



## *Child and Family Services*

*An Office of the  
Department of Health and Human Services*

*John E. Baldacci, Governor*

*Brenda M. Harvey, Commissioner*

# RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES WHO ARE CHILDREN IN NEED OF TREATMENT



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**RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES  
WHO ARE  
CHILDREN IN NEED OF TREATMENT**

**Maine Department Of Health and Human Services  
Office of Child and Family Services  
Children's Behavioral Health Services  
11 SHS Augusta, Maine 04333-0011**

## **BASIS STATEMENT**

Recipients of mental health services who are children in need of treatment shall suffer no loss of basic human, legal and civil rights.

These rules set forth the rights of patients/clients/consumers and provide procedural mechanisms to protect and enforce those rights by law, regulation or the Settlement Agreement in Bates v. Peet. When children are unable to exercise their rights, it is anticipated that a parent or guardian will exercise them on the child's behalf.

These rules apply to all facilities providing inpatient psychiatric services and to all agencies or facilities providing inpatient, residential or outpatient mental health service which are licensed, funded or contracted by the Department of Health and Human Services.

Where different standards of care or treatment apply, it is the intent of these rules that the more stringent standard be deemed applicable.

Part A, Section VII, Right to Due Process With Regard to Grievances, and Section IX, Confidentiality of And Access to Mental Health Records, were amended in 2000 as required by 34-B M.R.S.A. Section 15002.

Authority: 34-B M.R.S.A. Sections 3003, 15002(4), and 15002(7).  
Amended Effective Date: April 14, 2000

## **INTRODUCTION**

These rules are promulgated pursuant to the rulemaking authority granted to the Commissioner of the Department of Health and Human Services under 34-B M.R.S.A. Sections 3003 and 15002.

These rules apply to all facilities providing inpatient psychiatric services and to all agencies, facilities or programs providing inpatient, residential or outpatient mental health services which are licensed, funded or contracted by the Department of Health and Human Services, including state operated institutes and facilities.

Part A, Section VII, Right to Due Process With Regard to Grievances, and Section IX, Confidentiality of And Access to Mental Health Records, were amended in April of 2000 as required by 34-B M.R.S.A. Section 15002. The Department is aware that changes are still needed to bring these rules into alignment with changes in the Department and how its services are provided; these additional changes will be addressed as soon as feasible.

Questions regarding the applicability or interpretation of these rules should be directed to the Division of Licensing and Regulatory Services, 11 SHS, Augusta, Maine 04333-0011. Telephone: (207) 287-9300;1-800-791-4080; TDD 1-800-606-0215.

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TABLE OF CONTENTS

Basis Statement		
Introduction		
Table of Contents		
<b>A.</b>	<b>RULES OF GENERAL APPLICABILITY</b>	
I.	Statement of Intent	1
II.	Definitions	1
III.	Basic Rights	3
IV.	Least Restrictive Appropriate Treatment	4
V.	Notification of Rights	5
VI.	Assistance in the Protection of Rights	7
VII.	Right to Due Process with Regard to Grievances	9
VIII.	Complaints	15
IX.	Confidentiality and Access to Records	16
X.	Fair Compensation for Work	22
XI.	Protection During Experimentation and Research	23
XII.	Individualized Support Plans	29
<b>B.</b>	<b>RIGHTS IN INPATIENT AND RESIDENTIAL SETTINGS</b>	
I.	Statement of Intent	34
II.	Privacy and Humane Treatment Environment	34
III.	Individualized Treatment of Service Plan	37
IV.	Informed Consent to Treatment	41
V.	Free Association and Communication	46
VI.	Freedom From Unnecessary Seclusion and Restraint in Inpatient Settings	50
VII.	Freedom From Unnecessary Seclusion and Restraint in Residential Settings	61
<b>C.</b>	<b>RIGHTS IN OUTPATIENT SETTINGS</b>	
I.	Statement of Intent	66
II.	Individualized Treatment or Service Plan	66
III.	Informed Consent to Treatment	69
IV.	Freedom from Seclusion and Restraint	72

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**PART A  
RULES OF GENERAL APPLICABILITY**

**Maine Department of Health and Human Services  
Office of Child and Family Services  
Children's Behavioral Health Services  
11 SHS Augusta, Maine 04333-0011**

PART A. RULES OF GENERAL APPLICABILITY:

I. STATEMENT OF INTENT

The purpose of these rules is to articulate the rights of recipients of services who are children in need of treatment so that these rights may be enhanced and protected. Many children in need of services, particularly those who are very young or very disabled, cannot directly exercise their rights. In those cases, it is assumed that a legally responsible parent, guardian or custodian will exercise the child's rights on behalf of the child.

Service recipients should suffer no loss of basic human or civil rights. Because of the circumstances under which recipients are treated, however, the exercise of some rights may require special safeguards. These rules, therefore, intend to keep recipients' rights paramount, to assure that individual rights will be both recognized and protected during the course of services delivery, and to ensure treatment consistent with ethical and professional standards.

If two different standards could be applicable in determining care and treatment provided to any individual client - the law being these rules and federal, state, common law or federal or state administrative rules - the intent of these rules is that the more stringent standard should be applied.

Procedural mechanisms that exist to ensure enforcement of these rules include the licensing authority of the Department of Health and Human Services pursuant to 34-B MRSA section 3606, the grievance and complaint procedures set forth in these rules, and the Department's contracting authority.

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

These rights shall be interpreted consistent with the overall purposes and principles.

II. DEFINITIONS

A. Child means an individual who has not reached his or her 18th birthday and who has not been emancipated by a court order.

B. Community Support Worker means an individual who coordinates a recipient's ISP; locates and monitors the services identified in the plan; and performs other duties as specified in the settlement agreement in Bates v Peet , and in agency contracts. Community Support Workers are

employed by agencies or programs contracted with the Department of Health and Human Services to perform this function.

- C. Complaint means an allegation by a person or agency charged with investigating violations of client rights or with delivering or monitoring mental health services of violation of basic rights of a recipient, including those enumerated in these rules and the Settlement Agreement in *Bates v. Peet* or any other applicable law or regulation.
- D. Custodian means the Department of Health and Human Services or a person, other than a parent, awarded custody pursuant to Title 19 or Title 22 of the Maine Revised Statutes.
- E. Department means Department of Health and Human Services.
- F. Emancipated minor means a minor who has been emancipated by court order. Unless specifically indicated otherwise, an emancipated minor has the same rights, privileges and responsibilities as an adult recipient under the rules Rights of Recipients of Mental Health Services.
- G. Emergency means a situation in which, as a result of a recipient's behavior due to mental illness, there exists an imminent danger of bodily injury to the recipient or to others.
- H. Facility, Agency, or Program means any facility providing in-patient psychiatric services, and any agency or facility providing in-patient, residential or outpatient mental health services that are licensed, funded or contracted by the Department of Health and Human Services.
- I. Grievance means an allegation by a recipient of violation of basic rights, including those enumerated in these rules and the Settlement Agreement in *Bates v. Peet* or any other applicable law or regulation.
- J. Guardian means a person appointed by the Probate Court pursuant to Title 18-A of the Maine Revised Statutes.
- K. Individualized Support Plan (hereafter, "ISP") means a written document that is prepared by a team of persons and that includes an assessment of the recipient's strengths and needs, and describes the recipient's goals and objectives and the services the recipient needs to meet those goals and objectives. The team shall include the recipient except as otherwise provided in these rules.

- L. Mental Health Institute means a state-operated inpatient facility.
- M. Non-state Mental Health Institution means a public institution, a private institution or a mental health center as defined by 34-B MRSA, section 3801 (6).
- N. Program Area means any discrete part of a facility or agency, including any building, residential program, ward, unit or program site.
- O. Recipient means any child in need of mental health services as defined by 34-B 6201(2) receiving treatment from any facility, agency or program.
- P. Representative means any adult person who has been designated in writing by an emancipated recipient, or by his or her guardian or by his or her legally responsible parent, guardian or custodian to act to aid the recipient in upholding his or her rights under these rules, except that the representative may not be a client of or a staff person currently employed in the facility through which the recipient receives services.
- Q. Rights Protection and Advocacy Service of the Maine Mental Health System means the Office of Advocacy of the Department, the rights protection and advocacy agencies authorized under 42 U.S.C. §§ 10801 et. seq., or other public agencies authorized by law to investigate grievances and protect rights.
- R. Treatment means the provision of mental health services to children in need of treatment and their families as defined by 34-B MRSA section 6201(3). The services consisting primarily of: (i) psychiatric, psychological, counseling, developmental, and other therapeutic modalities and (ii) social, interpersonal and other living skills, related supportive services and habilitative training.
- S. Treatment Team means the group of persons, including the recipient, who plan, carry out and review treatment.

### III. BASIC RIGHTS

- A. Recipients have the same human, civil and legal rights accorded all minor citizens. Recipients have the right to a humane psychological and physical environment within the facility or program. Recipients have the right to be treated with courtesy and dignity. Recipients are at all times entitled to respect for their individuality and to recognition that their personalities, abilities, needs and aspirations are not determinable on the basis of a psychiatric label. Recipients have the right to have their privacy assured and protected to the greatest extent possible in light of their treatment needs. Recipients shall not be found incapacitated nor denied any right, benefit, privilege, franchise, license, authority or capacity of

whatever nature that they would otherwise have simply due to their status as recipients of mental health services.

- B. There shall be no limitation on the freedom of religious belief.
- C. Discrimination in the provision of services due to race, creed, gender, sexual orientation, national origin, political belief, or handicapping condition shall be prohibited.
- D. All basic rights of recipients and of legally responsible parents, guardians or custodians on behalf of recipients shall remain intact unless specifically limited through legal proceedings, as in the case of guardianship; or, in an emergency, or when necessary to protect the rights or safety of the recipient or others, only as outlined in specific sections of these rules.
  - (1) Recipients are entitled to receive individualized treatment, to have access to activities necessary to the achievement of their individualized treatment goals, to exercise daily, to recreate outdoors, and to exercise their religion.
  - (2) At no time shall the entitlements or basic human rights set forth in these rules be treated as privileges which must be earned by meeting certain standards of behavior.
- E. Services delivered to recipients shall be based on their identified individual needs and shall be delivered according to flexible models which accommodate changes in recipient's needs and the variations in the intensity of their needs.
- F. Recipients and their legally responsible parents, guardians or custodians, or other representatives have the right to exercise rights provided by these rules without reprisal, including reprisal in the form of denial of or termination of services.

#### IV. LEAST RESTRICTIVE APPROPRIATE TREATMENT

- A. Recipients have the right to be treated in the least restrictive available setting utilizing the least restrictive treatment means appropriate to their needs.
- B. Any restrictions in an inpatient or residential setting shall, where indicated, be determined and imposed pursuant to the Right to Individualized Treatment and Discharge Plan and the Right to Informed Consent.

- C. No recipient shall be held in treatment against his or her will by policy, procedure or practice, except by order of court, by emergency hospitalization procedures or by consent of the legally responsible parent, guardian or custodian.
- D. Agencies or facilities proposing persons for commitment shall first fully consider less restrictive appropriate settings and treatment modalities pursuant to 34-B -MRSA section 3864(5).
- E. Involuntary hospitalization provisions-shall not be utilized only as a means to accomplish admission, to obtain transportation, or for administrative reasons.

## V. NOTIFICATION OF RIGHTS

- A. Recipients and their legally responsible parents, guardians or custodians have the right to be notified of all rights accorded recipients of services, by Maine statute, these rules, the Bates v. Peet Settlement Agreement, as applicable and by associated policy. The notice shall provide information about the grievance process and the right to be assisted by a representative of one's choice. The notice shall include a list and description of the advocacy services available.
- B. At the time of admission or intake, or as soon afterwards as is reasonably feasible, each recipient and his or her legally responsible parents, guardians or custodians shall be informed, to the extent possible, of the recipient's rights under these rules in terms that are understandable.
  - (1) Such information shall be given in an age appropriate manner designed to be comprehensible to the individual receiving the information by an employee of the facility or program.
  - (2) In cases where the recipient does not understand English or is deaf, the notification of rights shall be conducted by an interpreter.
  - (3) If the recipient's condition at admission or intake precludes understanding of his or her rights, additional attempts to provide information about rights shall occur and be documented.
  - (4) Documentation of the results of the discussion about rights shall be noted in the recipient's permanent treatment record.

- (5) Recipients shall be further advised of their rights pursuant to these rules and the Settlement Agreement in *Bates v. Peet*, as applicable.
- C. At the time of admission or intake, each recipient shall be given a summary of these recipient rights written in plain language.
- (1) Copies of such summary shall also be given to:
    - a. The recipient's legally responsible parent, guardian or custodian; or,
    - b. In the case of any recipient without a legally responsible parent, guardian or custodian, up to three individuals, if designated by the recipient.
  - (2) Those persons, including the recipient, given copies of summaries shall be noted in the recipient's record.
  - (3) Copies of the summaries shall be conspicuously posted in all agencies, facilities, and program areas.
  - (4) The summaries shall contain instructions for viewing this document and associated policies developed to implement these regulations.
  - (5) The summaries shall be made available in foreign languages, if necessary.
- D. At the time of the notification required by this section, recipients shall be notified that they, their legally responsible parents, guardians or custodians acting on their behalf, or their designated representatives may bring grievances claiming that the practices, procedures or policies of the Department, a non-state mental health institution, or of any agency licensed, funded or contracted by the Department to provide mental health services, violate the terms of these rules, the applicable terms of the *Bates v. Peet* Settlement Agreement, or any other applicable law or regulation. They shall additionally be notified of other processes whereby grievances may be filed, and of their right to be assisted throughout the grievance procedure by a representative of their choice. In the written notice required by this section, recipients shall additionally be notified of the advocacy services available through the Office of Advocacy and the Protection and Advocacy Agency established pursuant to 42 U.S.C. §§ 10801 et seq.

- E. Each program area shall have complete copies of these recipient rights rules, the Settlement Agreement and associated agency policies. The copies shall be made available for review to any person upon request. Additional copies of these documents shall be available, at a reasonable cost, from the Department of Health and Human Services, Office of Child and Family Services, 11SHS, Augusta, Maine 04333-0011.
- F. The Office of Advocacy shall have copies of all statutes referenced in these rules. The statutes shall be available for review during regular working hours at the Office of Advocacy, !11 SHS, Augusta, Maine, 04333-0011.

VI. ASSISTANCE IN THE PROTECTION OF RIGHTS

- A. Recipients have the right to assistance in the protection of their rights.
- B. Right to Name Recipient Representative. Emancipated minor recipients and legally responsible parents, guardians or custodians of other minor recipients have the right to name a representative, in writing, to uphold the rights of the recipient. Aid may include one or more of the following activities: assistance in the formulation and processing of a grievance, participation in the informal or formal development and revision of, an ISP or hospital treatment and discharge plan, or any other type of representative assistance activity referenced in these rules. The provision of aid by a designated representative shall be governed by this section and by other relevant sections of these rules.
- C. Notification. Each agency, facility or program shall inform each recipient and legally responsible parent, guardian or custodian of the recipient's right to assistance. All emancipated minor recipients or legally responsible parents, guardians or custodians shall be notified of their right to name a representative.
  - (1) Designation in writing. If an emancipated minor recipient or the legally responsible parent, guardian or custodian of any other recipient desires a representative for the recipient, he or she shall designate, in writing, a person to aid the recipient in upholding his or her rights.
  - (2) Time for designation. The emancipated minor recipient or the legally responsible parent, guardian or custodian may designate a representative at any time.

- (3) Change in representative. Provision shall be made for change of representative upon request of the emancipated minor recipient or the recipient's legally responsible parent, guardian or custodian.
  - (4) Representative's physical access. The representative shall have reasonable access to all living and program areas and to staff involved in the treatment of the recipient in order to assist the recipient in the protection of his or her rights.
  - (5) Confidentiality. The representative may obtain access to confidential information as defined under 34B MRSA Section 1207 concerning the recipient by obtaining the appropriate party's written informed consent to such disclosure under Part B, Section IV or Part C, Section III of these rules.
  - (6) Communication. An emancipated minor recipient shall have access, at any reasonable time, to a telephone to contact his or her representative pursuant to Section VIII of these rules.
  - (7) Involvement in ISP and Treatment and Discharge Planning.
    - a. The recipient's representative shall be given no less than 10 days written notice of ISP meetings unless the emancipated minor recipient or the legally responsible parent, guardian or custodian directs that the representative not be invited. The representative's involvement may include, unless otherwise limited pursuant to these rules, participation in treatment meetings, alternative treatment meetings or discharge planning meetings. When the meeting is being convened to address an emergency, notice reasonable for the circumstances shall be given.
    - b. The representative shall be notified when the recipient is determined to lack clinical capacity pursuant to Section IV, Part B (Inpatient and Residential Settings) or Section 11, Part C (Outpatient Settings) of these rules.
    - c. The representative shall receive a copy of prescribed medication, dosage levels, schedules and side-effects and a copy of the aftercare plan upon the discharge of the recipient, if the emancipated recipient or the legally responsible parent, guardian or custodian of the recipient authorizes such a release.
- D. Protection and Advocacy Services. Each recipient and his or her legally responsible parent, guardian or custodian shall be informed of governmental rights protection and advocacy services available in the

state. Recipients and their legally responsible parents, guardians or custodians have the right to request assistance from the State's governmental rights protection and advocacy service at any time.

An advocate who assists a recipient shall attempt, either directly or through appropriate referral, to ensure that the recipient's and the legally responsible parent's, guardian's or custodian's interests are all represented, if possible. Such services are available through:

- (1) The Office of Advocacy of the Department, which is mandated by State law to investigate the claims and grievances of recipients of services provided by the Department and to monitor the compliance of any facility or agency administered by the Department with all laws, rules, and policies relating to the rights and dignity of service recipients.
  - (2) Other governmental agencies including the Protection and Advocacy Agency for Persons with Disabilities and the Maine Human Rights Commission.
- E. Recipients may, at their request, be represented by a private advocate. The unemancipated minor or the legally responsible parent, guardian or custodian of an unemancipated minor must authorize and bear the expense of representation by a private advocate.
- F. A report of formal complaints and grievances appealed to the chief administrative officer of an in-patient psychiatric facility, the Director of the Office of Child and Family Services and the Commissioner, be compiled semi-annually by the Department and submitted to the Office of Advocacy, the Office of the Master established pursuant for the terms of the Settlement Agreement in *Bates v. Peet*, and plaintiff's counsel in that action.

## VII. RIGHT TO DUE PROCESS WITH REGARD TO GRIEVANCES

- A. Recipients have the right to due process with regard to grievances.
- B. Notwithstanding any other civil or criminal recourse the person bringing the grievance may have, the facility, agency, and/or department shall afford every reasonable opportunity for informal resolution of concerns or formal resolution of grievances.
- C. A recipient or another person acting on behalf of the recipient may bring grievances regarding possible violations of basic rights, including any rights enumerated in these rules and the Settlement Agreement in *Bates v. Peet* or any other applicable law or regulation; any questionable or

inappropriate treatment or method of treatment; or any policy or procedure or action, or lack thereof, of the mental health agency or facility under these rules. Grievances may be brought by or on behalf of individual clients or groups of clients.

- D. Persons who may bring grievances include, but are not limited to:
- (1) The recipient; if a recipient files a grievance, his or her legally responsible parent, guardian or custodian shall be notified;
  - (2) The recipient's legally responsible parent, guardian or custodian;
  - (3) The recipient's attorney, designated representative or representative of a state governmental rights protection or advocacy agency; and
  - (4) Other persons specifically aggrieved.
- E. A grievant shall in no way be subject to disciplinary action, reprisal including reprisal in the form of loss, denial or termination of services or loss of privileges as a result of filing a grievance.
- F. Notice
- (1) Notices summarizing a grievant's right to due process in regard to grievances, including the process by which grievances may be filed, as well as copies of forms to be used for that purpose, shall be available within each program area.
  - (2) The Department, or its designee, shall provide notice to children and families and guardians receiving or seeking to receive services from the Department about rights to file a grievance and the mediation and administrative appeal process. Such notice shall be provided annually to all children served by the Department and shall include information on the right to be assisted in the grievance process by the representative of choice in a manner designed to be comprehensible to the individual, by an employee of the facility, agency or program.

## G. Grievances

- (1) A grievance may be undertaken by a grievant or other acting on his or her behalf, pursuant to D, above making a formal written claim that provisions of these rules, the Settlement Agreement in Bates v. Peet or any other applicable law or regulation have been violated by any facility, agency or program.

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

- (2) The filing of a grievance stays any action to reduce, terminate or suspend any service.

(3) The Department must have in place two grievance processes: mediation and administrative hearing. The Commissioner shall appoint a Grievance Coordinator to oversee the mediation and hearing processes.

### (4) Initiating the Grievance Process

- a. Prior to filing a grievance, persons authorized under Section VII(D) of these rules who wish to file a grievance (the "aggrieved party") must first obtain a Grievance Form. Grievance Forms are to be readily available from providers and from the Department's regional offices and are to be provided as soon as practicable upon request.
- b. The Grievance Form must include notice that aggrieved parties may request mediation or an administrative hearing and must inform aggrieved parties of the requisite timeframes applicable to each process, and a space for the aggrieved party to elect mediation or an administrative hearing. The Grievance Form must also request aggrieved parties to provide information about the nature of the complaint, as well as names, addresses and phone numbers of the child, the grievant and relevant providers.
- c. Aggrieved parties must file a Grievance Form with the Grievance Coordinator, whose name and address will be provided on the Grievance Form.

(5) Mediation

- a. When an aggrieved party elects mediation, the Grievance Coordinator must schedule a mediation to be held within 5 calendar days of the Grievance Coordinator's receipt of a properly completed Grievance Form. The aggrieved party, in consultation with the Grievance Coordinator and/or the mediator, shall determine the location and time of the mediation.
- b. At the conclusion of the mediation and when agreement has not been reached, an aggrieved party may request a subsequent administrative hearing by so notifying the Department representative present at the mediation, or the mediator if no one is present from the Department, before leaving the mediation. If the aggrieved party does not request an administrative hearing at the mediation, but requests an administrative hearing at any time thereafter, such request triggers the administrative hearing process as if it were chosen initially.
- c. An aggrieved party may waive the requirement that mediation be held within 5 calendar days of the filing of the Grievance Form, and will be deemed to have so waived that requirement if unwilling or unable to attend on any mediation date offered within the 5 day period. In that case, mediation will be held as soon as practicable.
- d. All parties shall participate in mediation in good faith.
- e. Neither mediation, nor any agreement or decision reached as a result of mediation, constitutes final agency action for judicial review purposes.

(6) Administrative Hearings

- a. When an aggrieved party elects administrative hearing, the Grievance Coordinator must schedule an administrative hearing to be held within 5 calendar days of the Grievance Coordinator's receipt of a properly completed Grievance Form.
- b. An administrative hearing must be presided over by an impartial hearing officer designated by the Commissioner.

- c. Providers of care and advocates for the affected child may be heard at the administrative hearing.
- d. Administrative hearing procedures must be in accordance with the Maine Administrative Procedure Act, 5 M.R.S.A. § 9051 *et seq.*
- e. An electronic recording must be made of any administrative hearing held pursuant to this section.
- f. Unless otherwise agreed by the parties, the hearing officer must issue a written recommended decision with findings of fact within one week from the Grievance Coordinator's receipt of the Grievance Form, or, if the administrative hearing was requested at the conclusion of a mediation, within two weeks from the Grievance Coordinator's receipt of the Grievance Form.
- g. An aggrieved party may waive the requirement that an administrative hearing be held within 5 calendar days of the filing of the Grievance Form, and will be deemed to have so waived that requirement if unwilling or unable to attend on any administrative hearing date offered within the 5 day period. In that case, the administrative hearing will be held as soon as practicable. An aggrieved party may also waive the deadline for a recommended decision and will be deemed to have so waived any applicable deadline if the hearing is held outside the 5 day period at the request of or due to the unavailability of the aggrieved party or any person the aggrieved party seeks to have present at the hearing, in which event the recommended decision will be rendered as soon as practicable.
- h. The aggrieved party may elect mediation at any point after requesting an administrative hearing, which alternate election suspends the deadline for scheduling the administrative hearing and the hearing officer's deadline for issuing a written recommended decision.
- i. All hearing officer recommended decisions are subject to further review by the Commissioner, who must issue a final decision adopting, modifying or rejecting the hearing officer's recommended decision no later than seven business days from the date of the hearing officer's recommended decision. Parties may submit written memoranda with the Commissioner within five business days of the hearing officer's recommended decision.

- j. The Commissioner's decision constitutes final agency action for judicial review purposes under the Maine Administrative Procedure Act. All decisions of the Commissioner must include notice of the aggrieved party's right to judicial review, including the requisite timeframe for filing an appeal.

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

#### H. Access to Files

An aggrieved party shall have reasonable access prior to a mediation or an administrative hearing and at either proceeding to examine the contents of his or her Department case file, and may request copies of documents within the file to be reproduced at the Department's expense.

#### I. Grievances regarding abuse, exploitation or neglect

- (1) Any allegation of abuse, exploitation or neglect shall be immediately reported to the Chief Administrative Officer of the facility or agency, to the Office of Advocacy and the required investigatory agency pursuant to the Child and Family Services and, Child Protection Act (22 M.R.S.A. Chapter 1071 s 4001 et seq.) and facility policy approved by the Department.
- (2) Investigation of any such allegation shall be conducted pursuant to statutory and regulatory standards including those relating to the Child and Family Services and Child Protection Act (22 M.R.S.A. Chapter 1071 s 4001 et seq.) and facility policy approved by the Department.

## VIII. COMPLAINTS

- A. A complaint may be filed by any person or agency which is charged with investigating violations of client rights or with delivering or monitoring mental health services. The complaint procedure may be used when:
- (1) such person or agency knows or has reason to believe that the practices, procedures (including the development, substantive terms or implementation of ISP's or hospital treatment and discharge plans) or policies of the Department or of any agency licensed, funded or contracted by the Department to provide services elsewhere described in these rules, violate these rules, the terms of the Settlement Agreement in *Bates v. Peet*, and any other applicable law or regulation; and
  - (2) the information was obtained during the general course of the person's or agency's performance of their responsibilities.
- B. Complaints which include allegations of employee misconduct shall be processed, but no disciplinary action may be taken nor facts found with regard to the alleged misconduct except in accordance with applicable personnel rules, policies, and labor contract provisions.
- C. Complaints arising in an in-patient setting shall be addressed to the chief administrative officer of said facility, who shall forthwith refer them to the supervisor of the service delivery unit in which the complaint arose.
- D. Complaints arising in the community shall be addressed to the agency employee designated to receive complaints.
- E. A formal written response shall be made within five days of receipt by the persons listed in (C) and (D) above, excluding weekends and holidays.
- F. Decisions described in (C) above shall be appealable within 5 working days to the Chief Administrative Officer of the facility, who shall respond within 5 working days.
- G. Decisions described in (D) above shall be appealable within five working days to the Director of the Office of Child and Family Services or designee, who shall respond within five working days.
- H. Decisions resulting from (F) and (G) above shall be appealable to the Commissioner within five working days, who shall respond within five working days.

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

#### IX. CONFIDENTIALITY OF AND ACCESS TO MENTAL HEALTH RECORDS

- A. Recipients have the right to confidentiality and to access to their record.
- B. All information regarding mental health care and treatment shall be confidential except as otherwise provided below.
- C. A legally emancipated recipient and an unemancipated recipient's legally responsible parents, guardians or custodians shall be notified, upon admission or intake to any facility or program of:
  - (1) what records will be kept, including any duplicate records;
  - (2) how the recipient and legally responsible parents, guardians or custodians may see those records;
  - (3) the use to which the records will be put;
  - (4) what will happen to the record after the recipient leaves the facility or program;
  - (5) how to add information to the records;
  - (6) how to obtain copies of material in records;
  - (7) the limits of confidentiality, as provided in J below; and
  - (8) his or her rights pursuant to these rules and the Settlement Agreement in Bates v. Peet, as applicable.
- D. The legally emancipated recipient or the legally responsible parents, guardians or custodians of an unemancipated minor recipient shall be informed when the possibility exists that the costs of the recipient's care, treatment, education or support will be borne by a third party. Such information shall indicate that clinical information may be used to

substantiate charges. The emancipated recipient or the legally responsible parent, guardian or custodian of an unemancipated recipient may indicate that he or she will bear such costs privately rather than allow the release of information.

- E. The legally emancipated recipient or the legally responsible parents, guardians or custodians of an unemancipated recipient shall have the right to written and informed consent prior to release of any information to any agency or individual whether or not such agency or individual's directly involved in the recipient's treatment or supervision thereof, except as provided in J below. Such informed consent shall include:
- (1) Identification of the specific information to be disclosed;
  - (2) Notice of the right to review mental health records upon request at any reasonable time including prior to the authorized release of such records;
  - (3) The name of persons or agencies to whom disclosure is to be made;
  - (4) The purpose to which the information is to be put;
  - (5) The length of time within which the information is to be disclosed not to exceed one year; and
  - (6) Notice of the right to revoke consent to release at any time.
- F. A legally emancipated recipient or an unemancipated recipient's legally responsible parents, guardians or custodians have the right to written informed consent for release of case record material which discloses the recipient's identity to students when they temporarily become a part of treatment team, except when the student is involved in a professional program which has a formal relationship with the facility or agency.
- G. All personnel of agencies or programs, including students or trainees, shall be trained regarding confidentiality and shall be held to confidentiality statutes, rules and policies.
- H. Duplication:
- (1) If the facility or agency duplicates a portion of, or the entire care record of a recipient pursuant to any exception contained in J.1.a. through e. below a legally emancipated recipient or his or her legally responsible parent, guardian or custodian shall be notified, if possible, as to the purpose of such duplication.

- (2) Copies of original records shall be noted as such.
- I. Separate personalized records shall be maintained when group treatment methods are employed except that individualized record keeping shall not be required in instances in which conjoint family treatment services are provided, under the following conditions:
    - (1) Informed consent must be obtained to the conjoint treatment recordkeeping, pursuant to B.IV., and such consent shall be documented by using a Department-approved form. This form shall be made a part of the permanent record.
    - (2) If any family member previously received treatment other than conjoint family treatment services at the facility, agency or program, or received conjoint family treatment services as a member of a different family group at the facility, agency or program, an extracted individualized discharge summary shall be placed in that family member's individualized record.
    - (3) If any family member refuses to have treatment records blended, separate records must be maintained for that family member.
    - (4) If any family member requests the release of his or her records subsequent to the termination of conjoint family treatment services, the facility, agency or program shall respond to this request by providing an extracted individualized discharge summary. The facility, agency or program shall not release information concerning an individual family member without that family member's written consent.
    - (5) Nothing in these regulations shall preclude individualized recordkeeping by any program, facility or agency. Intake data, evaluations or assessments collected or performed for the purposes of determining eligibility for conjoint family treatment services are not treatment records for the purposes of this exception.
    - (6) This exception shall be reviewed no later than June 30, 1996 to assess the impact and effect of these rules. The review shall include representatives of the Offices of Child and Family Services, Adult Mental Health, Quality Assurance, Consumer Affairs, Advocacy and other interested parties designated by the Commissioner of the Department of Health and Human Services.

J. Exceptions:

- (1) Information may be released without written informed consent, as provided by Maine statute (Section 34-B M.R.S.A. section. 1207, Sub-sections 1B and 1C) in the following circumstances:
  - a. Disclosure may occur as necessary to carry out the statutory functions of the department or statutory hospitalization provisions.
  - b. Disclosure may be made as necessary to allow investigation by the Protection and Advocacy Agency for Persons with Disabilities in Maine, or the Office of Advocacy.
    - i. Disclosure may be made to the Department of Health and Human Services to cooperate in a child protective investigation or other child protective activity pursuant to an interdepartmental agreement promulgated as a rule.
  - c. Disclosure may be ordered by a court of record subject to any limitations contained within the Maine Rules of Evidence.
  - d. Disclosure may be allowed of biographical or medical information concerning the recipient to commercial or governmental insurers or any other corporation, association or agency from which the Department or licensee of the Department may receive reimbursement for the care, treatment, education, training or support of the recipient.
    - i. Such disclosure may be made only after determination by the Chief Administrative Officer of the facility or designee that the information to be disclosed is necessary and appropriate.
  - e. Disclosure of information, including recorded or transcribed diagnostic or therapeutic interviews concerning any recipient may be allowed in connection with any educational or training program established between a public hospital and any college, university, hospital, psychiatric counseling clinic or school of nursing, provided that in the disclosure or use of any such information as part of a course of instruction or training the recipient's identity shall remain undisclosed.

- i. Such disclosure shall be conducted with care so that identifying material is disguised or altered according to uniform standards consistent with deidentification.
  - f. Disclosure may be made to persons involved in statistical compilation or research conducted in compliance with these rules pursuant to Section XI.
    - i. In the case of such disclosure records shall not be removed from the facility and reports shall preserve the anonymity of the recipient. Data which do not identify the recipient, or coded data, may be removed from the facility, provided the key to such code shall remain at the facility.
- (2) Information regarding the status and medical care of a recipient may be released by a professional, upon inquiry by law enforcement officials or treatment personnel, if an emergency situation exists regarding the recipient's health or safety.
- (3) Confidentiality may be breached if there is clear and substantial reason to believe that there is imminent danger of serious physical harm inflicted by the recipient on him or herself or upon another.
  - a. Information regarding such danger of harm shall be immediately given to supervisory personnel or appropriate professionals, civil authorities, and any specific person threatened by direct harm.

K. Recipient Access to Records

- (1) The recipient and the recipient's legally responsible parents, guardians or custodians have the right to review the recipient's record at any reasonable time upon request, including prior to its authorized release. Such records shall be made available within three working days of such request.
- (2) Review of the case record shall occur under the supervision of a designee of the Chief Administrative Officer of the facility or program.

- (3) In cases in which there exists a reasonable concern of possible harmful effect to the recipient if the review of the recipient or his or her legally responsible parents, guardians or custodians occurs, the Clinical Director or designee shall supervise the review.
    - a. In cases where access of the legally responsible parents, guardians or custodians to the recipient's record would create documented danger to the physical or mental well being of the recipient, the Clinical Director or designee may refuse to disclose a portion of or the entire record to the legally responsible parents, guardians or custodians and such refusal shall be documented in the case record.
  - (4) In cases in which a recipient is unable to review the record at the program site, a certified copy of the record shall be forwarded to a professional, designated by the recipient, in the recipient's area, who shall supervise review of the record.
  - (5) In cases in which the recipient or his or her legally responsible parents, guardians or custodians, after review of the recipient's record, requests copies of the record, or parts of the record, such copies shall be made available to the recipient, legally responsible parents, guardians or custodians at the actual cost of reproduction.
  - (6) A recipient may add written material to his or her record in order to clarify information which he or she feels is false, inaccurate or incomplete.
  - (7) Material which was obtained from another individual or facility through assurance of confidentiality shall not be available to the recipient or the legally responsible parent, guardian or custodian in reviewing the recipient's record. A summary description of such material shall be provided to the recipient or the legally responsible parent, guardian or custodian, and information shall be provided regarding the process to gain access to such material including aid in securing appropriate release of information.
- L. Nothing in these regulations should be viewed as an abrogation of the rights of recipients to confidentiality of records under federal or state law, particularly with regard to substance abuse records.

## X. FAIR COMPENSATION FOR WORK

- A. Recipients have the right to be paid a fair wage for work done.
- (1) Each individual or agency subject to the provisions of these regulations shall pay at least the minimum wage to each recipient who performs work regardless of level of performance regardless of whether or not the work is considered therapeutic, and regardless of whether or not the recipient replaces or would replace a non-recipient worker.
  - (2) Agencies shall compensate any recipient performing any work which is similar or identical to that performed by a non-recipient employee at the same rate as such non-recipient employee is compensated.
- B. Definitions. For purposes of this section, the following definitions shall apply:
- (1) Work shall mean any work having consequential economic benefit to the mental health agency, including any activity involved in the care, maintenance, and operation of the mental health agency.
  - (2) Work shall not mean those tasks performed by each recipient for his or her own basic care or hygiene or upkeep of personal living space.
  - (3) Federal law shall mean the Fair Labor Standards Act which sets national labor standards.
  - (4) Minimum wage shall mean that hourly rate of pay established by the United States Congress or by the State of Maine, whichever is higher, as the legal minimum.
- C. Agencies shall not directly or indirectly compel a recipient to perform any work, or punish any recipient for declining to perform work. Agencies shall not make any privilege or agency service conditional upon a recipient's agreement to perform work or withdraw a recipient's privileges or services because of that recipient's failure to perform work.
- D. Agencies shall not discriminate in the hiring of agency staff. Any recipient is eligible to apply for and occupy, if qualified, any job classification.

E. Exceptions:

- (1) Agencies and service providers subjected to these regulations may pay sub-minimum wage to a recipient who performs work after proper certification has been made by the United States Department of Labor under Handicapped Worker provisions contained in federal law.
- (2) Payment for work shall not be required when a recipient is a participant in an independent living program which requires a fair division of labor among all participants, including community-based psychosocial clubs and transitional living facilities, or in community-based transitional employment programs.

XI. PROTECTION DURING EXPERIMENTATION AND RESEARCH

- A. Recipients have the right to refuse to participate in experimentation and research without loss of services.
- B. All participation in experimentation and research shall be voluntary with full written informed consent, except as provided in these rules.
- C. A recipient's refusal to participate in a research project or an experimental activity shall not be cause for denying the provision of indicated services to that recipient.
- D. Definitions
  - (1) Experimentation and research
    - a. Experimentation and research means the use of any medical, behavioral, or environmental intervention involving practices not commonly accepted by the discipline involved, or the systematic accumulation and codification of data designed to develop or contribute to general knowledge.
    - b. Experimental drug use means:
      - i. the use of any Food and Drug Administration non-approved drug.
  - (2) Informed consent means the agreement obtained from a subject, or from his or her authorized representative, to participate in an activity. Informed consent requires that subjects understand the

purpose, benefits and risks of research in which they are asked to participate and are given the opportunity to consent to, reject, or withdraw from participation without penalty.

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

E. Research and Experimentation Review Board Membership

- (1) A. Research and Experimentation Review Board, selected by the administrative head of the particular facility or agency, shall have at least five members with varying backgrounds, in order to promote complete and adequate review of research and experimental activities proposed for consideration.
- (2) The Board shall be sufficiently qualified, through the experience and expertise of its members and the diversity of the members' backgrounds, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects.
- (3) In addition to possessing the professional competence necessary to review such activities, the Board shall be able to ascertain the acceptability of proposed research or experimentation in terms of institutional commitments, regulations, applicable law, and standards of professional conduct and practice.
- (4) The Board shall consist of interdisciplinary members of both sexes including at least one member whose primary concerns are in non-scientific areas, such as law, ethics or theology, and at least one member who is not otherwise affiliated with the institution or agency proposing the research or experimentation.
- (5) No Board member may participate in the Board's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the Board.
- (6) At the Board's discretion, individuals with competence in special areas may be invited to assist in the review of complex issues which require expertise beyond or in addition to that available on the Board. These individuals may not vote.

F. General Procedures

- (1) All experimentation and research shall commence only after review and approval by the Research and Experimentation Review Board.
- (2) The Research and Experimentation Review Board shall have the authority to approve, require modifications in, or disapprove, any proposed research or experimentation activities.
- (3) The Rights Protection or Advocacy Agency of the Maine mental health system shall be informed of any proposed experimentation or research involving more than minimal risk.
- (4) The Board shall maintain adequate documentation of its activities.
- (5) The Board shall provide written notification of its approval or disapproval of the proposed research or experimentation activity or of any modifications required to secure research and experimentation review board approval of any activity in question.
- (6) If the Board decides to disapprove a research or experimentation activity, it shall include, in its written notification, a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing.
- (7) Investigators and others directly involved in the research or experimentation shall, both in obtaining the consent and in conducting research, adhere to the ethical and research standards of their respective professions concerning the conduct of research or experimentation and to the regulations for research involving human subjects required by the U.S. Department of Health and Human Services in effect at the time of the adoption of these rules.
- (8) Researchers must report substantial changes or unanticipated problems immediately to the Chairperson of the Board.
- (9) The Board shall conduct continuing review of research covered by these regulations at intervals appropriate to the degree of risk, but not less than once a year, and shall have authority, to observe or have a third party observe the consent process and research.

- (10) The Board shall have the authority to suspend or terminate approval of research that is not being conducted in accordance with the Board's requirements, these rules, or that has been associated with unexpected harm to subjects. Any suspension or termination of approval shall include a statement of the reasons for the Board's action and shall be reported promptly to the investigator, appropriate institutional officials, and the secretary of the Department of Health and Human Services as required by federal regulations.
  - (11) Upon completion of the research and/or experimentation procedures the principal investigator shall attempt to remove any confusion, stress, physical discomfort, or other harmful consequences that may have been inadvertently produced as a result of the research or experimentation procedures.
- G. Criteria for Board Approval of Research and Experimentation. In order to approve research covered by these regulations the Board shall determine that all of the following requirements are satisfied:
- (1) Risks to subjects are minimized by using procedures which are consistent with sound research or experimentation design and which do not unnecessarily expose subjects to risk and, wherever appropriate, by using procedures already, being performed on the subject for diagnostic or treatment purposes.
  - (2) Risks to subjects are reasonable in relationship to anticipated benefits to subjects. In evaluating risks and benefits, the Board shall consider only those risks and benefits that may result from the research and experimentation, as distinguished from the risks and benefits of therapy these subjects would receive in not participating in the research, or possible long-range benefits of applying knowledge gained in the research.
  - (3) Selection of subjects is equitable, taking into account the purposes of the research and the setting in which the research will be conducted.
  - (4) Informed consent will be sought and appropriately documented in accordance with these rules.
  - (5) The research or experimentation plan makes adequate provisions for monitoring the data collected or the activities allowed to ensure the safety of the subjects.

- (6) There are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.
- (7) Where some or all of the subjects are likely to be vulnerable to coercion or undue influence, appropriate additional safeguards have been included in the project to protect the rights and welfare of these subjects.

H. Special Procedures; Exceptions to Informed Consent

(1) Research Involving the Need for Non-disclosure

- a. If the research or experimentation methodology requires that the purpose, nature, expected outcome and/or implications of the research not be disclosed to the participants before it begins, the researcher shall clearly and vigorously justify to the Research and Experimentation Review Board the need for non-disclosure.
- b. The Board may approve research or experimentation procedures which do not include, or which alter, some or all of the elements of informed consent set forth in these rules, or waive the requirements to obtain informed consent provided the Board finds and documents that:
  - i. the research involves no more than minimal risks to the subjects;
  - ii. the waiver or alteration will not adversely affect the rights and welfare of the subjects;
  - iii. the research or experimentation could not practicably be carried out without the waiver or alteration; and,
  - iv. whenever appropriate, the subjects will be provided with full disclosure or additional pertinent information after the research or experimentation project is completed.

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

- a. Research which is limited to archival review, statistical compilation or record review may be carried out pursuant to

Title 34, M.R.S.A., Section 1207(2). Such research may be carried out without informed consent provided that:

- i. said research is reviewed and approved by a Research and Experimentation Review Board;
- ii. all data involved in said research shall not be identifiable as to individual recipients of services;
- iii. the research plan shall be submitted to, and approved by, the head of the mental health facility or his or her designee.

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

- a. No experimentation or research involving more than minimal risks shall be conducted with persons unable to give informed consent, minors, or involuntary patients unless:
  - i. the experimentation or research poses a clearly expected benefit to the individual recipient involved; and,
  - ii. the experimentation or research has been reviewed and approved by the Research and Experimentation Review Board.
- b. Notwithstanding the provisions of sections A.XI.H.1. and A.XI.H.2, in the case of recipients under the age of 18 and in the case of recipients adjudicated incapacitated, consent must in all instances be obtained from the recipient's legally responsible parents, guardians or custodians, and such consent must be reviewed by the Rights Protection and Advocacy Services of the state mental health system.
- c. In the case of minor recipients over the age of 12, informed consent must also be obtained from the prospective recipient participant, except as described in sections AXI.H.1. and A.XI.H.2. This provision does not change the provision in section A.XI.H.3.b. requiring the consent of the legally responsible parents, guardians or custodians.

- (4) Any use of drugs approved by the Food and Drug Administration, when applied in an unlabeled manner, shall receive prior approval from the Clinical Director or equivalent.

I. Applicability

- (1) Questions regarding the applicability of this section to specific recipients or activities shall be referred in writing to the Chairperson of the Research & Experimentation Board who shall determine applicability.
- (2) Where disagreement continues to exist, questions may be presented through the Grievance Procedure, Section VI.
- (3) In issues regarding professional standards, referral of the question may be made to the appropriate national professional standards committee whose decision shall be final and binding.

XII. INDIVIDUALIZED SUPPORT PLANS

- A. Recipients have the right to an individualized support plan which shall be coordinated and monitored by a community support worker.
- B. These plans shall be developed based upon consideration of the recipient's housing, financial, social, recreational, transportation, medical, dental, emotional and psychiatric and/or psychological strengths and needs as well as his or her potential need for crisis intervention services. The plan shall reflect full consideration of the least restrictive appropriate treatment and related services taking into account factors that are supportive of each recipient's exercise of his or her basic rights, consistent with each individual's strengths, needs and treatment requirements pursuant to this section. Such considerations shall include accommodation of particular needs involving communication and physical accessibility to all treatment programs.
- C. The recipient and the legally responsible parent, guardian or custodian shall be notified of all ISP meetings, and shall be actively encouraged to attend. If the recipient and/or the legally responsible parent, guardian or custodian does not attend an ISP meeting, the Community Support Worker shall relay their views to other members of the team. The legally responsible parent, guardian or custodian may invite other persons to ISP meetings. Persons unable to attend the meeting shall be notified that they may submit information in writing for consideration at the meeting.

- D. ISP's shall be developed in a timely manner and shall be reviewed and revised no less frequently than every 90 days. Plans may be reviewed more frequently as necessary to address substantial changes in the recipient's life, such as hospitalization.
- E. The ISP shall be developed by a team consisting of the recipient, the legally responsible parent, guardian or custodian, and others among whom there exists the authorization to exchange information and who are needed to ensure that the recipient's needs are adequately assessed and that appropriate recommendations are made, based upon a comprehensive assessment of the recipient. The plan shall contain but not be limited to:
- (1) A statement of the recipient's specific strengths and treatment needs.
    - a. The ISP should include a description of any physical handicap and any accommodations necessary to provide the same or equal services and benefits as those afforded non-disabled individuals.
  - (2) A description of services to assist the recipient in meeting identified needs. Goals shall be written for each service. Short-range objectives shall be stated such that their achievement leads to the attainment of overall goals. Objectives shall be stated in terms which allow objective measurement of progress and which the recipient, to the maximum extent possible, both understands and adopts.
    - a. The description of services shall be based upon the actual needs of the recipient rather than on what services are currently available. If at the time of the meeting, members know on the basis of reliable information that the needed services are unavailable, they shall note them as "unmet" service needs" on the ISP based upon available services which meet, as nearly as possible, the actual needs of the recipient.
  - (3) A description of the manner of delivery of each service to be provided. The manner of delivery shall be one which maximizes the recipient's strengths, independence and integration into the community.
  - (4) A statement of the rationale or reason for specifying certain treatment or services to meet identified goals.

- (5) A specification of treatment responsibility, including the responsibility and involvement of staff, recipient and parent or guardian to attain treatment goals.
  
- F. Within one week of the meeting, the recipient and his or her parent, custodian or guardian shall be offered a written copy of the [SP. The recipient shall also be notified, by means he or she will most likely understand, of the right to file a grievance should he or she disagree with any aspect of the plan or the assessments upon which the Wan is based, or later be dissatisfied with the plan's implementation.
  
- G. All agencies providing Community Support Worker services shall maintain specific written guidelines describing their practices concerning development of ISP's.
  
- H. The legally responsible parents, guardians or custodians shall be actively involved in individualized support planning, to the maximum extent possible. The Department of Health and Human Services acting as legal custodian has an affirmative duty to be fully and actively involved in individualized support planning.

**RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES  
WHO ARE  
CHILDREN IN NEED OF TREATMENT**

**PART B  
RIGHTS IN INPATIENT AND RESIDENTIAL SETTINGS**

**Maine Department of Health and Human Services  
Office of Child and Family Services  
Children's Behavioral Health Services  
11 State House Station  
Augusta, Maine 04333-0011**

## CONTENTS

### B. RIGHTS IN INPATIENT AND RESIDENTIAL SETTINGS

	Contents	33
I.	Statement of Intent	34
II.	Privacy and Humane Treatment Environment	34
III.	Individualized Treatment of Service Plan	37
IV.	Informed Consent to Treatment	41
V.	Free Association and Communication	46
VI.	Freedom From Unnecessary Seclusion and Restraint in Inpatient Settings	50
VII.	Freedom From Unnecessary Seclusion and Restraint in Residential Settings	61

## B. RIGHTS IN INPATIENT AND RESIDENTIAL SETTINGS

### I. STATEMENT OF INTENT

These rules (Part B) apply to all inpatient and residential facilities, agencies and programs providing mental health services, which are licensed, funded or contracted by either the Department of Health and Human Services, including state operated institutes and facilities, except that Section III shall apply only to inpatient psychiatric units, while treatment planning in residential facilities shall be governed by Part C(II), Individualized Treatment or Service Plan. Part B should be read in conjunction with Part A, Rules of General Applicability.

### II. PRIVACY AND HUMANE TREATMENT ENVIRONMENT

- A. Recipients have the right to a humane psychological and physical environment within the facility.
- B. The facility shall be designed to afford recipients comfort and safety, shall promote dignity and independence and shall be designed to make a positive contribution to the efficient attainment of treatment goals.
- C. Each recipient has the right to be treated with courtesy and with full respect for his or her individuality and dignity, and to recognition that his or her personality, needs and aspirations are not determinable on the basis of a psychiatric label.
- D. Recipients have the right to have their privacy assured and protected and to preserve the basic rhythm of their lives to the greatest extent possible in light of their treatment needs.
- E. Each inpatient or residential facility shall provide at least:
  - (1) nutritious food in adequate quantities;
  - (2) access to or provision of adequate professional medical care;
  - (3) a level of sanitation, ventilation and light which meets health standards;
  - (4) a reasonable amount of space per person in sleeping areas;
  - (5) a reasonable opportunity for physical exercise and recreation, including access to outdoor activities subject to the requirements of Section 111, Individualized Treatment and Discharge Plan or ISP;

- (6) an area for private conversation with other recipients and family and friends if all designated areas are in use staff shall make other reasonable arrangements to assure the recipient's and visitor's comfort and privacy;
- (7) an area for private telephone conversations;
- (8) areas which assure privacy for personal hygiene, counseling, physical examinations;
- (9) a secure and accessible storage area of adequate size to accommodate the recipient's personal belongings; and,
- (10) opportunities for appropriate involvement in community activities, subject to the requirements of Section III, Individualized Treatment and Discharge Plan; and
- (11) common areas with space and equipment sufficient to permit recipients to comfortably socialize, relax, or engage in leisure time activities. To reduce the chance that recipients engaged in activity may intrude upon others not similarly engaged, such areas shall be equipped so that intrinsically incompatible activities are not performed in the same areas.
- (12) A schedule of available therapeutic, rehabilitative and recreational activities to each recipient. The schedule shall be updated monthly or more frequently as necessary.

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

- (1) Recipients shall not be subjected to humiliation or verbal abuse.
- (2) Recipients shall not be subjected to physical abuse and corporal punishment is expressly prohibited.
- (3) Recipients shall not be subjected to exploitation or neglect.
- (4) Any allegation of abuse, exploitation or neglect shall be immediately reported to the following: (1) Chief Administrator of the facility or agency and to the Office of Advocacy, pursuant to Section VI (1), PART A, Grievances; and (2) the Department of Health and Human Services pursuant to the Child and Family Services and Child Protection Act (22 MRSA, Chapter 1071).

- G. Simple, understandable written rules setting the limits of recipient's behavior required for the protection of the group and individuals shall be established and made known to the recipient and to his or her legally responsible parents, guardians or custodians.
- H. Personal Property
- (1) Except as provided below, recipients have the right to retain and use personal property.
  - (2) The use of personal property may be limited or items held in safekeeping only when the number or use of such items infringes upon the rights of other recipients, or poses a safety risk.
  - (3) Each recipient shall have the right to manage his or her own personal financial affairs and funds unless:
    - a. such restrictions are a part of a plan of treatment pursuant to informed consent to treatment; or,
    - b. a determination is made of the clinical or developmental incapacity of the recipient which, in all cases, shall be documented in the clinical record; or,
    - c. a conservator, guardian, custodian, legally responsible parent or representative payee has imposed the limitation; or,
    - d. court ordered restrictions exist; or,
    - e. restriction may be made to safeguard a recipient's assets during the initiation and pendency of any protective proceedings.
  - (4) Any limitations on personal property or financial affairs shall be documented and receipts for all money or material held in safekeeping shall be given to the recipient or his or her guardians, custodians or legally responsible parents.
  - (5) The facility or agency shall bear responsibility for any money or material held in safekeeping.
- L. Searches. Every recipient has the right to be free from unnecessary searches of the person, of personal space or of common areas. A search shall only be conducted when staff have a reasonable belief that

misappropriated articles are present or that certain items that would endanger the health or safety of a particular recipient or other recipients are present. Every search and the reasons therefor shall be documented.

### III. INDIVIDUALIZED TREATMENT OR SERVICE AND DISCHARGE PLAN

- A. Recipients of inpatient mental health or psychiatric services have the right to treatment according to a written individualized treatment or service and discharge plan which shall be incorporated into the recipient's ISP as a discrete sub-part.
- B. Treatment or service and discharge plans shall be developed based upon an individualized assessment of the recipient's physical, psychological and social needs, as well as the recipient's expressed desires. Each facility or agency shall fully consider the least restrictive appropriate treatment and related services taking into account factors that are supportive of each recipient's exercise of his or her basic rights, consistent with each individual's needs and treatment requirements pursuant to this section and sections VIII and X of these rules. Such considerations shall include accommodation of particular needs involving communication and physical accessibility to all treatment programs.
- C. Each recipient 14 or over has the right to be fully and actively involved in the development or revision of his or her treatment or service plan. Involvement of recipients who are younger shall be determined on a case by case basis, after assessment of the recipient's capacity to be involved. The exclusion of a recipient 14 or over, based on incapacity, developmental or mental, requires the approval of the clinical director or, in residential settings, the approval of an independently licensed clinician.. The guardian, custodian or legally responsible parent shall be fully and actively involved in treatment or service planning to the maximum extent possible, given time and location constraints. Each agency, program or facility shall make good faith efforts, including 48 hour notice in inpatient settings and 7 day notice in residential settings, of any meeting, to involve guardians or parents and such efforts shall be documented.
- D. Treatment or service plans shall be developed in a timely manner. Initial plans shall be developed within 72 hours in inpatient or residential facilities. Comprehensive plans shall be developed within 10 working days in inpatient facilities and 20 working days in residential facilities.
- E. The comprehensive treatment or service and discharge plan shall be developed by the treatment team, and shall be based upon a comprehensive assessment of the recipient. This plan shall contain, but not be limited to:

- (1) A statement of the recipient's specific strengths and treatment and/or service needs.
  - a. The treatment or service and discharge plan shall include a description of any physical handicap and any accommodations necessary to provide the same or equal services and benefits as those afforded non-disabled individuals.
  - b. Goals which must be met in order for the recipient to meet discharge criteria shall be clearly noted.
- (2) A. description of short-term and long-range treatment and/or service goals, with a projection of when such goals will be achieved;
- (3) A statement of the rationale or reason for utilizing a particular form of treatment and/or services;
- (4) A specification of treatment and/or service provision responsibility, including both staff, recipient and parent, guardian or custodian's responsibility and involvement to attain treatment and/or service goals;
- (5) An assessment, at each review, of whether the recipient may be safely discharged; and
- (6) Documentation of current discharge planning.

F. Limitations

- (1) Such a plan must include any limitation of rights or liberties. Such limitation shall be based upon professional judgment and may include a determination that the recipient is a danger to him or herself or to others absent such limitation. Such limitation shall meet criteria outlined for such limitation in other sections of these rules.
- (2) When such limitation occurs, the treatment or service plan shall address the specific limitation and such restriction shall be subject to periodic review. When possible, such limitation shall be time specific.

- (3) Whenever possible specific treatment and/or services shall be developed to address the basis of the limitation.
  - (4) Documentation regarding the limitation shall include documentation as per F(1 ) through 3 above and shall include specific criteria for removal of the limitation.
- G. A copy of the treatment or service plan shall be offered to each recipient, to a guardian, custodian or legally responsible parent, if any, and to a recipient's representative Of confidentiality has been waived pursuant to PART A, Section VIII). -47-
- H. All facilities or agencies shall maintain specific written guidelines describing their practices concerning development of treatment or service and discharge plans.
- I. The treatment and discharge plan shall be reviewed and revised as frequently as is clinically indicated. Each facility, agency or program shall establish, by policy, schedule for review of all] recipient's treatment and discharge plans.
- J. Discharge or termination
  - (1) Each recipient and his or her guardians, custodians or legally responsible parents have the right to be informed of and referred to appropriate resources upon discharge or termination from a facility or program.
  - (2) Each recipient has the right to a comprehensive discharge, or treatment or service plan, and to assisted referral to existing resources in such areas as transportation, housing, residential support service, crisis intervention and resolution services, vocational opportunities and training, family support, medical and dental services, recreational/social/vocational opportunities, financial assistance, and mental health treatment options. Recommendations made in discharge or termination plans shall not require the facility or department to provide recommended goods or service.
  - (3) Upon discharge from an inpatient facility, the facility shall provide each recipient and legally responsible parent, guardian or custodian with a copy of the aftercare plan and a written list of his or her prescribed medication, dosage levels, schedules, side-effects, precautions and contraindications. A copy of the medication list

and the aftercare plan shall be sent to the recipient's guardians, custodians or legally responsible parents and to the representative.

(4) Notification

a. Upon obtaining the permission of the guardians, custodians or legally responsible parents, the recipient's representative will be notified of any treatment or service and discharge planning. Additionally, the guardians, custodians or legally responsible parents and, with consent, the representative may, if available, be involved in any treatment or service and discharge planning. Involvement may include, but need not be limited to, participation in any discharge planning meeting. Invited persons who cannot attend shall be notified that they may submit information in writing for consideration at the meeting.

b. The recipient's guardians, custodians or and legally responsible parents shall be given notification of the recipient's discharge from an inpatient or residential facility. Upon the request of an emancipated recipient, his or her representative shall be notified, if possible. At least twenty-four hour notice shall be given in planned discharges, if possible. In the case of other discharges, such notice shall be given as quickly as possible.

K. The guardians, custodians or legally responsible parents shall be actively involved in the treatment, service, discharge or termination planning, to the maximum extent possible.

L. Exceptions

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

(2) A recipient may choose not to be involved in developing his or her treatment, service, discharge or termination plan and his or her guardians, custodians or legally responsible parents may refuse treatment discharge or termination planning or services.

a. All such cases shall be documented in the recipient's permanent treatment record.

- (3) An emancipated recipient may choose not to be involved in developing his or her treatment or service and discharge plan and may refuse treatment or service and discharge planning or services.
  - a. All such cases shall be documented in the recipient's permanent treatment or service record.
- (4) Exclusion from planning by professionals may only occur if the guardians, custodians or legally responsible parents pose a documented danger to the physical or mental well-being of the recipient.

#### IV. INFORMED CONSENT TO TREATMENT

- A. Recipients and their guardians, custodians and legally responsible parents have the right to informed consent for all treatment.
- B. Statement of purpose. This rule has the following purposes:
  - (1) To promote respect for individual autonomy and recipient participation in decision-making;
  - (2) To ensure that, whenever possible, the informed consent of a recipient or his or her legally responsible parent, guardian or custodian is obtained prior to treatment;
  - (3) To avoid, whenever possible, forcible imposition of any treatment;
  - (4) To provide reasonable standards and procedural mechanisms for determining when to treat a recipient absent his or her informed consent, consistent with applicable law; and
  - (5) To ensure that the recipient is fully protected against the unwarranted exercise of the state's *parens patriae* power.
- C. Treatment of recipients. Treatment may be provided to a recipient only when:
  - (1) Informed consent for such treatment has been obtained from the recipient in the following circumstances:

- a. The recipient has been living separately from parents or legal guardians for at least 60 days and is independent of parental or legal guardian support;
  - b. The recipient is or was legally married;
  - c. The recipient is or was a member of the Armed Forces of the United States; or
  - d. The recipient has been emancipated by the court pursuant to 15 M.R.S.A. s 3506-A; and
  - e. The recipient is clinically competent.
- (2) The recipient is an unemancipated minor, or clinically incapacitated minor and the informed consent of the legally responsible parent, custodian or guardian has been obtained; or
  - (3) The recipient is 14 or over, the treatment is psychotropic medication, and the informed consent of the recipient and the legally responsible parents, guardians or custodians has been obtained.

D. Informed consent to treatment. Informed consent to treatment is obtained only if the recipient, under C(1-3) above, or the legally responsible parent, guardian or custodian possess capacity to make a reasoned decision regarding the treatment and the recipient under C(1-3) above, and his or her legally responsible parent, guardian or custodian is provided with adequate information concerning the treatment; and the recipient, under C(1-3) above, and his or her legally responsible parent, guardian or custodian makes a voluntary choice in favor of the treatment. Informed consent must be documented in each case in accordance with this section.

- (1) Capacity. Capacity means sufficient understanding to comprehend the information outlined in section D(2) and to make a responsible decision concerning a particular treatment.

There is a general assumption in the law that a minor is legally incapacitated to make most health care decisions. However, legal incapacity is not synonymous with clinical or developmental capacity which should always be determined on a case by case basis for clinical purposes to participate in a treatment decision. Where non-emergency intrusive medical treatment is at issue, the refusal of a mature (+14) minor must be honored.

- (2) Adequate information. The licensed, certified or other qualified mental health professional recommending a particular treatment shall provide to the recipient, if appropriate under C(1-3) above, and his or her legally responsible parent, guardian or custodian, all information relevant to the formulation of a reasoned decision concerning such treatment. The recipient, and his or her legally responsible parent, guardian or custodian, shall have the right to have a person of his or her choice present during the presentation of this information, provided that the nominee can be available within 48 hours, or within such other reasonable period as may be agreed upon; and the recipient, and his or her legally responsible parent, guardian or custodian, shall be informed of this right. The information may be provided orally or in writing, shall be communicated in terms designed to be comprehensible to a lay person, and shall include, without limitation:
- a. An assessment of the recipient's condition and needs;
  - b. The nature of the proposed treatment, and a statement of the reasons why the professional believes it to be indicated in the recipient's case;
  - c. The expected benefits of the treatment, and the known risks which it entails, including the common side-effects, precautions and contraindications of a particular proposed medication;
  - d. The anticipated duration of the treatment;
  - e. A statement of reasonable alternatives to the proposed treatment, if any;
  - f. Information as to where the recipient and his or her legally responsible parent, guardian or custodian may obtain answers to further questions concerning the treatment;
  - g. A clear statement that the recipient, where appropriate, has the right to give or withhold consent to the proposed treatment.
- (3) Voluntary choice. Consent to treatment must be given willingly in all cases, and may not be obtained through coercion or deception. Special care shall be taken to assure that consent is voluntary

where the recipient's status as an involuntary inpatient militates against truly voluntary consent.

A recipient's or legally responsible parents', guardians' or custodians' initial refusal of treatment shall not preclude renewed attempts to obtain willing consent; and a recipient's or legally responsible parents' guardians' or custodians' initial willing consent shall not preclude him or her from validly withdrawing such consent at any time before or during treatment.

(4) Documentation. The informed consent of a recipient and his or her legally responsible parent, guardian or custodian to a particular treatment shall be documented to show:

- a. From whom consent is obtained, whether recipient, legally responsible parent, guardian or custodian;
- b. If consent is given by the recipient, a signed statement that the recipient possesses capacity to give informed consent;
- c. That adequate information, including at a minimum all the elements listed in section D(2) of this rule, was provided;
- d. The signature of the legally responsible parent, guardian or custodian and, where applicable under C(1-3) above, the recipient, indicating consent.

(5) Exception to Written Consent

- a. In cases of unanticipated treatment needs, the informed consent of a legally responsible parent, guardian or custodian may be obtained by telephone; but such oral consent shall be confirmed in writing in accordance with this section as soon as practicable.

#### E. Involuntary Emergency Treatment

- (1) An emergency is defined as a situation in which, as a result of a recipient's behavior due to mental illness there exists an imminent danger of bodily injury to the recipient or to others.
- (2) A licensed physician or a physician extender may declare an emergency when he or she reasonably believes an emergency exists as defined in subsection E (1) above, and when

- a. A recognized form of treatment is required immediately to ensure the physical safety of the recipient or of others; and
  - b. No-one legally entitled to consent on the recipient's behalf is available; and
  - c. A reasonable person concerned for the physical safety of the recipient or of others would consent under the circumstances.
- (3) If a physician or a physician extender declares an emergency, documentation of the emergency shall be immediately entered into the recipient's permanent treatment record, and endorsed, within 24 hours, by the physician, such documentation shall include:
- a. A description of the behaviors which were observed that created the emergency;
  - b. The period, not to exceed 72 hours, during which the emergency treatment may be administered;
  - c. The expected benefits of the emergency treatment; and
  - d. The specific behaviors or physical responses which staff should monitor and record, and the means to be used.
- (4) At no time may a physician or physician extender declare an emergency merely because the recipient refuses treatment.
- (5) Following a declaration of emergency pursuant to subsection E(1) above, a licensed physician or a person acting under his or her direction may administer a recognized form of treatment over the recipient's objection and absent his or her informed consent. Treatment imposed following a declaration of emergency may continue for a period not to exceed 72 consecutive hours.
- (6) The administrative head of the facility and the Clinical Director or his or her equivalent shall be notified, as soon as possible, of any emergency. Any renewal of emergency treatment requires review by and the written authorization of the Clinical Director of a mental health institute or his or her equivalent in any other mental health facility.

V. FREEDOM OF ASSOCIATION AND COMMUNICATION

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

B. Recipient's Right to Visitors

- (1) Each facility shall establish the most liberal visiting policies which are administratively feasible.
  - a. Each inpatient facility shall establish regular daily visiting hours. Such hours shall be prominently posted in the facility. Visitation during these hours shall not require prior notification or request by either the recipient or the visitor except when such visits would conflict with regularly scheduled therapeutic activities of which the recipient has been notified.
  - b. Each residential facility shall determine the most liberal and appropriate times for visitation with legally responsible parents, guardians or custodians. Such information shall be made available to recipients and legally responsible parents, guardians or custodians.
  - c. Recipients and/or their legally responsible parents, guardians or custodians have the right to refuse or terminate visitation from specific visitors or all visitors.
- (2) Suitable areas shall be provided by the facility for privacy during visitation.
- (3) The facility shall provide unrestricted visitation by a recipient's attorney, clergy, professional service provider, advocate of the rights protection or advocacy services of the Maine mental health system or, for educational issues, surrogate parents at any reasonable time.
- (4) Exceptions
  - a. When a physician, licensed clinical psychologist or, in residential settings, licensed clinical social worker, licensed clinical professional counselor or clinical nurse specialist treating a recipient determines, in consultation with the treatment team, that denial of access to a particular visitor or visitors, except those visitors listed in subsection 3 above, is

necessary for treatment, or for security purposes in the case of forensic recipients, such professional may, for a specific, limited and reasonable period of time, deny such access.

- i. A written order denying such visitation including the reasons for the denial, shall be entered into the recipient's permanent treatment record.
- ii. Any limitation of this right shall be explained to the recipient and his or her legally responsible parent, custodian or guardian and to the specifically restricted visitor. Those same people shall be immediately notified, if possible, when the restrictions on visitation have been lifted.
- iii. Any limitation on visitation may be appealed by the recipient or his or her legally responsible parent, custodian or guardian by the specifically restricted visitor, if aggrieved, through the grievance mechanism as outline in Section V.

#### C. Recipient's Right to Communicate by Mail

- (1) No facility shall censor, delay or restrict incoming or outgoing letters or packages. Incoming letters and packages shall be delivered sealed and unopened to the recipient, and outgoing letters and packages shall be mailed in like manner.
- (2) Writing materials and postage funds adequate to mail at least one letter per day shall be provided to inpatient recipients who are unable to procure such items.
- (3) Exceptions
  - a. If staff of a facility reasonably believes that mail contains contraband, such mail may, upon the written order of a physician, Chief Administrative Officer, or Chief Administrative Officer's designee be subjected to physical examination in the recipient's presence.
  - b. Any illegal items found during such an examination may be confiscated by the facility.
  - c. Any other contraband shall be held in safekeeping, and returned to the recipient upon discharge, except that no medication shall be released without the authorization of a physician.

- d. Any exception to the right to communicate by mail under subsection (a) above must be explained to the recipient. The justification for any such exception, an itemized list of any materials confiscated must be documented in the recipient's permanent record.
- e. Additional procedures may be developed to assure security in cases of forensic recipients.

D. Recipient's Right to Communicate by Telephone

- (1) Each inpatient and residential treatment facility shall provide all recipients reasonable access to telephones for placing and receiving confidential calls, including access to telecommunication devices for the deaf, when necessary.
- (2) Each inpatient and residential treatment facility shall assure, at any reasonable time, a recipient's access to a telephone for contact with a particular designated family member, clergy, professional service provider, or personally designated representative . Reasonable time means from the hours of 7:00 am to 10:00 pm, daily. Telephone access to an advocate of the rights protection and advocacy service or to an attorney shall be assured at all times.
- (3) Each inpatient facility shall provide use of telephones at no charge, or telephone usage funds in reasonable amounts, to recipients who would otherwise be unable to communicate with family or friends by telephone.
- (4) Exceptions
  - a. Upon recommendation of a physician or licensed psychologist, the chief administrator of the facility may restrict a recipient's right to communicate by telephone when the facility is notified, by a person receiving calls, that the person is being harassed and wishes the calls to be curtailed or halted. Telephone restrictions shall apply only to those persons so notifying the facility.
  - b. Upon the recommendation of a physician, licensed psychologist or, in residential settings, licensed clinical social worker, licensed clinical professional counselor or MOW

nurse specialist the chief administrator of the facility may restrict or monitor a recipient's right to communicate by telephone, if it is determined that the recipient has made obscene or threatening phone calls, or for other security reasons in the case of forensic recipients.

- c. If a physician, licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, clinical nurse specialist or legally responsible parent, guardian or custodian determines, in consultation with the treatment team, that restrictions on making or receiving telephone calls, except to those listed in 2 above, is necessary for treatment purposes, the physician, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor or clinical nurse specialist may restrict the recipient's right to communicate for a specific limited and reasonable period of time, not to exceed one week without reauthorization.
  - i. Any such restriction shall become incorporated in the recipient's treatment or service plan, and be a focus of treatment, pursuant to Section IV(F).
  - ii. An explanation of any such restrictions shall be given to the recipient's regular callers as designated by the recipient. The recipient's designated regular callers, so requesting, shall be immediately notified, if possible, when the restrictions on communication by telephone are lifted.
  - iii. Any limitation on telephone calling may be appealed by the recipient or his or her legally responsible parent guardian or custodian or the specifically restricted caller, if aggrieved, through the grievance mechanism as outlined in Part A.
- E. Recipients are entitled to receive individualized treatment, to have access to activities necessary to the achievement of their individualized treatment goals, to exercise daily, to recreate outdoors, and to exercise their religion.
- F. At no time shall the entitlement or basic human rights set forth in this Section be treated as privileges that the recipient must earn by meeting certain standards of behavior.

VI. FREEDOM FROM UNNECESSARY SECLUSION AND RESTRAINT IN INPATIENT SETTINGS

A. Seclusion

- (1) Seclusion means the placement of a recipient alone in an isolation room from which exit is denied.
- (2) Seclusion may be employed only in the following instances:
  - a. when absolutely necessary to protect the recipient from causing physical harm to self or others; and
  - b. to prevent further serious disruption that significantly interferes with other recipients' treatment. Behaviors causing serious disruption that interferes with others' treatment may include uncontrollable screaming, public masturbation, indecent exposure and uncontrolled intrusiveness on other recipients. Use of seclusion may be appropriate in these circumstances if the behaviors cannot be controlled through lesser restrictive means than seclusion and if the behaviors will likely be controlled with the use of seclusion. Seclusion may not be used solely to address the comfort, convenience or anxiety of staff; to address factors related to ward or unit dynamics; to control a recipient's mild obnoxiousness, rudeness, obstinacy, use of profanity or other unpleasantness; nor as discipline for resolved behaviors.

Seclusion under these circumstances shall be employed in the following manner

- i. if the recipient is examined in person by a physician or physician extender prior to the implementation of seclusion; or
  - ii. by a registered nurse in telephone consultation with a physician or physician extender.
- (3) Seclusion may be used only if less restrictive measures are inappropriate or have proven to be ineffective.
  - (4) The decision to place a recipient in seclusion shall be made by a physician or physician extender and shall be entered as a medical order in the recipient's records.

- (5) All recipients must be examined before being placed in seclusion in accordance with the following:
- a. If the physician or physician extender is not immediately available to examine the recipient, the recipient may be placed in seclusion following an examination by a registered nurse if the registered nurse finds that the recipient poses a risk of imminent harm to self or others or following an examination by the nurse and with telephone consultation from the physician or physician extender in order to prevent further serious disruption that significantly interferes with other recipients' treatment. Any recipient placed in seclusion under these circumstances shall be kept under constant observation while awaiting an examination by a physician or physician extender.
  - b. The examination by the registered nurse shall be conducted in accordance with a protocol approved by the chief of psychiatry or medicine and by the Director of Nursing. The protocol must include the following:
    - i. A list of indicators for organic causes of changed behaviors.
    - ii. Elements for assessment including but not limited to: known medical disorders;
      - (a) the recipient's medications including PRN administrations;
      - (b) mental status, with observation of behavior, speech, affect and suicidal/homicidal ideation;
      - (c) brief neurological examination: pupil size and reactivity, gait, limb movement and strength;
      - (d) vital signs; and
      - (e) cognition using a standard tool.

- iii. Provision for completion as soon as is clinically sound, those elements A assessment that require the recipient's cooperation and that the nurse may not be able to perform immediately due to the recipient's condition.
- c. A physician or physician extender shall personally evaluate the recipient within 30 minutes after the recipient has been placed in seclusion. If the evaluation does not take place within 30 minutes, the reasons for the delay shall be documented in the recipient's record. This provision applies to all recipients, including those placed in seclusion during the night. Any recipient placed in seclusion shall be kept under constant observation while awaiting an examination by a physician or physician extender. The physician examination must be conducted as follows:
- i. At Riverview Psychiatric Center the physician or physician extender examination shall be conducted in person in all instances.
  - ii. At all other facilities, the physician examination may be conducted via telephone consultation with the registered nurse and shall include consideration of the results of the nurse's formal assessment. The physician may order seclusion on the basis of this consultation and shall enter any additional orders for further assessments or treatment as appropriate. Thereafter a physician or physical extender shall examine the recipient in person:
    - (a) within 1 hour when the registered nurse requests that a physician evaluate the recipient in person;
    - (b) within 1 hour when the information is suggestive of organic causes that could lead to harm to the recipient;
    - (c) within 1 hour if the recipient has not had a physical examination during the current hospital stay; and
    - (d) within 12 hours in all other instances.

- (6) Documentation of the physician or physician extender's examination and, if applicable, the registered nurse's assessment must be entered in the recipient's file.
- (7) Staff who place recipients in seclusion shall have documented training in the proper techniques, in less restrictive alternatives to seclusion and in the detection of organic causes of behavioral disturbances.
- (8) As soon as possible, staff should make reasonable efforts to notify the recipient's parent, guardian or designated representative, if any, that the recipient has been placed in seclusion, and the reasons therefor.
- (9) Each order for initiation or extension of seclusion shall state the time of entry of the order. It shall state the number of hours the recipient may be secluded, not to exceed ten and the conditions under which the recipient may be sooner released.
- (10) No PRN orders for seclusion may be written and no treatment plan may include its use as a treatment approach.
- (11) The need for a recipient's continuation in seclusion shall be re-evaluated every 2 hours by a nurse. The nurse shall examine the recipient in person. This examination may be conducted outside the seclusion room. The nurse shall note the clinical reasons for selection of the examination site. The nurse shall assess the recipient to determine whether he or she continues to pose a danger to self or others, or continues to cause serious disruption of other recipients' treatment (in cases in which an examining physician or physician extender has ordered seclusion for this reason). If the nurse finds danger and that the recipient continues to require seclusion, seclusion may be continued if the physician's or physician extender's order has not yet lapsed. Should the recipient not need continued seclusion, the nurse shall release the recipient even if the time frame of the original order has not yet elapsed.
- (12) A special progress record/check sheet shall be maintained for each use of seclusion and shall include the following documentation:
  - a. The indication for use of seclusion, i.e. whether a danger to self, others, or serious disruption of other recipients' treatment;

- b. A description of the behaviors that constitute the recipient's danger to self, others, or serious disruption of other recipients' treatment;
  - c. A description of less restrictive alternatives used or considered, and a description of why these alternatives proved ineffective or why they were deemed inappropriate upon consideration.
- (13) All orders for the extension of seclusion shall include documentation as for an original order. If the recipient is examined outside of the seclusion room, progress notes shall additionally state where the recipient was examined and the clinical reasons for selecting the site.
- (14) Every recipient placed in seclusion shall be released, unless clinically contraindicated, at least every two hours to eat, drink, bathe, toilet and to meet any special medical orders.
- (15) Recipients placed in seclusion shall be given maximum observation and in no instance shall they be visually monitored less often than every 15 minutes.
- (16) A description of the recipient's behavior as observed shall be noted on the progress record/check sheet every 15 minutes.
- (17) The total amount of time that a recipient spends in seclusion may not exceed 24 hours unless:
- a. The recipient is reassessed in accordance with the protocol described at 5(b) above;
  - b. The recipient is examined at Riverview Psychiatric Center, by the director of psychiatry or clinical services and, in other hospitals, by a chief of psychiatry or medicine or his or her physician designee. In cases where the chief or director is also the treating physician, he or she shall appoint another physician to conduct the required examination;
  - c. The order extending seclusion beyond a total of 24 hours is entered by the (Director of psychiatry or clinical services or by the chief of psychiatry or medicine following the examination of the recipient and consultation with the other examiners; and

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

- (18) Records required by the above provisions shall be a part of the recipient's permanent record. At the mental health institutes, copies shall be forwarded to the medical director, the clinical services director and the recipient advocate. At all other facilities, copies shall be forwarded to the chief of psychiatry or medical services. For a period of one year following adoption of these regulations, these facilities shall submit summaries or copies of reports of each use of seclusion to the Division of Licensing and Regulatory Services of the Department of Health and Human Services. Said reports to Department shall be submitted on a quarterly basis, shall not contain information identifying the recipient by name but shall be reported in a manner to permit the reader to discern whether individual recipients have been secluded on repeat occasions.
- (19) Seclusion may be ordered on the basis of a recipient's self-report, provided the physician extender otherwise verified that the recipient meets the criteria of paragraph 2 above and provided the decision is otherwise clinically appropriate.

#### B. Restraint

- (1) Restraint is the immobilization of a recipient's arms, legs or entire body by an individual or through the use of an apparatus that is not a protective device as described in sub-section VI.C below.
- (2) Restraint may be employed only when absolutely necessary to protect the recipient from serious physical injury to self or others and shall impose the least possible restriction consistent with its purpose.
- (3) Restraint may be used only after less restrictive measures have proven to be inappropriate or ineffective. The extent to which less restrictive measures are attempted at the time of the incident will be governed by the degree of risk of physical harm to the recipient or others.
- (4) The decision to place a recipient in restraint shall be made by a physician or a physician extender and shall be entered as a medical order in the recipient's records.
- (5) All recipients must be examined before being placed in restraint in accordance with the following:

- a. If the physician or physician extender is not immediately available to examine the recipient, the recipient may be placed in restraint following examination by a registered nurse if the nurse finds that the recipient poses a risk of imminent harm to self or others.
- b. The examination by the registered nurse shall be conducted in accordance with a protocol approved by the chief of psychiatry or medicine and by the Director of Nursing. The protocol must include the following:
  - i. A list of indicators for organic causes of changed behaviors.
  - ii. Elements for assessment, including but not limited to: known medical disorders;
    - (a) the recipient's medications including PRN medications;
    - (b) mental status, with observation of behavior, speech, affect and suicidal/homicidal ideation;
    - (c) brief neurological examination: pupil size and reactivity, gait, limb movement and strength;
    - (d) vital signs; and
    - (e) cognition using a standard tool].
  - iii. Provision for completion as soon as is clinically sound, those elements of assessment that require the recipient's cooperation and that the registered nurse may not be able to perform immediately due to the recipient's condition.
- c. A physician or physician extender must thereafter examine the recipient within 30 minutes of the recipient's having been placed in restraint. If the evaluation does not take place within 30 minutes, the reasons for the delay shall be documented in the recipient's record. This provision applies to all recipients, including those placed in restraint during the night. The physician examination must be conducted as follows:

- i. At Riverview Psychiatric Center the physician or physician extender examination shall be conducted in person in all instances.
  - ii. At all other facilities, the physician examination may be conducted via telephone consultation with the registered nurse and shall include consideration of the results of the registered nurse's formal assessment. The physician may order seclusion on the basis of this consultation and shall enter any additional orders for further assessments or treatment as appropriate. Thereafter a physician shall examine the recipient in person:
    - (a) within 1 hour when the registered nurse requests that a physician evaluate the recipient in person;
    - (b) within 1 hour when the information is suggestive of organic causes that could lead to harm to the recipient;
    - (c) within 1 hour if the recipient has not had a physical examination during the current hospital stay; and
    - (d) within six hours in all other instances.
- (6) Documentation of the physician or physician extender's examination and, if applicable, the registered nurse's assessment must be entered in the recipient's file.
  - (7) Staff who place recipients in restraint shall have documented training in the proper techniques, in less restrictive alternatives to restraint and in the detection of organic causes of behavioral disturbances.
  - (8) As soon as possible, staff should make reasonable efforts to notify the recipient's guardian, or designated representative, if any, that the recipient has been placed in restraint and the reasons therefor.
  - (9) Each order for initiation or extension of restraint shall state the time of entry of the order. It shall state the number of hours the recipient

may be restrained, not to exceed six, and the conditions under which the recipient may be sooner released.

- (10) No PRN orders for restraint may be written and no treatment plan may include its use as a treatment approach.
- (11) The need for a recipient's continuation in restraint shall be re-evaluated every two hours by a nurse. The nurse shall examine the recipient in person. This examination may be conducted with the recipient free of restraints. The nurse shall note the clinical reasons for selecting whether the recipient is examined in or free of restraints. The nurse shall assess the recipient to determine whether he or she continues to pose a danger of imminent injury to self or others. If the nurse finds such danger and that the recipient continues to require restraint, restraint use may be continued if the physician's or physician extender's order has not yet lapsed. Should the recipient not need continued restraint, the nurse shall release the recipient even if the time frame of the original order has not yet elapsed.
- (12) A special progress/check sheet record shall be maintained for each use of restraint and shall include the following documentation:
  - a. The indication for use of restraint.
  - b. A description of the behaviors that constitute the recipient's danger to self or others.
  - c. A description of less restrictive alternatives used or considered, and a description of why these alternatives proved ineffective or why they were deemed inappropriate upon consideration.
- (13) In all facilities, the recipient shall be examined in person by a physician or physician extender before any order for restraint is extended. All orders for the extension of restraint shall include documentation as for an original order, but shall additionally state whether the recipient was examined in or free of restraints and the clinical reasons therefor.
- (14) Every recipient placed in restraint shall be frequently monitored and released as necessary to eat, drink, bathe, toilet, and to meet any special medical orders. Recipients in restraint shall have each extremity examined and the restraint loosened, sequentially, no less frequently than every 15 minutes. In instances in which blanket wraps are utilized for restraint, the recipient will be released and examined no less frequently than every hour.

- (15) Recipients in restraint shall be kept under constant observation.
- (16) A description of the recipient's behavior as observed shall be noted on the progress record/check sheet every 15 minutes.
- (17) The total amount of time that a recipient spends in restraint may not exceed 24 hours unless:
  - a. The recipient is reassessed in accordance with the protocol described at 5(b) above.
  - b. The recipient is examined at Riverview Psychiatric Center by the director of psychiatry or clinical services and in other hospitals, by a chief of psychiatry or medicine or his or her physician designee. In cases where the chief or director is also the treating physician, he or she shall appoint another physician to conduct the required examination.
  - c. The order extending restraint beyond a total of 24 hours is entered by the director of psychiatry or clinical services or by the chief of psychiatry or medicine following his or her examination of the recipient and consultation with the other examiners.
  - d. The recipient's guardian or designated representative, if any, has been notified.
- (18) Records required by the above provisions shall be made a part of the recipient's permanent record. At the mental health institutes, copies shall be forwarded to the medical director, the clinical services director and the recipient advocate. At all other facilities, copies shall be forwarded to the chief of psychiatry or medical services. For a period of one year following adoption of these regulations, these facilities shall submit summaries or copies of reports of each use of restraint to the Division of Licensing and Regulatory Services of the Department of health and Human Services. Said reports to Department shall be submitted on a quarterly basis, shall not contain information identifying the recipient by name but shall be reported in a manner to permit the reader to discern whether individual patients have been restrained on repeat occasions.

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

C. Protective Devices.

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

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

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

- a. The decision to use a protective device shall be made by a physician who has examined the recipient prior to its use. The decision shall be entered as a medical order in the recipient's record.
- b. When ordering use of a protective device, the physician shall select a device that interferes with the recipient's free movement and ability to interact with his or her environment to the least degree necessary to achieve the medical purpose for which the device is ordered.
- c. Staff who use protective devices shall have the documented training in their application.
- d. The need for the use of a protective device shall be re-evaluated bi-weekly by a physician who examines the recipient. Orders for devices that immobilize recipients shall be re-evaluated daily. If the physician determines that

continued use of the protective device is clinically indicated, further use may be ordered. The order for extension of use shall be entered as a medical order in the recipient's record.

- e. Protective devices that hamper a recipient's free movement, such as mitts or vest restraints, shall be removed every two hours, so that the recipient may be permitted free movement, unless the physician's order indicates that removal would interfere with the recipient's health care. The physician shall indicate in his or her order the level of staff supervision and assistance necessary during the recipient's periods of free movement. Where protective devices have been routinely used, the recipient's treatment plan will address ways of reducing or eliminating their use.
- f. A special progress record/checksheet shall be maintained for each use of protective devices that hamper a recipient's free movement. These checksheets shall be used to document the recipient's relief from the device every two hours and shall include a description of the recipient's condition as observed during the period of free movement.
- g. Every recipient to whom a protective device has been applied shall be frequently monitored and assisted as necessary to meet personal needs and to participate in treatment and activities.

## VII. FREEDOM FROM UNNECESSARY SECLUSION AND RESTRAINT IN RESIDENTIAL SETTINGS

A. SECLUSION. Locked seclusion will be prohibited in residential settings.

### B. RESTRAINT

- (1) Restraint is the immobilization of a recipient's arms, legs or entire body by the use of an apparatus that is not a protective device as described in subsection VI.C.
- (2) Restraint may be employed only when absolutely necessary to protect the recipient from serious physical injury to self or others and shall impose the least possible restriction consistent with its purpose.
- (3) Restraint may be used only after less restrictive measures have proven to be inappropriate or ineffective. The extent to which less restrictive measures are attempted at the time of the incident will be

governed by the degree of risk of physical harm to the recipient or others.

- (4) The decision to allow restraints to be employed for a particular recipient shall be made by a treatment team and shall be incorporated into the recipient's treatment or service plan.
- (5) The decision to place a recipient in restraints shall be made by one of the clinician with one of the following credentials: M.D., Licensed Clinical Psychologist, Licensed Clinical Social Worker, Licensed Clinical Professional Counselor or Clinical Nurse Specialist in mental health or psychiatry.
- (6) Within 30 minutes of being placed in restraints, the recipient shall be physically examined by a Registered Nurse.
- (7) Documentation of the RN's examination and assessment must be entered in the recipient's file.
- (8) As soon as possible, staff should make reasonable efforts to notify the recipient's legally responsible parent, guardian or custodian that the recipient has been placed in restraint and the reasons therefor.
- (9) Each decision for initiation or extension of restraint shall be documented, including the time the decision, the number of hours the recipient may be restrained and the conditions under which the recipient may be sooner released.
- (10) The need for a recipient's continuation in restraint shall be re-evaluated every two hours by a nurse. The nurse shall examine the recipient in person. This examination may be conducted with the recipient free of restraints. The nurse shall note the clinical reasons for selecting whether the recipient is examined in or free of restraints. The nurse shall assess the recipient to determine whether he or she continues to pose a danger of imminent injury to self or others. If the nurse finds such danger and that the recipient continues to require restraint, restraint use may be continued. If the number of hours contained in the original decision have elapsed, a clinician will be contacted for a decision on an extension of the use of restraint.
- (11) A special progress/check sheet shall be maintained for each use of restraint and shall include the following documentation:
  - a. The indication for the use of restraint.

- b. A description of the behaviors that constitute the recipient's danger to self or others.
  - c. A description of less restrictive alternatives used or considered and a description of why these alternatives proved ineffective or why they were deemed inappropriate upon consideration.
- (12) Every recipient placed in restraint shall be frequently monitored and released as necessary to eat, drink; bathe, toilet and to meet any special medical orders. Recipients in restraint shall have each extremity examined and the restraint loosened, sequentially, no less frequently than every 15 minutes. In instances in which blanket wraps are utilized for restraint, the recipient will be released and examined no less frequently than every hour.
- (13) Recipients in restraint shall be kept under constant observation.
- (14) A description of the recipient's behavior as observed shall be noted on the progress, record/check sheet every 15 minutes.
- (15) The total amount of time that a recipient spends in restraint may not exceed 24 hours.
- (16) Records required by the above provisions shall be made a part of the recipient's permanent record and copies forwarded to the clinical director or his or her designee.
- (17) If a recipient communicates via sign language, consideration will be given to restraining the recipient in such a manner as to permit the use of hands for communication purposes.

**RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES  
WHO ARE  
CHILDREN IN NEED OF TREATMENT**

**PART C  
RIGHTS IN OUTPATIENT SETTINGS**

**Maine Department of Health and Human Services  
Office of Child and Family Services  
Children's Behavioral Health Services  
11 State House Station  
Augusta, Maine 04333-0011**

## CONTENTS

### C. RIGHTS IN OUTPATIENT SETTINGS

	Contents	65
I.	Statement of Intent	66
II.	Individualized Treatment or Service Plan	66
III.	Informed Consent to Treatment	69
IV.	Freedom from Seclusion and Restraint	72

## C. RIGHTS IN OUTPATIENT SETTINGS

### I. STATEMENT OF INTENT

These rules, Part C are applicable to all facilities providing outpatient psychiatric services and to all agencies or facilities providing outpatient mental health services which are licensed, funded or contracted by either the Department of Health and Human Services. Part C should be read in conjunction with Part A, Rules of General Applicability

### II. INDIVIDUALIZED TREATMENT OR SERVICE PLAN

- A. Recipients have the right to an individualized treatment or service plan.
- B. Individualized treatment or service plans shall be developed based upon an individualized assessment of the recipient's physical, psychological and social needs, as well as the recipient's expressed desires. Each facility or agency shall fully consider the least restrictive appropriate treatment and related services taking into account factors that are supportive of each recipient's exercise of his or her basic rights, consistent with each individual's strengths, needs and treatment requirements pursuant to this section. Such considerations shall include accommodation of particular needs involving communication and physical accessibility to all treatment programs.
- C. Each recipient 14 or over has the right to be fully and actively involved in the development or revision of his or her treatment or service plan. Involvement of recipients who are younger shall be determined on a case by case basis, after assessment of the recipient's capacity to be involved. The exclusion of a recipient 14 or over, based on incapacity, developmental or mental, requires the approval of an independently licensed clinician. The guardian or legally responsible parent shall be fully and actively involved in treatment planning to the maximum extent possible, given time and location constraints. Each agency, program or facility shall make good faith efforts, including 24 hour notice of any meeting, to involve legally responsible parents, guardians or custodians and such efforts shall be documented.
- D. Treatment or service plans shall be developed within 30 days in outpatient agencies and shall thereafter be reviewed and revised no less frequently than every 90 days. Plans may be reviewed more frequently as necessary to address substantial changes in the recipient's life, such as hospitalization.

- E. A treatment or service plan shall be developed by a team consisting of the recipient, legally responsible parents, guardians or custodians and others among whom there exists the authorization to exchange information and who are needed to ensure the recipient's needs are adequately assessed and that appropriate recommendations are made, based upon a comprehensive assessment of the recipient. The plan shall contain but not be limited to:
- (1) A statement of the recipients specific strengths and treatment needs.
    - a. The treatment or service plan should include a description of any physical handicap and any accommodations necessary to provide the same or equal services and benefits as those afforded non-disabled individuals.
  - (2) A description of short-term and long-range goals with projection of when such goals will be achieved;
  - (3) A statement of the rationale or reason for specifying certain treatment or services to meet identified goals;
  - (4) A specification of treatment or service responsibility, including both staff and recipient responsibility and involvement to attain treatment or service goals;
  - (5) Documentation of current discharge planning.
- F. A copy of the treatment or service plan shall be offered to each recipient, to the guardians, custodians or legal, responsible parents and to recipient's representative (Of confidentiality has been waived pursuant to Part A Section VIII).
- G. All agencies shall maintain specific written guidelines describing their practices concerning development of treatment or service plans.
- H. The treatment or service plan shall be reviewed and revised as frequently as is clinically indicated. Each facility, agency or program shall establish, by policy, a schedule for review of all recipient's treatment or service plans.

I. Termination

- (1) Each recipient and his or her guardian, custodian or legally responsible parent has the right to be informed of and referred to appropriate resources upon termination from a program.
- (2) Each recipient terminated from the outpatient agency, after three visits or ten working days or longer term of treatment has the right to a comprehensive termination plan, and to assisted referral to existing resources in such areas as transportation, housing, financial assistance, crisis intervention and resolution services, family support, medical, dental, social and recreational services and mental health treatment.
- (3) Upon termination from an outpatient agency, the facility shall provide each recipient and legally responsible parent, custodian or guardian with a copy of his or her aftercare plan and a written list of his or her prescribed medication, dosage levels, schedules side effects, precautions and contraindications.
- (4) Notification
  - a. The recipient's representative, upon request of the recipient, and the recipient's guardian, custodian or legally responsible parent, shall be notified of and, if the representative, guardian, custodian or parent is available, involved in any termination planning. Involvement may include, but not be limited to, participation in any termination planning meeting.

J. Exceptions

- (1) No treatment or service plan is required for recipients who solely received informal social support and recreation in drop-in mental health programs.
- (2) At recipient may choose not to be involved in developing his or her treatment or service plan and may refuse such planning.
  - a. All such cases shall be documented in the recipient's permanent treatment record.
- (3) A recipient may be excluded from treatment or service planning if physically disruptive to the point that A is impossible to conduct a treatment or service planning session.

a. All such cases shall be documented in the recipient's permanent treatment or service record.

(4) A legally responsible parent or guardian shall be actively involved in the treatment, discharge or termination planning to the maximum extent possible. A public guardian has an affirmative duty to be fully and actively involved in treatment discussions and discharge planning. Exclusion from planning by professionals may occur if the parent or guardian poses a documented danger to the physical or mental well-being of the recipient.

### III. INFORMED CONSENT TO TREATMENT

A. Recipients and their legally responsible parents, guardians or custodians have the right to informed consent for all treatment.

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

- (1) To promote respect for individual autonomy and recipient participation in decision-making;
- (2) To ensure that, whenever possible, the informed consent of a recipient or his or her legally responsible parent, custodian or guardian is obtained prior to treatment;
- (3) To avoid, whenever possible, forcible imposition of any treatment;
- (4) To provide reasonable standards and procedural mechanisms for determining when to treat a recipient absent his or her informed consent, consistent with applicable law; and
- (5) To ensure that the recipient is fully protected against the unwarranted exercise of the state's *parens patriae* power.

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

- (1) Informed consent for such treatment has been obtained from the recipient in the following circumstances:
  - a. The recipient has been living separately from parents or legal guardians for at least 60 days and is independent of parental or legal guardian support;

- b. The recipient is or was legally married;
  - c. The recipient is or was a member of the Armed Forces of the United States; or
  - d. The recipient has been emancipated by the court pursuant to 15 M.R.S.A. s 3506-A; and
  - e. The recipient is clinically competent.
- (2) The recipient is an unemancipated minor, or clinically incapacitated minor and the informed consent of the legally responsible parent, custodian or guardian has been obtained; or
  - (3) The recipient is 14 or over, the treatment is psychotropic medication, and the informed consent of the recipient and the legally responsible parents, guardians or custodians has been obtained.
- D. Informed consent to treatment. Informed consent to treatment is obtained only if the recipient, under C(1-3) above, or the legally responsible parent, custodian or guardian possess capacity to make a reasoned decision regarding the treatment; and the recipient under C(1-3) above, and his or her legally responsible parent, custodian or guardian is provided with adequate information concerning the treatment; and the recipient, under C(1-3) above and his or her legally responsible parent, custodian or guardian makes a voluntary choice in favor of the treatment. Informed consent must be documented in each case in accordance with this section.
- (1) Capacity. Capacity means sufficient understanding to comprehend the information outlined in section D(2) and to make a responsible decision concerning a particular treatment.
- There is a general assumption in the law that a minor is legally incapacitated to make most health care decisions. However, legal incapacity is not synonymous with clinical or developmental capacity to participate in a treatment decision which should always be determined on a case by case basis for clinical purposes. Where non-emergency intrusive medical treatment is at issue, the refusal of a mature (+ 14) minor must be honored.
- (2) Adequate information. The licensed, certified or other qualified mental health professional recommending a particular treatment shall provide to the recipient under C(1-3) above and his or her legally responsible parent, custodian or guardian, all information

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

- a. An assessment of the recipient's condition and needs;
- b. The nature of the proposed treatment, and a statement of the reasons why the professional believes it to be indicated in the recipient's case;
- c. The expected benefits of the treatment, and the known risks which it entails, including the common side-effects, precautions and contraindications of a particular medication;
- d. The anticipated duration of the treatment;
- e. A statement of reasonable alternatives to the proposed treatment, if any;
- f. Information as to where the recipient may obtain answers to further questions concerning the treatment;
- g. A clear statement that the recipient has the right to give or withhold consent to the proposed treatment.

- (3) Voluntary choice. Consent to treatment must be given willingly in all cases, and may not be obtained through coercion or deception.

A recipient's or legally responsible parent's, guardian's or custodian's initial refusal of treatment shall not preclude renewed attempts to obtain willing consent and an initial willing consent shall not preclude him or her from validly withdrawing such consent at any time before or during treatment.

- (4) Documentation. The informed consent of a recipient and his or her legally responsible parent, custodian or guardian to a particular treatment shall be documented to show:

- a. From whom consent is obtained, whether recipient, legally responsible parent, custodian or guardian;
- b. If consent is given by the recipient under C(1-3) above, a signed statement that the recipient possesses capacity to give informed consent
- c. That adequate information, including at a minimum all the elements listed in subsection D(2) of this rule, was provided;
- d. The signature of the legally responsible parent, custodian or guardian, and where applicable under C(1-3) above, the signature of the recipient, indicating consent, in cases where psychotropic medication is prescribed.

(5) Exception to Written Consent

In cases of unanticipated treatment needs, the informed consent of a legally responsible parent, custodian or guardian may be obtained by telephone; but such oral consent shall be confirmed in writing in accordance with this section as soon as practicable.

IV. FREEDOM FROM SECLUSION AND RESTRAINT

Recipients shall not be held in locked seclusion in an outpatient setting. Holding techniques shall only be utilized in outpatient settings pursuant to rules to be jointly developed by the Department of Health and Human Services.



*John E. Baldacci, Governor*

*Brenda M. Harvey, Commissioner*

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