Community Client Rights Resource Manual

For and By
Behavioral Health Agency Staff and
Board Staff in Cuyahoga County

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COMMUNITY CLIENT RIGHTS RESOURCE MANUAL

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INTRODUCTION

This manual is meant to serve as a guide for Client Rights Advocates to assist in conducting investigations, ensuring compliance with state and federal law, and to ensure, to the best extent possible, that a satisfactory resolution is reached for each client utilizing the grievance process. This manual will provide information about the rights that clients have when they apply for, or receive any behavioral health service, in any public setting in the community. This manual navigates and interprets client rights as outlined by the Ohio Revised Code (ORC), the Ohio Administrative Code (OAC), and the Code of Federal Regulation (CFR). Allegations of client rights violations can often times be borne of client perception - clients have expectations regarding how they would *like* to be treated. The purpose of the investigation is to provide a resolution for the client that allows them to feel heard and respected. Under each right, you will notice an explanation, key review questions, and best practices that are applicable to each right. However, there are numerous key review questions and best practices that are applicable for investigations in general.

Please review the questions and best practices below that should be asked during each complaint and grievance investigation.

Key Review Questions:

- What is the evidence that supports the client's perspective?
- Is there an alleged violation of HIPAA or privacy?
- Did you review the agency policy/agency handbook? Is there an agency policy?
- Is the client under the appropriate level of care?
- Upon admission, was the client informed of the programmatic expectations?
- Has the safety of the client, and the safety of the setting been assessed; and the safety plan reviewed?
- If the client has consented, have mediation skills been utilized?

Best Practices:

- If necessary, has the incident been reported to the appropriate authorities?
- Have the allegations been documented and reported to your agency's administration?
- Has the OhioMHAS notification incident report been filed?
- Is the agency policy in compliance with applicable state/county policy and laws?
- Did you review your agency policy? Is there a violation of agency policy?
- Agency policy must be reviewed regularly to ensure compliance with state and federal law. Ensure that policies are updated in compliance with the agency's accrediting body.
- Have you referred to your ADAMHS Board contract?
- Does your agency work with an organization that supplies interpreting services for clients? All ADAMHS Board contract agencies are required to supply interpreting services under their current contract(s). This includes written translations such as Braille.

- Are staff members operating within the scope of their practice, training, and the bounds of agency policy?
- Has the client consented to the service being provided?
- Is client information sent and/or provided via methods that are HIPAA compliant (email, text message, photo messaging, fax, Skype, etc.)?
- Benefits and risks should be discussed with the client and said discussions should be thoroughly documented.
- Clinically necessary vs. clinically appropriate:
  - Clinically necessary – health care service that a clinically licensed provider exercises prudent clinical judgement which is provided to the patient within the scope of practice; must be for the purposes of evaluating, diagnosing, or treating an illness, injury, disease, or symptom. Example: services rendered to stabilize a pink-slipped client.
  - Clinically appropriate – services recommended by a provider based on observed needs, and voluntarily accepted by the client. Example: Individualized Service Plan (ISP) or Individualized Education Plan (IEP), which could recommend anger management classes.

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1. The right to be treated with consideration and respect for personal dignity, autonomy and privacy

Tool Box		
ORC - MH	**5119.61**	**Department of Mental Health**
OAC – MH and SUD	**5122-26-18: A thru D and H thru J**	**Client Rights & Grievance Procedures**
Certification Standards – OAC – MH and SUD	**5122-26-17**	**Accessibility, Availability, Appropriateness and Acceptability of Services**
OAC – MH and SUD	**5122-26-18**	**Client Rights and Abuse**
OAC – MH and SUD	**5122-29-01 thru 34 and 5122-40**	**OhioMHAS Service Standards**
OAC – MH and SUD	**5122-24-01**	**Certification definitions for abuse and neglect**
CFR-SUD	**42CFR**	**Reporting Grievances**

Explanation:
Provider agencies should promote an individual's recovery and resiliency by communicating respectfully and valuing each individual as having worth. Some examples of disrespectful and/or abusive behaviors are:

- Name calling
- Coarse language/verbal abuse
- Rude gestures
- Absence of common courtesies
- Shaming or embarrassing/ridiculing clients
- Lacking professional language/the use of jargon

Key Review Questions:
- ❖ Are agency staff communicating carefully and respectfully with clients?
- ❖ Have program expectations been reviewed and provided in writing to the client?

Best Practices:
- ❖ Has the incident been reviewed with the provider and/or supervisor?
- ❖ Has mediation been offered as a possible remedy?
- ❖ Have code of conduct policies and the provider's applicable code of ethics been reviewed?

2. The right to reasonable protection from physical, sexual or emotional abuse and inhumane treatment

Tool Box		
ORC – MH and SUD	**340.011**	**Interpretation and Construction**
OAC – MH and SUD	**5122-26-18 A- D and H - J**	**Client Rights and Grievance Procedure**
OAC – MH and SUD	**5122-26-13**	**Incident notification and risk management**
Certification Standards - OAC – MH and SUD	**5122-24-01**	**Definitions of Neglect and Abuse**
OAC – MH and SUD	**5122-29-10**	**Crisis Intervention Service**

Explanation:

Clients should be provided reasonable protection from abuse (physical, emotional, or sexual), neglect (including the dereliction of duty), or exploitation; perceived or alleged. Some examples of abusive behavior are:

- Consensual and non-consensual sex between a service provider and a client
  - This could also include encounters between clients and visitors, contract personnel, or other members of the agency's workforce.
  - Also included would be instances of sexual contact between two minor clients
- Financial Exploitation
- Fraud
- Corporal Punishment

An example of inhumane treatment is:

- A deliberate attempt or unintentional action/inaction resulting or causing harm

Key Review Questions:

- Are the appropriate steps and reasonable precautions in place to ensure the safety of the client?
- Is there any evidence of physical, sexual, and/or emotional abuse, neglect, or fraud?
  - This would include the unauthorized or inappropriate use of restraint and seclusion.
- If the Client is 60+ years old has Adult Protective Services been contacted?
- If the client has Developmental Disabilities has the Cuyahoga County Board of Developmental Disabilities been contacted?
- In appropriate instances, has law enforcement been notified?

Best Practices:

- Client Rights Officers must investigate allegations of this nature even if the client refuses to file a formal complaint.
- Ensure that standards related to mandated reporting are reviewed.
- Have code of conduct policies and the provider's applicable code of ethics been reviewed?

3. The right to receive services in the least restrictive, feasible environment

Tool Box		
ORC – MH and SUD	340.011 (3)	Interpretation and Construction
OAC – MH and SUD	5122-26-18 A-D and H-J	Client Rights & Grievance Procedures
OAC – MH and SUD	5122-26-16	Seclusion, Restraint and Time-Out
OAC – MH and SUD	5122-26-17	Accessibility, Availability, Appropriateness and Acceptability of Services
OAC – SUD/Dual	5122-27-09	SUD Level of Care Protocols
OAC – MH and SUD	5122-29-03	General Services
OAC – MH and SUD	5122-26-12	Environment of Care and Safety

Explanation:
Clients should be served in an environment that allows for the greatest possible freedom and individual choice in their recovery while maintaining the client's safety. Ensure that interventions and services are clinically appropriate and/or clinically necessary; with consideration of the multiple levels of service based upon a client's needs.

Key Review Questions:

- ❖ Has the client and/or legal guardian been informed in writing if changes in level of care or services are recommended or required?
- ❖ Has the client been told about the risks, benefits, and consequences and given the opportunity to ask questions, receive answers, and be informed of alternatives? Is this documented?
- ❖ Is the staff member appropriately trained and authorized to initiate any restrictive action? Is the provider certified to perform such an action?
- ❖ Has the client been informed of the levels of care offered at the provider agency? Are referrals provided when necessary?
- ❖ Has the client been informed, verbally and in writing, of the program and behavioral expectations? Has this been documented?
- ❖ Has the client been informed, verbally and in writing, of the consequences of participating or not participating in a program? Has this been documented?

Best Practices:

- ❖ In cases where a restrictive setting is utilized, is it documented in the treatment plan?
- ❖ Has staff been properly trained on de-escalation techniques in accordance with their certified training program?
- ❖ Is your agency certified for the restrictive setting being utilized (OhioMHAS certifications)?
- ❖ If a client has advance directives in place, is this documented in the client record?
- ❖ Have the ASAM requirements for level of care been reviewed and applied to the treatment plan (SUD)?
    - Recommendations for residential treatment, intensive outpatient (IOP), non-intensive outpatient (NIOP)

4. The right to participate in any appropriate and available service that is consistent with an individual service plan (ISP), regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person's participation

Tool Box		
ORC	340.011	Interpretation and Construction
OAC – MH and SUD	5122-26-18 A-D and H-J	Client Rights & Grievance Procedure
OAC – MH and SUD	5122-26-17	Accessibility, Availability, Appropriateness and Acceptability of Services
OAC – MH and SUD	5122-27-02	Individual Client Record Requirements
OAC – MH and SUD	5122-27-03	Treatment Planning
OAC – MH and SUD	5122-29	Service Standards
OAC – SUD/Dual	5122-27-09	SUD Level of Care Protocols

Explanation:
A client can refuse one service and still choose to accept others. Services cannot be universally linked to each other. For example, residential programs cannot require all clients to participate in a day treatment program or take medications; day treatment programs cannot require all clients to take medications; housing cannot be linked universally to case management/service coordinators; and case management cannot be linked universally to prescriber's services.

Services can be linked if such links are established as clinically necessary for an individual's successful treatment in his/her ISP/IEP.

Key Review Questions:

- ❖ Has the valid and specific clinical necessity for linking services been explained to the client in a way they understand and agree to, and is it documented?
- ❖ If a client has refused services that have been deemed clinically necessary, has this been documented in the client record? Have the benefits and risks of service refusal been discussed in a manner appropriate for the client's understanding and documented in the client's record?
- ❖ In cases where a client has been mandated to receive services (such as court ordered), have the consequences of refusing services been clearly explained in a manner appropriate for the client's understanding?

Best Practices:

- ❖ Does the client have a legal guardian? Did the guardian sign and receive a copy of the treatment plan?
- ❖ Has the agency monitored the client's ISP/IEP if the client has refused a specific service?
- ❖ Has the ISP/IEP been reviewed on a consistent basis in accordance with agency policy and/or accreditation and licensure requirements?
- ❖ Did the client refuse to sign the treatment plan and if so, is it documented?
- ❖ Does the progress note and ISP/IEP reflect a client's refusal to participate in the development of the treatment plan?
- ❖ All client's/guardians have the ability to exercise their right to receive or decline a copy of their treatment plan/ISP/IEP. Clients can request a copy of their ISP/IEP at any time even if they declined to receive a copy initially.
- ❖ If a client's access is restricted, please refer to OAC 5122-26-18-E (11).

5. The right to give informed consent to or to refuse any service, treatment or therapy, including medication, absent an emergency

Explanation:
Clients can say yes when they mean yes and no when they mean no to all proposed services. That includes saying yes or no to being involved in research, and also saying yes or no to having a payee. Service providers cannot require a client to have a payee as a condition of service.

Consent is defined as an agreement to participate in a research or treatment procedure on the basis of the subject's understanding of its nature and possible risks and benefits. Consent can only be given by a person with legal authority. In some cases (i.e. minors, client's adjudicated as incompetent), a guardian will need to provide informed consent. Check with your agency's legal counsel for an opinion about specific cases.

An emergency is defined as a situation that is a matter of life or death or of extreme drastic loss of a person's ability to manage a potentially dangerous situation where the goal is avoidance of loss and minimization of risks. Emergencies could include involuntary commitment, being unresponsive due to a medical condition, or substance overdose.

Tool Box		
ORC – SUD & MH	340.011	Interpretation and Construction
OAC – MH and SUD	5122-26-18 A-D and H-J	Client Rights & Grievance Procedures
OAC – MH and SUD	5122-26-17	Accessibility, Availability, Appropriateness and Acceptability of Services
OAC – MH and SUD	5122-28-05	Research and Evaluation Activities
OAC – MH and SUD	5122-27-02	Individual Client Record Requirements
OAC – MH and SUD	5122-27-03	Treatment Planning
OAC – MH and SUD	5122-29	Service Standards
OAC – SUD/Dual	5122-27-09	SUD Level of Care Protocols
OAC – MH and SUD	5122-24-01-B-(20), (31)	Certification Definitions (Emergency)
OAC – MH and SUD	5122-27-06	Release of Information

Key Review Questions:
- Are treatment recommendations documented in the treatment plan, ISP, or IEP?
- Is the client or guardian's consent, refusal, or withdrawal of approval documented in the plan?
- Does the situation meet the definition of emergency provided by OhioMHAS?
- If a client has a guardian, has guardianship been verified?
- Has consent or refusal been documented?

Best Practices:
- Has a consent to treat and a consent for the ISP/IEP been documented and do they align with the services rendered?
- Is the client receiving services voluntarily or involuntarily? Involuntary services could include a client's court order to SUD treatment or remaining medication compliant as a condition of probation. However, clients can still refuse treatment or services even though refusal may result in consequence for the client (i.e. referral to probation officer).
  Though rare, a very specific forced medication order issued by a court must be followed by an admitting hospital or provider agency – clients cannot refuse.

6. The right to participate in the development, review and revision of one's own individualized treatment plan and receive a copy of it

Tool Box		
ORC – SUD & MH	340.011	Interpretation and Construction
OAC – MH and SUD	5122-26-18 A-D and H-J	Client Rights & Grievance Procedures
OAC – MH and SUD	5122-26-17	Accessibility, Availability, Appropriateness and Acceptability of Services
OAC – SUD/Dual	5122-27-09	SUD Level of Care Protocols
OAC – MH and SUD	5122-27-02	Individual Client Record Requirements
OAC – MH and SUD	5122-27-03	Treatment Planning
OAC – MH and SUD	5122-29	Service Standards

Explanation:
Each client should have a plan that meets his or her own needs because it can help serve as a road map for dealing with life and promotes wellness, recovery, and resiliency. Clients must be permitted to help create or change their service plans and they should be invited to meetings about themselves. Clients should be clear on the goals outlined in the plan. Information about a client's medical doctor, conditions, and treatment.
Service plans should include:

- Volunteer opportunities, social activities, sources of peer support.
- Cultural issues related to a client's wellness/recovery/resiliency
- Financial issues such as budgeting, bill paying, payeeship, etc.

Key Review Questions:

- ❖ In cases where certain services are not provided by an agency, have outside referrals been explained and documented in the ISP/IEP?
- ❖ Is the ISP/IEP dated and current? Has the client or guardian signed the ISP/IEP and been provided a copy?
- ❖ Does the ISP/IEP address the individual's mental health, substance use disorder, physical health, social, economic, and cultural needs? Does the IEP address educational needs?
- ❖ Is there documentation that the client and/or guardian was involved in developing their ISP/IEP and is the response to and participation in the plan/program documented?

Best Practices:

- ❖ Does the client have a legal guardian? Did the guardian sign and receive a copy of the treatment plan?
- ❖ Has the agency monitored the client's ISP/IEP if the client has refused a specific service?
- ❖ Has the ISP/IEP been reviewed on a consistent basis in accordance with agency policy and/or accreditation and licensure requirements?
- ❖ Did the client refuse to sign the treatment plan and if so, is it documented?
- ❖ Does the progress note and ISP/IEP reflect a client's refusal to participate in the development of the treatment plan?
- ❖ All clients/guardians have the ability to exercise their right to receive or decline a copy of their treatment plan/ISP/IEP. Clients can request a copy of their ISP/IEP at any time even if they declined to receive a copy initially.

7. The right to freedom from unnecessary or excessive medication, and to be free from restraint or seclusion unless there is immediate risk of physical harm to self or others.

TOOL BOX		
ORC	**340.011**	**Interpretation and Construction**
OAC – MH and SUD	**5122-26-18 A-D and H-J**	**Client Rights & Grievance Procedures**
OAC – MH and SUD	**5122-26-17**	**Accessibility, Availability, Appropriateness and Acceptability of Services**
OAC – MH and SUD	**5122-29-03**	**General Services**
OAC – MH and SUD	**5122-26-13**	**Incident Notification and Risk Management**
OAC – MH and SUD	**5122-26-16**	**Seclusion, Restraint and Time Out**
OAC – MH and SUD	**5122-26-15**	**Medication Handling and Drug Theft**
OAC – SUD/Dual	**5122-27-07**	**SUD Level of Care Protocols**
OAC MH and SUD	**5122-25-04 (I)**	**Certification Procedure for Deemed Status**
OAC MH and SUD	**5122-25-03 (I)**	**Certification Procedure for Non-Deemed Status**

Explanation:
It is always recommended that clients take their medications as prescribed to ensure continued wellness. However, clients have the right to refuse medications that could be construed and/or perceived by the client as excessive or unnecessary. Clients should be educated that refusal to take medications could potentially lead to decompensation, and would possibly result in consequences such as being removed from a group home or being asked to leave a day program if the client's behavior infringes upon the rights of others. Encourage clients to talk with their medical team about how medications make them feel. Clients are best equipped to interpret the reactions of their own bodies and can best communicate this to the treatment team. Prescribers must provide education about possible side effects for each medication prescribed. Though rare, a very specific forced medication order issued by a court must be followed by an admitting hospital or provider agency – clients cannot refuse.

Restraints and seclusion are types of control which should only be utilized by trained and qualified staff. Restraints and seclusion should be used only in response to a crisis situation where an immediate threat of physical harm exists to the client or others, and no other safe and effective intervention is identified.
Restraints – medicinal, physical/manual, or mechanical means of controlling a client.
Seclusion – involuntary confining of a person alone in a room where the person is physically prevented from leaving.
Asking a client to leave a common area for a period of time, for behavioral or safety reasons, **is** permitted by **any** staff.

Key Review Questions:

- Has the client had a recent health assessment; both for prescribed medications or seclusion/restraint?
- Has the client been given the opportunity to ask questions, seek additional information, and provide input before medications are prescribed?
- Has the client been advised of all possible side effects, risks, and benefits of prescribed medications in a manner that the client can understand? Has this been documented?

- When appropriate, has the client been monitored for the appropriate level of medication in their system and effectiveness? Has this been properly documented?
- Has training been provided to the client and/or direct care staff regarding the proper storage, labeling, and refill procedures for medications and has this been documented?

Best Practices:

- Has the prescriber checked Ohio Automated Rx Reporting System (OARRS) prior to prescribing medications?
- Are all medications properly labeled so that the client can easily distinguish between them?
- Has the appropriate incident report and notification been completed after the use of seclusion or restraint? Refer to agency policy and OhioMHAS incident reporting for specifications.
- What are the evidence based de-escalation techniques that are utilized by the agency?
- Are all staff properly trained in de-escalation and the appropriate uses of restraint and seclusion?
- Have program descriptions been provided to the client and/or guardian regarding the use of seclusion and restraint?

8. The right to be informed and the right to refuse any unusual or hazardous treatment procedures

Tool Box		
ORC	**340.011**	**Interpretation and Construction**
OAC – MH and SUD	**5122-26-18 A-D and H-J**	**Client Rights & Grievance Procedures**
Certification Standards - OAC - MH	**5122-26-17**	**Accessibility, Availability, Appropriateness and Acceptability of Services**
OAC - MH	**5122-27-03**	**Treatment Planning**
OAC – MH and SUD	**5122-28-05**	**Research and Evaluation Activities**
OAC – MH and SUD	**5122-29**	**Service Standards**
OAC – SUD/Dual	**5122-27-07**	**SUD Level of Care Protocols**

Explanation:
Client (and/or legal guardians) must be informed of and consent to any treatment or techniques that would be defined as unusual, experimental, or hazardous such as Electroconvulsive therapy (shock therapy), or experimental drugs. Clients can say NO to these forms of treatment and this cannot be used to deny other forms of treatment. In the case of research, there are specific research protocols that must be followed (such as Institutional Review Boards [IRB]). Clients may consult with another prescriber for a second opinion if an unusual or hazardous treatment procedure has been recommended.

Key Review Questions:
- ❖ Is there documentation that alternatives have been offered and referrals made?
- ❖ Has the client's informed consent or refusal been documented in the treatment plan?
- ❖ Has the unusual, experimental, or hazardous procedure(s) been explained and a copy of information supplied to the client and/or guardian?
- ❖ Have all of the risks been explained in detail and in a manner appropriate for the clients' understanding?
- ❖ Does the client appear to have been coerced in to participating?

Best Practices:
- ❖ No client should be required to participate in an unusual, experimental, or hazardous treatment procedure for which they did not give prior consent.
- ❖ Full informed consent or refusal needs to be clearly documented in the treatment plan.
- ❖ Research studies are required to have IRB approval prior to any client participation.
- ❖ Any treatment procedure should be evidence based; otherwise, it is considered a research study.

9. The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio and visual technology. This right does not prohibit an agency from closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms or sleeping areas

TOOL BOX		
ORC	340.011	Interpretation and Construction
OAC – MH and SUD	5122-26-18	Client Rights & Grievance Procedures
OAC – MH and SUD	5122-26-17	Accessibility, Availability, Appropriateness and Acceptability of Services
OAC – MH and SUD	5122-27-06	Release of Information
OAC – MH and SUD	5122-27-03	Treatment Planning
OAC – MH and SUD	5122-29-03	General Services
OAC – MH and SUD	5122-26-08	Confidentiality
SUD	42CFR Part 2	Confidentiality of SUD Patient Records

Explanation:
Nobody can take a client's picture or record him/her in a mental health, SUD or prevention setting for any reason (including clinical, research, or public relations reasons) without their written permission. A voice recorder can be used without notice at an open general public meeting attended by clients and others. Clients have to give permission for programs or agencies to use their image or words in public and/or educational materials, including websites and other new and developing forms of technology. This includes client-to-client pictures, audio tapes, videotape etc. Where closed circuit monitoring is taking place, signage must be posted to alert clients, visitors, etc., that they are being recorded. Agency staff may not use client pictures, images, words, creations, etc. on their personal social media accounts. Technology can be used for clearly documented clinical or safety reasons, but the client must be informed of its use. Each agency should have a policy for obtaining, retaining, and disseminating any picture, video, image, audio recording, etc. Each agency should also have a policy regarding cellular phone usage while on agency property.

At times, an agency may have a person observing services provided to a client. This could include students/interns, accrediting/certification personnel, quality improvement personnel, etc. The client must be informed of the reason for the observation and of the observer's purpose. The observer must be identified to the client. The client may refuse to have an observer present that is not directly a part of the client's treatment team.

Key Review Questions:

- ❖ Does the agency have a policy, including policy for staff members, about taking client pictures, videotape, audio recording etc.?
- ❖ Does the agency have a policy regarding cellular phone usage?
- ❖ Is there documentation that the client has been advised of the uses of technology, including the purpose, and has their consent or refusal been documented?
- ❖ Did any outside observer properly identify themselves and their purpose for observing the client's services?

Best Practices:

- ❖ Each agency must have a formal consent policy in place for photos, video and audio recording of clients and a policy regarding obtaining, retaining, disseminating, and destruction of such materials.
- ❖ Each agency must have a release for a client to sign when taking photos, video or recording audio.
- ❖ When dealing with children or adults with a legal guardian, each agency must obtain written consent from the parent or legal guardian.
- ❖ Surveillance cameras may be used by agencies without the consent of the client and/or their legal guardians.
- ❖ Technology of any kind may not be used in restrooms or bedrooms.

10. The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations

Tool Box		
ORC	**340.011**	**Interpretation and Construction**
OAC – MH and SUD	**5122-26-18**	**Client Rights & Grievance Procedures**
OAC – MH and SUD	**5122-26-17**	**Accessibility, Availability, Appropriateness and Acceptability of Services**
OAC – MH and SUD	**5122-27-06**	**Release of Information**
OAC – MH and SUD	**5122-27-03**	**Treatment Planning**
OAC MH and SUD	**5122-27-02**	**Individual Client Records Requirements**
CFR – SUD	**42CFR Part 2**	**Confidentiality of SUD Patient Records**
OAC – MH and SUD	**5122-26-08**	**Confidentiality**
OAC – MH and SUD	**5122-28**	**Performance Improvement, Client Outcomes & Research Activities**

Explanation:

All clients have the right to keep personal and protected health information (PHI) private. Clients control what information is shared, and with whom the information is shared. Exceptions to this right would include those allowed by HIPAA or 42CFR, or for continuity of care in an emergency or crisis situation. In these cases, only information that would assist with resolving the crisis may be shared. For questions regarding what information can be shared and when, consult with your agency's legal counsel. During an investigation, a Client Rights Officer, should only review information necessary to resolve the grievance, and the client should have a thorough understanding of exactly what information is being reviewed.

Note: Remember that HIV status is federally protected health information. HIV status should only be disclosed if it is authorized and relevant to the services being provided. Also, diagnosis and treatment for SUD is also protected information under federal law. Ensure that the proper fields are indicated on the release of information if this information is to be shared.

Key Review Questions:

- Is there a signed and dated release of information (signed by the client, guardian, parent etc.)? Have all of the required fields been completed? Is the release **current?**
- Has the client been informed of the exact information that was released? Did the client have a *choice* as to what information was released?
- Is it documented with which family member(s) or friend(s) information can be shared?
- Is the agency policy and procedure, and the release form in compliance with HIPAA and 42CFR?

Best Practices:

- Are clients made aware that they can revoke their release of information?
- Has the client been informed that they can file a complaint with the Privacy Officer in addition to the Client Rights Officer, at the agency when they believe confidentiality has been breached?
- Please note that a court order takes precedence over a release of information.
- Have staff members been properly trained on HIPAA/42CFR policy?
- Although it may not always be necessary, for best practice you should always get a completed, signed, dated, release of information for all clients.

11. The right to have access to one's own client record unless access to certain information is restricted for clear treatment reasons. If access is restricted, the treatment plan shall include the reason for the restriction, a goal to remove the restriction, and the treatment being offered to remove the restriction.

Tool Box		
ORC – MH SUD	340.011	Interpretation and Construction
OAC – MH and SUD	5122-26-18	Client Rights grievance Procedure
OAC – MH and SUD	5122-29 and 5122-40	Certification Standards
OAC – MH and SUD	5122-26-17	Accessibility, Availability, Appropriateness and Acceptability of Services
OAC – MH and SUD	5122-27-06	Release of Information
OAC – MH and SUD	5122-27-02	Individual Client Record Requirements
OAC – MH and SUD	5122-27-03	Treatment Planning
OAC – MH and SUD	5122-29-03	Behavioral Health Counseling and Therapy Service
OAC – MH and SUD	5122-29-22	Referral and Information Service
CFR - SUD	42 CFR Part 2	Confidentiality of SUD Patient Records

Explanation:
Access means the ability to view or get a copy of one's own records. Federal regulation allows for fees to be charged for clients requesting a copy of their record; however, a client may review their record at any time at no cost. Only specific items, not the whole record, can ever be restricted. If a restriction is placed on a client's access to a portion of the record, a plan must be identified regarding how the restriction can be lifted. A restriction cannot be added upon a records request.

Key Review Questions:
- Does the agency have a policy about accessing records and is the policy available to all clients?
- Does the agency have a policy regarding fees to be charged and the waiver of those fees for copying records?
- Has the client been allowed to make amendments or corrections (not changes) to their records via the appropriate method?
- Does the agency have a policy regarding staff observation when clients review records?

Best Practices:
- Treatment plans should always be written with the notion in mind that the client has the right to review and receive copies of their record at any time.
- HIPAA/42CFR is the regulatory authority regarding confidentiality and access to records.

12. The right to be informed a reasonable amount of time in advance of the reason for terminating participation in a service, and to be provided a referral, unless the service is unavailable or unnecessary

Tool Box		
ORC - MH	340.011	Interpretation and Construction
OAC – MH and SUD	5122-26-18	Client Rights and Grievance Procedure
OAC – MH and SUD	5122-29 and 5122-40	Certification Standards
OAC – MH and SUD	5122-26-17	Accessibility, Availability, Appropriateness and Acceptability of Services
OAC - MH	5122-27-06	Release of Information
OAC – MH and SUD	5122-27-05	Discharge Summary
OAC – MH and SUD	5122-26-13	Incident Notification and Risk Management
OAC – MH and SUD	5122-26-09	Provider Service Plan

Explanation:
A client must be informed in a reasonable amount of time of the reasons for termination in a particular service or program. A reasonable amount of time should be defined as equitable and appropriate. A referral must be made to meet the needs of the client unless the service is unavailable or not necessary.

Key Review Questions:

- Does the agency have a policy that defines a reasonable amount of time?
- Does the agency have a policy regarding the amount of advance notice the person is to receive and is it clearly documented?
- Is there adequate time for making alternative plans?
- Does the agency have a policy for documenting that the client was informed of the termination both verbally and in writing in a language appropriate for their understanding?

Best Practices:

- Remember, even if a client is terminated, the client may reapply for services at a later date.
- In certain settings, such as housing, other rules or laws may apply. Consult with your legal team to ensure the appropriate law is being followed.

13. The right to be informed of the reason for denial of a service.

Tool Box		
ORC - MH	340.011	Interpretation and Construction
OAC – MH and SUD	5122-26-18	Client Rights and Grievance Procedure
OAC – MH and SUD	5122-29 and 5122-40	Certification Standards
OAC – MH and SUD	5122-26-17	Accessibility, Availability, Appropriateness and Acceptability of Services
OAC - MH	5122-27-06	Release of Information
OAC – MH and SUD	5122-27-05	Discharge Summary
OAC – MH and SUD	5122-26-13	Incident Notification and Risk Management
OAC – MH and SUD	5122-26-09	Provider Service Plan

Explanation:
Clients have the right to know why an agency will or will not serve them. They must be informed in writing and/or verbally in a language that they can understand. This is also true for Medicaid appeals. Agencies should provide alternative services during a grievance, including a transition plan, or referral to another service provider. Agencies are obligated to cooperate with the new service provider.

Key Review Questions:
- ❖ If a client has been denied service, is there documentation of a referral?
- ❖ Is the reason for the denial documented? This could include a letter to the client explaining the denial, a discharge summary, progress notes, emails of appeal, etc.
- ❖ Is there documentation that an explanation has been provided to the client of the client's interfering behaviors and potential consequences of ongoing behaviors including case closure?
- ❖ Is there documentation of discussion/notice of the issue with the client?

Best Practices:
- ❖ Remember, clients cannot be terminated based on behaviors that are an exacerbation of their mental health symptoms.
- ❖ Did the agency follow their discharge policy?
- ❖ Remember, the involuntary termination of a client is an MUI that must be reported to OhioMHAS and the ADAMHS Board.

14. The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws,

Tool Box		
ORC – MH and SUD	340.011	Interpretation and Construction
OAC – MH and SUD	5122-26-18	Client Rights and Grievance Procedure
OAC – MH and SUD	5122-26-17	Accessibility, Availability, Appropriateness and Acceptability of Services
OAC – MH and SUD	5122-26-09	Provider Service Plan
CFR	29 CFR	Guidelines on Discrimination

Explanation:
Discrimination is defined as an actual or perceived, intentional or unintentional inequality of treatment. The classes stated in the rule are protected by federal and state law. For example, clients cannot be denied services or access to services due to poor hygiene or poor attitude. Denying clients services without reasonable accommodations can be discriminatory as well. All clients must be treated equitably regardless of class or affiliation.

Key Review Questions:

- ❖ Are reasonable accommodations made to individuals with physical or other challenges in a way that does not deny their dignity?
- ❖ Have agency staff been trained on cultural competency and diversity?

Best Practices:

- ❖ Accommodations must be made for a client that speaks another language. Remember, your agency is responsible for supplying interpreters, if needed, at the agency's expense.
- ❖ HIV/AIDS status is federally protected. No agency can deny services based on this status. Clients do not have to disclose HIV/AIDS status.
- ❖ Gender identity is a protected class with regards to housing and employment. A client cannot be denied employment or housing services based upon gender identity.
- ❖ All agencies should have a policy for service/emotional support animals. Please reference state and federal law (Americans with Disabilities Act [ADA]).

15. The right to know the cost of services

Explanation:
Clients must be told what, if anything, a service will cost, and then may be asked to sign a fee agreement. This explanation must be made orally and in writing in a language the client can understand. They have the right to an explanation before the service(s) is occurring so they have an opportunity to refuse the service. Clients are billed for public services when it is deemed that they have the ability to pay. Providers of public services are required to have payment plans, methods to assess an individuals ability to pay, and sliding fee scales. It is unethical to deny services to a client based on ability to pay.

Key Review Questions:
- Is there documentation that the client has been told the cost of services?
- Has the agency discriminated against the client based on inability to pay?

Best Practices:
- Was the client given a notice of the agency's privacy practices?

TOOL BOX		
ORC – MH and SUD	**340.011**	**Interpretation and Construction**
ORC – MH and SUD	**3701.741**	**Fees for Providing Copies of Medical Records**
ORC - MH and SUD	**3701.742**	**Client Price Index Adjustment to Fees for Providing Medical Records**
OAC – MH and SUD	**5122-26-18**	**Client Rights and Grievance Procedures**
OAC – MH and SUD	**5122-26-17**	**Accessibility, Availability, Appropriateness and Acceptability of Services**
OAC – MH and SUD	**5122-29 and 5122-40**	**Certification Standards**
OAC – MH and SUD	**5122-27-02**	**Individual Client Record Requirements**
CFR - SUD	**42CFR 401.140**	**Fees and Charges**

16. The right to be verbally informed of all client rights, and to receive a written copy upon request.

TOOL BOX		
ORC – MH and SUD	**340.011**	**Interpretation and Construction**
OAC – MH and SUD	**5122-26-18 (C) (D) and (J)**	**Client Rights and Grievance Procedures**
OAC – MH and SUD	**5122-26-17**	**Accessibility, Availability, Appropriateness and Acceptability of Services**
OAC – MH and SUD	**5122-29 and 5122-40**	**Certification Standards**

Explanation:
Rights should be explained on an on-going basis at each agency a client from which receives services, and the client should be given a written copy of their rights that includes the name of the agency's current Client Rights Advocate. If a client loses their copy, they should be able to get another. All clients should be aware of how to file a grievance and with which entities they can pursue their grievance in addition to the agency's Client Rights Advocate.

Key Review Questions:

- Is there documentation that the rights have been explained in a language and manner appropriate for the clients' understanding?
- Were the rights distributed to the client in writing if/when requested?
- Are the rights posted in a conspicuous location?

Best Practices:

- The agency must have the following information posted in a conspicuous location where clients and visitors can see: CRA name, hours and phone number, grievance policy and procedure, and all designated client rights.
- All agency staff, regardless of their position, must be informed of who the CRA is and their functions/role.
- All entities, in addition to the provider agency, with whom a client can pursue their grievance must also be posted along with contact information and location.

17. The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations.

Tool Box		
ORC – MH and SUD	**340.011**	**Interpretation and Construction**
OAC – MH and SUD	**5122-26-18 (C) (D) and (J)**	**Client Rights and Grievance Procedures**
OAC – MH and SUD	**5122-26-17**	**Accessibility, Availability, Appropriateness and Acceptability of Services**
OAC – MH and SUD	**5122-29 and 5122-40**	**Certification Standards**
OAC – MH and SUD	**5122-27-02 (E)(1)**	**Individual Client Record Requirements**

Explanation:

Service providers and their staff cannot deny services to a client service, give them lesser or worse service, be rude or mean, or punish the client when clients assert or exercise their rights. Staff should be educated about their responsibilities and ways to avoid subtle or subconscious punishment and reprisals. One example of a common reprisal is to discourage a client from talking to the Client Rights Advocate or discouraging them from contacting the ADAMHS Board or OhioMHAS. However, there is a difference between service limitations based on safety requirements and reprisal for filing a complaint.

Key Review Questions:

- Is your agency reviewing patterns and trends to identify reprisals?
- Has the agency monitored and reviewed all client rights complaints and grievances?
- Is there evidence that a client has experienced reprisal as a result of filing a complaint or grievance?
- Are identified trends and patterns documented?

Best Practices:

- Have your staff been trained on this right?

18. The right to file a grievance

Tool Box		
ORC – MH and SUD	**340.011**	**Interpretation and Construction**
OAC – MH and SUD	**5122-26-18**	**Client Rights and Grievance Policy**
OAC – MH and SUD	**5122-29 and 5122-40**	**Certification Standards**

Explanation:

Clients have the right to file a grievance any time they feel that their rights have been violated; even if the service provider disagrees with the client's perception. The grievance policy must be posted in a conspicuous location accessible to all clients and visitors. Staff members should also be trained regarding the grievance policy and process; each staff member should be able to direct a client whom wishes to file a grievance. Clients must also have access to any assistance needed when filing a grievance. This includes but is not limited to paper grievance forms, assistance in writing the grievance through an advocate, dictation, or Braille. Instructions regarding the grievance process must be in a language appropriate for the client's understanding. Clients should be encouraged to file their grievance with their provider agency. However, clients cannot be prevented from filing a grievance with any outside entity including the ADAMHS Board, OhioMHAS, or Disability Rights Ohio.

Key Review Questions:

- Is the grievance policy posted in a conspicuous location accessible to all clients and visitors?
- Are all staff members trained on the grievance policy? Do all staff members know who the CRA is and how a client would file a formal grievance?
- Was the client provided a copy of all client rights and the grievance process upon request?
- Was the client provided contact information for appeal options if they were not satisfied with the results of their grievance?
- Does the CRA have a current signed release of information?

Best Practices:

- Remember that all grievances must be in writing.
- All grievances must be answered in writing within 20 business days from the date the grievance was filed.
- A letter must be sent to the client within 3 days of the CRA's receipt of the grievance and must include the date the grievance was received, a summary of the grievance, an overview of the investigation process, a timeline for completion, and the treatment provider contact information.

19. The right to have oral and written instructions concerning the procedure for filing a grievance and to have assistance in filing a grievance if requested.

Tool Box		
ORC - MH and SUD	**340.011**	**Interpretation and Construction**
OAC – MH and SUD	**5122-26-18**	**Client Rights and Grievance Policy**
OAC – MH and SUD	**5122-26-17**	**Accessibility, Availability, Appropriateness and Acceptability of Services**
OAC – MH and SUD	**5122-29 and 5122-40**	**Certification Standards**

Explanation:
This includes the right to make a complaint and/or to appeal a decision in such a way that the system is required to respond. The instructions should be in a language that individual clients can understand, and they should have access to a Client Rights Advocate to help them. There must be more than one method for filing (e.g. in writing, through an advocate, orally, in Braille, etc.). It is the client's right to have any assistance needed to file a grievance.

Key Review Questions:

- ❖ Does the agency policy identify the Client Rights Advocate name, location, hours of availability, and phone number?
- ❖ Has the client been offered support in filing and/or writing a grievance?
- ❖ Is the grievance procedure posted in a conspicuous location and are copies distributed upon request?
- ❖ Has the grievance process been explained to the client and does the process explain what happens from original filing to final resolution?
- ❖ Do the instructions list outside entities that a client can contact for further assistance?
- ❖ Is the agency following state-established timelines for resolution of the grievance?
- ❖ Clients must be provided a letter within 3 days acknowledging that the Client Rights Advocate has received their grievance.
    - All grievances must be answered in writing within 20 business days from the date the grievance is filed. All complaints must be answered within 30 calendar days.

Best Practices:

- ❖ When a grievance is filed on behalf of a client, written consent must be given by the client.
- ❖ Guardians do not need written permission from the client to file a grievance on behalf of their ward.

20. The right to be informed of one's own condition.

Tool Box		
ORC – SUD & MH	**340.011**	**Interpretation and Construction**
OAC – MH and SUD	**5122-26-17**	**Accessibility, Availability, Appropriateness and Acceptability of Services**
OAC – MH and SUD	**5122-26-18**	**Client Rights and Grievance Policy**
OAC – MH and SUD	**5122-29 and 5122-40**	**Certification Standards**
OAC – MH and SUD	**5122-27-02 (E)(1)**	**Individual Client Record Requirements**

Explanation:

Clients have the right to be informed of their treatment options and one's own condition. Clients have the right to ask questions, receive answers, and to know what is going on throughout the course of treatment. This must include information about their diagnosis, prescribed medications, prognosis, the risks, benefits, and consequences of treatment, including client operated services or businesses. The client must be able to understand the language used when communicating their treatment options and explanation of their condition. This also means that interpreters must be provided free to the client if they are non-English speaking, or visually/hearing impaired. Clients should also be referred to alternative sources of information such as books, videos, lectures, etc.

Key Review Questions:

- Has the client and/or legal guardian been informed in writing of treatment options and condition? Is this documented?
- Has the provider confirmed the client's and/or guardian's understanding of the client's treatment options and condition?
- Have additional resources been provided for any clarifications as needed?

Best Practices:

- All ADAMHS Board contract agencies are required to supply interpreting services under their current contract. Does your agency work with an organization that supplies an interpreting service for clients?

21. The right to consult with an independent treatment specialist or legal counsel at one's own expense.

Explanation:
Clients have the right to utilize a doctor, counselor, lawyer, etc., of their choosing, however, they will incur the cost of the services rendered. This does not apply during probate hearings if someone cannot afford to pay. Clients are not required to release information from these independent consultations, and agencies are not required to accept or utilize the opinion of the consultation. Agencies should take into consideration and document their reasons for disagreement or agreement. Consultation is a time limited service. Duplication of ongoing services is prohibited. Clients have the right to choose an ongoing provider.

Key Review Questions:
- ❖ Are the clinical outcomes of the consultation documented?
- ❖ How does the agency address continuity of care in situations where more than one provider is involved?
- ❖ Have releases of information been signed and is the information included in the treatment plan?
- ❖ Does the agency consider and document second opinion evaluations?

Tool Box		
ORC – SUD & MH	**340.011**	**Interpretation and Construction**
OAC – MH and SUD	**5122-26-18**	**Client Rights & Grievance Procedures**
OAC – MH and SUD	**5122-26-17**	**Accessibility, Availability, Appropriateness and Acceptability of Services**
OAC – MH and SUD	**5122-27-06**	**Release of Information**
OAC – MH and SUD	**5122-27-03**	**Treatment Planning**
OAC –MH and SUD	**5122-27-02**	**Individual Client Records Requirements**
OAC – SUD	**42CFR Part 2**	**Confidentiality of SUD Patient Records**
OAC – MH and SUD	**5122-26-08**	**Confidentiality**

Best Practices:
- ❖ The agency should consider providing second opinions within the agency.
- ❖ CRA's will advocate for client's wishes; however, MH and SUD providers have professional judgements. CRA's can assist clients with verbalizing their preferences.
- ❖ CRA's will facilitate communication between the client and provider, however they are not to direct the practice of clinicians.

Client Rights – Forensic Evaluations
OAC 5122-26-18-F (1-12)

Each client receiving a forensic evaluation service from a certified forensic center* has these rights:

(1) The right to be treated with consideration and respect for personal dignity;

(2) The right to be evaluated in a physical environment affording as much privacy as feasible;

(3) The right to service in a humane setting which is the least restrictive feasible if such setting is under the control of the forensic center;

(4) The right to be informed of the purpose and procedures of the evaluation service;

(5) The right to consent to or refuse the forensic evaluation services and to be informed of the probable consequences of refusal;

(6) The right to freedom from unnecessary restraint or seclusion if such restraint or seclusion is within the control of the forensic center;

(7) The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recordings, televisions, movies, or photographs, or other audio and visual technology, unless ordered by the court, in which case the client must be informed of such technique. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms;

(8) The right not to be discriminated against in the provision of service on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;

(9) The right to be fully informed of all rights;

(10) The right to exercise any and all rights without reprisal in any form;

(11) The right to file a grievance; and,

(12) The right to have oral and written instructions for filing a grievance including an explanation that the filing of a grievance is exclusively an administrative proceeding within the mental health system and will not affect or delay the outcome of the criminal charges.

*The only ADAMHS Board contracted agency that provides certified forensic evaluations is the Court Psychiatric Clinic.

Client Rights – Driver Intervention Programs
OAC 5122-26-18-G (1-18)

Each client participating in a driver intervention program has these rights:

(1) The right to be treated with consideration and respect for personal dignity, autonomy and privacy;

(2) The right to reasonable protection from physical, sexual or emotional abuse and inhumane treatment;

(3) The right to give informed consent to or to refuse any service:

(4) The right to be free from restraint or seclusion unless there is immediate risk of physical harm to self or others;

(5) The right to be informed and the right to refuse any unusual or hazardous procedures;

(6) The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio and visual technology. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms or sleeping areas;

(7) The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations;

(8) The right to have access to one's own client record;

(9) The right to be informed of the reason for terminating participation in a service;

(10) The right to be informed of the reason for denial of a service;

(11) The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;

(12) The right to know the cost of services;

(13) The right to be verbally informed of all client rights, and to receive a written copy upon request;

(14) The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations;

(15) The right to file a grievance;

(16) The right to have oral and written instructions concerning the procedure for filing a grievance, and to assistance in filing a grievance if requested;

(17) The right to be informed of one's own condition; and,

(18) The right to consult with an independent treatment specialist or legal counsel at one's own expense.

Resident Rights for Class 2 and Class 3 Facilities
OAC 5122-30-22.1-E (1-33) Resident Rights and Grievance Procedure

(E) Each resident has all of the following rights.

(1) The right to be verbally informed of all resident rights in language and terms appropriate for the resident's understanding, prior to or at the time of residency, absent a crisis or emergency.

(2) The right to request a written copy of all resident rights and the grievance procedure.

(3) The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations.

(4) The right to file a grievance.

(5) The right to be treated at all times with courtesy and respect, and with consideration for personal dignity, autonomy and privacy.

(6) The right to receive services in the least restrictive, feasible environment.

(7) The right to receive humane services in a clean, safe, comfortable, welcoming, stable and supportive environment.

(8) The right to reasonable protection from physical, sexual and emotional abuse, neglect, and exploitation.

(9) The right to freedom from unnecessary or excessive medication and the right to decline medication.

(10) The right to be free from restraint or seclusion.

(11) The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio and visual technology. This right does not prohibit a facility from using closed-circuit monitoring to observe areas in the facility other than bathrooms or sleeping areas, or other areas where privacy is reasonably expected.

(12) The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of resident information under state and federal laws and regulations.

(13) The right to have access to one's own record.

(14) The right to be informed of one's own condition.

(15) The right not to be discriminated against on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental disability, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws.

(16) The right to practice a religion of his or her choice or to abstain from the practice of religion.

(17) The right to visit the facility alone or with individuals of the prospective resident's choosing.

(18) The right to be informed in writing of the rates charged by the facility as well as any additional charges, and to receive thirty days' notice in writing of any change in the rates and charges.

(19) The right to continued residency unless the facility is no longer able to meet the resident's care needs, the resident presents a documented danger to other residents, staff or visitors, or the monthly charges have not been paid for more than thirty days.

(20) The right to receive thirty days prior written notice for termination of residency except in an emergency when the resident presents a documented danger to other residents, staff or visitors.

(21) The right not to be locked out of the facility at any time.

(22) The right not to be locked in the facility at any time for any reason.

(23) The right to consent to or refuse services in a class two facility, or if the resident has a legal custodian, the right to have the legal custodian make decisions about services for the resident.

(24) The right to consult with an independent treatment specialist or legal counsel at one's own expense.

(25) The right to communicate freely with and be visited at reasonable times by private counsel and, unless prior court restriction has been obtained, to communicate freely with and be visited at reasonable times by a personal physician, psychologist or other health care providers, except that employees of a board, a provider, personnel of the Ohio protection and advocacy system, or representatives of the state long-term-ombudsman program may visit at any time when permitted by the Revised Code.

The right to communicate includes receiving written communications, which may be opened and inspected by facility staff in the presence of the resident recipient so long as the communication is then not read by the staff and given immediately to the resident.

(26) The right to meet with staff from the Ohio department of mental health and addiction services in private.

(27) The right not to be deprived of any legal rights solely by reason of residence in the facility.

(28) The right to personal property and possessions:

(a) The right of an adult resident to retain personal property and possessions.

(b) The right of a child resident to personal property and possessions in accordance with one's health and safety considerations, and developmental age, and as permitted by his/her parent or guardian.

(29) The right of an adult resident to manage his/her own financial affairs, and to possess a reasonable sum of money.

(30) The right to use the common areas of the facility.

Adult residents shall have right of access to common areas at all times.

Children and adolescent residents shall have the right of access to common areas during routine non-sleeping hours in accordance with facility expectations, e.g. school attendance, homework, implementation of natural and logical consequences, etc.

(31) The right to engage in or refrain from engaging in activities:

(a) The right of an adult to engage in or refrain from engaging in cultural, social or community activities of the resident's own choosing in the facility and in the community.

(b) The right of a child or adolescent to access cultural and social activities.

(32) The right to meet or communicate with family or guardians, and visitors and guests:

(a) The right of an adult:

(i) To reasonable privacy and the freedom to meet with visitors and guests at reasonable hours.

(ii) To make and/or receive confidential phone calls, including free local calls.

(iii) To write or receive uncensored, unopened correspondence subject to the facility's rules regarding contraband.

(b) The right of a minor:

(i) To visitors and to communicate with family, guardian, custodian, friends and significant others outside the facility in accordance with instructions from the minor's parent or legal guardian.

(ii) To write or receive mail subject to the facility's rules regarding contraband and directives from the parent or legal guardian, when such rules and directives do not conflict with federal postal regulations.

(33) The right to be free from conflicts of interest; no residential facility employee may be a resident's guardian, custodian, or representative.

5122-26-18 Client rights and grievance procedure.

(A) The purpose of this rule is to state the minimum client rights and grievances requirements for a provider certified pursuant to Chapter 5122-25 of the Administrative Code.

(B) The following definitions are in addition to or supersede the definitions in rule 5122-24-01 of the Administrative Code:

(1) Client advocate means the individual designated by a provider with responsibility for assuring compliance with the client rights and grievance procedure rule as implemented within each provider or board, and shall have the same meaning as client rights officer or client rights specialist.

(2) Grievance means a written complaint initiated either verbally or in writing by a client or by any other person or provider on behalf of a client regarding denial or abuse of any client's rights.

(3) Reasonable means a standard for what is fair and appropriate under usual and ordinary circumstances.

(C) Each provider shall have the following:

(1) Written client rights policy that lists all of the client rights identified in this rule;

(2) Written client grievance procedure;

(3) Policy for maintaining for at least two years from resolution, records of client grievances that include, at a minimum, the following:

(a) Copy of the grievance;

(b) Documentation reflecting process used and resolution/remedy of the grievance; and,

(c) Documentation, if applicable, of extenuating circumstances for extending the time period for resolving the grievance beyond twenty-one calendar days.

(D) Posting of client rights

(1) The client rights policy and grievance procedure shall be posted in each location in which services are provided, unless the certified agency location is not under the control of the provider, i.e. a shared location such as a school, jail, etc. and it is not feasible for the provider to do so.

(2) The client rights policy and grievance procedure shall be posted in a conspicuous location that is accessible to persons served, their family or significant others and the public.

(3) When a location is not under the control of the provider and it is not feasible for the provider to post the client rights policy and grievance procedure, the provider shall assure that copies are available at the location for each person that may request a written copy.

(E) Except for clients receiving forensic evaluation service as defined in rule 5122-29-07 of the Administrative Code from a certified forensic center, or attending a driver intervention program as defined in rule 5122-29-12 of the Administrative Code, each client has all of the following rights:

(1) The right to be treated with consideration and respect for personal dignity, autonomy and privacy;

(2) The right to reasonable protection from physical, sexual or emotional abuse and inhumane treatment;

(3) The right to receive services in the least restrictive, feasible environment;

(4) The right to participate in any appropriate and available service that is consistent with an individual service plan (ISP), regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person's participation;

(5) The right to give informed consent to or to refuse any service, treatment or therapy, including medication absent an emergency;

(6) The right to participate in the development, review and revision of one's own individualized treatment plan and receive a copy of it;

(7) The right to freedom from unnecessary or excessive medication, and to be free from restraint or seclusion unless there is immediate risk of physical harm to self or others;

(8) The right to be informed and the right to refuse any unusual or hazardous treatment procedures;

(9) The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio and visual technology. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms or sleeping areas;

(10) The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations;

(11) The right to have access to one's own client record unless access to certain information is restricted for clear treatment reasons. If access is restricted, the treatment plan shall include the reason for the restriction, a goal to remove the restriction, and the treatment being offered to remove the restriction;

(12) The right to be informed a reasonable amount of time in advance of the reason for terminating participation in a service, and to be provided a referral, unless the service is unavailable or not necessary;

(13) The right to be informed of the reason for denial of a service;

(14) The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;

(15) The right to know the cost of services;

(16) The right to be verbally informed of all client rights, and to receive a written copy upon request;

(17) The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations;

(18) The right to file a grievance;

(19) The right to have oral and written instructions concerning the procedure for filing a grievance, and to assistance in filing a grievance if requested;

(20) The right to be informed of one's own condition; and,

(21) The right to consult with an independent treatment specialist or legal counsel at one's own expense.

(F) Client rights - forensic evaluations.

Each client receiving a forensic evaluation service from a certified forensic center has these rights:

(1) The right to be treated with consideration and respect for personal dignity;

(2) The right to be evaluated in a physical environment affording as much privacy as feasible;

(3) The right to service in a humane setting which is the least restrictive feasible if such setting is under the control of the forensic center;

(4) The right to be informed of the purpose and procedures of the evaluation service;

(5) The right to consent to or refuse the forensic evaluation services and to be informed of the probable consequences of refusal;

(6) The right to freedom from unnecessary restraint or seclusion if such restraint or seclusion is within the control of the forensic center;

(7) The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recordings, televisions, movies, or photographs, or other audio and visual technology, unless ordered by the court, in which case the client must be informed of such technique. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms;

(8) The right not to be discriminated against in the provision of service on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;

(9) The right to be fully informed of all rights;

(10) The right to exercise any and all rights without reprisal in any form;

(11) The right to file a grievance; and,

(12) The right to have oral and written instructions for filing a grievance including an explanation that the filing of a grievance is exclusively an administrative proceeding within the mental health system and will not affect or delay the outcome of the criminal charges.

(G) Client rights - driver intervention programs:

Each client participating in a driver intervention program has these rights:

(1) The right to be treated with consideration and respect for personal dignity, autonomy and privacy;

(2) The right to reasonable protection from physical, sexual or emotional abuse and inhumane treatment;

(3) The right to give informed consent to or to refuse any service:

(4) The right to be free from restraint or seclusion unless there is immediate risk of physical harm to self or others;

(5) The right to be informed and the right to refuse any unusual or hazardous procedures;

(6) The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio and visual technology. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms or sleeping areas;

(7) The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations;

(8) The right to have access to one's own client record;

(9) The right to be informed of the reason for terminating participation in a service;

(10) The right to be informed of the reason for denial of a service;

(11) The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;

(12) The right to know the cost of services;

(13) The right to be verbally informed of all client rights, and to receive a written copy upon request;

(14) The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations;

(15) The right to file a grievance;

(16) The right to have oral and written instructions concerning the procedure for filing a grievance, and to assistance in filing a grievance if requested;

(17) The right to be informed of one's own condition; and,

(18) The right to consult with an independent treatment specialist or legal counsel at one's own expense.

(H) Provision of client rights

(1) The provider shall explain and maintain documentation in the ICR of explanation of rights to each person served prior to or when beginning assessment or treatment services.

(2) In a crisis or emergency situation, or when the client does not present for services in person such as through a hotline; the provider may verbally advise the client of at least the immediately pertinent rights only, such as the right to consent to or to refuse the offered treatment and the consequences of that agreement or refusal. Full verbal explanation of the client rights policy shall be provided at the first subsequent meeting.

(3) Clients or recipients of information and referral service, consultation service, mental health education service, and prevention service as described in Chapter 5122-29 of the Administrative Code may have a copy and explanation of the client rights policy upon request.

(4) Explanations of rights shall be in a manner appropriate for the person's understanding.

(I) All staff shall be required to follow the client rights policy and client grievance procedure. There shall be documentation in each employee's personnel file, including contract staff, volunteers and student interns that each staff member has received a copy of the client rights policy and the client grievance procedure and has agreed to abide by them.

(J) The client grievance procedure shall have provisions for at least the following:

(1) Statement to whom the client is to give the grievance;

(2) Designation of a client advocate who will be available to assist a client in filing of a grievance, the client advocate shall have their name, title, location, hours of availability, and telephone number included with the posting of client rights as required by paragraph (D) of this rule;

(3) Requirement that the grievance must be put into writing; the grievance may be made verbally and the client advocate shall be responsible for preparing a written text of the grievance;

(4) Requirement that the written grievance must be dated and signed by the client, the individual filing the grievance on behalf of the client, or have an attestation by the client advocate that the written grievance is a true and accurate representation of the client's grievance;

(5) Requirement that the grievance include, if available, the date, approximate time, description of the incident and names of individuals involved in the incident or situation being grieved;

(6) Statement that the program will make a resolution decision on the grievance within twenty business days of receipt of the grievance. Any extenuating circumstances indicating that this time period will need to be extended must be documented in the grievance file and written notification given to the client;

(7) Statement that a client has the option to file a grievance with outside organizations, that include, but are not limited to, the following, with the mailing address and telephone numbers for each stated:

(a) Applicable board of alcohol, drug addiction, and mental health services;

(b) Ohio department of mental health and addiction services;

(c) Disability rights Ohio; or,

(d) U.S. department of health and human services, civil rights regional office in Chicago.

(8) Requirement that a written acknowledgment of receipt of the grievance be provided to each grievant. Such acknowledgment shall be provided within three business days from receipt of the grievance. The written acknowledgment shall include, but not be limited to, the following:

(a) Date grievance was received;

(b) Summary of grievance;

(c) Overview of grievance investigation process;

(d) Timetable for completion of investigation and notification of resolution; and,

(e) Treatment provider contact name, address and telephone number.

Replaces: 5122-26-18

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42 CFR PART 2 SUB-PART A—CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

2.1 Statutory authority for confidentiality of drug abuse patient records.

The restrictions of these regulations upon the disclosure and use of drug abuse patient records were initially authorized by section 408 of the Drug Abuse Prevention, Treatment, and Rehabilitation Act (21 U.S.C. 1175). That section as amended was transferred by Pub. L. 98-24 to section 527 of the Public Health Service Act which is codified at 42 U.S.C. 290ee-3. The amended statutory authority is set forth below:

§ 290 ee -3. CONFIDENTIALITY OF PATIENT RECORDS.

(a) *Disclosure authorization*

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) *Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent*

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) *Prohibition against use of record in making criminal charges or investigation of patient*

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) *Continuing prohibition against disclosure irrespective of status as patient*

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) *Armed Forces and Veterans' Administration; interchange of records; report of suspected child abuse and neglect to State or local authorities*

The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or witrhin those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(f) *Penalty for first and subsequent offenses*

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not nore than $5,000 in the case of each subsequent offense.

(g) *Regulations; interagency consultations; definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders*

Except as provided in subsection (h) of this section, the Secretary, after consultation with the Administrator of Veterans' Affairs and the heads of other Federal departments and agencies substantially affected thereby, shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C) of this section, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(Subsection (h) was superseded by section 111(c)(3) of Pub. L. 94-581. The responsibility of the Administrator of Veterans' Affairs to write regulations to provide for confidentiality of drug abuse patient records under Title 38 was moved from 21 U.S.C. 1175 to 38 U.S.C. 4134.)

2.2 Statutory authority for confidentiality of alcohol abuse patient records.

The restrictions of these regulations upon the disclosure and use of alcohol abuse patient records were initially authorized by section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4582). The section as amended was transferred by Pub. L. 98-24 to section 523 of the Public Health Service Act which is codified at 42 U.S.C. 290dd-3. The amended statutory authority is set forth below:

§ 290 dd -3. CONFIDENTIALITY OF PATIENT RECORDS

(a) *Disclosure authorization*

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) *Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent*

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent

to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) *Prohibition against use of record in making criminal charges or investigation of patient*

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) *Continuing prohibition against disclosure irrespective of status as patient*

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) *Armed Forces and Veterans' Administration; interchange of record of suspected child abuse and neglect to State or local authorities*

The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(f) *Penalty for first and subsequent offenses*

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(g) *Regulations of Secretary; definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders*

Except as provided in subsection (h) of this section, the Secretary shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C) of this section, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(Subsection (h) was superseded by section 111(c)(4) of Pub. L. 94-581. The responsibility of the Administrator of Veterans' Affairs to write regulations to provide for confidentiality of alcohol abuse patient records under Title 38 was moved from 42 U.S.C. 4582 to 38 U.S.C. 4134.)

5122.31 Confidentiality.

(A) All certificates, applications, records, and reports made for the purpose of this chapter and sections 2945.38, 2945.39, 2945.40, 2945.401, and2945.402 of the Revised Code, other than court journal entries or court docket entries, and directly or indirectly identifying a patient or former patient or person whose hospitalization or commitment has been sought under this chapter, shall be kept confidential and shall not be disclosed by any person except:

(1) If the person identified, or the person's legal guardian, if any, or if the person is a minor, the person's parent or legal guardian, consents, and if the disclosure is in the best interests of the person, as may be determined by the court for judicial records and by the chief clinical officer for medical records;

(2) When disclosure is provided for in this chapter or Chapters 340. or 5119. of the Revised Code or in accordance with other provisions of state or federal law authorizing such disclosure;

(3) That hospitals, boards of alcohol, drug addiction, and mental health services, and community mental health services providers may release necessary medical information to insurers and other third-party payers, including government entities responsible for processing and authorizing payment, to obtain payment for goods and services furnished to the patient;

(4) Pursuant to a court order signed by a judge;

(5) That a patient shall be granted access to the patient's own psychiatric and medical records, unless access specifically is restricted in a patient's treatment plan for clear treatment reasons;

(6) That hospitals and other institutions and facilities within the department of mental health and addiction services may exchange psychiatric records and other pertinent information with other hospitals, institutions, and facilities of the department, and with community mental health services providers and boards of alcohol, drug addiction, and mental health services with which the department has a current agreement for patient care or services. Records and information that may be released pursuant to this division shall be limited to medication history, physical health status and history, financial status, summary of course of treatment in the hospital, summary of treatment needs, and a discharge summary, if any.

(7) That hospitals within the department and other institutions and facilities within the department may exchange psychiatric records and other pertinent information with payers and other providers of treatment , health services, and recovery supports if the purpose of the exchange is to facilitate continuity of care for a patient or for the emergency treatment of an individual;

(8) That a patient's family member who is involved in the provision, planning, and monitoring of services to the patient may receive medication information, a summary of the patient's diagnosis and prognosis, and a list of the services and personnel available to assist the patient and the patient's family, if the patient's treating physician determines that the disclosure would be in the best interests of the patient. No such disclosure shall be made unless the patient is notified first and receives the information and does not object to the disclosure.

(9) That community mental health services providers may exchange psychiatric records and certain other information with the board of alcohol, drug addiction, and mental health services and other services providers in order to provide services to a person involuntarily committed to a board. Release of records under this division shall be limited to medication history, physical health status and history, financial status, summary of course of treatment, summary of treatment needs, and discharge summary, if any.

(10) That information may be disclosed to the executor or the administrator of an estate of a deceased patient when the information is necessary to administer the estate;

(11) That records in the possession of the Ohio history connection may be released to the closest living relative of a deceased patient upon request of that relative;

(12) That records pertaining to the patient's diagnosis, course of treatment, treatment needs, and prognosis shall be disclosed and released to the appropriate prosecuting attorney if the patient was committed pursuant to section 2945.38, 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code, or to the attorney designated by the board for proceedings pursuant to involuntary commitment under this chapter.

(13) That the department of mental health and addiction services may exchange psychiatric hospitalization records, other mental health treatment records, and other pertinent information with the department of rehabilitation and correction and with the department of youth services to ensure continuity of care for inmates or offenders who are receiving mental health services in an institution of the department of rehabilitation and correction or the department of youth services and may exchange psychiatric hospitalization records, other mental health treatment records, and other pertinent information with boards of alcohol, drug addiction, and mental health services and community mental health services providers to ensure continuity of care for inmates or offenders who are receiving mental health services in an institution and are scheduled for release within six months. The release of records under this division is limited to records regarding an inmate's or offender's medication history, physical health status and history, summary of course of treatment, summary of treatment needs, and a discharge summary, if any;

(14) That records and reports relating to a person who has been deceased for fifty years or more are no longer considered confidential.

(B) Before records are disclosed pursuant to divisions (A)(3), (6), and (9) of this section, the custodian of the records shall attempt to obtain the patient's consent for the disclosure. No person shall reveal the contents of a medical record of a patient except as authorized by law.

(C) The managing officer of a hospital who releases necessary medical information under division (A)(3) of this section to allow an insurance carrier or other third party payor to comply with section 5121.43 of the Revised Code shall neither be subject to criminal nor civil liability.

Amended by 131st General Assembly File No. TBD, SB 319, §1, eff. 7/1/2017.

Amended by 131st General Assembly File No. TBD, HB 64, §101.01, eff. 9/29/2015.

Amended by 131st General Assembly File No. TBD, HB 141, §1, eff. 9/29/2015.

Amended by 130th General Assembly File No. TBD, SB 43, §1, eff. 9/17/2014.

Amended by 130th General Assembly File No. 25, HB 59, §101.01, eff. 9/29/2013.

Amended by 129th General AssemblyFile No.127, HB 487, §110.10, eff. 10/1/2012.

Amended by 129th General AssemblyFile No.127, HB 487, §101.01, eff. 9/10/2012.

Amended by 129th General AssemblyFile No.28, HB 153, §120.20, eff. 10/1/2012.

Amended by 129th General AssemblyFile No.28, HB 153, §101.01, eff. 9/29/2011.

Amended by 128th General AssemblyFile No.9, HB 1, §101.01, eff. 10/16/2009.

Effective Date: 09-05-2001; 01-01-2006

ORC 5119.27 Confidentiality of records pertaining to identity, diagnosis or treatment.

(A) Records or information, other than court journal entries or court docket entries, pertaining to the identity, diagnosis, or treatment of any person seeking or receiving services that are maintained in connection with the performance of any drug treatment program or services licensed by, or certified by, the director of mental health and addiction services under this chapter shall be kept confidential, may be disclosed only for the purposes and under the circumstances expressly authorized under this section, and may not otherwise be divulged in any civil, criminal, administrative, or legislative proceeding.

(B) When the person, with respect to whom any record or information referred to in division (A) of this section is maintained, gives consent in the form of a written release signed by the person, the content of the record or information may be disclosed if the written release conforms to all of the following:

(1) Specifically identifies the person, official, or entity to whom the information is to be provided;

(2) Describes with reasonable specificity the record, records, or information to be disclosed; and

(3) Describes with reasonable specificity the purposes of the disclosure and the intended use of the disclosed information.

(C) A person who is subject to a community control sanction, parole, or a post-release control sanction or who is ordered to rehabilitation in lieu of conviction, and who has agreed to participate in a drug treatment or rehabilitation program as a condition of the community control sanction, post-release control sanction, parole, or order to rehabilitation, shall be considered to have consented to the release of records and information relating to the progress of treatment, frequency of treatment, adherence to treatment requirements, and probable outcome of treatment. Release of information and records under this division shall be limited to the court or governmental personnel having the responsibility for supervising the person's community control sanction, post-release control sanction, parole, or order to rehabilitation. A person, described in this division, who refuses to allow disclosure may be considered in violation of the conditions of the person's community control sanction, post-release control sanction, parole, or order to rehabilitation.

(D) Disclosure of a person's record may be made without the person's consent to qualified personnel for the purpose of conducting scientific research, management, financial audits, or program evaluation, but these personnel may not identify, directly or indirectly, any individual person in any report of the research, audit, or evaluation, or otherwise disclose a person's identity in any manner.

(E) Upon the request of a prosecuting attorney or the director of mental health and addiction services, a court of competent jurisdiction may order the disclosure of records or information referred to in division (A) of this section if the court has reason to believe that a treatment program or facility is being operated or used in a manner contrary to law. The use of any information or record so disclosed shall be limited to the prosecution of persons who are or may be charged with any offense related to the illegal operation or use of the drug treatment program or facility, or to the decision to withdraw the authority of a drug treatment program or facility to continue operation. For purposes of this division the court shall:

(1) Limit disclosure to those parts of the person's record considered essential to fulfill the objective for which the order was granted;

(2) Require, where appropriate, that all information be disclosed in chambers;

(3) Include any other appropriate measures to keep disclosure to a minimum, consistent with the protection of the persons seeking or receiving services, the physician-patient relationship, and the administration of the drug treatment and rehabilitation program.

(F) As used in this section:

(1) Community control sanction has the same meaning as in section 2929.01 of the Revised Code.

(2) Post-release control sanction has the same meaning as in section 2967.01 of the Revised Code.

Renumbered from § 3793.13 by 130th General Assembly File No. 25, HB 59, §101.01, eff. 9/29/2013.

Former section renumbered as § 5119.05 by 130th General Assembly File No. 25, HB 59, §101.01, eff. 9/29/2013.

Prior History: (R.C. § 3793.13)

(Effective Date: 01-01-200.)

5119.28 Confidentiality of records pertaining to person's mental health condition, assessment, provision of care or treatment, or payment for assessment, care or treatment.

(A) All records, and reports, other than court journal entries or court docket entries, identifying a person and pertaining to the person's mental health condition, assessment, provision of care , treatment, or recovery supports, or payment for assessment, care , treatment, or recovery supports that are maintained in connection with any services certified by the department of mental health and addiction services, any recovery supports paid for with funds administered by the department or a board of alcohol, drug addiction, and mental health services, or any hospitals or facilities licensed or operated by the department, shall be kept confidential and shall not be disclosed by any person except:

(1) If the person identified, or the person's legal guardian, if any, or if the person is a minor, the person's parent or legal guardian, consents;

(2) When disclosure is provided for in this chapter or Chapter 340. or 5122. of the Revised Code or in accordance with other provisions of state or federal law authorizing such disclosure;

(3) That hospitals, boards of alcohol, drug addiction, and mental health services, licensed facilities, and community mental health services providers may release necessary information to insurers and other third-party payers, including government entities responsible for processing and authorizing payment, to obtain payment for goods and services furnished to the person;

(4) Pursuant to a court order signed by a judge;

(5) That a person shall be granted access to the person's own psychiatric and medical records, unless access specifically is restricted in a person's treatment plan for clear treatment reasons;

(6) That the department of mental health and addiction services may exchange psychiatric records and other pertinent information with community mental health services providers and boards of alcohol, drug addiction, and mental health services relating to the person's care or services. Records and information that may be exchanged pursuant to this division shall be limited to medication history, physical health status and history, financial status, summary of course of treatment, summary of treatment needs, and a discharge summary, if any.

(7) That the department of mental health and addiction services, hospitals and community providers operated by the department, hospitals licensed by the department under section 5119.33 of the Revised Code, and community mental health services providers may exchange psychiatric records and other pertinent information with payers and other providers of treatment and health services if the purpose of the exchange is to facilitate continuity of care for the person or for the emergency treatment of the person;

(8) That the department of mental health and addiction services and community mental health services providers may exchange psychiatric records and other pertinent information with boards of alcohol, drug addiction, and mental health services for purposes of any board function set forth in Chapter 340. of the Revised Code. Boards of alcohol, drug addiction, and mental health services shall not access any personal information from the department or providers except as required or permitted by this section, or Chapter 340. or 5122. of the Revised Code for purposes related to payment, care coordination, health care operations, program and service evaluation, reporting activities, research, system administration, oversight, or other authorized purposes.

(9) That a person's family member who is involved in the provision, planning, and monitoring of services to the person may receive medication information, a summary of the person's diagnosis and prognosis, and a list of the services and personnel available to assist the person and the person's family, if the person's treatment provider determines that the disclosure would be in the best interests of the person. No such disclosure shall be made unless the person is notified first and receives the information and does not object to the disclosure.

(10) That community mental health services providers may exchange psychiatric records and certain other information with the board of alcohol, drug addiction, and mental health services and other providers in order to provide services to a person involuntarily committed to a board. Release of records under this division shall be limited to medication history, physical health status and history, financial status, summary of course of treatment, summary of treatment needs, and discharge summary, if any.

(11) That information may be disclosed to the executor or the administrator of an estate of a deceased person when the information is necessary to administer the estate;

(12) That information may be disclosed to staff members of the appropriate board or to staff members designated by the director of mental health and addiction services for the purpose of evaluating the quality, effectiveness, and efficiency of mental health services and recovery supports and determining if the services and supports meet minimum standards. Information obtained during such evaluations shall not be retained with the name of any person.

(13) That records pertaining to the person's diagnosis, course of treatment, treatment needs, and prognosis shall be disclosed and released to the appropriate prosecuting attorney if the person was committed pursuant to section 2945.38, 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code, or to the attorney designated by the board for proceedings pursuant to involuntary commitment under Chapter 5122. of the Revised Code;

(14) That the department of mental health and addiction services may exchange psychiatric hospitalization records, other mental health treatment records, and other pertinent information with the department of rehabilitation and correction and with the department of youth services to ensure continuity of care for inmates and offenders who are receiving mental health services in an institution of the department of rehabilitation and correction or the department of youth services and may exchange psychiatric hospitalization records, other mental health treatment records, and other pertinent information with boards of alcohol, drug addiction, and mental health services and community mental health services providers to ensure continuity of care for inmates or offenders who are receiving mental health services in an institution and are scheduled for release within six months. The release of records under this division is limited to records regarding an inmate's or offender's medication history, physical health status and history, summary of course of treatment, summary of treatment needs, and a discharge summary, if any.

(15) That a community mental health services provider that ceases to operate may transfer to either a community mental health services provider that assumes its caseload or to the board of alcohol, drug addiction, and mental health services of the service district in which the person resided at the time mental health services or recovery supports were most recently provided any records concerning the services or supports that have not been transferred elsewhere at the person's request;

(16) That records and reports relating to a person who has been deceased for fifty years or more are no longer considered confidential.

(B) Before records are disclosed pursuant to divisions (A)(3), (6), and (10) of this section, the custodian of the records shall attempt to obtain the person's consent for the disclosure.

(C) No person shall reveal the content of a medical record of a person that is confidential pursuant to this section, except as authorized by law.

Amended by 131st General Assembly File No. TBD, SB 319, §1, eff. 7/1/2017.

Amended by 131st General Assembly File No. TBD, HB 64, §101.01, eff. 9/29/2015.

Added by 130th General Assembly File No. 25, HB 59, §101.01, eff. 9/29/2013.

5122-24-01 Certification definitions.

(A) Purpose

The purpose of this rule is to provide definitions for key words and phrases used in the department certification standards.

(B) Applicability

The following definitions apply to Chapters 5122-24 to 5122-29 of the Administrative Code:

(1) Abuse means any act or absence of action inconsistent with human rights which results or could result in physical injury to a person served, unless the act is done in self defense or occurs by accident; any act which constitutes sexual activity, as defined under Chapter 2907. of the Revised Code, where such activity would constitute an offense against a person served under that chapter; insulting or coarse language or gestures directed toward a person served which subjects the person served to humiliation or degradation; or depriving a person served of real or personal property by fraudulent or illegal means. For children, the definition of abuse is the same as in sections 2919.22 and 2151.031 of the Revised Code.

(2) Acceptability means the way in which the agency ensures that its services and activities are sensitive to the individual needs of people, and that the agency addresses issues of freedom of choice, and of ethnic, racial, gender and cultural characteristics. Acceptability includes seeking out the advice of people being served, or of populations who may not be receiving sufficient services as reflected by a comparison of community demographics and the demographics of persons served by the agency, in order to understand how acceptability varies within the general population.

(3) Accessibility means the ability for persons served to enter, approach, communicate with, or make use of the services of an agency, including but not limited to the need for bilingual staff, minority-specific programming, staffing patterns that reflect community demographics and adequacy of hours of operation.

(4) Activity means an action performed by an agency that does not constitute a mental health service as defined in paragraph (B)(66) of this rule, and therefore does not have a cost per unit, but that is reimbursable by the department, either as an activity, e.g., research, or as a portion of the unit cost of services, e.g., administrative.

(5) Administer means the direct application of a single drug to the body of a client either by injection, inhalation, ingestion or any other means. The complete act of administration entails the following:

(a) Removal of an individual dose from a previously dispensed, properly labeled container;

(b) Verification of drug dose with the practitioner's order;

(c) Properly identifying the client before giving the individual dose; and

(d) Properly recording the time and dose given in the client's integrated clinical record.

(6) Administrative supervision means to monitor the administrative aspects of a service or group of services within an agency.

(7) Admission means an agency's decision to offer direct services to a person, and includes opening an integrated clinical record for the person at the time of the first admission to the agency.

(8) Affiliation agreement means a signed, written understanding among two or more organizations that describes how they will work together to benefit persons in the community.

(9) Affirmative action plan means the identification and analysis of employment opportunities for minority persons in an agency, and a plan to achieve equal employment opportunity.

(10) Agency means:

(a) Any agency, subcontract agency, facility, or organization funded by a community mental health board to provide the mental health services listed in section 340.09 of the Revised Code;

(b) Any community mental health board approved by the department in accordance with division (A)(6) of section 340.03 of the Revised Code to provide any of the mental health services listed in section 340.09 of the Revised Code, or any mental health board determined by the department to be providing a service subject to department approval;

(c) Any residential facility licensed according to section 5119.22 of the Revised Code that provides any of the mental health services listed in rules 5122-29-03 to 5122-29-27 of the Administrative Code; and

(d) Any agency providing a service approved by the community mental health board and the director of mental health as listed in division (R) of section340.09 of the Revised Code.

Community Mental Health Agency has the same meaning and may be referred to as Agency, Subcontract Agency, Facility, or Organization.

(11) Appropriateness means actions, treatment or service that promote empowerment, dignity, and self-worth as defined by the person served in consultation with the individuals providing the service.

(12) Career exploration means one aspect of a vocational service in which agency staff work with a person to assess vocational interests and aptitudes in preparation for employment.

(13) Certificate means the official document containing the department's written authorization to the agency to operate specific services or activities. These services and activities are those which are included in the agency's contract or sub-contract with the community mental health board or for which a non-contract agency has voluntarily applied.

(14) Certification means the written authorization from the department for an agency to operate specific services and provide activities according to Chapters 5122-24 to 5122-29 of the Administrative Code. These services and activities are those which are included in the agency's contract or sub-contract with the community mental health board or for which a non-contract agency has voluntarily applied.

(15) Certification standards means the requirements as stated in Chapters 5122-24 to 5122-29 of the Administrative Code with which an agency must comply in order to receive certification by the department to provide mental health services and activities listed in section 340.09 of the Revised Code. These services and activities are those which are included in the agency's contract with the state of Ohio medicaid agency, contract or sub-contract with the community mental health board or for which a non-contract agency has voluntarily applied.

(16) Client means a person admitted by an agency for mental health services or who receives mental health services from an agency. Persons, Persons Receiving Services, Persons Being Served, Persons Served, or Client has the same meaning as client. The terms include all categories of persons of all ages, unless specified.

(17) Community mental health board means the body constituted according to section 340.02 of the Revised Code, and has the same duties as described in section 340.03 of the Revised Code. Community mental health board means both a community mental health board and a board of alcohol, drug addiction and mental health services. If the term community mental health board is used, it also refers to a board of alcohol, drug addiction and mental health services.

(18) Community mental health plan means the plan for providing mental health services as developed by a community mental health board and approved by the department of mental health in accordance with section 340.03 of the Revised Code.

(19) Community support system means an array of services and activities that provides treatment, support, and rehabilitation services according to division (A)(11) of section 340.03 of the Revised Code.

(a) Location of persons in need of mental health services to inform them of available services and benefits mechanisms;

(b) Assistance for clients to obtain services necessary to meet basic human needs for food, clothing, shelter, medical care, personal safety, and income;

(c) Mental health care, including, but not limited to outpatient, partial hospitalization, and, where appropriate, inpatient care;

(d) Emergency services and crisis intervention;

(e) Assistance for clients to obtain vocational services and opportunities for jobs;

(f) Provision of services designed to develop social, community, and personal living skills;

(g) Access to a wide range of housing and the provision of residential treatment and support;

(h) Support, assistance, consultation, and education for families, friends, clients of mental health services, and others;

(i) Recognition and encouragement of families, friends, neighborhood networks, especially networks that include racial and ethnic minorities, churches, community organizations, and meaningful employment as natural supports for clients of mental health services;

(j) Grievance procedures and protection of the rights of clients of mental health services; and

(k) Case management, which includes continual individualized assistance and advocacy to ensure that needed services are offered and procured.

(20) Consent means agreement to participate in a research or treatment procedure on the basis of the subject's understanding of its nature and possible risks and benefits.

(21) Continuing education means a process that is designed to improve or enhance the skills, knowledge, attitudes or competencies related to professional development of agency staff.

(22) Crisis means a situation with a high stress level, for either an individual or a system, and where usual coping methods do not succeed in resolving the issues presented by the precipitating event. A crisis is usually short in duration, lasting less than eight to twelve weeks.

(23) Culturally specific and relevant service means a service that responds effectively to the values present in all cultures, including but not limited to such cultures as African American, Hispanic, Asian, Amish, native American, and deaf persons. This also includes participation by persons from such cultures in decision making, service design and evaluation.

(24) Culturological assessment means the systematic appraisal or examination of individuals, groups and communities as to their cultural beliefs, values and practices to determine explicit needs and intervention practices within the cultural context of the people being evaluated, and includes the following domains:

(a) Patterns of life style;

(b) Specific cultural values/norms;

(c) Cultural taboos/myths;

(d) Worldview and ethnocentric tendencies;

(e) General features that client perceives similar to other cultures;

(f) Health and life care rituals and rites of passage to maintain health;

(g) Folk and professional health/illness systems utilized;

(h) Degree of cultural change and acculturation noted;

(i) Caring behaviors;

(j) Cultural restrictions;

(k) Spiritual needs; and

(l) Family

(25) Department means the Ohio department of mental health.

(26) Destruction means the act of making a drug unusable.

(27) Director means the chief executive and administrative officer of the Ohio department of mental health.

(28) Dispense means the professional judgment and the physical act of placing a specific drug in final association with the name of a particular client pursuant to the lawful prescription of a practitioner and according to paragraph (B) of rule 4729-5-01 of the Administrative Code. Dispensing includes the proper selection, measuring, packaging, labeling, and issuing of a drug or biological for a client or a service unit. Only a pharmacist or physician may dispense medications.

(29) Distribute means the general system of moving drugs from a supplier to final destination, whether administered to a person served, stored, returned to supplier or destroyed.

(30) DSM means the Diagnostic and Statistical Manual of Mental Disorders published by the American psychiatric association .

(31) Emergency means a situation that is a matter of life or death or of extreme drastic loss of a person's ability to manage a potentially dangerous situation where the goal is avoidance of loss and minimization of risks.

(32) Ethnic, minority, or cultural group means population groups such as African Americans, Hispanic persons, Asian persons, native Americans, persons from the Amish culture, deaf persons or other groups that share a set of values or experiences that are important to understand in order to provide effective and relevant mental health services.

(33) Executive director means the individual responsible for the day-to-day operation of an agency. The executive director, as defined by this paragraph, may be referred to by other titles, such as chief executive officer.

(34) Governing board means the designated individuals or governing body legally responsible for conducting the affairs of the agency.

(35) Grievance means a formal request for further review of any unresolved written complaint or a complaint containing allegations of the denial, exercise or violation of the rights of persons served. A grievance may be initiated either verbally or in writing by a person served, client, ex-client, or any other person or agency acting on behalf of a person served.

(36) Hazardous materials means any substance considered to be potentially harmful to humans, including, but not limited to, toxic chemicals or flammable substances.

(37) ICR means individual client record as described in Chapter 5122-27 of the Administrative Code.

(38) IEP means an individualized education program designed by the child's school personnel that describes the specialized educational services to be provided by the school system.

(39) In-service education means a process relating to specific job duties and responsibilities designed to improve or enhance specific content skills, knowledge, attitudes and competencies.

(40) Interactive videoconferencing means the use of secure, real-time audiovisual communications of such quality as to permit accurate and meaningful interaction between client and provider. This expressly excludes telephone calls, with the exception of calls made utilizing communication devices which allow visual interaction between the provider and deaf and hard of hearing individuals, images transmitted via facsimile machines, and text messages without visualization of the client, i.e., electronic mail. The client must be present and participating in the session.

(41) Intervention means a procedure that is intended to produce a change in behavior, cognition, and/or physiological or biochemical process.

(42) ISP means individualized service plan as described in rule 5122-27-05 of the Administrative Code.

(43) Misconduct means any act that may affect, interrupt or interfere with the performance of official duties and that is illegal or a wrongful performance or omission of a legal duty.

(44) Neglect means a purposeful or negligent disregard of duty by an employee or staff member. Such duty is one that is imposed on an employee or staff member by statute, rule, or professional standards and which is owed to the person served by that employee or staff member.

(45) Orientation means a process designed to improve or enhance an employee's knowledge about his or her job responsibilities and physical environment to increase awareness of the expectations, choices, resources, and constraints that affect job performance and adjustment.

(46) Outcomes means the impact on the system or person served.

(47) Parent means the parent(s) having custody or the legal custodial agent for a minor.

(48) Person with serious emotional disturbance means a person less than eighteen years of age who meets criteria that is a combination of duration of impairment, intensity of impairment and diagnosis.

(a) Criteria:

(i) Under eighteen years of age;

(ii) Marked to severe emotional/behavioral impairment;

(iii) Impairment that seriously disrupts family or interpersonal relationships; and

(iv) May require the services of other youth-serving systems (e.g., education, human services, juvenile court, health, mental health/mental retardation, youth services, and others).

(b) Marked-to-severe behavioral impairment is defined as impairment that is at or greater than the level implied by any of the following criteria in most social areas of functioning:

(i) Inability or unwillingness to cooperate or participate in self-care activities;

(ii) Suicidal preoccupation or rumination with or without lethal intent;

(iii) School refusal and other anxieties or more severe withdrawal and isolation;

(iv) Obsessive rituals, frequent anxiety attacks, or major conversion symptoms;

(v) Frequent episodes of aggressive or other antisocial behavior, either mild with some preservation in social relationships or more severe requiring considerable constant supervision; and

(vi) Impairment so severe as to preclude observation of social functioning or assessment of symptoms related to anxiety (e.g., severe depression or psychosis).

(c) An impairment that seriously disrupts family or interpersonal relationships is defined as one:

(i) Requiring assistance or intervention by police, courts, educational system, mental health system, social service, human services, and/or children's services;

(ii) Preventing participation in age-appropriate activities;

(iii) In which community (home, school, peers) is unable to tolerate behavior; or

(iv) In which behavior is life-threatening (e.g., suicidal, homicidal, or otherwise potentially able to cause serious injury to self or others).

(49) Person with severe mental disability means a person eighteen years of age or older with a severe mental or emotional disability who meets at least two of the three following criteria of diagnosis, duration, and disability:

(a) Diagnosis: the current primary diagnosis is delusional disorders (DSM IIIR 297.10); dissociative disorders (DSM IIIR 300.14); eating disorders (DSM IIIR 307.10, 307.51, 307.52); mood disorders (DSM IIIR 296.3 x, 296.4 x, 296.5 x, 296.6 x, 296.70, 300.40, 301.13, 311.00); organic mental disorders (DSM IIIR 290.0, 290.10, 290.1 x, 290.4 x, 294.10, 294.80); personality disorders (DSM IIIR 301.00, 301.20, 301.22, 301.40, 301.50, 301.60, 301.70, 301.81, 301.82, 301.83, 301.84, 301.90), psychotic disorders (DSM IIIR 395.40, 295.40, 295.70, 298.90); schizophrenia (DSM IIIR 295.1 x, 295.2 x, 295.3 x, 295.6 x, 295.9 x); somatoform disorder (DSM IIIR 307.80); other disorders (DSM IIIR 313.23, 313.81, 313.82); or other specified.

(b) Duration: the length of the problem can be assessed by either inpatient or outpatient use of service history, reported length of time of impairment, or some combination, including at least two prior hospitalizations of more than twenty-one days or any number of hospitalizations (more than one) totaling at least forty-two days prior to the assessment, or ninety to three hundred sixty-five days in a hospital or nursing home within three prior years, or major functional impairment lasting more than two years, resulting in utilization of outpatient mental health services on an intermittent and/or continuous basis.

(c) Disability/functional impairment: severity of disability can be established by disruption in two or more life activities, including but not limited to: employment, contributing substantially to one's own financial support

(not to be entitlements), independent residence, self-care, perception and cognition, stress management/coping skills, interpersonal and social relations.

(50) Physical health assessment means a comprehensive evaluation of a person's physical and emotional status including, but not limited to, physiological, emotional, nutritional and lifestyle components.

(51) Physician (DO or MD) means the same as medical doctor and doctor of osteopathic medicine.

(52) Plan means a written document related to a service or activity that describes goals and objectives, assigns responsibility for implementation, establishes outcome measures, and assigns responsibility for monitoring and reporting results.

(53) Policy means a written statement developed by an agency that gives specific direction regarding how the agency intends to operate, either administratively or programmatically. Policies are developed to ensure that agency staff perform their duties in a consistent manner and that the public can expect that all services and activities will be conducted according to the policy statement.

(54) Practitioner means a person eligible to provide a service in accordance with Chapter 5122-29 of the Administrative Code.

(55) Prescribe means the professional judgment of selecting a specific drug, dosage and schedule of administration appropriate to the therapeutic needs of a person served.

(56) Principal means a person who has controlling authority or is in a leading position, (e.g., executive director, chief financial officer, or chief clinical officer).

(57) PRN order (pro re nata order) means a written practitioner's order for a medication, treatment, or procedure which is only carried out when a person served manifests a specific, previously defined clinical or behavioral characteristic.

(58) Procedure means a written set of instructions describing the step-by-step actions to be taken by agency staff in implementing the policies of the agency.

(59) Psychiatrist (DO or MD) means an individual who holds a current valid license to practice medicine according to section 4731. of the Revised Code, issued by the state medical board, who has satisfactorily completed a residency training program in psychiatry as approved by the residency review committee of the accreditation council for graduate medical education of the American medical association, the committee on postgraduate education of the American osteopathic association, or the American osteopathic board of neurology and psychiatry, or who has been recognized as of July 1, 1989, as a psychiatrist by the Ohio medical association or Ohio osteopathic association, on the basis of formal training and five or more years of medical practice limited to psychiatry, or who is a licensed physician working under a temporary license and completing a residency in psychiatry.

(60) Psychoeducational milieu means a treatment design based on a blending of mental health services and educational services.

(61) Purchase means the act of requesting a drug(s) from a licensed supplier.

(62) Recovery means a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence. It is an interpersonal dynamic process of embracing hope, defining oneself, and participating in meaningful roles in the community.

(63) Referral means a recommendation to seek or request services and/or evaluation between agencies in order to assess or meet the needs of persons served. Referral, as used in information and referral service, means the act of assisting an individual gain access to services of a community agency.

(64) Resiliency means a dynamic process which takes into account the interaction of risk and protective factors, contextual conditions, as well as the individual's traits and abilities.

(65) Self-administration means a person taking medication independently.

(66) Service means any action named and defined in Chapter 5122-29 of the Administrative Code as a mental health service provided for persons served by the agency and their families and significant others, community organizations, and the general public for the purpose of treating or preventing mental illness, emotional disturbance, or substance abuse.

(67) Significant others means individuals who are significant and important to the well-being of a person served, as identified by the person served.

(68) Standard means a stated level of performance for a service or activity expressed as an accepted and adhered-to practice in the mental health service system.

(69) Stock supply means a volume of medications that are not dispensed, or not labeled with the specific name of a person served, and has the same meaning as limited stock supply.

(70) Student means an individual enrolled in an educational program that is approved, certified or accredited, and who may provide mental health services as part of his/her practicum, internship, or field placement, and with appropriate supervision according to the requirements of the educational institution, applicable licensing board standards, and in coordination with applicable agency policies and procedures.

(71) Supervise means to monitor, instruct and be accountable for agency staff in their performance of clinical services to persons served according to the policies of the agency, and has the same meaning as clinical supervision.

(72) Termination means the decision to no longer provide services to a person served by the agency.

(73) Transfer means an agency's recommendation to discontinue providing one or more services to a person and to begin providing another service(s) in the same agency.

(74) Variance means written permission granted by the department to an agency to meet a modified requirement of a rule of the Administrative Code.

(75) Waiver means written permission granted by the department to an agency to be exempted from a rule or specific provision of a rule of the Administrative Code.

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GRIEVANCE PROCEDURE AND THE ROLE OF THE CLIENT RIGHTS OFFICER/SPECIALIST/ADVOCATE AT A MENTAL HEALTH AND SUD AGENCY

The following is a checklist designed to help agencies review their own client rights policy and grievance procedures:

CODE	CODE DESCRIPTION	YES	NO
OAC 5122-26-13	**Each agency shall develop policies and procedures regarding the neglect and abuse of clients served including, but not limited to, the following requirements:**		
	Each allegation of neglect and/or abuse by agency staff of a client served, regardless of the source, shall be investigated. The written results of an investigation into an allegation of neglect and/or abuse of clients served shall be reviewed by the executive director of the agency. The agency shall keep documentation of the findings of the investigation and of actions taken as a result of the investigation.		
	The agency shall report any allegation of staff neglect or abuse to the community mental health board *[or ADAMHS Board]* within twenty-four hours of the event occurring and shall communicate the results of the investigation to the community mental health board.		
	In situations that involve child abuse or adult abuse, any notification required by law shall be made to the appropriate authorities.		
OAC 5122-26-18	**Each agency shall have written policies and procedures that are consistent with state law and OhioMHAS's guidelines regarding rights of clients served. Effective: 04/01/2016**		
(C)	Each agency shall develop a policy on the rights of clients receiving services and a grievance policy for those clients according to relevant federal, state, and local statutes including the following:		
(C)(1)	Written client rights policy that lists all of the client rights		
(C)(2)	Written client grievance procedure		
(C) (3) (a) (b) (c)	Policy for maintaining for at least two years from resolution, records of client grievances that include, at a minimum, the following: • Copy of the grievance; • Documentation reflecting process used and resolution/remedy of the grievance; and, • Documentation, if applicable, of extenuating circumstances for extending the time period for resolving the grievance beyond twenty-one calendar days. •		

(D)	**Posting of client rights:**		
(D) (1)	The client rights policy and grievance procedure shall be posted in each location in which services are provided, unless the certified agency location is not under the control of the provider, i.e. a shared location such as a school, jail, etc. and it is not feasible for the provider to do so.		
(D) (2)	The client rights policy and grievance procedure shall be posted in a conspicuous location that is accessible to persons served, their family or significant others and the public.		
(D) (3)	When a location is not under the control of the provider and it is not feasible for the provider to post the client rights policy and grievance procedure, the provider shall assure that copies are available at the location for each person that may request a written copy.		
(H)	**Provision of client rights:**		
(H) (1)	The provider shall explain and maintain documentation in the ICR of explanation of rights to each person served prior to or when beginning assessment or treatment services.		
(H) (2)	In a crisis or emergency situation, or when the client does not present for services in person such as through a hotline; the provider may verbally advise the client of at least the immediately pertinent rights only, such as the right to consent to or to refuse the offered treatment and the consequences of that agreement or refusal. Full verbal explanation of the client rights policy shall be provided at the first subsequent meeting.		
(H) (3)	Clients or recipients of information and referral service, consultation service, mental health education service, and prevention service as described in Chapter 5122-29 of the Administrative Code may have a copy and explanation of the client rights policy upon request.		
(H) (4)	Explanations of rights shall be in a manner appropriate for the person's understanding.		
(I)	All staff shall be required to follow the client rights policy and client grievance procedure. There shall be documentation in each employee's personnel file, including contract staff, volunteers and student interns that each staff member has received a copy of the client rights policy and the client grievance procedure and has agreed to abide by them.		
(J)	**The client grievance procedure shall have provisions for at least the following:**		
(J) (1)	Statement to whom the client is to give the grievance		
(J) (2)	Designation of a client advocate who will be available to assist a client in filing of a grievance, the client advocate shall have their name, title, location, hours of availability, and telephone number included with the posting of client rights		

(J) (3)	Requirement that the grievance must be put into writing; the grievance may be made verbally and the client advocate shall be responsible for preparing a written text of the grievance		
(J) (4)	Requirement that the written grievance must be dated and signed by the client, the individual filing the grievance on behalf of the client, or have an attestation by the client advocate that the written grievance is a true and accurate representation of the client's grievance		
(J) (5)	Requirement that the grievance include, if available, the date, approximate time, description of the incident and names of individuals involved in the incident or situation being grieved		
(J) (7) (a) (b) (c) (d)	Statement that a client has the option to file a grievance with outside organizations, that include, but are not limited to, the following, with the mailing address and telephone numbers for each stated: • Applicable board of alcohol, drug addiction, and mental health services • Ohio department of mental health and addiction services • Disability rights Ohio • U.S. department of health and human services, civil rights regional office in Chicago		
(J) (8) (a) (b) (c) (d) (e)	Requirement that a written acknowledgment of receipt of the grievance be provided to each grievant. Such acknowledgment shall be provided within three business days from receipt of the grievance. The written acknowledgment shall include, but not be limited to, the following: • Date grievance was received • Summary of grievance • Overview of grievance investigation process • Timetable for completion of investigation and notification of resolution • Treatment provider contact name, address and telephone number		

CLIENTS MAY FILE A GRIEVANCE REGARDING THE CUYAHOGA COUNTY PUBLIC SUD OR MH SYSTEM OF CARE BY CONTACTING ANY OR ALL OF THE FOLLOWING:

The Client Rights Officer (CRO) at the agency where services are applied for, or where the client received or had previously received services.

Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County
Client Rights Officer
2012 W. 25th St., 6th Floor
Cleveland, OH 44113
216-241-3400
Ohio Relay at 1-800-750-0750

Ohio Department of Mental Health and Addiction Services (OhioMHAS)
30 East Broad Street, 8th Floor
Columbus, OH 43215-3430
Client Advocacy and Protection Specialist: Kathryn Remer
Client and Family Toll Free: 1-877-275-6364
TTY: 1-888-636-4889
Fax: 614-466-1571
E-mail: Kathryn.Remer@mha.ohio.gov
Ohio Relay at 1-800-750-0750

Disability Rights Ohio (Mental Health Only)
Attn: Intake Department
50 W. Broad Street, Suite 1400
Columbus, OH 43215-5923
1-614-466-7264 or
1-800-282-9181
(toll-free in Ohio only)
Ohio Relay at 1-800-750-0750

U.S. Department of Health and Human Services
Office of Civil Rights – Region V
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Customer Response Center: 1-800-368-1019
TDD: (800) 537-7697

To grieve social workers, counselors, and marriage and family therapists:
Ohio Counselor, Social Worker and Marriage & Family Therapist Board
Ethics/Investigations
77 South High Street, 24th Floor, Room 2468
Columbus, OH 43215-5919
1-614-466-0912
Ohio Relay at 1-800-750-0750

To grieve psychiatrists and/or other doctors:
State Medical Board of Ohio
Clients/Action
30 E. Broad St., 3rd Flr
Columbus, OH 43215-6127
1-614-466-3934
Complaint Form 1-800-554-7717
Ohio Relay at 1-800-750-0750

To grieve nurses:
Ohio Board of Nursing
Complaints, Investigations and Discipline
17 S. High St., Suite 400
Columbus, OH 43215-7410
1-614-466-3947
disciplinary@nursing.ohio.gov
Ohio Relay at 1-800-750-0750

To grieve psychologists:
State Board of Psychology of Ohio
Enforcement, Complaints, and Action
77 S. High St., Suite 1830
Columbus, OH 43215-7081
1-614-466-8808
Ohio Relay at 1-800-750-0750

To grieve Chemical Dependency Counselors and Prevention Staff
Ohio Chemical Dependency Professionals Board
77 South High Street, 16th Floor
Columbus, OH 43215
1-614-387-1109
www.ocdp.ohio.gov for Ethics Enforcement/Violation Form

To complain about staff or conditions at Assisted Living or Nursing Facilities:
Long Term Care Ombudsman
Investigating Concerns
2800 Euclid Ave., Suite 200
Cleveland, OH 44115
216-696-2719

Community Client Rights Resource Manual Development

2019 Version Developed by:
The ADAMHS Board of Cuyahoga County in cooperation with
contracted community Mental Health and Substance Use Disorder Service Providers

Consultant:
Ohio Department of Mental Health
Office of Community Supports and Clients Rights
ODMH: Kathryn Remer, Client Rights Advocate

2014 Version Developed by:
The ADAMHS Board of Cuyahoga County in cooperation with
contracted community Mental Health and Substance Use Disorder Service Providers

Consultant:
OhioMHAS: Kathryn Remer, Consumer Advocacy & Protection Specialist

1999 Original Version Developed by:
Cynthia Hill
Judy Jackson-Winston
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John Woods

Consultant:
Jill Spangler