performed, or which was failed to be performed, knowlingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual, and includes such acts as

2.15.a. The rape or sexual assault of an individual;

2.15.b. The striking of an individual;

2.15.c. The use of excessive force when placing an individual in bodily restraints; and

2.15.d. The use of bodily or chemical restraints on an individual which is not in compliance with federal and State laws and regulations.

2.16. Seclusion. -- The placement of any consumer alone in a room or enclosed space with closed doors which the consumer cannot open from inside.

2.17. Secretary. -- The secretary of the West Virginia department of health and human resources or his or her designee.

2.18. Service. -- A behavioral health service.

2.19. Sexual Harassment. -- Physical advances or nonverbal conduct that is sexual in nature and is either: (1) unwelcome, offensive, or creates a hostile environment, when the staff member is aware or has been informed that his or her conduct falls into one of these categories; or (2) is sufficiently severe or intense to be abusive to a reasonable person in the particular context.

2.20. Verbal Abuse. -- The use of language, tone or inflection of voice that would likely be construed by an impartial observer as a threat to or, harassment, derogation or humiliation of a consumer. Verbal abuse includes, but is not limited to: the use of a threatening or abusive tone or manner in speaking to a consumer; the use of derogatory, vulgar, profane, abusive or threatening language; verbal threats; teasing, pestering, deriding, harassing, mimicking or humiliating a consumer; derogatory remarks about the consumer, his or her family or associates; or sexual innuendo, sexually provocative language or verbal suggestion.

§ 64-74-3. Adoption of Other Standards.

In addition to the standards set forth in this rule, the relevant portions of Conditions of Participation for Hospitals, 42 C.F.R. Part 482 (Oct. 1, 1997), and Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded, 42 C.F.R. Part 483, Subpart I (Oct. 1, 1997), pertaining to certification for participation in Medicare and Medicaid; the Patient Rights and Organizational Ethics Standards set forth in the 1995 Comprehensive Accreditation Manual for Hospitals of the Joint Commission on the Accreditation of Health Care Organizations, pages 63-83; and the standards set forth in the 1993 edition of Outcome Based Performance Measures of The Accreditation Council on Services for People with Disabilities, pages 1-11 and 133-137, are hereby adopted by reference: Provided, That to the extent there is a conflict between the federal regulations or the accreditation standards and the standards specified in this rule, the more stringent standard applies, except that, if there is a conflict between a standard set forth in this rule and a federal standard required for purposes of certification for participation in Medicare or Medicaid, the relevant federal standard prevails.

§ 64-74-4. Consumers' Rights Generally.

4.1. Persons with behavioral health problems are more likely to have their human and civil rights denied because of their condition. Consequently, special attention and effort are required to assure that these human and civil rights are exercised and protected in all behavioral health services.

4.2. No Discrimination. All behavioral health services licensed by the department of health and human resources shall make available all offered services to persons in need without discrimination because of race, creed, color, gender, age, national origin, marital status, sexual preference,

physical or mental disability, or duration of residence. Crisis services, if offered, cannot be denied on the basis of inability to pay.

4.3. Civil Rights of Consumers. Every consumer served by any behavioral health service licensed by the department shall be permitted to exercise all of his or her civil rights, including but not limited to: civil service status and appointment; the right to register and vote at elections; the right to acquire and dispose of property; the right to execute instruments or rights relating to the granting, forfeiture or denial of a license, permit, privilege or benefit pursuant to any law; the right to enter into contractual relationships, to marry or to obtain a divorce; or the right to hold a professional, occupational or vehicle operator's licenses, unless he or she has had a legal representative appointed and the court has made a specific finding that the consumer is incompetent to exercise the specific right or category of rights.

4.4. Responsibility of Administrator. It is the responsibility of the service's administrator to assure that each consumer is informed of his or her rights and to make all necessary arrangements to allow the consumer to exercise his or her rights.

4.5. Consumers' Rights in a Group Setting Generally. Consumers shall be housed with other consumers of similar age and need, unless specific reasons such as the need to protect a consumer with a low level of adaptive skills and ability for self defense are noted in the treatment plan.

4.6. Right to Least Restrictive Residential Setting. The consumer has the right to access to treatment in the least restrictive setting. The goal of treatment for a consumer shall be to address needs so as to permit the consumer to be in the least restrictive setting.

4.7. Right of Privacy. A consumer has a right to privacy and the right to move about freely unless his or her safety or the safety of others is threatened.

4.8. No Deprivation of Rights As Punishment. No consumer can be deprived of a right provided by law or regulation as punishment. No consumer may be deprived of a right for clinical reasons except for an incident related to the exercise of that right and then only for so long as is necessary to permit correction of the situation or behavior.

4.9. Every consumer, upon his or her admission to a behavioral health service, and at any later time upon request, shall be given a summary of the rights afforded by this rule. A copy of this rule shall be available upon request.

4.10. The service shall establish simple and understandable rules for consumers and staff of the service which set the limits of behavior required of a group and individual consumers within the group.

§ 64-74-5. Advance Directives.

5.1. A consumer may enter a behavioral health service with an advance directive or may write and sign an advance directive during the time he or she is receiving service from the behavioral health service. Advance directives may address preferences in health care, behavioral health care,

or conduct of business. Advance directives may be withdrawn verbally or in writing by the consumer at any time. The existence of an advance directive does not indicate a lack of competency or other inability to care for oneself.

5.2. The behavioral health service shall ascertain if a consumer has a written advance directive at admission into the behavioral health service. If there is a written advance directive, it shall be copied into the consumer's record at the behavioral health service, with the consumer's permission. All members of the team shall be informed of the advance directive. The consumer should be informed of his or her rights concerning advance directives including:

5.2.a. All advance directives concerning preferences in health care shall be honored until withdrawn verbally or in writing;

5.2.b. All advance directives concerning preferences in the conduct of business shall be honored until withdrawn verbally or in writing; and

5.2.c. Advance directives concerning preferences in behavioral health services shall be honored to the extent resources are available, until withdrawn verbally or in writing, unless honoring the advance directive would cause serious harm to the consumer, endanger the consumer's life, or be dangerous to others. The behavioral health service shall consider initiating commitment proceedings whenever it is believed following an advance behavioral health service directive would pose a danger to the consumer or others.

5.3. If a consumer does not have an advance directive at the time of admission, the behavioral health service shall provide information and education concerning advance directives. The information shall cover advance directives for health care, behavioral health services, and conduct of business. Information presented shall be easily understood and shall be presented verbally and in writing.

5.3.a. Consumers may not be coerced into writing or signing an advance directive, nor shall the provision of service be conditioned on the existence of an advance directive.

§ 64-74-6. Consumers' Right to Treatment.

6.1. General. All consumers of behavioral health services have a right to treatment in the least restrictive setting, which may include care and treatment including habilitation, rehabilitation, medical care, education and training, when available and appropriate, and to behavioral health and support services suited to their individual needs. Treatment shall be provided humanely in an environment that affords civil, legal and regulatory rights, and provides freedom from verbal or physical abuse or neglect.

6.2. Trained and Competent Personnel. Every consumer of a behavioral health service has a right to treatment by trained and competent personnel in numbers sufficient to administer adequate treatment and individualized treatment plans.

6.3. Appropriate Treatment Based on Examination and Diagnosis. Every consumer of a

behavioral health service has a right to treatment based on diagnosis and assessment of needs by a staff member operating within the scope of his or her professional license.

6.4. Program Plan. Every consumer of a behavioral health service has a right to a program or treatment plan. The plan shall identify immediate needs and interventions, determine data or assessment needs, and establish responsibility for implementing the plan. The plan shall be updated on a regular basis, as the consumer's needs change. The consumer has the right to participate in the development of the program or treatment plan and any revisions.

6.5. Minimum Requirements of the Individualized Program Plan (IPP). Every consumer's program plan shall at a minimum:

6.5.a. Be based on a comprehensive assessment of the consumer's presenting problems, physical health, mental health, emotional status, behavioral status, and environmental status and needs;

6.5.b. Contain written, functional objectives, methods for achieving them, expected achievement dates, and anticipated or desired outcomes;

6.5.c. Describe treatment, services, activities, therapies, and programs to be accessed and provided;

6.5.d. Identify who is responsible for implementing the specific treatment services, activities, therapies, and programs;

6.5.e. Indicate the frequency and duration of treatment, services, activities, therapies and programs;

6.5.f. Delineate the specific criteria, including outcomes, to be met for termination of treatment or programming;

6.5.g. Document the extent of consumer and family participation in planning; and

6.5.h. Document by name and role all participants in developing the plan.

6.6. Evidence of Treatment. Evidence that recognized procedures applicable to meeting behavioral health needs have been administered to the consumer in accordance with his or her treatment plan, including but not limited to individual psychotherapy, group therapy, family therapy, physical therapy, appropriate physical fitness routines, chemotherapy, planned occupational therapy, and recreational therapy shall be documented in the consumer's record by the appropriate member of the interdisciplinary team.

6.7. Accepted Service Standards. Every consumer using a behavioral health service is entitled to care and treatment in accordance with accepted behavioral health and medical practice standards. If any of the rights set forth in this rule related to treatment are not afforded to the consumer, then the reasons for the restriction of the specific right shall be specified in the consumer's treatment plan

in the consumer's clinical record.

§ 64-74-7. Informed Consent.

7.1. Treatment cannot be given without written consent unless committed pursuant to WV Code §§ 27-5-3, 27-5-4, 27-6A-2(b) or 27-6A-3 without his or her written consent. If no informed consent is documented in the chart, the physician or person prescribing treatment shall provide information on his/her right to refuse treatment before treatment is begun.

7.2. Informed Consent. Consent is not valid unless it is informed consent. To assure informed consent, an appropriate behavioral health professional shall explain and discuss the following with each consumer:

7.2.a. The nature of the consumer's condition;

7.2.b. The reasons for taking any proposed medication, including the likelihood of the consumer's condition improving or not improving without the proposed medication;

7.2.c. That consent, once given, may be withdrawn at any time by stating the intention to any member of the treating staff;

7.2.d. The reasonable alternative treatments available, if any;

7.2.e. The type, range of frequency and amount, including the use of PRN (as needed) orders, the method (oral or injection) of administration, and the duration of taking the proposed medication;

7.2.f. The probable side effects to the proposed medication known to occur commonly, and any particular side effects likely to occur with the particular consumer;

7.2.g. Possible additional side effects of the proposed medications which may occur to consumers taking the medication beyond three (3) months; and

7.2.h. His or her rights under this rule.

7.2.i. This explanation and discussion shall be documented and signed by an appropriate behavioral health professional and consumer.

7.3. Requirement for Consent. Antipsychotic medication may be administered to an adult consumer only after the consumer has given informed, voluntary consent in writing, except as provided in the procedures set forth in this subsection.

7.3.a. Consent shall be considered to be informed only after the consumer has been provided with the information specified in subsection 7.2 of this rule by the physician prescribing the medication.

7.3.b. The consumer shall be asked to sign the consent form utilized in obtaining informed consent from voluntary consumers, and this signed consent form shall be included in his or her chart. In the event that the consumer has been shown the form and communicates consent but does not wish to sign the written consent form, it is sufficient for an appropriate behavioral health professional to place the unsigned form in the consumer's record together with the notation that while the consumer understands the nature and effect of antipsychotic medication and consents to the administration of the medication, the consumer does not want to sign a written consent form.

7.3.c. Consent is effective for ninety (90) days or until the consumer consents to a new/revised treatment plan, unless it is revoked by the consumer, whichever comes first.

7.4. Revocation of Consent. A consumer who has consented to treatment may refuse a specific treatment at any time, by stating or writing that he or she does not wish to continue that treatment. That treatment may not then be provided to the consumer, except as authorized in a psychiatric emergency. A revocation of consent shall be documented on the consent form and renders the previously given consent void.

7.5. Consent to Treatment. Except with respect to psychiatric emergencies, an individual has a right to refuse treatment. In some cases conditions exist which, if not treated, reasonably can be expected to cause permanent damage or severe pain. When considering whether to proceed with treatment in these instances, a decision shall be made in accordance with clear and objective criteria.

7.5.a. There is no statutory authority to provide treatment prior to actual commitment in the absence of informed consent. The procedures outlined in this rule are provided for use only when:

7.5.a.1. Treatment is not refused;

7.5.a.2. No informed consent is forthcoming;

7.5.a.3. The risk of harm from failure to treat is demonstrably greater than the risks from treatment; and

7.5.a.4. The individual is unable to make any judgement to consent or refuse treatment.

7.5.b. When an individual is admitted to a behavioral health service, he or she shall be evaluated. The staff performing the evaluation shall employ the following procedures:

7.5.b.1. Determine whether the individual is clinically competent to understand the nature and purpose of the proposed treatment, as well as its prospective benefits and possible side effects. The examining physician and other behavioral health service staff shall utilize, and document the utilization of, accepted professional procedures for determining competency to understand the proposed treatment.

7.5.b.2. If the individual is determined to be able to make an informed decision relative to treatment, the proposed treatment shall be explained in detail and written consent to

treatment shall be requested. No individual shall be asked to sign consent to treatment until the individual's competence to give consent has been determined. Treatment may be initiated if the individual gives consent, but a refusal to consent shall be honored and no treatment shall thereafter be forced upon the individual prior to receiving a written commitment order from the circuit court pursuant to a commitment hearing.

7.5.b.3. If it is determined that the individual is not capable of giving informed consent to treatment, and there is no legal representative or other advance directive to provide the consent, the examining physician shall determine whether there is a significant likelihood that the symptoms for which the treatment is proposed are likely to become either more severe or long-lasting or both if treatment is withheld, and whether the proposed treatment is likely to produce side effects which may be harmful to the individual. Proposed treatments shall be those which are commonly accepted and recognized as appropriate for the condition being treated. In every instance, the more conservative of the available treatment options shall be chosen.

7.5.b.4. If the examining physician determines that there is little risk of serious deterioration in the absence of treatment and that the proposed treatment carries relatively little risk to the consumer, the physician shall present to another physician the facts upon which these conclusions were based.

7.5.b.5. If the other physician agrees with the recommendations, treatment may commence without consent for treatment.

7.5.b.6. All steps in this procedure, as well as all of the facts on which treatment decisions are based, shall be carefully documented in the medical record and signed by the attending physician.

7.5.c. The procedures outlined in this section are not intended to apply to those individuals who are in need of life-saving medication for chronic medical conditions such as diabetes or heart disease, who have been taking medications prior to admission and who are not actively refusing to continue the medication, notwithstanding that they may not currently be able to give consent.

§ 64-74-8. Right to Refuse Treatment.

8.1. General. As a participant in the program planning process, the consumer has the right to exercise a voice in his or her program plan and to object to or refuse aspects of the plan.

8.2. Use of Internal Discussion, Negotiation and Grievance Procedure. The consumer's right to object to or refuse treatment is recognized as legitimate, and shall be responded to in accordance with the provisions of the consumer grievance procedure if informal discussion and negotiation do not resolve differences.

8.3. Alternatives Offered and Provided. The treatment team for any consumer who has refused psychotropic medications or other recommended therapy shall meet and work toward an agreed-upon effective alternative treatment which is offered and provided if the consumer consents.

8.4. Oral Refusal Overrides Prior Written Consent. An individual consumer's oral refusal to accept medication or other treatment always overrides prior written consent except in emergency situations as defined in this rule.

§ 64-74-9. Research and Experimental Treatment.

The federal regulations Protection of Human Subjects, 45 C.F.R. Part 46 (Oct. 1, 1997), are hereby adopted by reference, and all research, studies, or investigations conducted in behavioral health services shall comply with this rule.

§ 64-74-10. Seclusion and Restraints.

10.1. General. Consumers have the right to freedom from seclusion or mechanical or chemical restraints. Seclusion and restraint shall be used only where there is imminent danger that the consumer will injure himself or herself or others and only when all other less restrictive measures have been exhausted.

10.2. Seclusion Prohibited for People with Developmental Disabilities. Seclusion for developmentally disabled consumers is strictly prohibited. Only the "time-out" procedure developed specifically for each consumer in his or her program plan in accordance with standards of the Accreditation Council on Services for People with Disabilities may be used for the developmentally disabled consumer.

10.3. Emergency Measure Only. Seclusion is an emergency control measure only and may be used only as a last resort to control imminent destructive behavior that is a threat to the consumer or others. It may be used only when the consumer has not responded to less restrictive measures and only as long as is necessary for the consumer to regain self-control. Under no circumstances may it be used as a preventive measure or for punishment.

10.4. Seclusion is a severely restrictive form of intervention. Each behavioral health service shall provide to appropriate staff annual training in commonly accepted and recognized procedures to be used as an alternative to seclusion. Training in these procedures shall be documented in personnel records. Whenever seclusion is ordered or provided, all steps taken prior to seclusion shall be documented, with reference to procedures used, which are relevant to training provided. The steps and procedures outlined below shall be followed prior to its use.

10.4.a. Examination by Physician. No consumer may be placed in seclusion until he or she is examined by the attending physician, and a discussion is held with available team members. In the event an attending physician is not immediately available, the person in charge shall discuss the situation with the team members and obtain a telephone order from the physician if the physician concurs that seclusion is required.

10.4.b. Telephone Orders. A telephone order for seclusion is valid for a maximum of eight (8) hours, notwithstanding time limitations noted below (e.g., subsection 10.7). Regardless of the length of seclusion and whether or not the consumer is still in seclusion, the attending physician shall examine a consumer within eight (8) hours of a telephone order for seclusion. The attending

physician shall determine and document the appropriateness of seclusion, whether staff have complied with this rule regarding seclusion, and whether staff have followed and utilized training in alternative measures prior to requesting and/or instituting seclusion.

10.5. Time. The time spent in seclusion shall be the shortest time required for the consumer to regain his or her self-control.

10.6. Seclusion Inappropriate for Suicidal Consumers. Seclusion shall not be used for a consumer who is actively suicidal or for a consumer for whom constant observation has been ordered. If the physician determines that seclusion is necessary, special documentation and one-on-one observation are required.

10.7. Seclusion Orders Valid Only for Three (3) Hours. No seclusion order is valid for more than three (3) hours. Any consumer requiring seclusion beyond three (3) hours shall have his or her status reviewed by his or her treatment team and a written plan developed for responding to the consumer's crisis. Continued seclusion requires an examination and written order by a physician after every three (3) hour period. In the event an attending physician is not immediately available, the person in charge shall discuss the situation with the team members and obtain a telephone order from the physician if the physician concurs that seclusion is required. If a telephone order is obtained pursuant to subdivision 10.4.b above, a person may be placed in seclusion for up to three (3) hours. If the treatment team believes the seclusion should be continued beyond the three (3) hour period, another telephone order is required if a physician is not immediately available. Within eight (8) hours of each of the two (or more) telephone orders (each lasting three hours), a physician shall document the appropriateness of the seclusion as required by subdivision 10.4.b above.

10.8. PRN (as needed) orders for seclusion are not permissible.

10.9. Items Entitled During Seclusion. A consumer who is placed in seclusion is entitled to clothing, a bed, a mattress, and bedding.

10.10. Supervision of Individuals in Seclusion. Any room used for seclusion shall permit constant supervision of the consumer by staff.

10.11. Seclusion Room Supervision. The person in charge of care or of the area containing the seclusion room is responsible for assuring that the following seclusion room checks and procedures are carried out:

10.11.a. Each consumer in seclusion shall be checked no less frequently than every five (5) minutes, and the seclusion room "check sheet" shall be updated and initialed to assure the presence and safety of the consumer in the seclusion room;

10.11.b. The consumer shall have access to fluids and to the toilet hourly, or more frequently if needed. Meals shall be delivered at regular meal times. Compliance with these requirements shall be documented on the check sheet; and

10.11.c. A member of the team or the person in charge of the area containing the seclusion

room shall talk directly with the consumer and assess the need for continued seclusion at least every fifteen (15) minutes. The attending physician shall review and approve the documentation of assessments within eight (8) hours.

10.12. Mechanical Restraints As Emergency Measure. The use of mechanical restraints is an emergency control measure only, and may be used only as a last resort to control imminent destructive behavior that is a threat to the consumer or others and that has not responded to medications or other less restrictive measures.

10.12.a. All forms of physical restraint require constant monitoring and consideration of a consumer's physical needs and status.

10.12.b. Adequate numbers of staff are essential both for consumer monitoring and for safe placement of consumers in restraints.

10.13. Restraint Procedures for Consumers with Developmental Disabilities. Only procedures developed in accordance with standards of the Accreditation Council on Services for People with Disabilities may be used for consumers with developmental disabilities.

10.14. Examination by Physician. No consumer may be placed in mechanical restraints until he or she is examined by the attending physician and a discussion with available treatment team members is held. Mechanical restraints may be initiated only on written order of a physician.

10.15. Mechanical Restraint Order Valid Only for Three (3) Hours. No mechanical restraint order is valid for more than three (3) hours. Any consumer requiring restraint beyond three (3) hours shall have his or her status reviewed by his or her treatment team, and the treatment team shall confer and develop a written plan which responds to the consumer's crisis. Continued use of mechanical restraints requires an examination and written order by the attending physician after every three (3) hour period in addition to the treatment team conference and plan.

10.16. PRN (as needed) orders for mechanical restraint are not permissible.

10.17. Supervision of Mechanical Restraints. If the physician determines that mechanical restraints are necessary, special documentation and one-on-one observation are necessary. The procedure for the application of mechanical restraints shall be followed to assure that no restraint is applied in a manner as to produce physical pain or damage to the consumer. Opportunity for motion and exercise shall be provided for a period of not less than ten (10) minutes during each two (2) hours in which restraint is employed.

10.18. Metal Handcuffs Unacceptable. Metal handcuffs are not considered an acceptable form of restraint for consumers and shall not be used for that purpose.

10.19. Continued Assessment. A team member or person in charge of the unit or shift shall talk directly with the consumer and assess the need for continued restraint at least once every fifteen (15) minutes.

10.20. Punishment or Convenience. Mechanical Restraints shall not be used as punishment or for the convenience of staff.

10.21. Limitation on Use of Chemical Restraint. Drugs or medications shall not be used as punishment, for the convenience of staff, as a substitute for adequate staffing, or as a substitute for a treatment plan. Drugs and medication may only be administered pursuant to informed consent.

10.22. Documentation. In every instance in which emergency control measures are used for any length of time and each time the consumer is reexamined and a new order written (every three (3) hours), a full report shall be made by the attending physician, describing in detail the rationale for the decision of the treatment team and the failure of less restrictive measures to resolve the crisis.

10.23. Copies. Copies of the attending physician's report shall be sent to the clinical director and shall be attached to the consumer's medical record.

10.24. Minimum Required Documentation. The following minimum required documentation is necessary for seclusion or restraint:

10.24.a. The attending physician's written order for seclusion or restraint shall be placed on the doctor's order sheet in the consumer's record. Staff securing a verbal order for seclusion shall document the date and time the attending physician was called and the reason for the order;

10.24.b. Documentation stating the time that the consumer was placed in seclusion or restraint, the time the physician examined the consumer, and the time the consumer was released;

10.24.c. A full report by the staff using emergency control measures of each and every incident in which the emergency control measures are used, describing the situation, other measures taken, the failure of less restrictive measures and the rationale for seclusion. The staff person responsible for the unit or shift shall see that this report is completed and sent to appropriate parties, including the clinical director, and attached to the consumer's medical record;

10.24.d. A reflection of the decision of the treatment team for handling the crisis in the consumer's program plan;

10.24.e. A note on the twenty-four (24) hour report;

10.24.f. The five (5) minute check sheet for use of seclusion;

10.24.g. Progress notes from other disciplines if applicable; and

10.24.h. Hourly assessment of the continued need for seclusion or restraints by a team member or supervisor of the unit or shift.

10.25. Trial Release Procedure for Seclusion and Restraint. Seclusion and restraint are intended to provide external controls for the protection of the consumer or to prevent the consumer from injuring others. Continued use of the controls beyond the time when they are needed is

inappropriate, regardless of the maximum period of three (3) hours allowed. It is the responsibility of the staff person in charge to assure that the seclusion or restraint measures are stopped when the behavior of the consumer makes their continued use unnecessary.

10.25.a. When it is clear that the consumer has regained self-control, the person in charge of the area in which restraints have been applied shall authorize, in writing, release for a trial period prior to the expiration of the three (3) hour period allowed. Under these circumstances, staff should continue close observation of the consumer. Restraints shall be removed in a graduated, stepwise manner, negotiated with the consumer as part of an ongoing assessment of the consumer's clinical state. An inconsistent, impulsive, non-graduated, or non-negotiated "on-again, off-again" approach shall be avoided.

§ 64-74-11. Confidentiality.

11.1. Confidential Information

11.1.a. Communications and information obtained in the course of treatment or evaluation of any consumer is considered to be confidential information, including: the fact that a person is or has been a consumer; information transmitted by a consumer or his or her family for purposes relating to diagnosis or treatment; information transmitted by persons participating in the accomplishment of the objectives of diagnosis or treatment; all diagnoses or opinions formed regarding a consumer's physical, mental or emotional condition; any advice, instructions or prescriptions issued in the course of diagnosis or treatment; and any record or characterization of these matters. Confidential information does not include information which does not identify a consumer, information from which a person acquainted with a consumer would not recognize the consumer, and encoded information from which there is no possible means to identify a consumer.

11.1.b. In order to protect the consumer from demeaning remarks about his or her condition, medical and behavioral health care professionals, staff and other employees shall not discuss a consumer's assessment, diagnosis, treatment, or any other aspects of his or her condition among themselves unless this discussion directly relates to the consumer's treatment.

11.2. Disclosure of Confidential Information.

11.2.a. Confidential information may be disclosed:

11.2.a.1. In a proceeding under WV Code § 27-5-4 to disclose the results of an involuntary examination made pursuant to WV Code §§ 27-5-2 or 27-5-3;

11.2.a.2. In a proceeding under WV Code § 27-6A-1 et seq. to disclose the results of an involuntary examination made pursuant thereto;

11.2.a.3. Pursuant to an order of any court based upon a finding that the information is sufficiently relevant to a proceeding before the court to outweigh the importance of maintaining the confidentiality established by this section. Once a subpoena is received it is the duty of the custodian of the records to request a determination from the court having jurisdiction to make this

finding before the records are provided;

11.2.a.4. To protect against a clear and substantial danger of imminent injury by a consumer to himself or herself or to another; and

11.2.a.5. For treatment or internal review purposes, to staff of the behavioral health service where the consumer is being cared for or to other health professionals involved in treatment of the consumer.

11.2.b. Consumers shall be informed upon the commencement of any contact with medical or behavioral health professional that their rights to confidentiality are limited in the ways set forth in this rule.

11.3. Authorization for Disclosure.

11.3.a. All consents for the transmission or disclosure of confidential information, regardless of the mode of transmission, shall be in writing and signed by the consumer or by his or her legal representative. Every person signing an authorization shall be given a copy.

11.3.b. Every person requesting an authorization shall inform the consumer or authorized representative that refusal to give an authorization will in no way jeopardize his or her right to obtain present or future treatment except where and to the extent disclosure is necessary for treatment of the consumer or for the substantiation of a claim for payment from a person other than the consumer.

§ 64-74-12. Right to Unrestricted Communication.

12.1. Generally. Every consumer has the right to unimpeded and private communication with whomever the consumer chooses by mail, telephone, visits, or otherwise, except as specified in this rule.

12.2. Restrictions. Any deviation from the rights afforded by subsection 12.1 of this rule can only be authorized by the interdisciplinary team or the attending physician for a time specified by the team. A complete report relative to the restriction of telephone or mail rights and the reasons therefore shall be made a part of the consumer's medical record, signed and dated by the consumer's attending physician, and reflected in the consumer's treatment plan. Restrictions of mail and telephone rights shall expire in thirty (30) days.

§ 64-74-13. Consumers' Labor, Earnings and Funds.

13.1. Consumer Labor Generally.

13.1.a. No consumer may be required to perform uncompensated labor which involves the operation and maintenance of the behavioral health service. Privileges or discharge from the service shall not be conditional upon the performance of labor.

13.1.b. Consumers may be voluntarily employed in labor which involves the operation and maintenance of the behavioral health service, if the labor is compensated in accordance with the requirements of relevant State and federal law and regulations.

13.1.b.1. Consumers who are employed to perform work of economic benefit to the service shall be paid wages which are commensurate with those paid other workers for essentially the same type, quality and quantity of work.

13.2. Vocational Training/Employment. Consumers may perform vocational training tasks which do not involve the operation and maintenance of the service, so long as an assignment:

13.2.a. Is an integrated part of the consumer's interdisciplinary program plan;

13.2.b. Has been approved as a program activity by the professional responsible for the vocational training program; and

13.2.c. Is supervised by a staff member.

13.3. Sheltered Workshops. Approval for a sheltered workshop may be obtained for a specific workshop program. Sheltered workshops operated by a service are required to be in compliance with applicable State and federal laws, rules and regulations.

13.4. Training and Evaluation Program. A certificate can be obtained for programs which provide competent instruction and supervision and are designed to determine a working consumer's potential and to teach adjustment to a work environment or the skills related to one (1) or more types of work. The duration of the evaluation and training shall depend upon the total facts of the situation, but in no case shall exceed twelve (12) months. Time spent in an employment relationship in the service, prior to the effective date of participation in the training program, shall be counted in determining the duration of the work evaluation and training. It is not permissible to place a consumer who has been involved in any work situation within the service for more than twelve (12) months in a work and training evaluation program without pay.

13.5. Personal Housekeeping. Consumers may be required to perform personal housekeeping tasks, such as making their bed, tidying their room, doing their laundry, etc.

13.6. Access to Personal Funds. Consumers shall have unlimited access to their funds except as provided by this rule or by West Virginia law.

13.6.a. Any service which establishes a system to be payee for consumers' Supplemental Security Income (SSI) or Disability Insurance (SSDI), or both, shall have written policies and procedures to ensure reasonable personal access to funds. The policies and procedures shall comply, at a minimum, with requirements imposed by federal rules promulgated by the Social Security Administration.

13.6.b. If a service is a payee for SSI or SSDI, there shall be information in the treatment record describing reasons for the service serving as a payee. The record shall indicate why the

consumer needs a payee and why no other source was available or was chosen to be the payee. The necessity of a payee shall be documented quarterly. If there is no justification for a payee, the service shall assist the consumer in applying to be his or her own payee.

13.6.c. If a service is a payee, the service shall maintain records of income and expenses. Each consumer for whom the service is a payee shall receive a statement of income and expenses monthly.

13.6.d. Consumers who have been adjudicated incompetent and have had a conservator or other individual with financial authority appointed shall have the same access to their funds as set forth in subsection 13.4 of this rule, subject to reasonable limitations by his or her conservator.

13.6.e. The treatment record of a consumer who has an appointed conservator or other individual with financial authority shall document this appointment and the reasons for the appointment. The need for a conservator shall be evaluated quarterly. If the service believes the consumer no longer requires an appointed conservator or other financial authority, the service shall assist the consumer in applying for release.

13.6.f. If a consumer who has an appointed conservator or other individual with financial authority believes he or she does not have sufficient access to his or her funds, the service shall evaluate the grievance and assist the consumer in filing to seek redress.

13.6.g. A consumer, conservator, or other court appointed financial authority may be required to pay for care and treatment provided by a service.

13.6.h. Any consumer who has a payee for SSI or SSDI, or has a court appointed conservator or other financial authority shall receive training in money management, unless the treatment record indicates the consumer has refused such the training or will not benefit from such the training.

13.6.i. The service shall cease to be payee for SSI or SSDI and shall assist the consumer in applying for release from having a payee, conservator, or other court appointed financial authority, if the consumer demonstrates ability at money management.

13.7. Notification. All consumers assigned to a work situation shall be informed of the rights provided by this rule. The information shall be provided as follows:

13.7.a. The consumer workers and their responsible relative or legal representative may be notified in writing of these rights; and

13.7.b. Written notification of rights under this rule shall be posted in every licensed living unit operated by the service.

§ 64-74-14. Legal Representative.

14.1. Generally. On admission to a behavioral health service, it shall be determined if the

consumer has a legal representative. If the consumer has a legal representative, identifying information shall be entered in the consumer's record. The responsibilities and limitations of the legal representative shall be listed.

14.2. Protection of Rights. The behavioral health service shall not honor requests or demands of a consumer's legal representative which are in excess of the detailed responsibilities and limitations of the legal representative.

14.3. Reporting Violations. The behavioral health service shall, with written permission of the consumer, report any violations of the legal representative's responsibilities and limitations. Reports shall be provided to the consumer's choice of advocate, attorney, or both.

§ 64-74-15. Employee Responsibilities.

15.1. Duty of All Employees. Every employee has the responsibility to assure that all rights afforded to consumers by applicable State and federal laws, rules and regulations, including this rule, are protected and afforded to consumers.

15.2. Abuse and Neglect. No employee shall verbally or physically abuse, or neglect any consumer.

15.3. Sexual Harassment. Employees shall not engage in sexual harassment of consumers.

15.4. Mandatory reporting. Every employee has a duty to report any incident of actual or suspected abuse or neglect to the administrator and to adult protective services workers or child protective service workers.

15.5. Training of Employees. The administrator has the duty to train and educate all new employees and all current employees on a periodic and consistent basis on the content of this rule so that all employees are thoroughly familiar with it.

§ 64-74-16. Juveniles' Additional Rights.

16.1. Separation. No consumer under eighteen (18) years of age shall be housed in any area licensed or operated by a behavioral health service and also occupied by any consumer over eighteen (18) years of age. Except that, individuals above the age of eighteen (18) who have not yet been emancipated can room with persons under the age of eighteen (18).

16.2. Education. Any behavioral health service serving consumers under twenty-one (21) years of age shall advocate for education for the consumers in conformity with applicable portions of relevant State or federal law.

16.3. Family Contact. The behavioral health service shall make every effort to assure appropriate family contact and communication between consumers under the age of eighteen (18) and their family members. These efforts, and the results of the efforts, shall be documented.

16.4. Inclusion. All rights under this rule apply equally to consumers under the age of eighteen (18).

16.5. The service shall establish simple and understandable rules which set the limits of behavior required for the protection of a group and individual consumers within the group. The rules shall be written for consumers under the age of eighteen (18) and staff serving these consumers.

16.5.a. No consumer under the age of eighteen (18) shall be withdrawn from any therapy program as a disciplinary measure.

§ 64-74-17. Consumer Advocacy and Grievance Procedure.

17.1. Each service shall offer clear and timely review of any alleged violation or infringement of the rights afforded by this rule.

17.2. During the admission process, consumers and their families shall be advised of their right to initiate a grievance concerning the quality of care or violation of their rights during time they receive service.

17.2.a. Consumers already being provided service shall be advised of the grievance policy and procedure at their next treatment planning meeting.

17.2.b. Each service affected by this rule shall conduct regular inservice training sessions for staff covering the grievance procedure.

17.2.c. Consumers shall be advised that if they believe their rights are being violated, they should talk to an advocate such as their doctor, social worker, therapist, nurse, other external advocate, or individual with whom they feel comfortable. Staff of any service affected by this rule shall assist a consumer in the initiation of the grievance process.

17.2.d. Each consumer shall be provided a brief, easily understood, statement of consumer rights, the service's grievance policy, and the name and telephone number of an external advocate.

17.2.e. Failure of a consumer to file a grievance shall not prevent pursuit of other relief.

17.3. Any complaint which does not contain allegations of abuse or neglect should be resolved through an attempt at informal problem resolution, including mediation.

17.4. Initiating the Grievance Process. The grievance may be initiated verbally or in writing. Grievance forms shall be made available to a consumer on request, by any person employed by the service.

17.4.a. Individuals with a grievance shall not be prevented from using the grievance procedure.

17.4.b. Individuals always have the right to withdraw grievance at any step in the process.

17.4.c. The designated grievance representative employed by the service shall offer assistance to any consumer unable to write the complaint and shall assure that the grievance report is fair and accurately represents the individual's concern.

17.4.d. Once finalized, the grievance shall be delivered by the designated grievance representative employed by the service to the appropriate designated internal committee.

17.5. Allegations of Abuse, Neglect, or other Serious Breach of Consumer Rights. The designated grievance representative employed by the service shall interview the grievant upon receipt of a grievance. A report of all violations or suspected violations of a consumer's rights accorded by this rule shall be made within twenty-four (24) hours to the appropriate designated internal committee of the service and the administrator of the service. In the event of abuse or neglect or suspicion of abuse or gross neglect, the appropriate designated committee and administrator shall be immediately notified following the interview.

17.5.a. Any reasonable suspicion of abuse or neglect shall be reported to civil and criminal authorities in accordance with the applicable West Virginia Adult Protective Services Act or West Virginia Child Protective Services Act, in addition to reporting to the appropriate designated internal committee and the administrator.

17.5.b. Reporting incidents of abuse or neglect in accordance with the Adult Protective Services Act or the Child Protective Services Act does not relieve the service of the obligation to respond to the grievance filed, monitor staff, and to enforce this rule. The duty of the service to conduct an investigation under this rule is independent of any investigation conducted under those Acts or by law enforcement officers or the prosecuting attorney.

17.6. Complaints of violations of rights, once filed, require a written administrative response. The service may delay or defer its investigation until law enforcement authorities have completed their investigation only if the administrator of the service concludes that a delay will not adversely affect the health and safety of the grievant or other consumers.

17.7. Formal Complaints and Resolution. The appropriate designated committee of the service shall convene within five (5) working days of receiving a report of a grievance, to investigate the allegations contained in the written grievance.

17.7.a. The appropriate designated committee shall ascertain the facts by communicating with all parties involved in the complaint. The aggrieved, with his or her representatives, shall have the opportunity to appear in person before the committee.

17.7.b. The appropriate designated committee shall render a decision on the grievance and report to the administrator of the service within ten (10) working days following the initial meeting convened for the purpose of hearing the grievance.

17.8. The governing board of the service, or the board member or members who have been

appointed by the board as consumer grievance hearing officer or officers to render a decision on behalf of the board, shall convene within ten (10) working days after receipt by the administrator of the recommendation and report of the appropriate designated committee, review all evidence gathered, request any additional information, and to render a decision concerning the grievance. The aggrieved individual, with his or her representatives, shall have the opportunity to appear before the governing board or consumer grievance hearing officer or officers, as applicable, if he or she so chooses.

17.8.a. If the governing board or consumer grievance hearing officer or officers find evidence to substantiate the grievance, the board or a consumer grievance hearing officer shall notify all interested parties, and the governing body shall take appropriate action.

17.8.b. If the grievance is disapproved by the governing board, or consumer grievance hearing officer or officers, the board or a consumer grievance hearing officer shall:

17.8.b.1. Notify all interested parties of the grievant's right to request a hearing by the Secretary or to bring action in circuit court against the service;

17.8.b.2. Provide information on the process for requesting a hearing by the Secretary; and

17.8.b.3. Provide the reason that no substantiation of the grievance was made.

17.9. A grievant may, after receipt of the decision on his or her grievance, request a hearing by the Secretary or bring action in circuit court against the service.

17.9.a. A hearing held by the Secretary shall be held in accordance with West Virginia Code Chapter 29A. Articles 4 and 5, and the Rules for Procedure for Contested Case Hearings and Declaratory Rulings, 64 CSR 1, except that: the "Director" defined in such rules shall be the Secretary; and the Secretary may at his or her discretion deny a hearing request, in which case the grievant may bring an action in circuit court against the service.

17.9.b. The governing body of the behavioral health service shall be a party to a hearing by the Secretary.

17.9.c. The final order entered by the Secretary after a hearing shall be binding upon the parties unless appealed in accordance with West Virginia Code Chapter 29A, Articles 5 and 6.

§ 64-74-18. Severability. The provisions of this rule are severable. If any portion of this rule is held invalid, the remaining provisions remain in effect.

FISCAL NOTE FOR PROPOSED RULE

Rule Title: Behavioral Health Consumer Rights, 64CSR74

Type of Rule: X Legislative __Interpretive __Procedural

Agency: Division of Health
Department of Health and Human Resources

Address: Building 3, Capitol Complex
Charleston, WV 25305

1. Effect of the Proposed Rule	ANNUAL		FISCAL YEAR		
	Increase	Decrease	Current	Next	Thereafter
Estimated Total Cost	$	$	$	$ 0	$ 0
Personal Services					
Current Expense					
Repairs and Alterations					
Equipment					
Other					
Revenue					

2. Explanation of above estimates

It is not anticipated this rule will add any additional costs to the Department. Monitoring for protection of rights and investigation of complaints and grievances is already included in the Department's budget.

3. Objectives of this rule:

This rule establishes rights for persons served by community-based behavioral health programs.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

This rule will have no economic impact on state government.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific Groups of Citizens.

This rule may require the expansion of grievance procedures by providers of community-based behavioral health providers. Economic impact should be minimal.

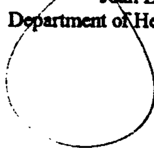
C. Economic Impact on Citizens/Public at Large.

This rule will have no economic impact on citizens or public at large.

Date:

Signature of Agency Head or Authorized Representative

Joan E. Ohl, Secretary
Department of Health and Human Resources



64CSR74

Behavioral Health Consumer Rights Rule

Commenters

George W. Lilley, Jr., Ed.D., CBHE, Chief Executive Officer, Valley Health Care

Richard Kiley, Ph.D., Executive Director, The Appalachian Community Health Center

Elizabeth Vandall, M.A., Quality Improvement Director, FMRS Mental Health Council, Inc.

Discussion of Public Comments Received
Concerning the Proposed Rule
Behavioral Health Consumer Rights, 64CSR74

Comment: General Comment: This Rule after passing the Legislature becomes law. There is excessively detailed PROCEDURE and medical PRACTICE that will become the legal standard and thus establish evidence for malpractice suites. This Rule in many areas duplicates the Licensure Rule. Thus when one Rule requires change, both would. This Rule incorporates by reference accreditation body standards, changes in which the Legislature would have no control over and the Legislature would be "giving over" its sole ability to create law to an accreditation body. Furthermore, confusion as to jurisdiction will occur should the accreditation body change its standards.

Response: The commenter has grouped several objections to adoption of the proposed rule in one short paragraph. Each objection is responded to separately as follows:

(1) It is true that if the proposed rule passes the Legislature, it will become law. This is the procedure in West Virginia. Each proposed rule undergoes an extensive review and comment period, followed by Legislative hearings, before it is adopted and becomes law.

(2) The rule outlines the rights of individuals receiving services from community-based behavioral health services and the steps providers of such services must take to assure that those rights are protected. The rule attempts to replicate an existing rule for persons served in State-operated behavioral health facilities. Up to 240 individuals may be served in such facilities; many thousands more receive community-based services and are not guaranteed the same rights as individuals in State-operated facilities.

(3) It is true that the rule governing licensing of behavioral health centers includes a section on the rights of individuals served by these entities. This rule specifically deals with the rights of individuals receiving behavioral health services; it is not specific to the status of the provider of such services. Additionally, if these rules are adopted, the licensing rule may be amended to reference these rules.

(4) The construction of this rule was based on identifying and recommending adoption of the highest standard of rights protection. Many sections of the rule replicate existing standards already adopted and afforded by prudent providers of behavioral health services. Many sections of this proposed rule are standards required of providers who accept as payment Medicaid, Medicare, or Block Grant funds. The reference to these standards enables providers to constantly strive for quality improvement in the identification and guarantee of rights of consumers of their services.

Comment: Fiscal Note for the Proposed Rule

This note indicates that economic impact on community-based behavioral providers will be minimal. We disagree with that assessment as it appears to us that we will have to provide more formal and lengthy training for all staff. We are not receiving any reimbursement while staff are in training but we must pay their salary for that time spent in training. The requirements regarding advance directives, informed consent, and access to consumer personal funds will require a great deal of time and effort to establish policies and procedures and may also require hiring additional staff.

It also appears that to comply with the requirements of the advance directives will require services to initiate commitment proceedings much more frequently. This will be a major cost to the system, including mental hygiene commissioners, police and the prosecuting attorney's office.

Response: The type of training discussed above should already be in place for those community behavioral health service providers meeting licensing requirements, requirements for Medicaid reimbursement, and requirements for Medicare reimbursement. Other behavioral health service providers have subscribed to standards of accrediting bodies—whether or not they seek accreditation—and/or have instituted quality improvement measures which require training in the issues discussed in this rule.

Generally, the availability of an advance directive decreases the need for and utilization of commitment procedures. It is anticipated system costs will decrease, as commitments will decrease. Simply put, if an advance directive is followed, there will be little need for a commitment to be initiated.

Comment: 64-74-1.6 Applicability – This rule applies to behavioral health services licensed by the division of health, department of health and human resources. Are all providers of behavioral health services licensed by the division of health, department of health and human resources? Does this rule apply to private psychiatrist's offices, for example?

Response: This rule applies only to behavioral health services licensed by the Department to provide behavioral health services of any kind. It would apply to a private psychiatrist's office if it is licensed by the Department.

Comment: 64-74-2.3 The aggrieved definition is vague and may lend to easy misinterpretation that a family member has a right to information through filing a grievance that would otherwise not be available to the family without the consent ofthe individual receiving service. The more appropriate definition would be "Aggrieved – an individual, guardian or legal representative who believes rights accorded by this rule have been violated by a service or employee of the service."

Response: The proposed amendment clarifies the intent of the definition and is accepted. The definition will be amended.

Comment: 64-74-2.10 Individualized Program Plan (IPP) "A master plan which is a written, individualized plan specifically tailored to individual needs, including...response to initial interventions and prognosis for resolution of acute symptoms and other components as indicated in this rule." Licensing and Medicaid regulations do not require a response to initial interventions and prognosis for resolution of acute symptoms, etc. on the master treatment plan. Will this rule supercede the licensing and medicaid regulations?

Response: This definition conforms with licensing regulations and Medicaid regulations. In addition, behavioral health services providers receiving reimbursement for services from Medicaid have been required to conduct assessments at intake and every 90 days thereafter. It is anticipated that information gained through these assessments—including response to initial interventions and prognosis for resolution of acute symptoms—will be utilized in developing the IPP.

Comment: 64-74-4.2 No Discrimination. "All behavioral health services...shall make available all offered services...Crisis services, if offered, cannot be denied on the basis of inability to pay". If the service offers crisis services, which include a CRU, does the rule stipulate that the service has to provide services at the CRU or does it still remain the service's determination as to what type of crisis service will be provided?

Response: The rule does not specify which crisis services shall be available regardless of inability to pay. Important in this section is that inability to pay is protected from discrimination only for crisis services.

Comment: 64-74-3 delete all cross references to other, non legislated regulations. Unwise for reasons give above.

Response: See comments in (4) above.

Comment: 64-7-4.1 Change to a positive statement, "Human and civil rights of consumers are of utmost importance. Consequently....."

Response: The first sentence of this paragraph is one essential reason for this rule. People with behavioral health needs are perhaps the most stigmatized of any class of people. The rule is being proposed not because rights are important—the Constitution guarantees that—but because rights are often ignored.

Comment: 64-74-4.3 This reads as if having a driver's license is a right. Having a driver's license is not a right, it is a privilege.

Response: This paragraph specifies that an individual's civil rights shall not be abridged simply by receiving behavioral health services. One civil right is obtaining a driver's license. One may not exercise their civil rights if they are found to be incompetent or have been convicted of a felony. This section clearly prohibits this loss of civil rights merely due to seeking and obtaining behavioral health services.

Comment: 64-74-4.4 Taken literally this standard would require the Administrator to make all necessary arrangements for a consumer's marriage. We request removing this standard.

Response: Taken literally, this section requires the Administrator to make all necessary arrangements to assure that a consumer's rights are protected.

Comment: 64-74-4.4 This section would be clearer if it read "Responsibility of Administrator. It is the responsibility of the services' administrator to assure that each consumer is informed of his or her rights and to make necessary arrangements to allow the consumer to exercise his or her rights while the organization is providing the service."

Response: Adoption of this proposed language might prevent a consumer from exercising rights to grieve a service's actions after the consumer is no longer being served by the service.

Comment: 64-74-4.5 "Group Setting", capitalized, needs to be in Definitions section.

Response: "Group Setting" is capitalized due to its place as a "title" of a paragraph.

Comment: 64-74-4.6 4.6 conflicts with 4.5 also "to access to treatment" is awkward wording.

Response: There is no conflict; the least restrictive setting may be a group setting. The sentence is clear: a consumer has the right to access to treatment in the least restrictive setting.

Comment: 64-74-4.9 The Center strongly suggests that this rule include or have as an attachment a copy of the Summary in order to assure uniform application of the rule. Further, in certain crisis situations there may be an exception to the rule due to the consumer's condition, circumstance or competency.

Response: The Department intends to make available a summary of this rule if it is adopted. It is anticipated the service would document requests for rights information and application of any exception to the rule.

Comment: 64-74-5 Advance Directives What is the intent of advance directives for behavioral health services, why are they needed and when and how do they work?

Response: The intent of an advance directive for behavioral health services is that a consumer when not in crisis can, with the assistance of a behavioral health services provider, friends, family, and other persons significant in the consumer's life describe how, when, and/or where she or he wants to be treated in the event of a psychiatric crisis. They are needed, particularly as the State considers managed behavioral health care, to reduce high cost services and activities such as commitment or voluntary hospitalization. In short, they create an effective and efficient interface and communication between consumer and provider and often serve as an excellent source of information and education for both consumer and provider. The way that they work is that a consumer writes an advance directive if he or she chooses, which describes what, where, and how she or he is to receive services in the event of a crisis. Crisis for that consumer is defined in the advance directive. The advance directive is provided to individuals key to the life of the consumer and instrumental in implementing crisis intervention services. The Department has provided training in advance directives and offers a free copy of a tool kit for providers, consumers, and family members.

Comment: 64-74-5.2 The standard assumes the patient is coherent at time of admission. Suggest that if not able to ascertain, document the attempt.

Response: A service does not need to rely solely on a consumer's input to ascertain if there is an advance directive.

Comment: 64-74-5.2.c If "Do not Resuscitate" is an Advanced Directive, following this rule would imply that a commitment proceeding should be initiated.

Response: "Do not Resuscitate" orders are not "Advance directives concerning preferences in behavioral health services."

Comment: 64-74-5.2.c Who will decide if resources are available? Will the service be allowed to make that decision or will some other entity tell us how we should use our resources? Also, this could result in increased commitment proceedings.

If someone is admitted to and is experiencing acute symptoms, who makes decisions about advance directives?

We think this section as written is not informative enough to really understand what will be required of the service.

Response: A consumer may have indicated she or he wants to be admitted to a CRU when in crisis. However, when a crisis as defined by the consumer occurs, the CRU has no space. The situation dictates that resources are not available to honor the advance directive. Treatment can proceed without resorting to commitment proceedings—just not in the CRU. If the overarching intent of advance directives is realized—mutual education, trust, and understanding between the consumer and provider—the resulting treatment will be congruent with the consumer's wishes

regarding the application of crisis services.

The advance directive as written makes decisions about advance directives. That is, it must be honored unless rejected by the consumer verbally or in writing, or if following the directive is a danger to the consumer or to others.

The Department has provided training in advance directives and offers a Tool Kit on the subject.

Comment: 64-74-5.3 This regulation presumes a non-crisis admission. Clarify expectations of a person being admitted under a psychiatric emergency where providing education about advance directives is impractical.

Response: This paragraph does not require information and education at the time of admission; it requires the service to ascertain if there is an advance directive at the time of admission and, if there is none, to provide information and education about it.

Comment: 64-74-6.1 One way to read the first sentence is that all consumers have a right to treatment – no conditions have to be met. Without sufficient funding and staff, this presents an impossibility. A service needs be able to say no. Please reword or remove the inference.

Response: The sentence neither nor states nor infers that all individuals have a right to treatment. The sentence is clear that all consumers of behavioral health services (e.g., all persons enrolled or admitted to treatment in accord with the service's rules, and the rules of funding entities, insurances agencies, or regulatory bodies) have the right to treatment in the least restrictive setting.

Comment: 64-74-6.5 Redundant with existing Licensure Rule. See comments above.

Response: This rule is applicable to entities in addition to those licensed as behavioral health centers.

Comment: 64-74-6.6 Suggest delete this as is procedural unless you are conferring a new right called "a right to have evidence of treatment."

Response: This paragraph recognizes that a consumer has a right to have created for him or her a record of treatment(s) provided.

Comment: 64-74-7.2 Informed Consent says "an appropriate behavioral health professional shall explain and discuss the following with each consumer...(which includes information about medication). 7.3.a then says it can only be informed consent after information specified above is provided by a physician. This will use a lot of physician time (that we don't have). Could not R.N.'s be utilized to provide consumers with information?

Response: The rule anticipates that a physician prescribing a medication will meet with the consumer for whom the medication is prescribed. Further, it specifies that a consumer has the right to learn from that physician the benefits and side effects of the medication, in order to provide informed consent for this treatment.

Comment: 64-74-7.2.b and 7.2.e – This covers specific medication. In reading this section it appears that informed consent must be given at the first meeting, prior to any treatment being provided. Usually, the doctor is not seen at the first meeting and has not provided any medication. How can we complete 7-2-a to 7-2-l prior to the doctor being seen?

Response: How can medication be prescribed prior to the doctor being seen? This rule does not prescribe actions or sequence of actions of a provider of behavioral health service—it outlines the rights of individuals receiving behavioral health services. An individual has a right to a explanation of the purpose of medication and its possible positive and negative effects in order to provide informed consent.

Comment: 64-74-7.3.c "Consent is effective for 90 days or until the consumer consents to a new/revised treatment plan"...Does this mean that signing the treatment plan is in effect giving consent for treatment? Or will the complete process of gaining consent be required? There are several types of consumers for which this would not be appropriate.

Response: Note that all treatments are a part of a treatment plan. Note, further, that treatment may be administered only after informed consent. This right has been written in regulation (64 CSR 11) for many years.

Comment: 64-74-7.5.a This particular paragraph is confusing and unclear.

Response: The comment is incomplete.

Comment: 64-74-7.5.b This is procedure and should be deleted as too specific for a Rule. See comments above.

Response: The rule specifies that this is procedure and assures the consumer the right to this procedure.

Comment: 64-74-7.5.b.1 In this section and throughout the proposed rule the determination of clinical competency of an individual to give informed consent for medical service would rest with competent physician. The determination of the individuals to give consent for behavioral health nonmedical service would rest with a properly licensed behavioral health provider such as a psychologist or other who is

qualified to make said determination in accordance with Chapter 30 of the West Virginia Code. To only have a physician make such a determination will interfere with timely delivery of service and interfere with qualified practitioners from practicing their trade.

Response: This section clearly references "other behavioral health service staff....(using) accepted professional procedures..." Specific, limiting references to a physician are in accord with West Virginia law and/or standards of practice.

Comment: 64-74-7.5.b.2 This section appears to be written for an institution. The concept of informed consent includes consent being given by an individual or a guardian and not just the individual. The concept of implied consent also needs to be explored. While the term "forced" is used in this section at times an individual will say no and still actively participate in treatment thus giving implied consent.

Response: If the individual is determined to be able to make an informed decision would preclude the need to obtain treatment permission from a guardian. If there is a guardian, informed consent would also need to be obtained from that individual. In no circumstance should treatment be provided without enacting emergency treatment procedures outlined in the rule if a consumer has refused to accept treatment after being informed of the treatment. The rule provides for treatment when a consumer has agreed to treatment but refuses to sign the informed consent.

Comment: 64-74-7.5.b.3 As this is the first mention of a physician, it presumes a physician is performing the evaluation mentioned in 7.5.b.

Response: This is not the first mention of examining physician (see 64-74-7.5.b.1). Most third party payers and other funding entities require an examining physician for admission evaluations.

Comment: 64-74-7.5.b.3 It appears to say that we can never provide treatment unless we have informed consent or initiate commitment proceeding. Then in 7.5.b.4 there is outlined a process to provide treatment without consent or commitment. This is confusing.

The whole process described for determining competence and for obtaining informed consent will be time consuming (particularly for the physician who is already overbooked) and complicated. It is the kind of process that usually ends up being a paper process.

Response: 7.5.b.4 presupposes treatment is advisable, but is commitment to require treatment may not be possible ("...little risk of serious deterioration in the absence of treatment...").

It is not understood how treatment can be or is provided in the absence of informed consent and in the absence of commitment. Paper, such as agreement to prescribed treatment, should not be processed unless such agreement has been authorized following an explanation of the potential benefits and/or disadvantages/side effects of the proposed treatment.

Comment: 64-74-7.5.b.4 Getting second opinion good but impractical in many rural clinics where there is only one doctor. More evidence for removing this procedure from the Rule.

Response: Second opinions may come from a physician not employed by the clinic, if necessary.

Comment: 64-74-7.5.b.6 First mention of the term "attending physician". The above procedure seems to be a subset of 7.5.b.3. Fist use of the term "medical record."

Response: This section requires documentation of the steps taken to obtain consent for treatment and documentation of steps taken in the event an individual is so incapacitated as to require extraordinary measures to initiate treatment in the absence of informed consent.

Comment: 64-74-8.1 If a consumer has the right to refuse aspects of the plan, then it should be stated that the service must have the right to deny any treatment to protect its legal liability. Please reword or make the right of the service explicit.

Response: This is a rule relating to the rights of consumers of behavioral health services.

Comment: 64-74-8.2 The wording is unclear. What is the object of "legitimate"? Also we believe the standard is meaning to convey that a consumer's objection or refusal should be taken seriously, as a legitimate objection or refusal.

Response: The wording is clear: A consumer's objection or refusal is not to be framed as the response of someone clearly needing the treatment she or he is refusing.

Comment: 64-74-8.9.b It is suggested that (this) be incorporated into the Rulesfor 64 CSR 11.

Response: It is intended that 64 CSR 74 is a compilation of all rights of individuals receiving behavioral health services.

Comment: 64-74-10.6 The two sentences under the same standard number, contradict each other. "Seclusion shall not be used" is the first sentence. The second states, "If seclusion is needed...If the two sentences are separate, separate and renumber.

Response: The first sentence is not stated in its entirety in the comment.

Comment: 64-74-10.18 This standard is understood to mean that the service would not use metal handcuffs but that a sheriffs department might.

Response: This standard is written to specify that metal handcuffs are not considered an acceptable form of restraint.

Comment: 64-74-2.10.21 Some group homes or crisis units utilize PRN medications for symptoms such as increased agitation. Will this kind of situation require the consumer seeing a physician prior to the medication being administered?

Response: PRN medication is not prescribed except for a specific consumer for specific purposes and specific times. Informed consent is necessary.

Comment: 64-74-10.24 We suggest deleting this entire section as too specific for a rule. If kept, move this complete section to follow 10.25, Trial Release.

Response: This section describes a consumer's rights to a record of seclusion or restraint. This section precedes 10.25 because 10.25 is a potential beginning of a loop, not the ending of a period of restraint or seclusion.

Comment: 64-74-10.24.b These procedures appear to contemplate a hospital setting.

Response: This right applies to any setting in which seclusion or restraint is utilized; nurses are employed in many settings other than hospitals.

Comment: 64-74-10.24.c "....full report by staff...." at 10.22, the full report was by the attending physician. Are these two separate reports or incorrect rule drafting?

Response: These are two separate reports: 10.22 is a report by the physician ordering the seclusion or restraint; 10.24.c is a report by the staff carrying out the orders.

Comment: 64-74-10.24.h Conflicts with fifteen minute requirement of pg. 12, 10.11.c.

Response: No conflict. 10.11.c references talking to the consumer and assessing the need for continuation. 10.24.h references documentation. Thus, a person talking to a consumer and assessing the need must record hourly notes, not notes every fifteen minutes.

Comment: 64-74-11 Redundant with Licensure Rule.

Response: This rule is applicable to entities in addition to those licensed as behavioral health centers.

Comment: 64-74-13.1 The right being protected here is not identified. Is it the right to work, not to work, right to what?

Response: The right being protected is the right to compensation for work performed.

Comment: 64-74-13.4 Training and Evaluation Program. A certificate (from whom) can be obtained. To what kinds of programs does this apply? There are day treatment programs serving the developmentally disabled population that are working on teaching adjustment to work environment and work skills. This rule would only allow this training to be done for one year. This is not at all an appropriate length of time for that population.

Response: A consumer should be evaluated regarding necessary treatment(s) every 90 days. Indicating that an entire population of consumers of behavioral health services should not be evaluated for a possible change in treatment at least annually is a negative self-fulling prophecy that this rule would alter.

Comment: 64-74-13.6.b Requirements set forth in 13.6.a subsume this. Therefore, delete remaining procedure as redundant.

Response: 13.6.a establishes the right for a consumer to be protected with policies governing the handling of his or her funds. 13.6.b establishes the consumer's right to justification to have a payee.

Comment: 64-74-13.6.b The necessity of a payee shall be documented quarterly. For chronic consumers this would be too often. These are almost always individuals who will require ongoing help with their finances long term. This is another paper process to be imposed. Everyone involved knows the consumer cannot handle his own finances, including the consumer but a paper process has to be developed to comply with the regulation. A yearly evaluation would be more appropriate.

Response: These comments presuppose the inability of the provider of behavioral health services to provide effective and outcome-oriented rehabilitation program for a provider-identified class of consumers. It is likely this self-fulfilling prophecy will, in fact, result in the failure of a number of provider programs or services.

Comment: 64-74-13.6.c See above as redundant.

Response: 13.6.a establishes the right for a consumer to be protected with policies governing the handling of his or her funds. 13.6.c establishes the consumer's right to a monthly statement of income and expenses.

Comment: 64-74-13.6.d See above as redundant.

Response: 13.6.a establishes the right for a consumer to be protected with policies governing the handling of his or her funds. 13.6.d establishes that individuals adjudicated incompetent have the same rights to access to their funds as other individuals.

Comment: 64-74-13.6.e See above as redundant. The judicial system has oversight of the conservator process. Adding more law may confuse the roles. The service needs to know that a consumer has a conservator but not the reason why. When the service is not the conservator, it should not review the need.

Response: 13.6.a establishes the right for a consumer to be protected with policies governing the handling of his or her funds. 13.6.e does not usurp nor duplicate the role of the judicial system in the conservator system. It does, however, establish a right of a consumer to have a record of the reasons for the conservatorship and to have an advocate to assist in the removal of conservatorship in the event the consumer is rehabilitated to the point of being able to handle his or her own affairs.

Comment: 64-74-13.6.e Should not the court who appoints a conservator have a system for continued evaluation of the need for a conservator? Is that the behavioral health service's responsibility?

Response: See above response.

Comment: 64-74-13.6.f A behavioral health service should not be required to evaluate the role of a conservator as the judicial system has that responsibility.

Response: 64-74-13.6.f establishes a consumer right to obtain the assistance of the service in bringing perceived inequities to the attention of the judicial system.

Comment: 64-74-13.6.h This standard establishes in law that any consumer with a payee must receive money management training. Is this the intent?

Response: If the consumer's record with the service documents that attempts to rehabilitate money management skills will be for naught, these skills do not need to be taught to the consumer.

Comment: 64-74-13.6.h Who will provide this training? Case Managers can no longer provide this kind of service and the future of Basic Living Skills and Development is unsure.

Response: The rule specifies a consumer right to receive this training.

Comment: 64-74-13.6.i Demonstrating money management – too subjective. Suggest removing.

Response: Any service teaching money management is expected to have objective criteria to measure whether the skills have been learned.

Comment: 64-74-13.7 "Work situation" needs to be defined.

Response: Work situation is self-defined. The important factor in this paragraph is "assigned to a work situation."

Comment: 64-74-13.7.b Having rights posted in a house is not natural. Suggest having rights available to people. "Living unit" needs to be defined. Is this the consumer worker's home.

Response: This section should be amended to add the words operated by the service at the end of the sentence.

Comment: 64-74-14.3 Why have you not considered allowing the consumer to self-report?

Response: This does not prevent the consumer from self-reporting.

Comment: 64-74-15.5 This is a procedure, not a consumer right – suggest deleting.

Response: This establishes a consumer's right to have available rules in language understandable to her or him.

Comment: 64-74-15.5 (and 17.2.b) Is not the grievance procedure included in the training on the rule? It is part of the rule.

Response: It is anticipated that specific training on the grievance procedure will be included in the training required by this rule.

Comment: 64-74-16.1 What is the definition of emancipated? Could someone developmentally disabled and incompetent be emancipated? If not, could they, regardless of age, share a room with someone under the age of eighteen?

Response: An individual over the age of eighteen (generally regarded as the age of emancipation) who is in the custody of the state would not be considered as emancipated. An individual who is adjudicated as incompetent (with or without a diagnosis of a developmental disability) may or not be emancipated. If the status of the individual is that someone acts as parent for that individual, the individual is not emancipated.

Comment: 64-74-16.3 This standard does not contemplate family contact being contra-indicated.

Response: If contact is contraindicated, it would be documented as provided by the rule.

Comment: 64-74-17 It is not clearly stated what happens if a grievance is resolved prior to going to the board of directors.

Response: If the grievance is resolved, it is resolved an no further action is needed.

Comment: 64-74-17.1 End this standard here. The rest is procedure that does not need to be in the Rule.

Response: Standards following paragraph 17.1 establish rights of consumers concerning advocacy and grievance procedures.

Comment: 64-74-17.2.d It is unrealistic to make a "brief" statement and condense this 22 page Rule into something "brief".

Response: If this Rule is adopted, the Department will assist in the development of an easily understood and brief statement.

Comment: Single point of reporting with assured follow up is more appropriate than multiple reporting to a committee that would have to be an on call committee in order to meet the requirements set forth in section 17 in general. Immediate investigation as called for in the current licensing regulations makes more sense and is far more practical. The current licensing requirements for client grievances 64 CSR 11.12.8 Violations of a Clients Rights is reasonable and appropriate and could replace the rule section 17. The Center would strongly suggest that Licensing and Behavioral Health get together and rewrite Section 17 so it does not conflict with either current or proposed licensing regulations.

The Client Advocacy and Grievance Procedure outlined in 64 CSR 59 Section 21 outlines a grievance procedure that with minor modification would serve the community behavioral health system well. The Grievance process in 64 CSR 59 is more in line with current licensing regulations and is reasonable with some modification.

Response: In drafting Section 17, a coalition of providers, Department personnel, and other stakeholders reviewed all documents cited in the comment. It was determined that the procedure as outlined was necessary to protect consumer rights to a grievance procedure. It is anticipated that this rule will replace the rights section of 64 CSR 11.

Comment: 64-74-17.5.a The service should report to APS/CPS and A/CPS should involve the civil authorities.

Response: This Rule assumes the service will follow the requirements established in the Adult Protective Services Act and/or the Child Protective Services Act.

Comment: 64-74-17.7 More procedure. See comments above to remove procedural steps.

Response: This rule establishes a consumer's rights to speedy resolution of a grievance.

Comment: 64-74-17.5 through 64-74-17.8 should be reviewed in light of current and proposed licensing regulations. Notification of an individual of their right to appeal to the Secretary is appropriate. However, notification of right to bring action in a circuit court is inappropriate and may constitute practicing law without a license.

Response: This rule is intended to replace the rights section of 64 CSR 11. The reference to the circuit court is to inform the consumer that all administrative appeals have been exhausted and the only recourse, should she or he desire to continue to pursue the grievance, is to obtain legal services.

Comment: 64-74-17.8 Governing boards are often volunteers. It may not always be possible to require them to adhere to such a short time period.

Response: The rule does not require convening the entire governing board.

Comment: 64-74-17.9 Remove reference to circuit court and possibly include informing the individual that he/she may request a hearing by the Secretary or seek legal advise for other remedies available.

Response: See above response.

Comment: 64-74-17.9.a — c Are appropriate as presented.

Response: No response.

MEMORANDUM

TO: Marsha Dadisman
Acting Director, Regulatory Development

FROM: George W. Lilley, Jr., Ed.D., CBHE
Chief Executive Officer

DATE: July 28, 1998

SUBJECT: Behavioral Health Consumer Rights Rule- 64-CSR-74

Attached are specific comments from Valley concerning the proposed Rule 64-CSR-74.

If the Department continues to support this Rule, please give careful consideration and great weight to the attached recommended changes for specific items. I believe you will find the suggestions appropriate. If you have questions of my meaning or intent, please call. It is always good to hear from you.

\s

Enclosure

VALLEY HEALTHCARE
COMMENTS TO PROPOSED
BEHAVIORAL HEALTH CONSUMER RIGHTS RULE
64-CSR-74

PAGE #	REF. #	DISCUSSION
		General Comment: This Rule after passing the Legislature becomes law. There is excessively detailed PROCEDURE and medical PRACTICE that will become the legal standard and thus establish evidence for malpractice suites. This Rule in many areas duplicates the Licensure Rule. Thus when one Rule requires change, both would. This Rule incorporates by reference accreditation body standards, changes in which the Legislature would have no control over and the Legislature would be "giving over" its sole ability to create law to an accreditation body. Furthermore, confusion as to jurisdiction will occur should the accreditation body change its standards.
4	64-94-3	delete all cross references to other, non legislated regulations. Unwise for reasons given above
4	4.1	Change to a positive statement, "Human and civil rights of consumers are of utmost importance. Consequently. . . ."
4	4.3	This reads as if having a driver's license is a right. having a driver's license is not a right, it is a privilege
5	4.4	taken literally this standard would require the Administrator to make all necessary arrangements for a consumer's marriage. We request removing this standard.
5	4.5	"Group Setting", capitalized, needs to be in Definitions section
5	4.6	4.6 conflicts with 4.5 also "to access to treatment" is awkward wording
5	5.2	the standard assumes the patient is coherent at time of admission. Suggest that if not able to ascertain, document the attempt.
6	5.2.c	if "Do Not Resuscitate" is an Advanced Directive, following this rule would imply that a commitment proceeding should be initiated.
6	5.3	This regulation presumes a non-crisis admission. Clarify

		expectations of a person being admitted under a psychiatric emergency where providing education about advanced directives is impractical.
6	6.1	One way to read the first sentence is that all consumers have a right to treatment - no conditions need to be met. Without sufficient funding and staff, this presents an impossibility. A service needs to be able to say no. Please reword or remove the inference.
7	6.5	redundant with existing Licensure Rule. See comments above
7	6.6	Suggest delete this as it is procedural unless you are conferring a new right called, "a right to have evidence of treatment".
9	7.5.b	this is procedure and should be deleted as too specific for a Rule. See comments above
9	7.5.b.3	As this is the first mention of a physician, it presumes a physician is performing the evaluation mentioned in 7.5.b.
9	7.5.b.4	getting second opinion is good but impractical in many rural clinics where there is only one doctor. More evidence for removing this procedure from the Rule.
10	7.5.b.6	first mention of the term, "attending physician". The above procedure seems to be a subset of 7.5.b.3. First use of the term, "medical record".
10	8.1	If a consumer has the right to refuse aspects of the plan, then it should be stated that the service must have the right to deny any treatment to protect its legal liability. Please reword or make the right of the service explicit.
10	8.2	the wording is unclear. What is the object of "legitimate"? Also we believe the standard is meaning to convey that a consumer's objection or refusal must be taken seriously, as a legitimate objection or refusal.
11	10.6	the two sentences under the same standard number, contradict each other. "Seclusion shall not be used" is the

		first sentence. The second states ,"If seclusion is needed. . . If the two sentences are separate, separate and renumber
13	10.18	This standard is understood to mean that the service would not use metal handcuffs but that a sheriffs department might
13	10.24	we suggest deleting this entire section as too specific for a rule. If kept, move this complete section to follow 10.25, Trial Release
14	10.24.b	these procedures appear to contemplate a hospital setting
14	10.24.c	". . .full report by staff. . . ." At 10.22, the full report was by the attending physician. Are these two separate reports or incorrect rule drafting?
14	10.24.h	conflicts with fifteen minute requirement of pg 12, 10.11.c
15	64-74-11	redundant with Licensure Rule.
16	13.1	The right being protected here is not identified. Is it the right to work, not to work, right to what?
17	13.6.b	Requirements set forth in 13.6.a subsume this. Therefore, delete remaining procedure as redundant.
17	13.6.c	See above as redundant
17	13.4.d	See above as redundant
17	13.6.e	See above as redundant. The judicial system has oversight of the conservator process. Adding more law may confuse the roles. The service needs to know that a consumer has a conservator but not the reason why. When the service is not the conservator, it should not review the need.
17	13.6.f	a behavioral health service should not be required to evaluate the role of a conservator as the judicial system has that responsibility
17	13.6.h	this standard establishes in law that any consumer with a payee must receive money management training. Is this the intent?

18	13.6.i	demonstrating money management - too subjective. Suggest removing.
18	13.7	"work situation" needs to be defined
18	13.6.b	Having rights posted in a house is not natural. Suggest having rights available to people. "living unit" needs to be defined. Is this the consumer worker's home?
18	14.3	Why have you not considered allowing the consumer to self-report?
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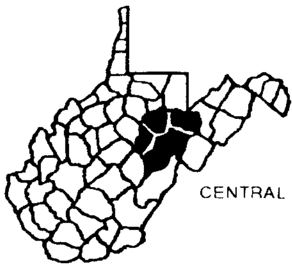
19	16.3	this standard does not contemplate family contact being contra-indicated
19	17.1	end this standard here. The rest is procedure that does not need to be in the Rule.
20	17.2.d	It is unrealistic to make a "brief" statement and condense this 22 page Rule into something "brief".
20	17.5.a	the service should report to APS/CPS and A/CPS should involve the civil authorities
21	17.7	more procedure. See comments above to remove procedural steps.



THE APPALACHIAN COMMUNITY HEALTH CENTER

CENTRAL OFFICE • 725 YOKUM STREET • ELKINS, WV 26241 • PHONE 304-636-3232 • FAX 304-636-9243

Participating: BARBOUR, RANDOLPH, TUCKER, and UPSHUR COUNTIES

July 27, 1998

Ms. Marsha Dadisman, Acting Director
Regulatory Department
Department of Health and Human Resources
Capitol Complex - Building 3, Room 265
Charleston, WV 25305

Dear Ms. Dadisman:

The following are comments regarding 64 CSR 74, Proposed Rule Title 64, West Virginia Division of Health, Department of Health and Human Resources, Series 74, Behavioral Health Consumers Rights 1998.

64-74-2. Definitions

2.3 Aggrieved - An individual or family member who believes rights accorded by this rule have been violated by a service of employee of the service.

Comment: The aggrieved definition is vague and may lend to easy misinterpretation that a family member has the right to information through filing a grievance that would otherwise not be available to the family with out the consent of the individual receiving service. The more appropriate definition would be " Aggrieved - An individual, guardian or legal representative who believes rights accorded by this rule have been violated by a service or employee of the service."

64-74-4 Consumers' Rights Generally

4.4 Responsibility of Administrator. It is the responsibility of the services' administrator to assure that each consumer is informed of his or her rights and to make all necessary arrangements to allow the consumer to exercise his or her rights.

Comment: The section would be clearer if it read " Responsibility of Administrator. It is the responsibility of the services' administrator to assure that each consumer is informed of his or her rights and to make necessary arrangements to allow the consumer to exercise his or her rights while the organization is providing the service.

4.9. Every consumer upon his or her admission to a behavioral health service, and at any later time upon request, shall be given a summary of the rights afforded by this rule. A copy of its rule shall be available upon request.

Comment: The Center strongly suggest that this rule include or have as an attachment a copy of the Summary in order to assure uniform application of the rule. Further in certain crisis situations there may be an exception to the rule due to the consumers condition, circumstance or competency.

64-74-7 Informed Consent

7.5.b.1 Determine whether the individual is clinically competent to understand the nature and purpose of the proposed treatment, as well as its prospective benefits and possible side effects. The examining physician and other behavioral health service staff shall utilize, and document the utilization of accepted professional procedures for determining competency to understand the proposed treatment.

Comment; In this section and throughout the proposed rule the determination of clinical competency of an individual to give informed consent for medical service would rest with competent physician. The determination of the individuals to give consent for behavioral health nonmedical service would rest with a properly licensed behavioral health provider such as a psychologist or other who is qualified to make said determination in accordance with Chapter 30 of the West Virginia Code. To only have a physician make such a determination will interfere with timely delivery of service and interfere with qualified practitioners from practicing their trade.

7.5.b.2 If the individual is determined to be able to make an informed decision relative to treatment the proposed treatment shall be explained in detail and written consent to treatment shall be requested. No individual shall be asked to sign consent to treatment until the individual's competence to give consent has been determined. Treatment may be initiated if the individual gives consent, but a refusal to consent shall be honored and no treatment shall thereafter be forced upon the individual prior to receiving a written commitment order from the circuit court pursuant to a commitment hearing.

Comment: This section appears to be written for an institution. The concept of informed consent includes consent being given by an individual or a guardian not just the individual. The concept of implied consent also needs to be explored. While the term "forced" is used in this section at times an individual will say no and still actively participate in treatment thus giving implied consent.

Proposed Rule 64 CSR 59 Section 8.9.b allows for a client to receive service when the client does not sign the consent for. The Proposed Rule states:

"The client shall be asked to sign the consent form utilized in obtaining informed consent from voluntary clients, and this signed consent form shall be included in his or her chart. In the event that the client has been shown the form and communicates consent but does not wish to sign the written consent form, it is sufficient for the appropriate behavioral health professional to place the unsigned form in the client's record together with the notation that while the client understands the nature and effects of anti psychotic medication and consents to the administration of the medication, the client does not want to sign a written consent form.

It is suggested that the above be incorporated into the Rules for 64 CSR 11.

64-74-17. Consumer Advocacy and Grievance Procedure.

17.5 Allegations of Abuse, Neglect or other Serious Breach of Consumer Rights. The designated grievance representative employed by the service shall interview the grievant upon receipt of a grievance. A report of all violations or suspected violations of a consumer's rights accorded by this rule shall be made within twenty-four (24) hours to the appropriate designated internal committee of the service and the administrator of the service. In the Event of abuse or neglect or suspicion of abuse or gross neglect, the appropriate designated committee and administrator shall be immediately notified following the interview.

Comment: Single point of reporting with assured follow up is more appropriate than multiple reporting to a committee that would have to be an on call committee in order to meet the requirements set forth in section 17 in general. Immediate investigation as called for in the current licensing regulations makes more sense and is far more practical. The current licensing requirements for client grievances 64 CSR 11, 12.8 Violations of a Clients Rights is reasonable and appropriate and could replace the rule section 17. The Center would strongly suggest that Licensing and Behavioral Health get together and rewrite Section 17 so it does not conflict with either current or proposed licensing regulations.

The Client Advocacy and Grievance Procedure outlined in 64 CSR 59 Sec 21 outlines a grievance procedure that with minor modification would serve the community behavioral health system well. The Grievance process in 64 CSR 59 is more in line with current licensing regulations and is reasonable with some modification.

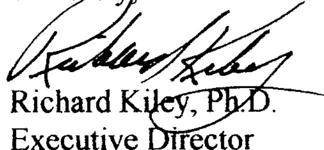
17.5 through 17.8 should be reviewed in light of current and proposed licensing regulations. Notification of an individual of their right to appeal to the Secretary is appropriate However, notification of right to bring action in a circuit court is inappropriate and may constitute practicing law without a license.

17.9 Remove reference to circuit court and possibly include informing the individual that he/she may request a hearing by the Secretary or seek legal advise for other remedies available.

17.9.a,b,c. Are appropriate as presented.

Thank you for the opportunity to comment on this Rule. If the Center may be of assistance in rewriting any of the sections indicated above, please do not hesitate to contact me.

Sincerely,



Richard Kiley, Ph.D.
Executive Director

FMRS MENTAL HEALTH COUNCIL, INC.

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July 30, 1998

Regulatory Development
Department of Health & Human Resources
Capitol Complex – Building 3, Room 265
Charleston, West Virginia 25305
ATTN: Marsha Dadisman, Acting Director

Dear Ms. Dadisman:

Please find attached our comments on Proposed Legislative Rule – Behavioral Health Consumer Rights.

Thank you for taking our comments and concerns into consideration.

Sincerely,

Elizabeth Vandall, M.A.
Quality Improvement Director

Comments on Legislative Rule regarding Behavioral Health Consumer Rights

Fiscal Note for Proposed Rule

This note indicates that economic impact on community-based behavioral health providers will be minimal. We disagree with that assessment as it appears to us that we will have to provide more formal and lengthy training for all staff. We are not receiving any reimbursement while staff are in training but we must pay their salary for that time spent in training. The requirements regarding advance directives, informed consent, and access to consumer personal funds will require a great deal of time and effort to establish policies and procedures and may also require hiring additional staff.

It also appears that to comply with the requirements of the advance directive will require services to initiate commitment proceedings much more frequently. This will be a major cost to the system, including mental hygiene commissioners, police and the prosecuting attorney's office.

1.6. Applicability – This rule applies to behavioral health services licensed by the division of health, department of health and human resources. Are all providers of behavioral health services licensed by the division of health, department of health and human resources. Does this rule apply to private psychiatrist's offices, for example?

2.10 Individualized Program Plan (IPP) "A master plan which is a written, individualized plan specifically tailored to individual needs, including . . . response to initial interventions and prognosis for resolution of acute symptoms, and other components as indicated in this rule." Licensing and Medicaid regulations do not require a response to initial interventions and prognosis for resolution of acute symptoms, etc. on the master treatment plan. Will this rule supercede the licensing and medicaid regulations?

4.2. No Discrimination. "All behavioral health services...shall make available all offered services . . . Crisis services, if offered, cannot be denied on the basis of inability to pay". If the service offers crisis services, which include a CRU, does the rule stipluate that the service has to provide services at the CRU or does it still remain the service" determination as to what type of crisis service will be provided?

64-74.5 Advance Directives

What is the intent of advance directives for behavioral health services, why are they needed and when and how do they work?

5.2.c. "Advance directives concerning preferences in behavioral health services shall be honored to the extent resources are available, ...The behavioral health service shall consider initiating commitment proceedings whenever it is believed following and advance behavioral health service directive would pose a danger to the consumer or others.

Who will decide if resources are available? Will the service be allowed to make that decision or will some other entity tell us how we should use our resources? Also, this could result in increased commitment proceedings.

If someone is admitted to and is experiencing acute symptoms, who makes decisions about advance directives?

We think this section as written is not informative enough to really understand what will be required of the service.

64-74-6. Consumer's Rights to Treatment

7.2. Informed Consent says "an appropriate behavioral health professional shall explain and discuss the following with each consumer. . . (which includes information about medication). 7.3.a. then says it can only be informed consent after information specified above is provided by a physician. This will use a lot of physician time (that we don't have). Could not R.N.'s be utilized to provide consumers with information?

7.2.b. and 7.2.e. – This covers specific medication. In reading this section it appears that informed consent must be given at the first meeting, prior to any treatment being provided. Usually, the doctor is not seen at that first meeting and has not prescribed any medication. How can we complete 7-2-a to 7-2-i prior to the doctor being seen?

7.3.c. "Consent is effective for 90 days or until the consumer consents to a new/revised treatment plan"... Does this mean that signing the treatment plan is in effect giving consent for treatment? Or will the complete process of gaining consent be required? There are several types of consumers for which this would not be appropriate.

7.5..a. This particular paragraph is confusing and unclear.

7.5.b.3 It appears to say that we can never provide treatment unless we have informed consent or initiate commitment proceeding. Then in 7.5.b.4 there is outlined a process to to provide treatment without consent or commitment. This is confusing.

The whole process described for determining competence and for obtaining informed consent will be time consuming (particularly for the physician who is already overbooked) and complicated. It is the kind of process that usually ends up being a paper process.

64-74-10 Seclusion and Restraints

10.21 Limitation on Use of Chemical Restraint. "Drugs and medication may only be administered pursuant to informed consent." Some group homes or crisis units utilize prn medicaitons for symptoms such as increased agitation. Will this kind of situation require the consumer seeing a physician prior to the medication being administered?

64-74-13 Consumers' Labor, Earnings and Funds

13.4. Training and Evaluation Program. A certificate (from where?) can be obtained. To what kinds of programs does this apply? There are day treatment programs serving the developmentally disabled population that are working on teaching adjustment to work environment and work skills. This rule would only allow this training to be done for one year. This is not at all an appropriate length of time for that population.
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13.6.b "If a service is a payee for SSI or SSDI, there shall be information in the treatment record describing reasons for the service serving as a payee" . . . The necessity of a payee shall be documented quarterly. For chronic consumers this would be too often. These are almost always individuals who will require ongoing help with their finances long term. This is another paper process to be imposed. Everyone involved knows the consumer cannot handle his own finances, including the consumer but a paper process has to be developed to comply with the regulation. A yearly evaluation would be more appropriate.

13.6.h. "Any consumer who has a payee for SSI or SSDI, . . . shall receive training in money management" . . . Who will provide this training? Case Managers can no longer provide this kind of service and the future of Basic Living Skills and Development is unsure.

13.6.e. "The treatment record of a consumer who has an appointed conservator or other individual with financial authority shall document this appointment and the reasons for the appointment. The need for a conservator shall be evaluated quarterly." Should not the court who appoints a conservator have a system for continued evaluation of the need for a conservator? Is that the behavioral heath service's responsibility?

64.74.15. Employee Responsibilities.

15.5 and 17.2.b. "All new staff and current employees will receive periodic and continued training on the rule." Also, "regular inservice training on the grievance procedure." Is not the grievance procedure included in the training on the rule? It is part of the rule.

64-74-16 Juveniles' Additional Rights

16.1 Separation. "No consumer under eighteen years of age shall be housed in any area licensed operated by a behavioral health service and also occupied by any consumer over eighteen years of age. Except that, individuals above the age of eighteen who have not yet been emancipated can room with persons under the age of eighteen." What is the definition of emancipated? Could someone developmentally disabled and incomptent be emancipated? If not, could they, regardless of age, share a room with someone under the age of eighteen?

64-74-17 Consumer Advocacy and Grievance Procedure.

It is not clearly stated what happens of a grievance is resolved prior to going to the board of directors.

17.8. "The governing board of the service, or the board member or members who have been appointed by the board as consumer grievance hearing officer or officers to render a decision on behalf of the board, shall convene within ten working days after receipt by the administrator of the recommendation and report of the appropriate designated committee" . . . Governing boards are often volunteers. It may not always be possible to require them to adhere such a short time period.

With the requirements regarding advance directives, informed consent and grievances we will add one half hour to an hour to the initial assessment/intake process, which with the functional assessments takes approximately two hours. We agree that consumers rights are extremely important and should always be considered but we questions everything that will be required at that first visit. Often, consumers are very ill, or distraught at that first visit. The intake process is already lengthy.