

DEPARTMENT OF HEALTH

Amendments to Chapter 11-175
Hawaii Administrative Rules

December 1, 2010

SUMMARY

DEC 01 2010

1. §11-175-02 is amended.
2. §11-175-14 is amended.
3. A new §11-175-25 is added.
4. §11-175-31 is amended.

§11-175-02 Definitions. As used in this chapter:

"Adult mental health division" or "AMHD" means the division of the department that promotes and provides for the establishment and operation of a community-based mental health system pursuant to section 334-3, Hawaii Revised Statutes.

"Continuing support" means continuing services designed to provide safety-net supports. The population focus is on individuals with a qualifying severe and persistent mental illness with accompanying severe functional impairment who do not have access to other mental health services.

"Crisis services" means time-limited services that are intensive and focused services designed to assess, stabilize and provide linkage to treatment and other community supports, as appropriate. Crisis services are intended for individuals in mental health crisis or situational crisis and not already eligible for continuing support.

"Disaster" means an event of significant community impact that is outside the range of usual human experience and that would be markedly distressing to almost anyone, provoking, or expected to provoke intense helplessness, terror, or fear of serious threat to life of physical integrity, or sudden destruction of home or community infrastructure.

"Disaster services" means services that may include counseling, debriefing, or education intended to relieve or minimize the development of psychological distress or dysfunction in persons who have experienced stress from a disaster.

"Eligibility determination" or "eligibility assessment" means an assessment approved by AMHD, which is sufficient to establish as diagnosis of severe and persistent mental illness, persons in an acute, service mental health crisis, and those experiencing distress and trauma from a declared disaster, conducted in a standardized and timely manner for consumers who are applying for AMHD services to determine whether they are eligible for continuing support.

"Global assessment of functioning" or "GAF" means a score assigned by the clinician, which is used as a criteria for psychological, social and occupational functioning on a numerical rating from 1-100 as described in the Diagnostic and Statistical Manual of Mental Disorders.

"Qualifying diagnosis" means one of the following diagnoses listed in the Diagnostic and Statistical Manual of Mental Disorders - DMS-IV-TR (The numeral preceding each diagnosis reflects the corresponding number in the DMS-IV-TR.):

- 295.xx Schizophrenia
 - i. 295.10 Disorganized Type
 - ii. 295.20 Catatonic Type
 - iii. 295.30 Paranoid Type
 - iv. 295.60 Residual Type
 - v. 295.90 Undifferentiated Type
- 295.70 Schizoaffective Disorder
- 296.34 Major Depression, Recurrent Type, Severe with Psychotic Features
- 296.xx Bipolar Disorder
 - i. 296.0x Single Manic Episode
 - ii. 296.4x Most Recent Episode Manic
 - iii. 296.5x Most Recent Episode Depressed
 - iv. 296.6x Most Recent Episode Mixed
 - v. 296.7 Most Recent Episode Unspecified
- 296.89 Bipolar II Disorder
- 297.1 Delusional Disorder.

"Severe and persistent mental illness" or "SPMI" means that a person has been assessed with the presence of a qualifying diagnosis for the previous 12 months, or will be expected to demonstrate the presence of a qualifying diagnosis for the next 12 months, and that person demonstrates functional impairment that seriously limits the person's ability to function independently in an appropriate and effective manner, as evidenced by a score of 50 or lower on the GAF.

[Eff 12/19/89, am and comp DEC 30 1988; comp [**DEC 16 2010**
] (Auth: HRS §§334-9) (Imp: HRS §§334-2, 334-3)

§11-175-14 Service elements, standards and minimum levels. (a) Elements of the mental health and substance abuse system shall include, but are not limited to the following services and each service area shall ensure adherence to the following standards and availability of the specific minimum levels of service to persons eligible for services in that service area.

- (b) Information services shall:
 - (1) Be publicized annually through brochures, newspapers, telephone directories, and one other medium
 - (2) Include special efforts such as auxiliary aids and bilingual resources to ensure that ethnic minority groups and other special populations are provided knowledge of and easy access to the service area center's services.
- (c) Educational services shall:
 - (1) Increase understanding of the nature of mental illness and substance abuse;
 - (2) Impart knowledge and skills to prevent, treat, or ameliorate the effects of mental illness and substance abuse;
 - (3) Provide knowledge to reduce the stigma of mental illness and substance abuse;
 - (4) Impart knowledge to the general public regarding problems of vulnerable, high risk persons, the need for community involvement in programs designed to address the problems outside of institutional settings, and the resources available or needed to help such programs succeed;
 - (5) Be provided to lay and to professional groups at least annually and upon request and shall include:
 - (A) At least one contact per year with each public school and police station in the service area to assess mental health and substance abuse education needs;
 - (B) Offering one educational program responsive to identified needs to each school district and police station in the service area;

- (6) Be provided by trained and qualified individuals.
- (d) Consultation services shall:
 - (1) Be announced each year to the judiciary, health, welfare and educational agencies in each service area;
 - (2) Be provided at least monthly, on request, to a judiciary agency, a health agency, a welfare agency, and to public schools;
 - (3) Be provided by trained and qualified personnel as required by the respective disciplines;
 - (4) Be provided by a mutually agreed upon consultant.
- (e) Training services shall:
 - (1) Be provided for each staff person of the service area center and contract providers;
 - (2) Total at least 12 hours per year for each staff person providing clinical services;
 - (3) Include orientation for all few service area center personnel, including volunteers and advisory board members;
 - (4) Be recorded individually for each person trained including the date of training, subject of training, and total time involved with an outcome evaluation on the education and training received.
- (f) Outreach services shall:
 - (1) Include aggressive and persistent efforts to invoice resistant individuals in other needed services;
 - (2) Provide easily understandable communications to individuals and target populations about the available services and their locations;
 - (3) Identify and be systematically offered to at least one target population each year;
 - (4) Involve as many organizations, agencies, and individuals as may be in contact with the target population, and alert relevant agencies and individuals to the importance of early problem detection and to their role as case finders.
- (g) Evaluation determination services shall:

- (1) Be performed by a professional mental health worker;
- (2) Determine eligibility for:
 - (A) Crisis services, which are limited to 5 days after initiation of those services;
 - (B) Disaster services, which are limited to 60 days after initiation of those services; or
 - (C) Continuing support, which are not limited in duration, but may be found ineligible after resolution of qualifying criteria;
- (3) Consider the eligible population for crisis services for adults in need of emergent (within 24 hours) or urgent (within 24-72 hours) intervention who are exhibiting symptoms of a mental health crisis, or individuals suspected of having a primary mental illness with an associated situational crisis;
- (4) Consider the eligible population for disaster services for adults who have experienced a disaster and for whom a disaster has been officially declared by the State of Hawaii of the AMHD chief after having received and approved a request for disaster services from legitimate community leadership, such as a school administrator, state or county official, or religious, social or business organization;
- (5) Consider the eligible population for continuing support for adults who have been diagnosed with a qualifying diagnosis, who have co-occurring mental and substance use disorders, and those who are legally encumbered;
- (6) Determine eligible for crisis services adults who:
 - (A) Have had a brief telephone or face-to-face assessment to determine immediacy of needs;
 - (B) In the assessment are found to be exhibiting symptoms of significant degree of functional impairment in the

- areas of self protection, impulse control, or social judgment, or high risk of harm to self or others or both; or
- (C) In the assessment are suspected of having a primary mental illness and exhibiting symptoms of significant clinical distress and some degree of functional impairment expected to worsen because of the situation;
- (7) Determine eligible for disaster services adults who:
- (A) Have had a screening completed that indicates the individual is a member of the identified and designated community or social system that has suffered from a disaster; and
 - (B) Need not have a mental health diagnosis, but is assessed to have the presence or risk of significant distress or dysfunction.
- (8) Determine eligible for continuing support adults who:
- (A) Have participated in an approved clinical eligibility assessment sufficient to establish a qualifying diagnosis and severe functional impairment; and
 - (B) In the eligibility assessment are found to have a qualifying diagnosis; have demonstrated the presence of the disorder for the last 12 months, or will be expected to demonstrate the disorder for the next 12 months; and have demonstrated functional impairment that seriously limits the person's ability to function independently in an appropriate and effective manner, as evidenced by a GAF score of 50 or lower at the time of the eligibility; and
 - (C) In the eligibility assessment are found to live in Hawaii and be a citizen of, or have permanent resident status in the United States of America; and

- (D) In the eligibility assessment are found not to have access to mental health services through health plan benefits, or have financial means or resources to obtain mental health services privately; or
 - (E) Have been found to be detained by Hawaii courts for forensic examination, or committed to certain psychiatric facilities under the care and custody of the director for appropriate placement by the family courts, district courts, or circuit courts; placed on conditional release or released on conditions by a judge in Hawaii courts; or are involved in mental health court or a jail diversion program.
- (9) Be conducted:
- (A) At least once every two calendar years from the initial determination of eligibility; or
 - (B) Upon the discovery of credible information that calls into question the continuing eligibility of the person.
- (h) Referral services shall:
- (1) Be provided to every person who has been evaluated for services, and who has been found not to be eligible for services at the service area center or contract agencies;
 - (2) Include at least one contact to determine if a service linkage has been made.
- (i) Treatment shall:
- (1) Be provided by, or under the supervision of professional or certified personnel;
 - (2) Be provided to every person screened, admitted, and evaluated who has been determined to be in need of treatment at the service area center or contract agencies, unless lack of service area center resources or the unavailability of a service needed by a consumer prevent provision of the service.
- (j) Rehabilitation shall:

- (1) Be provided through activities intended to reduce the residual effects of mental, emotional, and substance abuse disabilities;
 - (2) Be provided to every person screened, admitted, and evaluated who has been determined to be in need of rehabilitation at the service area center or contract agencies, unless lack of service area center resources or the unavailability of a service needed by a consumer prevent provision of the service;
 - (3) Enhance the capacity of the consumer for self-sufficiency and productive community living;
 - (4) Provide opportunities to learn about paid and volunteer work;
 - (5) Develop the attitudes required of workers and volunteers.
- (k) Case management services shall:
- (1) Be provided to every person evaluated who has been determined to need case management services and who has been found eligible for crisis services, disaster services, or continuing support;
 - (2) Be provided to enhance the natural support system and to ensure continuity of care, continuing service responsibility, overall coordination and integration of all relevant services and linkages to applicable agencies;
 - (3) Be the responsibility of a professional mental health worker or a certified individual;
 - (4) Be provided by non-professional staff or non-certified personnel only under the supervision of professional or certified personnel.
- DEC 16 2010 [Eff. and comp DEC 30 1988; comp] (Auth: HRS §334-9)
(Imp: HRS §334-3)

§11-175-14

§11-175-25 Changes or reductions in services. In the event of budget restrictions, budget reductions, reductions in force, or similar measures limiting the department's available resources, the director may change or reduce community mental health services. The following are among the criteria to be considered:

- (1) Whether the service is required by statute or rule;
 - (2) Whether the service is a minimum level of accessible services;
 - (3) The role of the service in the statewide plan;
 - (4) The need for the service, including the severity of the condition it serves;
 - (5) The effectiveness of the service;
 - (6) The cost of the service compared with its benefit;
 - (7) Whether the service is or will be duplicated elsewhere in the department's programs;
 - (8) The availability of the service through other sources, including but not limited to other government entities, and private or public insurance plans;
 - (9) Whether providers are available to provide the services; or
 - (10) Any other relevant criteria. [Eff
- DEC 16 2010**] (Auth: HRS §334-9) (Imp.: HRS §334-3)

§§11-175-26 to 11-175-29 (Reserved)

§11-175-31 Right to confidentiality of the clinical record. (a) Information in the clinical record of a consumer shall be confidential and shall not be shared outside the mental health division, outside a contract program, or by a private provider, except information shall be disclosed:

- (1) When there is an emergency which requires immediate sharing of information; however a consumer of substance abuse services shall not be identified directly or indirectly as a substance abuser;
- (2) When it is determined that a consumer poses a serious danger or threat of violence toward another. Information shall be released in keeping with the duty to exercise reasonable care to protect foreseeable victims; however, a consumer of substance abuse services shall not be identified directly or indirectly as a substance abuser;
- (3) When there is suspected abuse or neglect of a minor as provided in chapter 350, HRS, and when there is suspected abuse or neglect of an elderly or vulnerable adult as provided in chapter 349C, HRS; however, any person named in such a report who is a consumer of substance abuse services shall not be identified directly or indirectly as a substance abuser;
- (4) When disclosure is deemed necessary by the director or the administrator of a private psychiatric facility to carry out the provisions of chapter 334, HRS, and after justification has been placed in the consumer's clinical record;
- (5) When specific information is ordered to be disclosed by a court, and is deemed by the court to be necessary in connection with the proceedings before it;
- (6) For management information purposes to the mental health division by the department's direct and contract services;
- (7) For monitoring purposes to authorized mental health division monitors by the department's direct and contract services;

- (8) When required by federal or state statutes;
or
- (9) When the holder of the record has obtained
informed consent to release of information
from the consumer or the consumer's legal
guardian.

[Eff. And comp 12/30/88; comp **DEC 16 2010**]
(Auth: HRS §321-9) (Imp: HRS §§334-5, 334E-2)

DEPARTMENT OF HEALTH

Amendments to chapter 11-175, Hawaii Administrative Rules, on the Summary page dated December 1, 2010, were adopted on December 1, 2010, following public hearings held on Oahu, Maui, Hilo, Kona, and Kauai on November 22, 2010, after public notice was given in The Maui News on October 18, 2010, the Honolulu Star-Advertiser and The Garden Island on October 19, 2010, and the Hawaii Tribune-Herald and West Hawaii Today on October 20, 2010.

These amendments shall take effect ten days after filing with the Office of the Lieutenant Governor.

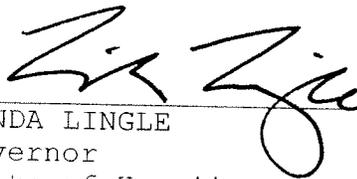


CHIYOME LEINIALA FUKINO, M.D.
Director
Department of Health

APPROVED AS TO FORM:



Deputy Attorney General



LINDA LINGLE
Governor
State of Hawaii

Date:

DEC 06 2010

Filed

DEPARTMENT OF HEALTH

Amendment and Compilation of Chapter 11-175
Hawaii Administrative Rules

October 1, 2007

SUMMARY

1. §11-175-36 is amended.
2. Chapter 175 is compiled.

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DEPARTMENT OF HEALTH
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TITLE 11

DEPARTMENT OF HEALTH

CHAPTER 175

MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEM

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SUBCHAPTER 1

PURPOSE AND DEFINITIONS

§11-175-1 Purpose. The purposes of this chapter are to:

- (1) Establish the elements of and minimum requirements for a comprehensive community-based mental health and substance abuse system utilizing public and private resources to reduce the incidence of mental or emotional disorders and substance abuse problems; and
- (2) Establish the provisions for the treatment and rehabilitation for those disorders and problems in the least restrictive and most therapeutic environment possible. [Eff 12/19/86 am and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §§334-9, 334-2, 334-3)

§11-175-2 Definitions. As used in this chapter:

"Abuse" means actual or threatened physical injury, psychological harm, or sexual violation of a consumer by another person.

"Aftercare" means activities offered, in order to maintain gains received, to persons who formerly received treatment or rehabilitation services.

"Case management services" means those activities performed with consumer involvement by a single accountable individual to support the consumer and ensure that the consumer has maximal access to and receives all resources and services which can help the consumer reach and maintain an optimal level of community functioning and integration.

"Center" means the identifiable administrative unit which shall be the focal point for the development, delivery coordination of services in each service area.

"Certified substance abuse counselor" means a person who is certified as a substance abuse counselor by the Department of Health.

"Clinical record" means an individualized written transcript which documents a consumer's treatment plans, the treatment provided, response to treatment, and justification for any deviation from the treatment plan and any individual limitation of rights.

"Community based mental health and substance abuse system" means a publicly accountable and integrated array of accessible mental health and substance abuse services.

"Comprehensive treatment plan" means an individualized written design for service based on all available information and which contains goals related to identified problems, measurable objectives related to the goals methods for achieving objectives, expected achievement dates, frequency of treatment procedures, names of staff assigned, and date(s) the plan is reviewed and revised.

"Consultation services" means providing advice or assistance on matters relating to mental health or substance abuse to other service providers in their provision of services.

"Consumer" means a person who is receiving or has received mental health or substance abuse services or identifies oneself as receiving or having received such services.

"Contract provider" means an individual or agency providing mental health or substance abuse services by contract with the Department of Health.

"Council" means the state council on mental health and substance abuse.

"Department" means the department of health, State of Hawaii.

"Director" means the director of health, State of Hawaii.

"Education services" means promotion, distribution and dissemination of relevant information on mental health and substance abuse.

"Emergency" means a circumstance or combination of circumstances which requires immediate response, the omission of which would seriously and immediately endanger the life or safety of a consumer or others. Bizarre or inappropriate behavior by a consumer without attendant dangerousness shall not constitute an emergency.

"Emergency treatment" means any treatment, the omission of which would seriously and immediately endanger the life or safety of a consumer or others.

"Evaluation services" means problem identification, clinical diagnosis or diagnostic impression, assessment of the severity of each problem identified, identification of strengths and assets, and determination of treatment and rehabilitation services needed.

"Follow-up services" means contact with consumers who have been discharged or who have discontinued affiliation with a program.

"Imminent harm" means that the staff of a psychiatric facility or residential treatment facility has reason to believe that without intervention by staff, a consumer would seriously and immediately endanger the life or safety of the consumer or others.

"Information services" means informing the public of available mental health, substance abuse and related services and how they may be obtained.

"Informed consent" means a voluntary, knowledgeable decision to allow any procedure, release of information, or other action, made by the patient or consumer, or the patient or consumer's attorney-in-fact, or guardian, based on a full disclosure and understanding of facts needed to make the decision and with appropriate documentation including the signature of the person who made the decision.

"Initial treatment plan" means an individualized written design for service used during the period from admission to completion of a comprehensive treatment plan.

"Intervention" means assisting individuals in using the system's services; and assuring that individuals and families receive immediate and appropriate services in a crisis. intervention shall include:

- (1) "Crisis services" which means activities provided at any location where the needs of the individuals can best be met to assure that individuals and families receive immediate and appropriate attention in an emergency, maintaining to the greatest degree possible, the consumer's status as a

functioning community person. Emergency services include but are not limited to around-the-clock telephone service, availability of on-call trained personnel, outreach, counseling of individuals and families, and short term admission to a crisis or psychiatric facility for stabilization, and short term planning to arrange linkages to needed services.

- (2) "Non-crisis services" which means activities which assist consumers to enter or make use of the service delivery system in a non-emergency situation.

"Least restrictive level of service" means treatment modalities and service settings which are the most therapeutic alternatives available for a consumer and which allow the consumer the greatest possible effective exercise of liberty.

"Long-term" care or long-term treatment" for the purpose of these rules, means care or treatment in a psychiatric facility exceeding 30 days or in a residential treatment facility exceeding 60 days.

"Neglect" means actual or potential physical injury psychological harm, or sexual violation of a consumer as the result of omission by a person with a duty to act.

"Non-indigent" means that a person has been determined to have the financial ability to pay a portion or all of the fees for care and treatment.

"Non-residential settings" means sites where consumers do not live and where mental health and substance abuse services are provided to those consumers.

"Outreach services" means actively seeking out persons at risk or in need of mental health or substance abuse services in non-treatment settings, alerting them and their families to the availability of resources, and motivating them to seek help.

"Paraprofessional" means a person working in a mental health or substance abuse program as part of a treatment team whose position does not require a professional degree or certification.

"Prevention" means activities which create conditions, opportunities and experiences designed to

encourage and develop healthy self-sufficiency, increase personal competence, and reduce excessive stress, or assist in managing stress more effectively. Prevention occurs before a person loses the ability to function and before a person needs remedial services.

"Primary provider of service" means a staff member who is assigned primary responsibility for treatment of a consumer.

"Private provider" means an individual or agency providing mental health or substance abuse services which are not provided by or under contract with the department of health.

"Program" for the purpose of these rules, means the only or smallest distinct unit within a service setting offering treatment or care.

"Provider" of mental health, substance abuse, or other health services means:

- (1) For the purpose of the state council and service area board membership, an individual whose training, purpose, or primary current activity, or identified affiliation is in the direct provision or administration of mental health, substance abuse, or other health services;
- (2) Otherwise, it means an individual or agency providing mental health and substance abuse services.

"Qualified interpreter" means a person who has demonstrated competence in both English and the other language for which interpretation is to be provided and who has within the last 12 months participated successfully in a course approved by the department dealing with ethics, practices, and consumer rights related to mental health and substance abuse services.

"Referral services" means providing information about services not available through the service area center or its contract agencies or information to persons not eligible for available services, and linking individuals with needed services.

"Rehabilitation" means psychosocial services which assist individuals to develop daily and community living skills, to set goals for themselves, to learn problem solving to handle social relationships, and to utilize self-help group experiences and prevocational

services including educational and experiential activities, arrangements for linkages with vocational and volunteer programs and job placement services.

"Residential settings" means non-hospital sites where consumers live and where mental health or substance abuse services are provided to those consumers.

"Residential treatment facility" means a facility which provides a structured therapeutic residential program for two or more consumers identified as needing mental health or substance abuse services and which provides, in addition to room and board, treatment and rehabilitation/habilitation services within the context of a group living experience to each consumer based on an individual treatment plan.

"Screening services" means determining an individual's possible need for mental health and substance abuse services and eligibility for service area center services.

"Seclusion" means placing a consumer alone in a room or other enclosed space with the door locked or held closed.

"Service area" means a defined geographical area for which there is designated responsibility for the delivery of mental health and substance abuse services to persons residing, working or attending school within the area.

"Service area center" means the identifiable administrative unit which shall be the focal point for the development, delivery and coordination of mental health and substance abuse services in each service area.

"Substance abuse" means a pattern of alcohol or drug use which impairs physical, social or occupational functioning and has a minimal duration of disturbance of at least one month.

"Target population" means a group of persons at risk or in need of mental health or substance abuse services.

"Training services" means increasing job-related knowledge and skills of administrative, professional and support personnel or others providing mental health and substance abuse services.

"Treatment" means activities intended to alleviate or reduce the duration and severity of mental illness and substance abuse problems.

"Work" means the performance of tasks in exchange for fair monetary compensation at the prevailing minimum wage in compliance with state and federal requirements or, if below the minimum wage in compliance with applicable requirements of the Fair Labor Standards Act, excluding, for the purpose of these rules, care of personal belongings, light tasks appropriate to group activities and to small group working and living arrangements designed as part of a treatment program, and unpaid work in recognized volunteer program. [Eff 12/19/89, am and comp DEC 30 1988; comp [OCT 19 2007] (Auth: HRS §§334-9) (Imp: HRS §§334-2, 334-3)

SUBCHAPTER 2

ADVISORY BODIES AND SERVICE AREAS

§11-175-3 State council on mental health and substance abuse. (a) The state council on mental health and substance abuse shall serve as an advisory body to the department and the council's function shall not include any clinical, administrative, or supervisory functions of the department.

- (b) The council shall:
- (1) Advise the department on statewide needs for mental health and substance abuse services through a review of needs assessment data and by acquiring knowledge of community needs and by service area board representation;
 - (2) Review the services, statistics, and other available non-confidential information to assure that services are responsive and appropriate;
 - (3) Advise the department on the allocation of funds and resources for mental health and substance abuse services;
 - (4) Review and comment on the state plan;

- (5) Prepare and submit an annual report on implementation of the state plan to the governor and the legislature not later than ten days before the convening of each regular session of the legislature;
- (6) Consider issues and program direction concerning two or more service areas; and
- (7) Meet at least quarterly and conduct all council meetings in accordance with chapter 92, HRS, and submit recommendations to the department quarterly.

(c) The council shall accept all written testimony. Oral testimony on agenda items by other than an appointed member of the council may be limited to not less than three minutes per person for each agenda item.

(d) When the department's actions are at variance with the council's written recommendations concerning the allocation of resources, statewide needs and programs affecting two or more service areas, the department shall submit a written explanation within thirty days after receipt of such recommendations.

(e) The department shall provide technical assistance including but not limited to orienting and training council members, furnishing copies of applicable statutes, administrative rules, policies and procedures, and providing stenographic services to assist the council in the performance of its functions. [Eff. 12/19/86; am and comp DEC 30 1988; comp **OCT 19 2007**]
] (Auth: HRS §334-9) (Imp: HRS §§334-2, 334-3, 334-10)

§11-175-4 Composition of council. (a) Each service area board shall be represented on the council by one designated council member who is also a service area board member.

(b) Members of the council shall be consumers providers, and other residents with the majority being consumers and other residents who are nonproviders of mental health, substance abuse, and other health services.

(c) Members of the council shall not vote on any question about which they are in conflict of interest. Criteria for conflicts of interest, shall be as established in section 84-14 HRS. (Eff. 12/19/86; am comp DEC 30 1988; comp **OCT 19 2007**] (Auth: §334-9) (Imp: HRS §§334-2, 334-10)

§11-175-5 Vacancies. When a vacancy on the council occurs, the council shall:

- (1) Publish notice of the vacancy;
- (2) Solicit nominations from a variety of sources, including consumers, individual providers, agencies, and other resident sources; and
- (3) Forward to the governor, the names of all persons nominated. [Eff. 12/19/86; comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §§334-2, 334-10)

§11-175-6 Designation of service areas. (a) Any changes in the number or boundary of service areas proposed by the director shall be preceded by public hearing pursuant to chapter 91, HRS.

(b) Any proposals for redesignation of number or boundary of service areas shall address the following factors:

- (1) Estimated number of persons in need of mental health and substance abuse services;
- (2) The optimum number of persons who can be effectively and efficiently served in any single service area;
- (3) Geographic, demographic, cultural, and social factors;
- (4) Accessibility of mental health and substance abuse services;
- (5) Area boundaries of other health and human services; and.
- (6) Other factors which foster the effective development, delivery, and coordination of mental health and substance abuse services. [Eff. 12/19/86; comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §§334-2, 334-3)

§11-175-7 Service area center. The service area center shall be the focal point for the development, delivery and coordination of services in that area. The location of each service area center shall be in its geographical service area. [Eff. 12/19/86; comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §§334-2, 334-3)

§11-175-8 Service area boards. (a) A service area board shall seek public comment, review, advise, and make recommendations to its respective service area center chief on the services of the center and the board's function shall not include any clinical, administrative, or supervisory functions of the center.

- (b) A service area board shall:
- (1) Serve as a communication link to and from consumers and residents of the service area by providing liaison with residents, community leaders, and organized groups to comment and advise on unmet needs and problems;
 - (2) Bring to the attention of the service area center chief and the state council through its council representative, issues which appear to have an impact upon or may be of concern to two or more service areas;
 - (3) Review the service area center's program of services, statistics, and other available nonconfidential information to assure that services are responsive to the needs of service area consumers and residents;
 - (4) Review general policies and procedures and make recommendations regarding the delivery of services to assure accessibility, availability, and acceptability of services;
 - (5) Participate and make recommendations in the development and updating of the service area plan and budget;
 - (6) Assist the center in providing information to the community about services available through the center;
 - (7) Perform such other functions as agreed upon by the service area board and service area center chief; and

- (8) Meet at least quarterly and conduct all board meetings in accordance with chapter 92, HRS, and submit recommendations to the service area center chief quarterly.

(c) The service area board shall accept all written testimony. Oral testimony on agenda items by other than an appointed member of the service area board may be limited to not less than three minutes per person for each agenda item..(d) When the service area center's actions are at variance with the service area board's written recommendations concerning the plans and budget, the center chief shall submit a written explanation not later than thirty days after receipt of the recommendations.

(e) The service area center shall provide orientation and training, technical assistance, and stenographic support to assist the board in the performance of its functions. The department shall provide copies of available statutes, administrative rules and policies and procedures to the board. [Eff. 12/19/86; am and comp DEC 30 1988; comp

OCT 19 2007
] (Auth: HRS §334-9) (Imp: HRS §§334-2, 334-3, 334-11)

§11-175-9 Composition of service area boards.

(a) Members of the service area board shall be service area consumers, and other persons including providers, who live or have their principal place of business in the service area and who as a group are broadly representative of the service area. The majority shall be consumers and other residents who are not providers of mental health, substance abuse or other health services.

(b) Members of the service area board shall not vote on any question about which they are in conflict of interest. Criteria for conflicts of interest shall be as established in section 84-14, HRS. [Eff. 12/19/86; am and comp DEC 30 1988; comp

OCT 19 2007]
(Auth: HRS §334-9) (Imp: HRS §§334-2, 334-3, 334-4)

§11-175-10 Vacancies. Whenever a service area board vacancy occurs, the service area board shall:

- (1) Publish notice of the vacancy;

- (2) Solicit nominations from a variety of sources, including consumers, individual providers, agencies, and other resident sources; and
- (3) Nominate four persons and forward their names through the department to the governor for consideration. [Eff. 12/19/86; am and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §334-11)

SUBCHAPTER 3

SERVICES AND PLANNING

§11-175-11 General requirements for service delivery. (a) Services to all consumers shall be appropriate to their age, level of development, current situation, social, ethno-cultural, educational, religious and economic background and shall take into account the central nature of the family, parents or parent substitutes and peer groups.

(b) Each service area center shall maintain an inventory of general community resources available to clients by agency name, location, telephone number, services provided, type of individuals served, referral or admission procedures, and other relevant information. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §334-3)

§11-175-12 Continuum of services. Mental health and substance abuse services shall be delivered in a continuum which includes prevention, intervention treatment, rehabilitation and aftercare. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §334-2)

§11-175-13 Locations of service delivery. Services shall be accessible and delivered in non-residential residential, and hospital settings. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §334-2)

§11-175-14 Service elements, standards and minimum levels. (a) Elements of the mental health and substance abuse system shall include, but are not limited to the following services and each service area shall ensure adherence to the following standards and availability of the specific minimum levels of service to persons eligible for services in that service area.

(b) Information services shall:

- (1) Be publicized annually through brochures, newspapers, telephone directories, and one other medium
- (2) Include special efforts such as auxiliary aids and bilingual resources to ensure that ethnic minority groups and other special populations are provided knowledge of and easy access to the service area center's services.

(c) Educational services shall:

- (1) Increase understanding of the nature of mental illness and substance abuse;
- (2) Impart knowledge and skills to prevent, treat, or ameliorate the effects of mental illness and substance abuse;
- (3) Provide knowledge to reduce the stigma of mental illness and substance abuse;
- (4) Impart knowledge to the general public regarding problems of vulnerable, high risk persons, the need for community involvement in programs designed to address the problems outside of institutional settings, and the resources available or needed to help such programs succeed;
- (5) Be provided to lay and to professional groups at least annually and upon request and shall include:
 - (A) At least one contact per year with each public school and police station in the service area to assess mental health and substance abuse education needs;
 - (B) Offering one educational program responsive to identified needs to each school district and police station in the service area ;

- (6) Be provided by trained and qualified individuals.
- (d) Consultation services shall:
- (1) Be announced each year to the judiciary, health, welfare and educational agencies in each service area;
 - (2) Be provided at least monthly, on request, to a judiciary agency, a health agency, a welfare agency, and to public schools;
 - (3) Be provided by trained and qualified personnel as required by the respective disciplines;
 - (4) Be provided by a mutually agreed upon consultant.
- (e) Training services shall:
- (1) Be provided for each staff person of the service area center and contract providers;
 - (2) Total at least 12 hours per year for each staff person providing clinical services;
 - (3) Include orientation for all new service area center personnel, including volunteers and advisory board members;
 - (4) Be recorded individually for each person trained including the date of training, subject of training, and total time involved with an outcome evaluation on the education and training received.
- (f) Outreach services shall:
- (1) Include aggressive and persistent efforts to invoice resistant individuals in other needed services;
 - (2) Provide easily understandable communications to individuals and target populations about the available services and their locations;
 - (3) Identify and be systematically offered to at least one target population each year;
 - (4) Involve as many organizations, agencies, and individuals as may be in contact with the target population, and alert relevant agencies and individuals to the importance of early problem detection and to their role as case finders.
- (g) Screening services shall:

- (1) Be provided to every person who seeks assistance or who is referred for services. This includes family members or other persons in the support system of a person with mental health or substance abuse problems; (2) Not be limited by the ability to pay;
- (3) Be provided by personnel qualified and trained in interviewing techniques and knowledgeable about available services in the community.
- (h) Evaluation services shall:
 - (1) Be provided to every person screened except those found to be in need of prevention services and result in one of the following actions:
 - (A) Provision of appropriate service;
 - (B) Referral to appropriate service;
 - (C) Provision of a written statement as to why the service area center cannot provide the appropriate service;
 - (2) Be performed by professional mental health workers or certified substance abuse counselors;
 - (3) Include documenting that a physical examination was done within the past six months or that provision has been or will be made for such an examination.
- (i) Referral services shall:
 - (1) Be provided to every person who has been screened, or evaluated for services, and who has been found not to be eligible for services at the service area center or contract agencies;
 - (2) Include at least one contact: to determine if a service linkage has been made.
- (j) Treatment shall
 - (1) Be provided by, or under the supervision of professional or certified personnel;
 - (2) Be provided to every person screened, admitted, and evaluated who has been determined to be in need of treatment at the service area center or contract agencies, unless lack of service area center resources

or the unavailability of a service needed by a consumer prevent provision of the service.

- (k) Rehabilitation shall:
 - (1) Be provided through activities intended to reduce the residual effects of mental, emotional, and substance abuse disabilities;
 - (2) Be provided to every person screened, admitted, and evaluated who has been determined to be in need of rehabilitation at the service area center or contract agencies, unless lack of service area center resources or the unavailability of a service needed by a consumer prevent provision of the service;
 - (3) Enhance the capacity of the consumer for self-sufficiency and productive community living;
 - (4) Provide opportunities to learn about paid and volunteer work;
 - (5) Develop the attitudes required of workers and volunteers.
- (1) Case management services shall
 - (1) Be provided to every person evaluated who has been determined to need case management services;
 - (2) Be provided to enhance the natural support system and to ensure continuity of care, continuing service responsibility, overall coordination and integration of all relevant services and linkages to applicable agencies:
 - (3) Be the responsibility of a professional mental health worker or a certified individual;
 - (4) Be provided by non-professional staff or non-certified personnel only under the supervision of professional or certified personnel.
- (m) Follow-up services shall:
 - (1) Be provided within three months of discharge or discontinuance of services to every consumer who has received treatment or rehabilitation services from a state psychiatric facility, service area center or contract agency:

- (2) Be for the purpose of gathering information about current status of former consumers, their satisfaction or dissatisfaction with the services provided, and arranging additional services if required. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §334-3)

§11-175-15 Needs assessment. (a) No single needs assessment model or procedure shall be used as the sole criterion for determining service area mental health and substance abuse needs. At least one assessment of need shall be made by a multi-disciplinary team or group of persons which includes at least one specialist with knowledge of a variety of needs assessment procedures for assessing a community-based mental health and substance abuse system.

(b) All available needs assessment data shall be utilized in the development of the 4-year plan. [Eff and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §334-3)

§11-175-16 Community-based planning. (a) Each service area center in conjunction with its service area board shall seek information, opinions, and recommendations from service area residents through such measures as community forums, public meetings, formal and informal surveys.

(b) Each service area center shall identify and evaluate existing public and private mental health facilities, personnel, and services available in its service area, and determine the additional facilities, personnel and services necessary to fill the gaps and meet the mental health needs of its area. This shall include but not be limited to the services listed in section 334-3, HRS.

(c) Each service area center shall describe its capacity to provide each mental health and substance abuse service element with respect to the minimum level of services available given its current resources, i.e., staff and budget. The minimum levels of services shall be established by the following process:

- (1) Establishment of a mechanism whereby residents have input into the planning,

- development, and review of services to meet their needs; and
- (2) Assessment of the social network.
 - (d) The service area center plan shall include a prioritized list of the mental health and substance abuse services in each service area.
 - (e) Each service area center shall provide a plan whereby mental health and substance abuse services shall be accessible to residents of the service area.
 - (f) Each service area center plan shall describe the methods by which it will:
 - (1) Identify children and adults from its area who could be discharged to less restrictive settings if such settings were available;
 - (2) Identify the kinds of settings that are required to meet the needs. The plan shall describe the specific actions the center will take to develop these settings, including reallocating existing funds or seeking additional resources if necessary;
 - (3) Provide a time line indicating how many children and adults needing less restrictive settings will be discharged to such settings in each biennium, and when all such individuals can be discharged;
 - (4) Assist the courts, other public agencies, and appropriate private agencies in screening persons being considered for publicly funded inpatient care in mental health facilities to determine if such care is indicated, avoid inappropriate hospitalization, and direct persons to appropriate treatment settings.
 - (g) Each service area center plan shall indicate the number of consumers to be served based on:
 - (1) An estimate of the number of staff required to deliver that service or the amount of money required to purchase that service;
 - (2) An estimate of the number of units of service the average consumer will require annually.

OCT 19 2007] (Auth: HRS §334-g) (Imp: HRS §334-3)

§11-175-17 Statewide planning. (a) The department shall provide a framework for need-based and

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community-based planning including the ongoing development and coordination of a statewide service delivery system.

(b) The department shall establish mechanisms to guide the planning of mental health and substance abuse services, including methods for:

- (1) Allocation of resources;
- (2) Ensuring community involvement; and
- (3) Evaluating the effectiveness of services.

[Eff. and comp DEC 30 1988; comp **OCT 19 2007**
] (Auth: HRS §334-9) (Imp: HRS §334-3)

§11-175-18 Discharge from psychiatric and residential treatment facilities. (a) Except for those consumers for whom no additional mental health or substance abuse care is necessary or accepted, no psychiatric facility or residential treatment facility shall discharge any consumer without notifying the provider of mental health, substance abuse, or other health services who will be responsible for the major portion of planned care.

(b) Facilities shall supply written discharge treatment plans and mental health and substance abuse service recommendations to the caregiver and consumer within seven (7) days of discharge. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**
] (Auth: HRS §334-9) (Imp: HRS §334-3)

§11-175-19 Additional standards for all services. (a) All providers of mental health or substance abuse services in the system shall:

- (1) Be functionally linked in a collaborative and cooperative manner to assure that consumer needs and potentials are met;
 - (2) Meet requirements established by the department;
 - (3) Establish written agreements between service agencies when two or more agencies are simultaneously providing services to a consumer and where roles need clarification;
 - (4) (4) Establish written policies and procedures for the safety of consumers and personnel.
- (b) Functional linkage shall be demonstrated by specific instruments including interagency conference

minutes, joint plans and budgets, or written memorandums of understanding.

(c) Providers of mental health or substance abuse services shall be linked with related services provided by other agencies such as the department of education, the department of human services, the police departments, and the judiciary, through joint planning and budgeting and written memoranda of understanding.

[Eff. and comp DEC 30 1988; comp OCT 19 2007]
(Auth: HRS §334-9) (Imp: HRS §334-3)

§11-175-20 Monitoring, evaluation and accountability. (a) All mental health and substance abuse services provided directly by or under contract by the department shall be monitored and evaluated at least annually in accordance with contractual provisions and requirements established by the department to ensure a high level of services to consumers and the community, and to assess service efficiency and effectiveness.

(b) Evaluation shall recommend activities and modifications designed to assist services in meeting established standards, requirements, goals, and objectives of the department.

(c) Evaluation shall include methods to measure cost effectiveness and cost efficiency of service delivery in order to increase program and fiscal accountability. [Eff and comp. DEC 30 1988; comp OCT 19 2007] (Auth: HRS §334-9) (Imp: HRS §334-3)

§11-175-21 Research. There shall be policies and procedures governing the promotion, conduct and range of research activities, demonstration projects and studies. [Eff. and comp DEC 30 1988; comp OCT 19 2007

] (Auth: HRS §321-9) (Imp: §334-2)

§11-175-22 Records and statistical data. The department shall maintain a system of data collection and record keeping to correlate resources, services and outcomes for accreditation or certification purposes and for reporting to the state and federal agencies.

[Eff. and comp DEC 30 1988; comp OCT 19 2007]
(Auth: §334-9) (Imp: HRS §334-3)

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§11-175-23 Four year state plan. (a) The four year state plan shall reflect plans developed in each of the service areas. It shall highlight plans for special populations and shall indicate what proportion of the division's budget is to be spent on each part of the continuum of services and each location of service delivery as described in section 11-175-12 and section 11-175-13. The proportion of resources directed toward mental health and substance abuse services and to children, adults and the elderly shall also be displayed.

(b) The allocations for residential services shall be separately displayed for those services delivered in a consumer's home and those delivered in a comprehensive range of small, homelike community treatment and rehabilitation facilities.

(c) The allocations for hospital settings shall be separately displayed for those services delivered in short-term and long-term facilities. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §334-3)

§11-175-24 Interpreters. Consumers who speak no or limited English or who are hearing impaired shall be provided the services of a qualified interpreter for the purpose of interpretation and translation and assisting the consumer to obtain all needed service elements as described in subchapter 3 of these rules, and for the purpose of exercising all rights as described in subchapter 4. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-g) (Imp: HRS §§334-3, 334E)

§§11-175-25 to 11-175-29 (Reserved)

SUBCHAPTER 4

RIGHTS OF CONSUMERS OF MENTAL HEALTH
AND SUBSTANCE ABUSE SERVICES

§11-175-30 Right to a clinical record; access to the record. (a) Each consumer admitted to a mental health or substance abuse program shall have a clinical record maintained at the program. The record shall be accessible to the consumer, the consumer's legal guardian, if any, and shall include, but not be limited to:

- (1) All documents relating to the consumer's status as a consumer of the program's services:
- (2) The current individual treatment plan; and
- (3) Documentation of any limitation of a right.

(b) Information received about a consumer from another provider of mental health or substance abuse services shall not be considered part of the consumer's clinical record; request; for release of such information shall be directed to the other provider.

(c) Within 72 hours of a request the consumer or the consumer's legal guardian shall be provided the opportunity to review and examine the consumer's clinical record in the presence of a staff member, less portions, if any, deemed detrimental to the consumer or others by the facility administrator. If information is withheld, justification shall be documented in the clinical record and the consumer shall be informed that information was withheld, why it was withheld, and that this determination may be appealed to the department as provided for in section 92E-9, HRS. Upon request, the consumer or legal guardian shall be provided a copy of the clinical record minus portions, if any, determined to be detrimental to the consumer or others.

(d) A full copy of the record shall be made available on request to the consumer's legal representative with the consumer's written consent. A reasonable fee may be charged for the cost of photocopying.

(e) Any consumer or the consumer's legal representative or legal guardian who believes the

clinical record is not accurate, relevant, timely, or complete shall be informed that a written statement of correction or amendment may be submitted to the program administrator. If such a statement is received it shall become part of the clinical record and the administrator shall determine whether or not the correction or amendment is warranted. If a change is necessary, the record shall be corrected or amended accordingly. The consumer shall be informed whether or not a correction amendment was made [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-31 Right to confidentiality of the clinical record. (a) Information in the clinical record of a consumer of mental health or substance abuse services shall be confidential and shall not be shared outside the mental health division, outside a contract program, or by a private provider, except information shall be disclosed:

- (1) When there is an emergency which requires immediate sharing of information; however, a consumer of substance abuse services shall not be identified directly or indirectly as a substance abuser;
- (2) When it is determined that a consumer poses a serious danger or threat of violence toward another. Information shall be released in keeping with the duty to exercise reasonable care to protect foreseeable victims; however, a consumer of substance abuse services shall not be identified directly or indirectly as a substance abuser;
- (3) When there is suspected abuse or neglect of a minor as provided in chapter 350, HRS, and when there is suspected abuse or neglect of an elderly or vulnerable adult as provided in chapter 349C, HRS; however, any person named in such a report who is a consumer of substance abuse services shall not be identified directly or indirectly as a substance abuser;
- (4) When disclosure is deemed necessary by the director or the administrator of a private

psychiatric facility to carry out the provisions of chapter 334, HRS, and after justification has been placed in the consumer's clinical record, except for consumers of substance abuse services, for which informed consent to release of information is required;

- (5) When specific information is ordered to be disclosed by a court, and is deemed by the court to be necessary in connection with the proceedings before it;
- (6) For management information purposes to the mental health division by the department's direct and contract services;
- (7) For monitoring purposes to authorized mental health division monitors by the department's direct and contract services;
- (8) When required by federal or state statutes; or
- (9) When the holder of the record has obtained informed consent to release of information from the consumer or the consumer's legal guardian.

(b) Information about a consumer requested by a member of the consumer's family shall only be released after informed consent to release information has been obtained from the consumer or the consumer's legal guardian.

(c) Information disclosed shall be only information relevant to the purpose stated in the request for disclosure, and redisclosure shall be prohibited.

(d) Information shared about a consumer among staff members within a program shall be restricted to information needed in order to provide adequate services and shall be conveyed in a manner which maintains its confidentiality.

(e) If information is released without informed consent, there lease shall be documented in the consumer's record. Documentation shall include to whom the information was released the purpose for which it was released, who authorized the release, when it was released, what was released, why consent could not be obtained, and the name of the person releasing the

information. When information is released with informed consent, the consent form shall be filed in the consumer's clinical record.

(f) Informed consent to release information shall be obtained in order to release information to another service setting when a consumer transfers from one mental health program to another or when a consumer receiving substance abuse services transfers to another program. Informed consent is not required when the consumer transfers between programs having the same direct administrative control over the programs. When consent is required, the referring program shall attempt to obtain consent to release information essential to ensure continuity of treatment and which is germane to the purpose of the new setting.

(g) Any substance abuse program which provides maintenance or detoxification treatment shall provide consumer identifying information to another maintenance or detoxification treatment program upon request for the purpose of determining whether an applicant for maintenance or detoxification services is currently enrolled in the program, provided that:

- (1) The programs have an agreement to share identifying information; and
- (2) The consumer has agreed in writing at the time of admission to release identifying information to the other program listed by name and address [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §§334-5, 334E-2)

§11-175-32 Right to determination of ability to pay for services. §11-175-32 Repealed. NOV 12 1991

§11-175-33 Right to informed consent to nonemergency treatment. a) Mental health and substance abuse programs shall obtain informed consent to treatment before nonemergency treatment of a consumer commences except for a person specifically ordered by a court to be involuntarily treated.

(b) A signed consent to treatment form shall be placed in the consumer's clinical record and a copy shall be given to the person providing consent.

(c) When a consumer is clinically determined to be unable to consent or not consent to nonemergency treatment because of incapacity and no guardian or attorney-in-fact for health care has been appointed, the program shall petition the court for a guardian to make treatment decisions. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-1)

§11-175-34 Right of access to a grievance procedure. (a) Mental health and substance abuse programs shall establish grievance policies and procedures for consumers and others on their behalf who allege violations of legally protected rights or have complaints concerning these rights. Such policies and procedures shall include mechanisms for

- (1) Informing consumers, parents of minor consumers, attorneys-in-fact and legal guardians, if any, upon admission, of the grievance procedure;
- (2) Informal dealing with and resolving verbal complaints;
- (3) Acknowledging and investigating written grievances;
- (4) Providing timely, appropriate, and adequate remedial action if it is determined that a right has been violated;
- (5) Informing the complainant in writing of the progress and results of an investigation, including any remedial actions taken, within 15 working days of receiving the complaint and every 15 working days thereafter, until the complaint is resolved;
- (6) Informing the complainant about how to appeal to external advocates if still dissatisfied.

(b) Any individual may petition the department for a declaratory ruling involving application of a statute or rule as provided for in section 91-8, HRS.

(c) Appeals filed by dissatisfied complainants shall be investigated and the complainant shall be informed of the progress and results of the investigation, including any remedial action taken, within 30 working days of receipt of the appeal and

every 30 days thereafter, until resolved. (d) Each service area center, Hawaii State Hospital, and provider shall designate a person as the rights advisor to consumers and staff.

(e) Consumers shall be informed by program administrators of the activities of advocacy agencies willing to act on behalf of consumers and how to contact such agencies and programs. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-g) (Imp: HRS §334E-2)

§11-175-35 Right of access to personal funds and valuables. (a) Psychiatric facilities and residential treatment facilities shall establish policies and procedures about the consumer's right of access to personal funds and valuables. Such policies and procedures shall include mechanisms for:

- (1) Informing consumers about their responsibility for the safekeeping of their own money personal effects, and other valuables which are not placed in locked storage or turned over to staff for safekeeping, and documenting in the clinical record that the consumer was informed;
- (2) Providing the consumers with a complete and detailed list of belongings the consumer turns over to the facility for safekeeping;
- (3) Petitioning the court for a guardian prior to denial of access to money, if denial appears to be essential to prevent unreasonable and significant dissipation of assets. Use of discretionary spending money or a regular allowance received by consumers shall not be considered a dissipation of assets.

(b) Psychiatric facilities and residential treatment facilities which provide long-term care or treatment shall establish additional policies and procedures about:

- (1) Methods for consumers to deposit money in a financial institution or a safe provided for that purpose and access to their money at least weekly. When monies are kept or deposited for consumers, a written accounting of all financial transactions made on behalf

- of the consumer shall be provided to the consumer or the consumer's legal guardian at least quarterly;
- (2) Voluntary access to locked storage space for each consumer or a procedure for consumers to give money and other valuables to staff for safekeeping;
 - (3) Assistance or counseling of consumers in budgeting spending money. Informed consent shall be obtained from the consumer or the consumer's legal representative or legal guardian to permit the facility to hold and periodically provide a consumer's money to the consumer. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §334-23)

§11-175-36 Civil rights. (a) Psychiatric facilities and residential treatment facilities shall presume that adult consumers are legally competent unless a court has determined otherwise, and shall establish policies and procedures for exercise of civil rights by consumers. Such policies shall include but not be limited to:

- (1) The right to be granted, forfeit, or be denied a license, permit, privilege, or benefit pursuant to any law, except a drivers license which may be revoked or conditioned;
 - (2) The right to dispose of property; execute legal documents, including a will, enter into contractual relationships, and to marry, obtain a separation, divorce or annulment;
 - (3) The right to make purchases;
 - (4) The right to freedom of speech;
 - (5) The right to register and to vote;
 - (6) The right to engage in religious practices.
- (b) The administrator of a psychiatric facility or residential treatment facility or the chief of a service area center shall petition the court for a finding of incapacity and appointment of a guardian to make informed decisions on behalf of a consumer if no guardian or attorney-in-fact has been appointed and;
- (1) If it is clinically determined that a consumer, from whom informed consent is

required for treatment, release of information, or other procedure which requires consent is incapacitated; or

(2) If it is determined that a consumer, who by statute may exercise a civil right, should be prohibited from exercising that right.

(c) A staff member of a facility, service area center, or contract agency providing mental health or substance abuse services to a consumer shall not serve as guardian for the consumer.

(d) Psychiatric facilities and residential treatment facilities shall designate accessible areas in which smoking is permitted or as allowed by law, designate themselves nonsmoking. [Eff. and comp DEC 30 1988; am and comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §§334-61, 334E-2)

§11-175-37 Right of authorized absence.

Psychiatric facilities and residential treatment facilities shall grant consumers authorized absence upon terms and conditions to be determined by the facility administrator for reasons such as, but not limited to personal business, family emergencies, visits, and trial periods of living in the community. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §§334-54, 334-75)

§11-175-38 Right of access to written rules and regulations.

(a) Psychiatric facilities and residential treatment facilities shall establish facility rules and regulations for staff and consumers which are in compliance with Federal and State laws, regulations, and administrative rules;

(b) Inform consumers upon admission of rules and regulations with which consumers are expected to comply and guidelines which describe the appropriate behavior expected. Such information shall be given orally and a written copy shall be provided to each consumer.

(c) Inform consumers verbally and in writing of any modifications of or additions to rules and regulations with which consumers are expected to comply; and

(d) Post in an area frequented by consumers a summary of rules and regulations with which consumers

are expected to comply and guidelines which describe the appropriate behavior expected. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-39 Right of freedom from reprisal. (a) Psychiatric facilities and residential treatment facilities are prohibited from retaliating either verbally or physically against consumers of services. Staff members shall:

- (1) Report to the person responsible for a consumer's individualized treatment plan any unexpected, first time behavior by a consumer which is adverse to staff or others; and
- (2) Address in the consumer's individualized treatment plan recurring behavior by a consumer which is aversive to staff or others.

(b) Any consequences which are unpleasant to a consumer but are designed as part of a treatment program or an individualized treatment plan shall not be considered as retaliation or reprisal if the program or plan has:

- (1) Approval of the facility administrator; and
- (2) Informed consent to the treatment proposed, except no such consent shall be required for consumers ordered by a court to undergo the particular treatment.

(c) A charge of assault or battery filed by a staff member as a result of aversive behavior by a consumer shall not be considered as retaliation or reprisal.

(d) A request that a consumer pay for damages or destruction caused by the consumer to property not belonging to the consumer shall not be considered as retaliation or reprisal. [Eff. and comp DEC 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-40 Right of privacy, respect and personal dignity. Psychiatric facilities and residential treatment facilities shall:

- (1) Require that staff members address each consumer by the consumer's legal name or a version thereof to which the consumer has

agreed. Adult consumers shall not be addressed in terms which imply that they are children;

- (2) Protect consumers from abuse and neglect;
- (3) Inform consumers in advance of a tour of a psychiatric facility or residential treatment facility and provide consumers the opportunity to move to an area not included in the tour;
- (4) Respect the privacy of consumers and not interfere with consumers' socially appropriate behavior, as specified in facility policies and procedures;
- (5) Search a consumer's belongings or living area only upon admission, after a leave of absence, in a life-threatening emergency, or if there is reasonable cause to believe an illegal item or item prohibited by the program's rules has been hidden;
- (6) Search belongings only in the presence of the consumer and a witness;
- (7) Search a consumer's person only by a staff member of the same sex as the consumer, in private, and only if there is reasonable cause to believe that such a search will reveal an illegal item or an item prohibited by the program's rules. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-41 Right to a humane environment. (a) Psychiatric facilities and residential treatment facilities shall provided consumers with a living environment which complies with department licensing provisions for housekeeping, infection control, life safety, and sanitation.

(b) Allow consumers to keep and display personal belongings in consumers' bed areas, provided that such items are not illegal or prohibited by facility rules.

(c) Post signs designating smoking and no smoking areas.

(d) Provide consumers with access to both smoking areas and smoke-free areas. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-42 Right to be free from discrimination.
 Psychiatric facilities and residential treatment facilities shall establish and implement admission criteria based on objective parameters justified in the program's design, licensed maximum capacity, or a contract's scope of service, but shall not otherwise deny services to an individual on the basis of race, color, creed, national origin, age, sex, or handicap. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**]
 (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-43 Right to a written treatment plan.
 (a) Psychiatric facilities and residential treatment facilities shall provide each consumer with:
 (1) An initial treatment plan before treatment begins and no later than 24 hours after admission;
 (2) A comprehensive treatment plan if the consumer's stay in a psychiatric facility exceeds 10 days, or stay in a residential treatment facility exceeds 30 days.
 (b) Each review of an involuntary consumer's comprehensive treatment plan shall include a determination about whether the consumer continues to meet the criteria for involuntary hospitalization. If the consumer does not meet the criteria, the consumer shall be discharged or offered the opportunity to apply for voluntary hospitalization.
 (c) When a consumer is receiving or has received mental health or substance abuse treatment outside the facility, the consumer shall be provided the opportunity to invite the provider of that service to participate in developing the consumer's initial and comprehensive treatment plans. [Eff and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9)
 (Imp: HRS §§334-35, 334E-2)

§11-175-44 Right to participate in planning the treatment plan. (a) Psychiatric facilities and residential treatment facilities shall establish policies and procedures for exercise of the right of the consumer to participate in treatment planning when the consumer's plan is developed, reviewed, or modified. Procedures shall include:

- (1) Meeting at least once with the consumer to discuss proposed treatment unless the consumer is unable or unwilling to do so;
- (2) Providing the consumer with information sufficient to be able to participate in decisions about proposed and alternative forms of treatment, if any;
- (3) Explaining to the consumer the right to disagree and, except for consumers specifically ordered by a court to be involuntarily treated, the right to refuse treatment, including medication.

(b) Informed consent to a treatment plan and to any significant change in the treatment plan by a consumer is one form of participation in planning the treatment plan. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-45 Right to refuse nonemergency treatment. (a) Psychiatric facilities and residential treatment facilities shall establish policies and procedures for exercise of the right to refuse nonemergency treatment by consumers, except consumers ordered by a court to receive specific policies and procedures shall include mechanisms for:

- (1) Not treating the consumer when informed consent to proposed nonemergency treatment is refused;
 - (2) Discontinuation of treatment when previously provided consent to nonemergency treatment is withdrawn. Verbally withdrawn consent shall be documented in the clinical record; and
 - (3) Proposing any appropriate and available alternative treatment, including alternative medications, whenever informed consent to proposed treatment is refused or withdrawn.
- (b) When informed consent to proposed treatment is not obtained, the facility shall:
- (1) Discharge the consumer; or
 - (2) Petition for a guardian for the consumer if the consumer has been clinically determined not to have the capacity to make a decision regarding treatment and the consumer does not have a guardian or attorney-in-fact, and

obtain consent from the guardian or attorney-in-fact before nonemergency treatment begins; or

- (3) Obtain a specific court order for involuntary treatment if the consumer appears to have the capacity to make a decision regarding treatment and has been ordered by a court to involuntarily hospitalized [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-46 Right to refuse participation in experimentation. Psychiatric facilities and residential treatment facilities shall establish policies and procedures for the consumer's right to refuse participation in experiments. Such policies and procedures shall include mechanisms for:

- (1) Review and approval of a proposed experiment by a research review committee before the consumer is invited to participate;
- (2) Informed consent by the consumer before participation in an experiment;
- (3) A written agreement between the consumer and the experimenters which specifically addresses:
- (A) The right to terminate participation at any time;
- (B) Whether monetary gain resulting from the experiment will be disbursed to consumer participants; and
- (C) Whether participants will be informed in writing of the progress and results of the project.
- (D) Prevention of differential treatment or reprisal by facility staff or experimenters when the consumer refuses to participate or continue participation in the experiment. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: §334E-2)

§11-175-47 Right to choose a primary provider of service. Psychiatric facilities and residential treatment facilities shall establish policies and

procedures for the consumer's right to choose a primary provider of service, or request a change in primary provider. These policies and procedures shall include:

- (1) How a consumer is assigned a primary provider of service;
- (2) How the consumer may request a change of primary provider; and
- (3) Limitation of this right only when:
 - (A) The agreed upon treatment plan does not include a primary provider; or
 - (B) The person chosen by a consumer is not available or does not agree. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-48 Right to a qualified, competent staff. (a) Psychiatric facilities and residential treatment facilities shall:

- (1) Ensure that all staff members receive orientation training and in-service training including specific training on the rights of consumers, any changes in statutes, administrative rules, and policies and procedures concerning consumer rights and role playing as consumers of the program's services.
- (2) Provide orientation and periodic training for volunteers related to the work they perform. (b) Work of paraprofessionals and volunteers in mental health services shall be planned, supervised and evaluated by a mental health professional. Work of paraprofessionals and volunteers in substance abuse services shall be planned, supervised, and evaluated by a certified substance abuse counselor or certified substance abuse program administrator.
- (c) At a minimum, the performance of staff shall be evaluated within six months of employment and once a year thereafter based on criteria established as follows:

- (1) For employees of public psychiatric facilities, by the department of personnel services; and
- (2) For employees of private psychiatric facilities and for residential treatment facilities, by the facility. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-49 Right to a medical examination before nonemergency treatment. (a) Psychiatric facilities shall provide a physical examination of the consumer unless that consumer refuses to have a physical examination. Such examination shall include determining if the consumer has a previously unrecognized and undiagnosed organic disease, medical illness or evidence of substance abuse specifically related to the consumer's psychiatric symptoms which may either cause or exacerbate the symptoms significantly. If the consumer is known to the facility from a previous hospitalization and a physical examination including such determination occurred within the preceding twelve months, no examination shall be required. The physical examination shall be provided:

- (1) Before nonemergency treatment is initiated but no later than 24 hours after admission; or
- (2) As soon as possible after emergency treatment, but in no event later than 72 hours after admission; and
- (3) Prior to administration of any medication.

(b) Residential treatment facilities shall ensure that a consumer has had a physical examination within twelve months and that the examination included screening to determine if psychiatric symptoms are present and possible physical causes of these symptoms. A report of the examination shall be on file within 21 days of admission.

(c) Refusal to submit to a physical examination shall be construed as a refusal of nonemergency treatment. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-50 Right to knowledge of rights withheld or removed by a court or by law. Whenever staff of a psychiatric facility or residential treatment facility is informed that a consumer has a right withheld or removed by a court or by law, the program shall provide information verbally and in writing to the consumer on the right which has been withheld or removed, what this means, how long this will last, and how to appeal this determination, unless the consumer has been provided this information verbally and in writing by others. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-51 Right to physical exercise and recreation. Psychiatric facilities and residential treatment facilities shall establish policies and procedures for the consumer's right to physical exercise and recreation. Such policies and procedures shall include mechanisms for:

- (1) Providing consumers with opportunities for regular physical exercise and recreation suited to consumers' needs and interests unless contraindicated in the consumer's initial or comprehensive treatment plan;
- (2) Evaluating each consumer at least twice a year to determine the physical exercise or recreational activities needed by the consumer which are not provided and specifying in the consumer's treatment plan those which are needed and available. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-52 Right to an adequate diet. Psychiatric facilities and residential treatment facilities shall:

- (1) Post current menus at least 24 hours in advance when there is no choice of meals offered;
- (2) Ensure that at least three balanced meals are available at regular intervals within each 2-hour period and that snacks are available when there is more than 14 hours between a substantial evening meal and breakfast or the

intervals between other meals is more than five hours;

- (3) Require informed consent for any special diet prescribed by a physician and encourage, but not require a consumer to follow such a diet. Refusal to consent to a special diet shall be construed as a treatment. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-53 Right to know names and titles of staff. (a) Psychiatric facilities and residential treatment facilities shall provide consumers with the names and titles of members by requiring that all staff who have contact with consumers wear an identification badge or pin stating the staff member's name and title; or

(b) Posting the names, titles and pictures of all staff who have contact with consumers in a location frequented by consumers. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-54 Right to work. (a) Psychiatric facilities and residential treatment facilities which provide long-term care and treatment and on-site day activities shall establish policies and procedures for the consumer's exercise of the right to work. Such policies and procedures shall include mechanisms for:

- (1) Work at the facility for consumers as part of the treatment program offered;
- (2) The right to refuse to work;
- (3) Ensuring that when work is performed by a consumer, that the work is:
 - (A) Specified in the treatment plan with measurable objectives to be reached within specified time frames and based on a consumer's ability;
 - (B) Approved by the staff member who has primary responsibility for the consumer's treatment;
 - (C) Supervised by appropriate staff;
 - (D) Not used as a condition for privileges unrelated to the work or as a condition

of release from involuntary hospitalization.

(b) Consumers who work at a facility shall be informed about opportunities for work, training and educational programs available in the community and shall be assisted in gaining access to them.

(c) Consumers who desire to perform volunteer work outside the facility in a recognized volunteer program shall be assisted to do so if such volunteer work does not interfere with treatment. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2).

§11-175-55 Right to have visitors. (a) Psychiatric facilities and residential treatment facilities shall establish policies and procedures for consumer's exercise of the right of consumers to have visitors, which include:

- (1) Daily visiting hours of not less than one hour which apply to all consumers;
- (2) The consumer's option not to see any visitor.
- (3) Visits by the consumer's legal guardian or legal representative are not to be limited at any time;
- (4) Limiting a consumer's right to have visitors only if:
 - (A) The consumer poses a danger to others;
 - (B) A visitor poses a danger to the consumer or others or is disruptive to the program;
 - (C) A visitor refuses to be searched for contraband, upon request when there is reasonable cause to believe the visitor has contraband; or
 - (D) A voluntary consumer agrees to a temporary limitation of the right as a condition of a treatment program for which informed consent has been obtained.

(b) Psychiatric facilities which provide long-term care and treatment shall allow leaves of absence or provide privacy for conjugal visits upon the request of a consumer unless the consumer poses a

danger to others. [Eff. and comp DEC 30 1988; comp] (Auth: HRS §321-9) (Imp: HRS §334E-2) **OCT 19 2007**

§11-175-56 Right to uncensored communication.
Psychiatric facilities and residential treatment facilities shall have policies and procedures for the consumer's exercise of the right to uncensored communication. Such policies and procedures shall include:

- (1) Daily telephone hours of not less than one hour for placing and receiving telephone calls shall apply to all consumers;
- (2) No limitation on placing telephone calls outside telephone hours to a consumer's lawyer or legal representative;
- (3) Limiting the right to communicate by telephone only to prevent a consumer from:
 - (A) Being seriously hurt, physically or mentally;
 - (B) Breaking a law;
 - (C) Disrupting the facility; or
 - (D) Harassing an individual who has requested that the consumer be prevented from calling, provided that a limitation of up to one week shall follow a verbal request, and provided further that a limitation for more than one week shall require a written request.
- (4) Permitting a voluntary consumer to agree to a temporary limitation of the right as a condition of a treatment program for which informed consent to treatment is obtained.
- (5) Incoming and outgoing mail shall be unopened, except that that the consumer may be required to open incoming mail in the presence of a staff member if contraband is reasonably suspected and the reasonable suspicion is documented in the clinical record;
- (6) Limiting the right to send and receive mail only to prevent a consumer from breaking a law. [Eff. and comp DEC 30 1988; comp

OCT 19 2007] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-57 Right of freedom from seclusion and restraint. (a) Psychiatric facilities and residential treatment facilities which use seclusion or restraint shall:

- (1) Use seclusion or restraint only;
 - (A) When necessary to prevent imminent harm to the consumer, others, or property when other means of control are not appropriate or effective;
 - (B) When part of a consumer's treatment plan; or
 - (C) When deemed necessary by a psychiatrist or psychologist to protect the rights of other consumers or staff.
- (2) Document justification for any use of seclusion or restraint in the consumer's clinical record of the consumer;
- (3) Terminate seclusion or restraint immediately when justification no longer exists;
- (4) Document the names of the staff members who secluded the consumer or applied restraint in the clinical record;
- (5) Use emergency seclusion or restraint no longer than one hour without telephoned authorization from a physician and no longer than twelve hours without written authorization of a physician who has personally examined the consumer;
- (6) Use nonemergency seclusion or restraint only with authorization by a physician who has personally examined the consumer;
- (7) State in policy and procedures that the person empowered to use seclusion or restraint in an emergency and responsible for ending an episode of seclusion or restraint is the person in charge of the unit;
- (8) Require that written authorization for seclusion or restraint include:
 - (A) Conditions of seclusion or type of physical restraint;
 - (B) Duration of seclusion or restraint;
 - (C) Clothing to be removed, if any;
 - (D) Full justification for each use of seclusion or restraint, including why

the measure is essential and why a less restrictive measure did not suffice; and

- (E) The name of the authorizing physician.
- (9) Review and renew if appropriate all orders for seclusion or restraint authorized by a psychiatrist or psychologist every 8 hours until terminated, except that seclusion or restraint of a consumer for longer than 72 consecutive hours shall require review and approval of the facility administrator.

(b) When a consumer is secluded or restrained, the consumer shall be;

- (1) Personally examined and evaluated by a physician at least twice in each 24 hour period;
- (2) Inspected at least once every 15 minutes by designated staff;
- (3) Given the opportunity of hourly access to toilet facilities when awake; and
- (4) Bathed as often as needed, but at least once every 24 hours;

(c) Any consumer in physical restraint shall be given the opportunity to sit or lie down and to move freely for not less than 15 minutes during each 2-hour period during waking hours, unless medically contraindicated with justification documented in the clinical record.

(d) When seclusion or restraint is used as part of a treatment plan, the treatment plan shall include how this procedure is monitored and the expected therapeutic efficacy of the procedure. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-58 Right to disclosure of prior treatment at involuntary commitment hearings. (a) At any commitment or recommitment hearing for involuntary outpatient treatment or involuntary hospitalization, the petitioner shall ensure that the subject may choose to exercise the right to disclosure of any prior treatment, including what the treatment was, whether such treatment was with or without informed consent, and any effect such treatment has or can be expected to have on the current behavior or appearance of the

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subject, or that no treatment is known to have been administered.

(b) Release of information about treatment for substance abuse shall require prior written informed consent by the subject. [Eff. and comp DEC 3 0 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-59 Right to be informed of rights at time of admission. (a) Psychiatric facilities and residential treatment facilities shall:

- (1) Provide the consumer and the consumer's legal guardian, or attorney-in-fact, if any, a copy of a summary of consumers' rights either on admission or no later than at the time consent to the initial treatment plan is obtained;
- (2) Place in the consumer's clinical record an acknowledgment of receipt of the summary of rights signed by the consumer or the consumer's legal guardian or attorney-in-fact;
- (3) Post a summary of consumers' rights in an area easily accessible to consumers;
- (4) Verbally explain the consumer's rights to the consumer or the consumer's legal guardian or attorney-in-fact, if any, in an understandable manner, except:
 - (A) If a consumer is temporarily unable to understand because of mental disability or intoxication, documentation in the clinical record shall include why the explanation was not provided;
 - (B) Provide an explanation as soon as the consumer's ability to understand is regained, but no less than two weeks from the time of admission and every 60 days thereafter, as necessary; and
 - (C) Document in the clinical record when these explanations occur; or
 - (D) If a consumer is not expected to regain the ability to understand, documentation in the clinical record shall include

justification for not providing an explanation.

- (5) Provide staff members who have contact with consumers a copy of a summary of consumers' rights, inform them of their responsibility to protect consumers' rights, and require a signed statement acknowledging receipt of the summary;
 - (6) Before voluntary admission to a psychiatric facility or residential treatment facility, inform the potential consumer of any limitation, restriction or withholding of rights which is part of the treatment program offered and obtain a signed agreement to this condition of participation.
- (b) Unless withheld or removed by a court or by law, no right shall be limited, restricted, removed or denied a consumer unless;
- (1) There is a life threatening emergency;
 - (2) There is an administrative rule which specifies the basis for limitation of the right; or
 - (3) There is a policy and procedure which specifies the basis for limitation of a right and which is adopted pursuant to Hawaii Revised Statutes and applicable administrative rules.
- (c) When a right of the consumer is individually limited:
- (1) The consumer shall be informed of the limitation, the reason for it, and its duration; and
 - (2) The limitation shall be documented in the clinical record, including justification for the limitation, a time limit not to exceed one week unless specifically authorized by the facility administrator, and when and who explained the limitation for the consumer.
- [Eff. and comp DEC 30 1988; comp **OCT 19 1987**
] (Auth: HRS §321-9) (Imp: HRS §334E-2)

§11-175-60 Right to the least restrictive level of service. Psychiatric facilities and residential treatment facilities shall determine the least

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restrictive level of service for each consumer and shall:

- (1) Ensure that documentation in a consumer's clinical record includes this determination; and
- (2) When a less restrictive level of service is therapeutically appropriate, provide or refer the consumer directly to the appropriate level of service. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §334-104)

§11-175-61 Right to coordinated services. (a) When a consumer is admitted to a psychiatric facility and the consumer does not have a previously assigned case manager, the facility administrator or program administrator shall ensure that the consumer is offered case management services. Case management services shall include discharge planning, planning for services which may be needed subsequent to discharge, and follow up after discharge for assistance in obtaining such services.

(b) A consumer admitted to a residential treatment facility shall be offered the services of a staff person who shall:

- (1) Serve as the consumer's case manager or, if the consumer has a case manager assigned by the service area center, act as a liaison with the case manager;
- (2) Assist the consumer, as necessary, in obtaining other mental health and substance abuse services and in gaining access to other appropriate community services; and
- (3) Serve as an advocate for the consumer within and outside the program. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §§334-2; 334-3; 334-102)

§11-175-62 Right to prevocational and vocational programs in residential treatment facilities.

Residential treatment facilities shall:

- (1) Provide a program for consumers which includes increasing levels of independent functioning as appropriate; and

- (2) Ensure that consumers have access to prevocational and vocational programs. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**]
 (Auth: HRS §334-9) (Imp: HRS §334-102)

§11-175-63 Right to participation in operation, treatment planning, and evaluation of programs in residential

treatment facilities. Residential treatment facilities shall establish policies and procedures for the consumer's exercise of the right to participate in:

- (1) Decisions made concerning operating practices including house rules and consumer responsibilities;
- (2) Development of new treatment modalities and modification of current ,modalities; and
- (3) Evaluation of the program. including evaluation of operating and treatment modalities. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS§334-9) (Imp: HRS §334-02)

§11-175-64 Right to request a private physician in a psychiatric facility operated by the State or a county. Psychiatric facilities operated by the State or a county shall establish policies and procedures for the consumer's exercise of the right to request treatment by a private physician licensed under chapter 453, HRS. Such policies and procedures shall include mechanisms for:

- (1) Provision of evidence of appropriate liability insurance coverage by the physician; and
- (2) Agreement in advance by the physician that if private treatment is to be discontinued, written notification will be provided to the facility administrator 24 hours prior to such discontinuation. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-g) (Imp: HRS §334-36)

§11-175-65 Psychiatric facility emergency examination and admission rights. a) When a person is admitted or delivered for examination to a psychiatric facility, the facility shall ensure that:

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- (1) The person is inspected immediately for any bruises, marks, possible fractures, other injuries and scars, and that any findings are noted in writing;
- (2) The person is asked about any physical complaints and any reported are noted in writing;
- (3) The person is examined by a licensed physician within 3 hours.

(b) If an adult consumer is hospitalized under emergency hospitalization provisions and waives the right to notify others, facility staff shall attempt to obtain consent from the consumer to notify the consumer's family or legal representative or legal guardian, and shall notify the consumer's family or legal representative or legal guardian only if consent is obtained. [Eff. and comp DEC 30 1988; comp OCT 19 2007] (Auth: HRS §321-9) (Imp: HRS §334-59)

§11-175-66 Voluntary hospitalization rights.
Psychiatric facilities shall:

- (1) Not consider an application for voluntary hospitalization as lacking volition because an individual agreed to hospitalization as a result of a court proceeding;
- (2) Evaluate an individual's clinical suitability for voluntary admission based on criteria which include:
 - (A) That the individual has a condition which can benefit from inpatient treatment provided by the facility; and
 - (B) That appropriate alternatives to hospitalization were considered and adequate alternative treatment is not available or suitable.
- (3) Verbally advise the consumer or the consumer's legal representative or legal guardian of the right to terminate hospitalization at any time and the procedures to be followed. The notification shall be provided upon admission, followed up in writing, and shall be performed every six months thereafter;

- (4) When a voluntary consumer, or the consumer's legal representative or legal guardian indicates a desire for discharge of the consumer, within 24 hours discharge the consumer or in accordance with section 334-60.1, HRS, initiate proceedings for involuntary hospitalization.
- (5) When a consumer fifteen through seventeen years of age hospitalized as a result of countersigning an application for voluntary hospitalization informs the facility of a desire to object to further hospitalization, notify the consumer's parents, legal representative or legal guardian and discharge the consumer within 24 hours unless involuntary hospitalization proceedings in accordance with section 334-60.1, HRS, have been initiated.
- (6) When a minor consumer hospitalized as a result of countersigning an application for voluntary hospitalization becomes eighteen years of age while hospitalized, notify the consumer that application for voluntary hospitalization may be made by the consumer; if such application is not made, discharge the consumer or notify the consumer that proceedings for involuntary hospitalization have been initiated, as appropriate.
- (7) When a request for discharge is made by a consumer's legal representative or legal guardian on behalf of a voluntary consumer and the consumer was admitted as a result of the consumer's application, discharge the consumer only with the agreement of the consumer.
- (8) When a voluntary consumer is determined to be no longer clinically suitable for hospitalization, discharge the consumer or, if reasons exist to delay discharge of the consumer specific to placement after discharge, with the consumer's consent or the consent of the consumer's empowered guardian, continue to hospitalize the consumer for up to 30 days.

(9) When a voluntary consumer leaves a facility against medical advice and remains away from the facility, not take any action to have the consumer returned to the facility, including notification of others, and discharge the consumer unless:

(A) There is reason to believe the consumer meets the criteria for involuntary hospitalization and this is documented in the consumer's clinical record, in which case initiate proceedings for emergency examination and hospitalization; or

(B) The consumer is a minor, or is a consumer who has a guardian or attorney-in-fact empowered to make treatment decisions, in which case the parent or guardian or attorney-in-fact shall be notified with advise on possible action.

[Eff. and comp DEC 30 1988; comp
OCT 19 2007] (Auth: HRS §334-9) (Imp: HRS
§§334-34; 334-60.1).

§11-175-67 Involuntary hospitalization rights.

(a) When petition has been filed alleging that a person located in the county meets the criteria for commitment psychiatric facility, and in the absence of an ex parte order, the subject of such a petition has the right to refuse to submit to medical examination and the right to a hearing.

(b) Whenever an administrator of a psychiatric facility finds that an involuntary consumer no longer meets the criteria for involuntary hospitalization, within one working day the administrator shall provide the court which ordered the hospitalization notice of intent to discharge because the consumer is no longer a proper subject for commitment and, if no objection is filed within three calendar days of service, the facility shall discharge the consumer; a consumer so discharged who is determined to be clinically suitable for voluntary hospitalization or who is in need of continued hospitalization for reasons specific to placement in the community, shall be offered the opportunity to apply for voluntary hospitalization.

(c) A psychiatric facility shall ensure that involuntarily hospitalized consumers are informed that at any time after admission or after transfer to another psychiatric facility, and every six months thereafter, a consumer or anyone on the consumer's behalf may file a written request with the family court objecting to admission or continued hospitalization and that the facility administrator will assist an objecting consumer to obtain legal counsel. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §§334-60.7; 334-81)

§11-175-68 Rights concerning hospitalization as a result of unfitness to proceed or acquittal. (a) Any consumer committed by a court to the custody of the director of health for detention, care, and treatment in an institution because of unfitness to proceed shall be informed by facility staff verbally and in writing within one week of admission and at least annually thereafter of the right to apply at any time to the court for a determination that the consumer has regained fitness to proceed and to request a hearing. Notation of who provided this information to the consumer and when it was provided shall be placed in the consumer's clinical record.

(b) The director shall report to the court within 90 days of admission of a consumer committed because of unfitness to proceed. and every 90 days thereafter until discharge, on whether the consumer presents a substantial likelihood of becoming fit to proceed in the future.

(c) Any consumer committed by a court to the custody of the director of health for detention, care and treatment in an institution because of acquittal shall be informed by facility staff verbally and in writing within ninety days of admission, and at least annually thereafter if a previous determination by the court was adverse to an application. of the right to apply in writing to the court for an order of discharge or conditional release. Notation of who provided this information to the consumer and when it was provided shall be placed in the consumer's clinical record.

(d) A consumer who wishes to apply to the court for a determination of regained fitness to proceed, or

for discharge or conditional release, shall be assisted by facility staff to apply.

(e) When the clinical director of the facility determines that there is substantial clinical evidence that a consumer committed under provision of section 704-411, HRS, may be discharged or released on condition without danger to self or others or that the consumer no longer presents a risk of danger to self or others because of the effect of treatment, and there is substantial evidence that the consumer can be controlled adequately and will continue to receive proper care, supervision, and treatment following discharge or conditional release:

- (1) Within five working days of the clinical determination, the facility administrator shall prepare a statement setting forth the clinical findings supporting a conclusion in favor of discharge or conditional release including a summary of all pertinent clinical data. Copies of the statement shall be provided to the consumer and the director of health.
- (2) The director of health shall determine if there is sufficient evidence to petition for a judicial hearing and, if so, shall submit the petition to the court and provide a copy of the petition to the prosecuting attorney of the county from which the consumer was committed. [Eff. and comp DEC 30 1988; comp OCT 19 2007] (Auth: HRS §321-9) (Imp: HRS §§334-34; 334-35)

§11-175-69 Transfer rights. Any consumer in a psychiatric facility may be transferred to another psychiatric facility if transfer appears to be in the best interests of the consumer and if:

- (1) The consumer and any person specified in any current order of commitment has been given prior notice of and reason for the transfer. The notice of transfer shall be documented in the consumer's clinical record.
- (2) If there is no current order of commitment, persons enumerated in section 334-60.4, HRS, shall be given prior notice and reason for

the transfer. The notice of transfer shall be documented in the consumer's clinical record. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §§334-71; 334E-2)

§11-175-70 Non-facility admission rights.

Consumers admitted to mental health or substance abuse programs not provided in a psychiatric facility or residential treatment facility shall be informed verbally and in writing of the status of their admission to the program, including:

- (1) Information on how to terminate services;
- (2) Conditions which may lead to discharge;
- (3) Conditions which may lead to initiation of proceedings for involuntary treatment or hospitalization, if appropriate; and
- (4) For a consumer with a court order to obtain treatment:
 - (A) The legal basis of the order to obtain treatment;
 - (B) Expiration date of the order; and
 - (C) Types of information to be shared with the court as a result of a consent to release information. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §321-9) (Imp: HRS §§334-103; 334E-1).

§11-175-71 Involuntary outpatient admission rights. Outpatient treatment programs shall establish policies and procedures to protect the admission and discharge rights of involuntary outpatients and shall include mechanisms for:

- (1) Informing the subject of a petition for involuntary outpatient treatment of the right to:
 - (A) Refuse to submit to an examination by a licensed psychiatrist;
 - (B) Request that the hearing be open to the public;
 - (C) Be present at the hearing;
 - (D) Secure one or more independent psychiatric examinations and present evidence at the hearing; and

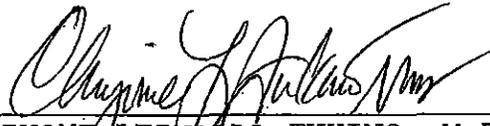
- (E) Have a psychiatric examination at a service area center, if an examination has not already been conducted which will lead to psychiatric testimony at the hearing.
- (2) Informing a person ordered by a court to obtain involuntary outpatient treatment of the right to:
 - (A) Not be denied treatment for failure to pay the fee for treatment;
 - (B) Be discharged before the end of the court ordered period of treatment. if it is determined that the consumer no longer meets the criteria for involuntary outpatient treatment;
 - (C) Not be physically forced to take medicine;
 - (D) Not be forcibly detained for treatment;
 - (E) Not have refusal of treatment constitute evidence for involuntary hospitalization; and
 - (F) Petition the court for discharge after 50 days from the most recent hearing [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §§334-121, 334-128, 334-129, 334-131, 334-134)

§§11-175-72 to 11-175-79 (Reserved)

§11-175-80 Severability. If any provision of this chapter or the application thereof to any person or circumstances is held invalid, the remainder of this chapter, or the application of the provision to other persons or circumstances, shall not be affected thereby. [Eff. and comp DEC 30 1988; comp **OCT 19 2007**] (Auth: HRS §334-9) (Imp: HRS §§334-121, 334-128, 334-129, 334-131, 334-134)

Amendments to and compilation of chapter 11, title 175, Hawaii Administrative Rules, on the Summary Page dated October 1, 2007 were adopted on October 1, 2007, following a public hearing held on May 8, 2007, after public notice was given in the Honolulu Star Bulletin, The Maui News, Hawaii Tribune Herald, West Hawaii Today, and The Garden Island on April 8, 2007.

They shall take effect ten days after filing with the Office of the Lieutenant Governor.



CHIYOME LEINAALA FUKINO, M.D.
Director of Health

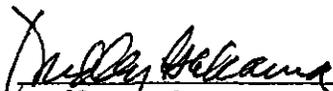


LINDA LINGLE
Governor of Hawaii

Dated: OCT - 8 2007

Filed

APPROVED AS TO FORM:



Dudley Akama
Deputy Attorney General

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LIEUTENANT GOVERNOR'S
OFFICE