OREGON INVOLUNTARY HOLDS INFORMATION:

Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe general standards and procedures relating to the involuntary commitment of mentally ill persons.

(2) Statutory authority. These rules are authorized by ORS 426.005 through 426.395 and carry out the provisions of ORS 426.005 through 426.395. These rules replace OAR 309-033-0100 though 309-033-0170, which were in effect from September 2, 1992 through August 31, 1994.

Stat. Auth.: ORS 413.042, 426.005 – 426.395
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0000

309-033-0210

Definitions

(1) "Administrator- means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. "Administrator- has the same meaning as "director of the facility- as that term is defined in ORS 426.005. Whenever "administrator- appears it means the administrator or designee.

(2) "Assignment- means the designation, pursuant to ORS 426.060, by the Division or its designee of the hospital, facility or CMHP where the committed person is to receive care, custody and treatment during the commitment period.

(3) "Assistant Administrator- means the Assistant Administrator of Addictions and Mental Health Division.

(4) "Caregiver- means the person who is appointed by the court under ORS 426.125 to be allowed to care for a mentally ill person on conditional release.

(5) “Clinical record- means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Services Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(6) “CMHP- means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(7) “Community hospital- means any hospital that is not a state hospital.

(8) “County governing body- means the county court or the board of county commissioners of one or more counties who operate a CMHP, or in the case of a Native American Reservation, the Tribal Council, or if the county declines to operate or contract for all or part of a CMHP, the board of directors of a public or private corporation selected by the county.

(9) “County of residence- means the county where the person currently maintains a mailing address or, if the person has no current mailing address within the state, the county where the person was found or the county in which a committed person has been conditionally released as defined by ORS 426.241 to 426.255.

(10) “Court- means the circuit court acting pursuant to ORS Chapter 426.

(11) “Custody- means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233;

(c) A health care facility licensed under ORS Chapter 441 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(12) “Designee- means a QMHP designated by the director or a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody pursuant to ORS 426.233.

(13) “Director- means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP.

“Director- also means a person who has been authorized by the director to act in the director’s capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(14) “Director of the county of commitment- means the director for the county where the person is committed.

(15) “Director of the county of placement- means the director for the county where the committed person is to be placed.

(16) “Director of the county of residence- means the director for the county of residence.

(17) “Diversion- means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237(1)(b).

(18) “Division- means the Addictions and Mental Health Division of the Oregon Health Authority.

(19) “Hospital hold- means the taking of a person into custody by order of a physician pursuant to ORS 426.232.

(20) “NMI- is the notification of mental illness required, pursuant to ORS 426.070, to be submitted by any two persons, a county health officer or a magistrate to the director and thereafter submitted by the director to the court or, pursuant to ORS 426.234, to be submitted by the physician or the director to the court. Pursuant to ORS 426.070 and 426.234, the court commences proceedings pursuant to ORS 426.070 to 426.130 upon receipt of the NMI.

(21) “Nonhospital hold- means the taking of a person into custody by order of a director pursuant to the provisions of ORS 426.233. A director’s hold and a trial visit hold are variations of a nonhospital hold.

(22) “Peace officer- means a sheriff, constable, marshal, municipal policeman, member of the Oregon State Police or investigator of the Criminal Justice Division of the Department of Justice and such other persons as may be designated by law.

(23) “Placement of a committed person- means the physical act of removing a committed person from the courtroom to the place where the person has been assigned to receive care, custody and treatment, or the transfer of a committed person from one location where the person has been assigned to receive care, custody and treatment to another location for the same purpose.

(24) “Psychiatrist- means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(25) “Psychologist- means a clinical psychologist licensed by the Oregon Board of Psychologist Examiners.

(26) “QMHP- means a qualified mental health professional that meets the following minimum qualifications:

(a) Psychiatrist licensed to practice in the State of Oregon;

(b) Physician licensed to practice in the State of Oregon;

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

(e) Graduate degree in psychiatric nursing and licensed in the State of Oregon;

(f) Graduate degree in another mental health-related field; or

(g) Any other person whose education and experience meet, in the judgment of the Division, a level of competence consistent with the responsibilities required by the Division.

(27) “Recertification- means the certification of continued commitment provided for under ORS 426.301.

(28) “Secure transport provider- means a secure transport provider approved according to OAR 309-033-0432, Standards for the Approval of a Secure Transport Provider to Transport a Person in Custody or on Diversion to an Approved Holding or Nonhospital Facility.

(29) “State hospital- means Oregon State Hospital in Salem and Portland, and Eastern Oregon Psychiatric Center in Pendleton.

(30) “Superintendent- means the chief executive officer of a state hospital, or designee, or a person authorized by the superintendent to act in the superintendent’s capacity for the purpose of this rule.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232 & 426.236
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0010; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

309-033-0220

General Standards

(1) Goals. The goals of the Division in implementing these civil commitment standards are:

(a) To promote the well-being of persons who are allegedly mentally ill and who are mentally ill during involuntary care, custody and treatment of mental illness pursuant to ORS Chapter 426;

(b) To promote the protection of the civil rights of each person who is allegedly mentally ill and who is mentally ill;

(c) To encourage consistent application of ORS Chapter 426 as it specifically pertains to each of the following groups:

(A) Persons who are alleged to be mentally ill; and

(B) Persons who are mentally ill.

(d) To encourage the provision of care, custody and treatment of persons in the least restrictive environment that currently is available within existing resources;

(e) To encourage voluntary enrollment of persons in available mental health service in lieu of pursuing involuntary treatment through civil commitment, whenever possible;

(f) To encourage that the director monitors the commitment process in their county, is knowledgeable of the statutes and administrative rules pertaining to civil commitment, provides leadership so that persons being held are afforded their civil rights and are treated with dignity in the implementation of ORS Chapter 426;

(g) To provide for the safety of the community when threatened by a person who is dangerous as a result of mental illness.

(2) State's interest. The state's interest is to establish sufficient facts for the court to make a decision that is consistent with the intent of ORS Chapter 426.

(3) Declaration for mental health treatment. The director shall establish procedure and policy which assures that every person who may become incapacitated by mental illness and unable to consent to treatment is educated about the Declaration for Mental Health Treatment at the time of admission or at the time of discharge from a hospital.

Stat. Auth.: ORS 413.042 & 426.060
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0030

309-033-0230

Custody of Persons Alleged to Be Mentally Ill Prior to Filing a Notification of Mental Illness

(1) Custody by a physician pursuant to ORS 426.231. A physician taking a person into custody pursuant to ORS 426.231 at a hospital approved under OAR 309-033-0550, Standards for the Approval of Hospitals Detaining Persons in Custody Pending Transport to an Approved Holding

Hospital or Nonhospital Facility, shall detain the person for no more than 12 hours and during that time shall either:

(a) Authorize the person for transportation to an approved hospital and provide transportation according to the agreement required under OAR 309-033-0550; or

(b) Release the person, if the physician determines that the person no longer is dangerous to self or others.

(2) Custody by a peace officer or secure transport provider. A peace officer taking a person into custody shall remove the person to an approved hospital as directed by the director in the county where the person was taken into custody. The peace officer or approved secure transport provider shall only take a person into custody under the provisions of one of the following:

(a) Custody on peace officer's own initiative. A peace officer may take a person into custody pursuant to the provisions of ORS 426.228 when the peace officer has probable cause to believe that the person is dangerous to self or others, and is in need of immediate care, custody or treatment for a mental illness;

(b) Custody on the director's authority. The director may direct, pursuant to the provisions of ORS 426.233, a peace officer or an approved secure transport provider to take into custody a person who is dangerous to self or others and in need of immediate care, custody or treatment for mental illness;

(c) Custody of a committed person on the director's authority. The director may direct a peace officer or an approved secure transport provider to take into custody, pursuant to the provisions of ORS 426.233, a committed person who is on trial visit, outpatient commitment or conditional release in the community, who is dangerous to self or others or who is unable to provide for basic personal needs, who is not receiving the care that is necessary for health and safety, and who is in need of immediate care, custody or treatment for mental illness.

(d) A peace officer may transfer a person in custody under this section to the custody of an approved secure transport provider. The peace officer may meet the approved Secure transport provider at any location that is in accordance with ORS 426.140 to effect the transfer. When transferring a person in custody to an authorized person, the peace officer shall deliver the report required under subsection (3) of this section to the authorized person.

(3) Peace officer's written report. When taking a person into custody pursuant to ORS Chapter 426.228 by a peace officer's own initiative, a peace officer shall prepare a written report which states:

(a) The reason for custody;

(b) The date, time and place the person was taken into custody; and

(c) The name of the director in the county where the person is taken into custody and a telephone number where the director may be reached at all times.

(4) Director's written report. When a peace officer or approved secure transport provider takes a person into custody pursuant to ORS Chapter 426.228 at the direction of the director, a director shall prepare a written report which states:

(a) The reason for custody;

(b) The date, time and place the person was taken into custody; and

(c) The name of the director in the county where the person is taken into custody and a telephone number where the director may be reached at all times.

(5) Transportation to a hospital or nonhospital facility more than one hour away. If the peace officer determines that more than one hour is required to transport the person to a hospital or nonhospital facility approved by the Division, the peace officer or approved secure transport provider shall obtain a certificate, if possible, from a physician prior to transporting the person. A physician authorizing transport shall sign a certificate, on a form approved by the Division, only if the person's condition, in the opinion of the physician, meets all of the following requirements:

(a) The travel will not be detrimental to the person's physical health;

(b) The person is dangerous to self or others; and

(c) The person is in need of immediate care or treatment for mental illness.

(6) The director directs peace officers or approved secure transport providers to appropriate facility. The director shall adopt written procedures for directing peace officers or approved secure transport providers to transport persons taken into custody, pursuant to ORS 426.228, to an approved hospital or nonhospital facility:

(a) The written procedures shall include one of the following, whichever, in the opinion of the director, serves the best interests of persons with mental illness and the community:

(A) A list of approved hospitals or nonhospital facilities where peace officers or approved secure transport providers are to transport persons;

(B) A procedure for contacting the director 24 hours-a-day, seven days-a-week.

(b) The director shall distribute copies of the written procedures to the sheriff and the chief of police of each municipality in the county and approved secure transport providers. The procedures shall be distributed as often as the procedure is amended.

(c) The director may develop a written agreement with the law enforcement agencies in the county which designates a site or sites where the director can safely evaluate the person and

determine which facility, in the director's opinion, can best serve the person's needs within the resources available. If such an agreement exists in a county, the director may direct a peace officer to transport a person in custody under ORS 426.228 to a site designated in the agreement. Once the director makes a determination, the peace officer shall transport and deliver the person to a hospital or nonhospital facility as directed by the director. The agreement shall:

(A) Designate the site or sites where the director can safely evaluate the person's needs for treatment;

(B) Define the minimum response time for the director meeting the peace officer at the site; and

(C) Be signed by all parties to the agreement.

Stat. Auth.: ORS 413.042, 426.228, 426.231 & 426.236
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0040; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

309-033-0240

Initiation of the Civil Commitment Process

(1) Initiation. The civil commitment process is initiated when an NMI is filed with the circuit court. The NMI shall be filed with the court as directed below:

(a) Public petition. When an NMI is given to the director of the county where the allegedly mentally ill person resides pursuant to ORS 426.070, the director shall immediately file the NMI with the court in the county where the allegedly mentally ill person resides. The following persons may give an NMI to the director:

(A) Any two persons;

(B) A county health officer; or

(C) Any magistrate.

(b) Hospital hold with no request from director. When a physician admits or retains a person in a hospital pursuant to ORS 426.232, Hospital Hold, and the director in the county where the person resides makes no request for the physician to file the NMI in the county where the person resides, the physician shall file the NMI with the court in the county where the person is hospitalized;

(c) Hospital hold with request from director. When a physician admits or retains a person in a hospital pursuant to ORS 426.232, and the director in the county where the person resides requests the physician to do so, the physician shall file the NMI with the court in the county where the person resides;

(d) Hospital hold subsequent to peace officer custody with no request from director. When a physician admits a person to a hospital pursuant to ORS 426.232, subsequent to the person being brought to the hospital by a peace officer or approved secure transport provider, and the director of the county where the hospital is located makes no request, pursuant to ORS 426.234, the physician shall file the NMI with the court in the county where the person initially was taken into custody by the peace officer;

(e) Hospital hold subsequent to peace officer custody with request from director. When a physician admits a person to a hospital pursuant to ORS 426.232, subsequent to the person being brought to the hospital by a peace officer or approved secure transport provider, and the director of the county where the hospital is located requests the physician to do so, the physician shall file the NMI with the court in the county where the person is hospitalized.

(f) Nonhospital hold with no request from director. When a director in the county where the director admits or retains a person in a nonhospital facility pursuant to ORS 426.233, and the director in the county where the person resides makes no request for the director to file the NMI be filed in the county where the person resides, the director shall file the NMI with the court in the county where the person initially was taken into custody; and

(g) Nonhospital hold with request from director. When a director admits or retains a person in a nonhospital facility pursuant to ORS 426.233, and the director in the county where the person resides requests the director to do so, the director shall file the NMI with the court in the county where the person resides.

(2) Initiation of commitment proceedings by two persons, a county health officer or magistrate. The NMI shall be given to the director in the county where the allegedly mentally ill person resides. If the person has no residence, then the NMI shall be given to the director in the county where the person currently is located. The director shall file the original NMI with the court on the day the NMI is received or, if the NMI is received outside the court's routine business hours, the next day the court is open for business. The director shall retain a copy of the NMI in the clinical record as required by OAR 309-033-0930, Procedures for the Investigation.

(3) Initiation by hospital hold. The physician who takes a person into custody, pursuant to ORS 426.232, in a hospital approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion, shall:

(a) File an NMI with the appropriate court as described in OAR 309-033-0240, Initiation; and

(b) Immediately notify the director in the county in which the person was hospitalized, unless the person resides in a county other than the county where the person is hospitalized in which case the physician shall immediately notify the director in the county where the person resides.

(4) Initiation by nonhospital hold. The director, after authorizing the taking of a person into custody pursuant to the provisions of ORS 426.233 (the director's hold and trial visit hold), shall file a NMI with the appropriate court as described in OAR 309-033-0240.

(5) How a director requests where the NMI is filed. A director may request that the physician, in the case of a hospital hold, or the director of the county where the person was taken into custody, in the case of a nonhospital hold, file the NMI according to the provisions of ORS 426.234 by either:

(a) On a case by case basis. Making the request immediately upon receipt of the notice required by ORS 426.234; or

(b) Upon general request. Sending a written general request to a hospital or a director.

Stat. Auth.: ORS 413.042, 426.228, 426.231 & 426.236
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0050; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

309-033-0250

Standards for Custody, Hospital and Nonhospital Holds, Emergency Commitment and Emergency Hospitalization of Persons Under Warrant of Detention

(1) Criteria for placement into custody. Only persons who are a danger to self or others and who are in need of treatment for mental illness shall be placed in custody at a facility approved by the Division.

(2) Warrant of detention. Upon the receipt of a warrant of detention issued by the court pursuant to ORS 426.070, the director or the sheriff of the county shall take the person into custody and remove the person to a hospital approved by the Division. Whoever takes the person into custody shall inform the person of his/her rights with regard to representation by or appointment of counsel as described in ORS 426.100 and be given the warning described under ORS 426.123 and OAR 309-033-0540, Warning.

(3) Hospital hold. Only a physician with admitting privileges or on staff at a hospital approved by the Division and who has completed a face-to-face examination of the person may retain the person in custody in the hospital as provided by ORS 426.232. When implementing hospital holds, the hospital shall assure the following:

(a) The consulting physician is not required to have admitting privileges at the hospital;

(b) The hospital shall not require the consulting QMHP to be a member of the hospital's allied staff. However, the hospital may extend allied staff privileges to the consulting QMHP;

(c) The admitting physician shall document the following information on the NMI, retaining a copy of the NMI in the clinical record:

(A) Examples of indicators that support the physician's belief that the person has a mental illness;

(B) Examples of thoughts, plans, means, actions, history of dangerousness or other indicators that support the physician's belief that the person is imminently dangerous.

(4) Peace officer custody requested by director. This section establishes standards and procedures for a director to direct a peace officer to take into custody a person who the director has probable cause to believe is dangerous to self or any other person and who the director has probable cause to believe is in need of immediate care, custody or treatment for mental illness:

(a) A county governing body may authorize the director, or a person named and recommended by the director, to direct a peace officer or approved secure transport provider to take allegedly mentally ill persons into custody. Such an authorization shall be made formally and in writing by the county governing body of the director. The director shall keep a copy of each authorization in each person's personnel file:

(b) Prior to directing a peace officer or approved secure transport provider to take a person into custody, a director shall have face-to-face contact with the person and document on forms approved by the Division, the evidence for probable cause to believe that the person is:

(A) Dangerous to self or others; and

(B) In need of immediate care, custody or treatment for a mental illness.

(5) When a person in custody can be released. A person shall who is detained, in custody, or on a hold shall be released as described:

(a) Physician's release of a person on peace officer custody. When a person is brought to a hospital by a peace officer or approved secure transport provider pursuant to ORS 426.228, Peace Officer Custody, the treating physician shall release the person if, upon initial examination prior to admission, the physician makes the determination that the person is not dangerous to self or others. It is not necessary to notify the court of the release;

(b) Physician's release of a person on transport custody. At any time during the 12 hour detention period, the treating physician shall release a person detained pursuant to ORS 426.231, Transport Custody, whenever the physician makes the determination that the person is not dangerous to self or others. In no case shall a physician involuntarily detain a person at a hospital approved solely for Transport Custody under OAR 309-033-0550 longer than 12 hours. It is not necessary to notify the court of the release;

(c) Physician's release of a person on a hospital hold. The treating physician shall release a person retained or admitted to a hospital pursuant to ORS 426.232, Hospital Hold, whenever the physician makes the determination that the person is not dangerous to self or others. The treating physician shall immediately notify the director and the circuit court where the NMI was filed. See OAR 309-033-0240; or

(d) Director's release of a person on a nonhospital hold. The director shall release a person detained in a nonhospital facility, approved under OAR 309-033-0530, pursuant to ORS

426.233, Nonhospital Hold, whenever the director, in consultation with a physician, makes the determination that the person is not dangerous to self or others. The director shall immediately notify the circuit court.

(6) When a person in custody cannot be released. Once the person is admitted to a hospital or nonhospital facility, a person taken into custody pursuant to ORS 426.070 (warrant of detention), may only be released by the court. However, a person may be discharged from a hospital or nonhospital facility when the person is transferred to another approved facility.

Stat. Auth.: ORS 413.042, 426.070, 426.231, 426.232, 426.233 & 426.234
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0060; MHD 2-2000(Temp), f. & cert. ef. 1-25-00 thru 7-22-00; MHD 9-2000, f. & cert. ef. 7-21-00

309-033-0260

Diversion from Commitment Hearing

(1) Notice to court by director. The director and a psychiatrist may certify a person for diversion at any time up to three judicial days after the person has been taken into custody.

(2) Treatment plan. The director and the treating psychiatrist shall prepare a treatment plan that describes, in general terms, the types of treatment and medication to be provided during the diversion. The general treatment plan shall be descriptive of the range of services and medications to be provided, and shall include a description of:

(a) Any of the following classes of medication, if medication is to be administered:

(A) Antipsychotics;

(B) Antidepressants;

(C) Mood stabilizers;

(D) Anti-anxiety medications; or

(E) Anti-side effect medications.

(b) Mental health interventions, therapies or diagnostic procedures to be employed;

(c) The person’s preferences about medications and therapies and any limitations on the specific use of medications or therapies to which the director and the treating psychiatrist have agreed;

(d) Location where treatment is to be initiated and the type of hospital or nonhospital facilities where the person may be transferred during the diversion; or

(e) Other conditions or limitations agreed to by the person and the director concerning the care or treatment that is to be provided.

(3) Notice to person. At the initiation of the diversion period, the director and the psychiatrist shall inform the person verbally, and in writing, of the usual and typical restraints or seclusion which may be employed in an emergency to assure health or safety.

(4) Psychiatrist to provide information. The psychiatrist shall provide the information described in OAR 309-033-0620, Procedures for Obtaining Informed Consent and Information to be Given, when administering a specific medication.

(5) Consent for non-psychiatric care. A treating physician shall obtain the person's consent for non-psychiatric medical care and treatments which may be prescribed during the diversion. The general treatment plan for psychiatric intervention shall not include plans for non-psychiatric medical care or treatment.

(6) Refusal of treatment/demand for discharge. The person on diversion may refuse psychiatric treatment described in the general treatment plan or demand discharge at any time during the diversion by signing the form described in this paragraph or, if the person refuses to sign the form, by verbally making his or her refusal of treatment or demand for discharge known to two staff of

the facility. In accepting the person's refusal of treatment or demand for discharge the staff of the facility shall:

(a) Provide the person a warning, both verbally and in writing, at the person's first indication that he/she wishes to refuse treatment or demand discharge, which states:

"If you refuse psychiatric treatment described in the general treatment plan or demand to be discharged you may be required to appear at an involuntary civil commitment hearing. It is your right to request an involuntary civil commitment hearing at this time. If a judge finds you to be a mentally ill person you may be committed for up to 180 days. However, if a judge finds you not to be a mentally ill person you may be released. The treatment in which you were to participate as a condition of avoiding a commitment hearing is described in your general treatment plan. You were given a copy of your general treatment plan when you agreed to diversion. You may see the copy of your general treatment plan on file with this facility at any time. You may talk with your attorney before you refuse this treatment, demand discharge or request a hearing."

(b) If the person refuses treatment, demands discharge or requests a hearing, offer the person the following form to sign:

"Warning

If you refuse psychiatric treatment described in your general treatment plan or demand discharge you may be required to appear at an involuntary civil commitment hearing. You have a right to request an involuntary civil commitment hearing at this time. If a judge finds you to be a

mentally ill person you may be committed for up to 180 days. The psychiatric treatment in which you were to participate as a condition of avoiding a commitment hearing is described in your general treatment plan. You were given a copy of your general treatment plan when you agreed to diversion. You may see the copy of your general treatment plan on file with this facility at any time. You may talk with your attorney before you refuse this treatment, demand discharge or request a hearing.

I refuse the treatment described in my general treatment plan.

I request a hearing before the circuit court.

_____

Signature of Certified Person.-

(c) If the person refuses to sign the form described in this section and verbally or nonverbally refuses treatment, the staff of the facility shall document the person's refusal on the form and in the person's clinical record;

(d) Immediately upon the person's refusal of treatment, demand for discharge or request for a hearing, the treating physician shall treat the person as a person in custody, as provided under ORS 426.072, and shall immediately notify the director. The director shall immediately request a hearing.

(7) Director of the county of residence approval of payment for diversion. A person shall be on diversion only if payment for the care, custody and treatment is approved verbally by the director of the county of residence as provided under ORS 426.237. The director of the county of residence's approval shall be documented by a written statement, signed by the director, and distributed by the end of the diversion period as follows:

(a) The original shall be filed in the clinical record at the CMHP; and

(b) A copy shall be delivered to each facility serving the person during the diversion.

Stat. Auth.: ORS 413.042, 426.236 & 426.237
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0070

309-033-0270

Provision of Care, Custody and Treatment of Persons Committed to the Division

(1) Provision of rights. In addition to the rights provided under ORS 426.385, committed persons also have the rights provided under ORS 430.205 through 430.210 and this rule, including:

(a) A Committed Person's Right to Fresh Air. For the purpose of this rule, these terms have the following meanings:

(A) "Fresh air- means the inflow of air from outside the facility where the committed person is receiving services. "Fresh air- may be accessed through an open window or similar method as well as through access to the outdoors.

(B) "Outdoors- means an area with fresh air that is not completely enclosed overhead. "Outdoors- may include a courtyard or similar area.

(b) If a committed person requests access to fresh air and the outdoors or the committed person's treating health care provider determines that fresh air or the outdoors would be beneficial to the committed person, the facility in which the committed person is receiving services shall provide daily access to fresh air and the outdoors unless this access would create a significant risk of harm to the committed person or others.

(c) The determination whether a significant risk of harm to the committed person or others exists shall be made by the committed person's treating health care provider. The treating health care provider may find that a significant risk of harm to the committed person or others exists if:

(A) The committed person's individual circumstances and condition indicate an unreasonable risk of harm to the committed person or others which cannot be reasonably accommodated within existing programming should the committed person be allowed access to fresh air and the outdoors; or

(B) The facility's existing physical plant or existing staffing prevent the provision of access to fresh air and the outdoors in a manner than maintains the safety of the committed person or others.

(d) If a facility determines that its existing physical plant prevents the provision of access to fresh air and the outdoors in a safe manner, the facility shall make a good faith effort at the time of any significant renovation to the physical plant that involves renovation of the unit or relocation of where committed persons are treated to include changes to the physical plan or location that allow access to fresh air and the outdoors, so long as such changes do not add an unreasonable amount to the cost of the renovation.

(2) Provision of care at a state hospital. The superintendent of the state hospital serving the county of commitment shall be responsible for all admissions to the state hospital:

(a) The superintendent, in consultation with the director, shall determine whether the best interests of a committed person are served by an admission to the state hospital;

(b) The superintendent shall implement policies and procedures which afford a committed person placed in a state hospital the rights provided by ORS 426.385, 430.205 through 430.210 and this rule.

(3) Provision of care at a community hospital. The director shall assign and place a committed person only at a community hospital approved under OAR 309-033-0530:

(a) The admitting physician, in consultation with the director, shall determine whether the best interests of a committed person are served by an admission to a community hospital;

(b) The administrator shall implement policies and procedures which afford a committed person placed in a community hospital the rights provided by ORS 426.385, 430.205 through 430.210 and this rule.

(4) Provision of care at a nonhospital facility or an outpatient program. The director shall only assign and place a committed person in a nonhospital facility that is licensed or certified by the Division:

(a) The administrator, in consultation with the director, shall determine whether the best interests of a committed person are served by an admission to a nonhospital facility or an outpatient program;

(b) The administrator shall implement policies and procedures which afford a committed person placed in a nonhospital facility or an outpatient program the rights provided by ORS 426.385, 430.205 through 430.210 and this rule;

(c) The director shall place on a trial visit a committed person who is discharged from a state hospital or a community hospital when the director assigns and places the person in a nonhospital facility;

(d) The director shall place a committed person, who the court has ordered on outpatient commitment at the commitment hearing, on outpatient commitment when the director assigns and places the person in a nonhospital facility.

(5) Provision of medical services for a committed person. The superintendent of a state hospital, the treating physician at a community hospital or the director may transfer a committed person to a general hospital, or transfer a committed person from a psychiatric ward to a medical ward for medical care:

(a) The treating physician shall only provide medical care with the consent of the committed person in accordance with OAR 309-033-0600 through 309-033-0650;

(b) The superintendent or treating physician shall transfer a committed person to a general hospital for medical services on a pass or discharge the person from the state hospital when it is determined that the person will not return to the state hospital within a reasonable length of time, or that discharge is clinically appropriate and is required for the person to have access to third-party insurance benefits;

(c) The treating physician shall immediately notify the director that a person was transferred to another hospital for medical care under this subsection.

Stat. Auth.: ORS 413.042, 426.060, 426.385 & 430.205 – 430.210
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0080; MHS 5-2009, f. & cert. ef. 12-17-09

309-033-0280

Procedures for Committed Persons on Outpatient Commitment or Trial Visit

(1) Outpatient commitment. At the time of the commitment hearing the director may place a committed person on an outpatient commitment if adequate treatment services are available in the county. The director shall be responsible for:

(a) Enrolling the committed person in treatment services and assuring that the committed person has an opportunity to participate in the development of the treatment plan;

(b) Distributing the conditions of placement as pursuant to ORS 426.278 and OAR 309-033-0280, Distribution of the Conditions of Placement, below;

(c) Monitoring and documenting the provision and consumption of services which fulfill the conditions set for the outpatient commitment;

(d) Petitioning the court for a revocation hearing if the best interests of the committed person require a modification in the conditions of placement for a treatment option which is more restrictive;

(e) With the participation of the committed person, changing the conditions to less restrictive conditions, if appropriate; and

(f) Documenting in the clinical record any conditions of placement requiring modification by means of a report which:

(A) Documents the need for a change in the conditions of outpatient commitment;

(B) Sets new conditions of commitment;

(C) Describes the reasons for the new conditions;

(D) Is signed by the committed person and the mental health professional assigned to the case, or, if the committed person refuses to sign the new conditions of placement, such fact shall be documented in the report; and

(E) Documents that a copy of the changes and the reasons for the changes was distributed to appropriate persons described in OAR 309-033-0280, Distribution of the Conditions of Placement, below.

(2) Trial visit. The director may grant a trial visit to any committed person during a period of commitment, upon approval of the director of the county of placement. A director may grant a trial visit to any committed person during a period of community inpatient treatment. While it may be clinically advisable, the director is not required to obtain the consent or signature of the committed person:

(a) Trial visit of a committed person shall not exceed the time remaining in the period of commitment;

(b) Conditions for trial visit shall include designation of a facility, service or other provider to provide care or treatment;

(c) The director shall place the person on trial visit in accordance with OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division;

(d) The director shall evaluate any complaints received from any person concerning the behavior or treatment of a committed person on trial visit. The director shall document the results of the evaluation in the clinical record;

(e) Modification of the conditions of trial visit. The director may modify the conditions of placement for trial visit:

(A) Any modification shall not include a treatment option which is more restrictive than the current conditions of placement;

(B) The director shall petition the court for a revocation hearing if the best interests of the committed person require a modification in the conditions of placement for a treatment option which is more restrictive;

(C) The director shall document in the clinical record any conditions of placement requiring modification by means of a report which:

(i) Documents the need for a change in the conditions of outpatient commitment;

(ii) Sets new conditions of commitment;

(iii) Describes the reasons for the new conditions;

(iv) Is signed by the committed person and the mental health professional assigned to the case, or, if the committed person refuses to sign the new conditions of placement, such fact shall be documented in the clinical record; and

(v) Documents that a copy of the changes and the reasons for the changes was distributed to appropriate persons provided under ORS 426.278 and OAR 309-033-0280, Distribution of the Conditions of Placement, below.

(f) Transfer of trial visit to another county. The director may transfer a person on trial visit to another county only if the director for the county where the person will reside agrees to accept the trial visit:

(A) The director of the county where the person currently resides shall provide the director of the county where the person will reside a copy of the current treatment plan for the person on trial visit;

(B) Immediately upon accepting the trial visit the director of the county where the person will reside shall enroll the person on trial visit in treatment services and shall make any modifications in the trial visit as necessary and distribute the modified conditions of placement as required under OAR 309-033-0280, Distribution of the Conditions of Placement, below.

(3) Distribution of the conditions of placement. When a committed person is placed on conditional release, outpatient commitment or trial visit, or when the conditions of placement are modified in any manner, the current conditions of placement shall be distributed by the director to the following persons, pursuant to ORS 426.278:

(a) The committed person;

(b) The director of the county in which the committed person is to receive hospital, nonhospital or outpatient treatment;

(c) The administrator of any facility, service or other provider designated to provide care or treatment;

(d) The court of current commitment; and

(e) The appropriate court of the county in which the committed person lives during the commitment period if the person is living in a different county than the county of the court that made the current commitment.

Stat. Auth.: ORS 413.042, 426.127, 426.273 & 426.278
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0090

309-033-0290

Assignment and Placement of Persons Committed to the Division

(1) Assignment authority. The Division, pursuant to ORS 426.060, delegates the responsibility for the assignment and placement of committed persons to the director of the county of commitment:

(a) The director may assign or transfer a committed person to any facility or program approved by the Division which, in the opinion of the director, will appropriately meet the mental health needs of the committed person;

(b) The director may discharge the committed person from commitment by notifying, in writing, the court having jurisdiction, if the director determines the person no longer is a mentally ill person as defined by ORS 426.005.

(2) Assignment outside the county of residence. The director of the county of commitment may assign the committed person to a facility in a county other than the county of residence only with the approval of the director of the county of residence and the director of the county of placement:

(a) When the director of the county of commitment assigns a committed person under this section, the director of the county of commitment shall transfer the responsibility for assignment and placement to the director of the county of placement;

(b) The Assistant Administrator shall assign a committed person under this section when the director of the county of commitment, the director of the county of residence and the director of the county of placement determine that they cannot agree on the assignment of the person and request the Division to make the assignment:

(A) The Assistant Administrator shall determine fiscal responsibility for the services to be delivered to the committed person and shall look to existing applicable laws, contracts and interagency agreements;

(B) The decision of the Assistant Administrator shall be final.

(c) When placement is determined, the director of the county of placement shall accept the responsibility for further assignment and placement;

(d) The director of the county of commitment shall petition the court in the county where the person was committed to transfer jurisdiction to the court in the county where the person is to reside, pursuant to ORS 426.275.

(3) Assignment to a state hospital. The director of the county of commitment shall only assign and place a committed person in a state hospital with the consent of the superintendent.

(4) Assignment procedure. The director of the county of commitment shall make the assignment in writing immediately upon commitment of a person by the court or at the time the placement of a committed person is changed during the commitment period. The director shall:

(a) Retain an original assignment order on file in safe keeping for seven years;

(b) Deliver a signed original copy of the assignment order to the person prior to placement;

(c) Enter into the Division's current computer data system information about the committed person including:

(A) Name and any known aliases;

(B) Date of birth;

(C) Address of current residence;

(D) Address where assigned for treatment if different from residence;

(E) Name and telephone number of the administrator of the hospital, facility or program responsible for the person's treatment; and

(F) Any other data as requested by the Division.

(d) Out of county assignments shall include a statement that assignment and placement responsibility is transferred to the director of the county of placement.

(5) Appeal of assignment procedure. At any time during the period of commitment, a committed person may appeal to the Assistant Administrator for Mental Health for a change in assignment made by a director.

(a) How to make an appeal. The committed person shall make the appeal in writing and shall include the following information in the appeal:

(A) A statement that the committed person appeals the current assignment;

(B) The reason(s) the committed person believes the current assignment is inappropriate; and

(C) The proposed alternate placement and the reasons the committed person is requesting the alternate placement.

(b) Appeal of an assignment to a community hospital or to the community. The Assistant Administrator shall make a determination of an appealed assignment for persons currently assigned to community hospitals or community placements. The Assistant Administrator shall determine the assignment for the committed person, and notify the committed person of the assignment, in writing or verbally, within five business days of the receipt of the written appeal. The Assistant Administrator's determination shall be final:

(A) In making a determination of an appealed assignment the Assistant Administrator:

(i) Shall review the written appeal;

(ii) Shall contact the director making the assignment, and consider the director's reason(s) for making the assignment;

(iii) Shall consider the opinion of the person's treating physician if the person is placed at a community hospital;

(iv) May require the director to submit a written statement which gives the reason(s) for the assignment; and

(v) May consider the consultation or opinion of any person that the Assistant Administrator believes has knowledge relevant to the case.

(B) The Assistant Administrator shall use the following criteria when making a determination of an appealed assignment:

(i) The assignment shall be in the best interests of the committed person;

(ii) The assignment shall assure the safety of the person and the community; and

(iii) The assignment shall be in the least restrictive environment that the resources of the person or Division will allow.

(c) Appeal of an assignment to a state hospital. The Administrator shall make a determination of an appealed assignment for persons currently assigned to a state hospital or where the appeal requests assignment to a state hospital. The Administrator shall determine the assignment for the committed person, and notify the committed person of the assignment, in writing or verbally, within five business days of the receipt of the written appeal. The Administrator's determination shall be final:

(A) In making a determination of an appealed assignment the Administrator shall consider the opinion of the superintendent, or designee, of the state hospital affected by the appeal, and the report of the Assistant Administrator. In making the report to the Administrator, the Assistant Administrator:

(i) Shall review the written appeal;

(ii) Shall contact the director making the assignment, and consider the director's reason(s) for making the assignment;

(iii) Shall consider the opinion of the person's treating physician if the person is placed at a community hospital;

(iv) May require the director to submit a written statement which gives the reason(s) for the assignment;

(v) May consider the consultation or opinion of any person that the Assistant Administrator believes has knowledge relevant to the case;

(vi) Shall make a recommendation about the proposed assignment; and

(vii) Shall submit the report within three business days after the Division receives the appeal.

(B) The Administrator shall use the following criteria when making a determination of an appealed assignment:

(i) The assignment shall be in the best interests of the committed person;

(ii) The assignment shall assure the safety of the person and the community; and

(iii) The assignment shall be in the least restrictive environment that the resources of the person or Division will allow.

Stat. Auth.: ORS 413.042, 426.060
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0100

309-033-0300

Transfers Between Classes of Facilities

(1) Transfers between classes of facilities. The director may transfer a committed person from one class of facility to another in the same class or in a less restrictive class as provided by ORS 426.060. However, the director shall transfer a committed person who has voluntarily agreed to placement at the facility only with the written consent of the person. The director shall transfer committed persons as provided by OAR 309-033-0400 through 309-033-0440, Standards for Transportation and Transfer of Persons in Custody or on Diversion, and OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division. The director shall modify the conditions of trial visit to reflect the change of placement and shall notify the following persons of the transfer:

(a) The committed person;

(b) The court in the county where the person was committed;

(c) The court in the county where the person is to be placed;

(d) The director in the county where the person is to reside;

(e) The administrator of the facility designated to provide care or treatment; and

(f) Any other provider designated to provide care or treatment.

(2) Transfers restricted by rule. The director may transfer a committed person from a facility of one class to another facility of a same class or lower class by:

(a) Assigning the committed person to the new facility; and

(b) Modifying the person's commitment status as follows:

(A) Persons transferred to a Class 2 or Class 3 facility. When the director transfers a committed person to a Class 2 or Class 3 facility, the director shall place the person on trial visit (see OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division);

(B) Transfers between Class 1 hospitals or facilities. The director shall transfer a person between Class 1 hospitals or facilities without placing the committed person on trial visit; or

(C) Transfer to any facility and discharged from commitment. When the director determines a committed person is no longer a mentally ill person, the director shall discharge the person from commitment (see OAR 309-033-0330, Discharge of Committed Persons from Commitment Status) and enroll the person in services voluntarily at the receiving facility.

(3) Transfers from a facility of one class to a facility of a more restrictive class:

(a) Involuntary transfers of committed persons. The director shall transfer a committed person, who is on trial visit, to a facility of a more restrictive class only:

(A) By order of the court after a hearing, pursuant to ORS 426.275; or

(B) Initiate involuntary procedures as provided in this paragraph and as provided by ORS 426.233 (see subparagraph (c) of this paragraph).

(b) Voluntary transfers of committed persons. The director may transfer a committed person, who is on trial visit, to a facility of a more restrictive class with the committed person's consent. However, if the committed person revokes his/her consent to the current more restrictive placement and requests to be placed at another facility of a less restrictive class, as soon as reasonably possible the director shall:

(A) Transfer the person to a facility where the person consents to receive services; or

(B) Initiate involuntary procedures as provided in this paragraph and by ORS 426.233.

(c) Emergency transfers of committed persons. As provided by ORS 426.233, the director may transfer a committed person, who is on trial visit, to a hospital or nonhospital facility approved by the Division when the director has probable cause to believe the person is dangerous to self or others or unable to provide for basic personal needs and is not receiving the care that is necessary for health and safety, and is in need of care, custody or treatment for mental illness. Upon the recommendation of the investigator, the director shall request the court to revoke the person's trial visit or recertify the person for continued commitment at a more restrictive facility as provided by ORS 426.275.

(4) Authority to retake persons. A Class 1 or Class 2 facility shall immediately notify a peace officer and the Division of any person who has left the facility without lawful authority and shall immediately request the assistance of a peace officer(s) in retaking and returning the person to a

Division-approved hospital or facility. The director shall show the peace officer a copy of the order of commitment.

Stat. Auth.: ORS 413.042, 426.060, 426.223, 426.233, 426.273, 426.275 & 426.278
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0110

309-033-0310

Recertification for Continued Commitment

(1) Recertification for continued commitment of persons placed in a state hospital:

(a) After consulting with the director of the person's county of residence, the superintendent shall issue a recertification to:

(A) The person whose 180 day period of commitment is due to expire, if the person is still mentally ill and in need of further treatment; and

(B) The director.

(b) The superintendent shall notify the court concerning:

(A) The date the recertification was issued to the person; and

(B) Whether the person protests, within 14 days of the issuance of the recertification, to continued commitment.

(2) Recertification for continued commitment of persons placed in a community hospital or nonhospital facility:

(a) After consulting with the director of the person's county of residence, the director shall issue a recertification to:

(A) The person whose 180 day period of commitment is due to expire, if the person is still mentally ill and in need of further treatment; and

(B) The director of the person's county of residence.

(b) The director shall notify the court concerning:

(A) The date recertification was issued to the person; and

(B) Whether the person protests continued commitment, within 14 days of the issuance of the recertification.

(3) Documentation of recertification for continued commitment in the clinical record. The director or the superintendent making the recertification shall include in the clinical record:

(a) The date and time the director's approval of continued commitment was obtained prior to the recertification being issued to the person;

(b) The date and time the recertification was issued to the persons;

(c) A copy of the recertification issued to the person;

(d) Concerning the notification to the court of the date the recertification was issued to the person:

(A) The date and time that the court was notified of the issuance of the recertification to the person; and

(B) A copy of the notification.

(e) Concerning the notification to the court of whether the person protests continued commitment, within 14 days of the issuance of the recertification:

(A) The date and time that the court was notified of whether the person protests; and

(B) A copy of the notification to the court whether the person protests.

(f) If an examination is requested by the person:

(A) The name of the psychiatrist or the certified mental health examiner ordered by the court to conduct the examination;

(B) The date that the examination was conducted; and

(C) A copy of the examination report sent to the court.

(g) If the court orders continued commitment, a copy of the order continuing the commitment; and

(h) If the court orders the release of the person:

(A) A copy of the order requiring release;

(B) If the person consents to services upon discharge, a copy of an aftercare plan signed by the person and the name of the case manager responsible for arranging outpatient services; or

(C) If the person refuses services upon discharge, a statement signed by the person indicating the person's refusal of outpatient services; and

(D) The date and time the person was released from the facility.

Stat. Auth.: ORS 413.042, 426.301, 426.307 & 430.041
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0120

309-033-0320

Revocation of Conditional Release, Outpatient Commitment or Trial Visit

(1) Conditional release. A caregiver appointed by the court to care for a committed person on conditional release is responsible for reporting to the court any violation of the conditions of placement. If a person on conditional release, whose conditions of placement include any service agreed to be provided by a CMHP, violates the conditions of conditional release, the director shall include in the clinical record a revocation report which documents the following:

(a) The person's noncompliance with those conditions of placement that include services provided by the CMHP;

(b) Efforts by the CMHP to inform the caregiver of the noncompliance and the caregiver's response to these efforts;

(c) Requests by the caregiver for the CMHP to assist in obtaining compliance from the committed person, or in notifying the court of the person's failure to comply with the conditions of placement, and the CMHP response to the requests for assistance;

(d) Documentation of the disposition made by the court, if the caregiver submits notification to the court; and

(e) The date the person was transported to an inpatient facility, and the name of the facility, if appropriate.

(2) Outpatient commitment and trial visit. The director is responsible for reporting to the court any violation of the conditions of placement for persons on outpatient commitment (including community inpatient or outpatient treatment) or trial visit. For persons on outpatient commitment or trial visit, the director shall include in the clinical record a revocation report which includes the following:

(a) Documentation of the person's noncompliance with the conditions of placement;

(b) Documentation of efforts from all parties attempting to obtain compliance from the committed person and the response of the person to these efforts;

(c) A copy of the notification to the court of the person's failure to comply with the conditions of placement;

(d) Documentation of the disposition made by the court;

(e) Documentation of the distribution of any modified conditions of placement or disposition placing the person in inpatient treatment to all parties originally receiving copies of the conditions of placement; and

(f) Date the person was transported to an inpatient facility, and the name of the facility, if appropriate.

Stat. Auth.: ORS 413.042 & 426.275
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0130

309-033-0330

Discharge of Committed Persons, Who Are Placed in the Community, from Commitment Status

(1) Only director of county of placement may discharge. Only the director of the county of placement may change the commitment status of a committed person placed in a community hospital or other community facility:

(a) The director shall discharge a person from commitment when:

(A) Release from treating facility. The director believes the committed person is no longer a mentally ill person as defined in ORS 426.005, and the person is to be released from the treating facility.

(B) Transfer to voluntary status. The director believes it is in the best interests of the person to transfer a committed person to voluntary status, but the person is to remain at the treating facility.

(b) The director shall discharge a person from commitment by notifying the last committing court and the court of residence, pursuant to the provisions of ORS 426.300.

(2) Discharge required unless new assignment and placement made. The director of the county of commitment shall discharge a person from commitment when a committed person is discharged from a hospital, nonhospital or residential facility, or an outpatient treatment program where the person has been assigned and placed unless the director of the county of commitment assigns and places the person with another provider of service as provided by OAR 309-033-0290, Assignment and Placement of Persons Committed to the Division.

(3) Persons required to notify director prior to discharge. The following persons shall notify the director of the county of commitment 48 hours before discharging a person from a hospital, nonhospital or residential facility, or outpatient treatment:

(a) If the committed person is in a state hospital, the superintendent or designee shall notify the director;

(b) If the committed person is in a hospital serving as a regional acute care hospital or a private hospital, the treating physician shall notify the director;

(c) If the committed person is in a nonhospital or residential facility, the administrator of the facility shall notify the director;

(d) If the person is on trial visit, outpatient commitment or conditional release receiving outpatient treatment, and is not living in a nonhospital or residential facility, the administrator of the program where the person is receiving outpatient treatment shall notify the director.

(4) Procedures for discharge. The director shall give written notice to the committed person within thirty days after the commitment was terminated. The notice shall state the date the commitment expired or was terminated. A copy of the notice shall be kept in the person's clinical record.

Stat. Auth.: ORS 413.042 & 426.300
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0140

309-033-0340

Variances

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept or procedure proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Division review. The Assistant Administrator or designee of the Division shall approve or deny the request for a variance.

(4) Notification. The Division shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Office.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovern-mental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 6-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-200-0150
Standards for Transportation and Transfer of Persons in Custody or on Diversion

309-033-0400

Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures relating to the involuntary commitment of mentally ill persons.

(2) Statutory authority. These rules are authorized by ORS 426.395.041, and 426.005 through 426.395 and carry out the provisions of ORS 426.005 through 426.395.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0000

309-033-0410

Definitions

(1) “Administrator- means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. “Administrator- has the same meaning as “director of the facility- as that term is defined in ORS 426.005. Whenever “administrator- appears it means the administrator or designee.

(2) “CMHP- means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems,

mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(3) “Community hospital- means any hospital that is not a state hospital.

(4) “Court- means the circuit court acting pursuant to ORS Chapter 426.

(5) “Custody- means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer or approved secure transport provider pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer or approved secure transport provider at the direction of the director pursuant to ORS 426.233;

(c) A health care facility licensed under ORS Chapter 441 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(6) “Director- means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. “Director- also means a person who has been authorized by the director to act in the director’s capacity for the purpose of this rule. In the case of the director ordering a peace officer or approved secure transport provider to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(7) “Director of the county of commitment- means the director for the county where the person is committed.

(8) “Division- means the Addictions and Mental Health Division of the Oregon Health Authority.

(9) “Mechanical Restraint- is any object or apparatus, device or contraption applied or affixed to the person to limit movement, and includes, but is not limited to handcuffs, leg irons, soft restraints or Posey Strait Jacket.

(10) “Secure transport provider- means any service which uses privately or publicly owned motor vehicles, other than city, county or state police, to transport Persons in Custody or on Diversion to an Approved Holding Hospital or NonHospital Facility.

(11) “State hospital- means Oregon State Hospital in Salem and Portland, and Eastern Oregon Psychiatric Center in Pendleton.

(12) “Superintendent- means the chief executive officer of a state hospital, or designee, or a person authorized by the superintendent to act in the superintendent’s capacity for the purpose of this rule.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232 & 426.236
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0010; MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; MHD 10-2000, f. & cert. ef. 7-21-00

309-033-0420

Transportation and Transfer of Persons in Custody or On Diversion

(1) Notification of court. The director shall immediately inform the court of a transfer and the location of the person and of the time the person is admitted to a new hospital or nonhospital facility.

(2) Transfer of persons in custody or on diversion. The director may transfer a person who is in custody or on diversion only when:

(a) The director believes there is an approved facility available that can provide necessary care or treatment which is sufficient to meet the emergency psychiatric needs of the person;

(b) The facility is approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion, to provide care, custody and treatment of persons in custody or on diversion;

(c) The director has obtained the consent required by OAR 309-033-0420(3), Consent by Treating Physician and Receiving Physician or Director for Transfer Between Hospitals, through 309-033-0420(4), Consent by Treating Physician for Transfer from Nonhospital Facility to Hospital.

(3) Consent by treating physician and receiving physician or director for transfer between hospitals. If the transfer is from a hospital to another hospital or to a nonhospital facility, the director shall obtain the consent of the treating physician, and the receiving physician or the director of the nonhospital facility, prior to transferring the person:

(a) The treating physician shall give consent by writing in the person’s clinical record an order over the physician’s signature within 24 hours of giving verbal, telephonic or facsimile consent;

(b) The receiving physician at a hospital or the administrator of a nonhospital facility shall accept the transfer orally or telephonically, and shall document the acceptance in the clinical record of the person.

(4) Consent by treating physician for transfer from nonhospital facility to hospital. If the transfer is from a nonhospital facility to a hospital, the director shall obtain the consent of the receiving physician prior to transferring the person:

(a) The receiving physician shall give consent by writing in the person's clinical record an order over the physician's signature within 24 hours of giving verbal, telephonic or facsimile consent to admit the person to the hospital;

(b) The director shall provide the nonhospital facility written approval of the transfer within 24 hours of giving verbal, telephonic or facsimile approval of the transfer;

(c) The administrator of the nonhospital facility shall document the director's verbal or telephonic approval and retain written approval of the transfer in the clinical record of the person.

(5) Consent by administrator for transfer between nonhospital facilities. If the transfer is from one nonhospital facility to another nonhospital facility, the director shall obtain the verbal, telephonic or facsimile consent of the administrator of the receiving nonhospital facility prior to transferring the person:

(a) The administrator of the receiving nonhospital facility shall consent to the transfer by documenting in the person's clinical record the consent within 24 hours of giving verbal, telephonic or facsimile consent;

(b) The director shall provide the nonhospital facility written approval of the transfer within 24 hours of giving verbal, telephonic or facsimile approval of the transfer;

(c) The administrator of the sending nonhospital facility shall document the director's verbal, telephonic or facsimile approval and retain written approval of the transfer in the clinical record of the person.

(6) Notice to person to be transferred. Except in cases of emergency, twenty-four hours before the transfer is to take place, the director shall provide a notice to the person to be transferred which includes:

(a) Transfer date and time;

(b) A statement that the person may use the grievance procedure; and a brief description of how to initiate a grievance; and

(c) Justification for the transfer.

Stat. Auth.: ORS 413.042, 426.060 & 426.235
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0030

309-033-0430

Transportation of a Committed Person to a State Hospital, Community Hospital or Nonhospital Facility

(1) Transportation of a committed person to a state hospital, community hospital or nonhospital facility. The director of the county of commitment shall arrange for the transportation of committed persons to the hospital or nonhospital facility:

(a) Only committed persons who have received prior approval for admission by the superintendent may be transported to a state hospital;

(b) A guardian, friend or relative may transport the committed person to the designated facility if all the following are met:

(A) The guardian, friend, or relative requests to transport the person to the designated facility prior to or at the time of the commitment hearing;

(B) The committing judge at the commitment hearing determines that the means of transportation would not be detrimental to the welfare of the mentally ill person or to the public.

(2) Medically unstable committed persons. The costs of providing care, custody and treatment for a committed person who is unable to be transported or cannot be admitted to a state hospital because of medical necessity shall be paid by the county of residence from funds provided it by the Division for the provision of mental health services. The hospital or other facility shall charge to and collect from the county of residence only after the hospital or other facility has charged to and collected from the person, third party payers or agencies otherwise legally responsible for the costs of emergency care, custody and treatment, as it would for any other patient.

(3) Transfer of a committed person to another hospital. The administrator of a facility caring for a committed person may transfer the person only with the recommendation of the director of the county of residence and the approval of the administrator of the receiving facility.

(4) Transfer of a committed person to voluntary status or discharge for commitment. The superintendent of a state hospital, on his/her own initiative or on the request of the committed person, shall transfer the committed person to voluntary status if the superintendent believes with reasonable medical certainty that the person will pursue voluntary treatment. The superintendent of a state hospital may discharge the person from commitment when the person meets the criteria for discharge in OAR 309-031-0210, Criteria for Admission to and Discharge from State or Other Adult Inpatient Psychiatric Hospitals:

(a) The administrator of a community hospital or nonhospital facility, other than a state hospital, caring for the committed person, in consultation with the director, may transfer the person to voluntary status or discharge the person from commitment;

(b) When a person is transferred to voluntary status, the superintendent or administrator shall notify the director and the court of the county of current commitment of such action within 72 hours;

(c) Any committed person transferred to voluntary status shall be discharged from the treating facility, at the request of the person or his legal guardian, within 72 hours of the request unless the person meets the criteria for prehearing custody and is placed in custody, thus initiating the commitment process.

(5) Grievance of transfer. The director and the superintendent shall have written procedures for resolving grievances about the transfer of committed persons from one facility to another. The director or the superintendent shall suspend the transfer of the person, until the grievance procedure is completed, unless immediate transfer is necessary for health or safety, upon the written or verbal protest of one of the following persons:

(a) The person being transferred;

(b) The legal guardian of the person being transferred.

Stat. Auth.: ORS 413.042, 426.150
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0040

309-033-0432

Standards for the Approval of a Secure Transport Provider to Transport a Person in Custody or On Diversion to an Approved Holding Hospital or Nonhospital Facility

(1) Approved Secure transport provider. A Secure transport provider must be approved by the Division under this rule in order to transport a person pursuant to the provisions of ORS 426.228, 426.231, and 426.233. A Secure transport provider approved under this rule may transport the person only to a hospital or nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion.

(2) Application for approval. A Secure transport provider shall submit a letter of application to the Division. If approved, a certificate of approval will be issued to the Secure transport provider to provide such services. This approval shall be renewed every two years subject to the application of the Secure transport provider and review by the Division.

(3) Requirements for approval include all of the following:

(a) Secure transport providers must comply with the requirements OAR 309-033-0435, Client Rights with Regards to a Secure Transport Provider, and OAR 309-033-0437, Mechanical Restraint by a Secure Transport Provider.

(b) The governing body of the county in which the secure transport is to be used shall submit a letter formally authorizing the Secure transport provider to Transport Persons in Custody or on Diversion.

(c) The director in the county in which the secure transport is to be used shall submit a letter of recommendation for approval to the Division on behalf of the Secure transport provider.

(d) The vehicles of the Secure transport provider must:

(A) Have a secured rear seat in an area separated from the driver:

(B) Have a safety shield that prohibits physical contact with the driver;

(C) Have plexiglass or secured window guards covering any windows in the secured area;

(D) Be washable and nonbreakable in the secured area;

(E) Be absent of inside locks or door handles in the secured area;

(F) Have wrist and ankle restraints (preferably soft non-metal) for use when necessary to control violent or overt behavior;

(G) Be absent of any foreign item(s) or instrument(s) in the secured area that may be used by the client to inflict harm to self, attendant or person accompanying client;

(H) Have an operating cellular phone or other communication device for use in transit;

(I) Have adequate ventilation/heating appropriate to the secured seating.

Stat. Auth.: ORS 413.042, 430.041
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; MHD 10-2000, f. & cert. ef. 7-21-00

309-033-0435

Client Rights with Regards to a Secure Transport Provider

(1) A secure transport provider shall maintain written policies and procedures with regard to client rights. The policies and procedures must assure that a client has the right to be treated with consideration, respect, and full recognition of human dignity and individuality. These rights are in addition to any other rights provided for in law.

(2) The client care policies and procedures must include but are not limited to:

(a) Considerate and respectful care;

(b) Reasonable privacy concerning a client's transportation and care;

(c) Confidentiality of all communications and records relating to client transportation and care except to the extent otherwise required by law;

(d) An environment in the secure transport that is free from recognized hazards.

(3) A secure transport provider shall keep a record of any formal complaint or report of misconduct made against an employee. The record must contain a copy of the complaint or report or a detailed written summary of the allegation. A provider shall investigate the accuracy of the complaint, report, or allegation and shall include a summary of the investigation and resulting action taken, if any, in the record. These records must be included in the driver's file with a copy provided to the Division.

(4) A secure transport provider shall report any client abuse in accordance with OAR 407-045-0250 through 407-045-0370.

(5) A secure transport provider shall obtain criminal offender information on all employees who are Transporting a Person in Custody or on Diversion in accordance with OAR chapter 407, division 007.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 426.005 – 426.395

Hist.: MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; MHD 10-2000, f. & cert. ef. 7-21-00; MHS 5-2007, f. & cert. ef. 5-25-07]

309-033-0437

Mechanical Restraint by a Secure Transport Provider

(1) A mechanical restraint may be used by secure transport providers in emergency situations to prevent a person from inflicting immediate and serious harm to self or others, or property. A mechanical restraint shall only be used for health and safety reasons. Mechanical restraint that results in injury to the person requires immediate written notification to the Division.

(2) Checking a person in a mechanical restraint:

(a) The provider shall monitor the client's need for adequate circulation.

(b) Staff shall document that the client was checked and appropriate attention paid to the person's needs.

(3) A Secure transport provider shall have adequately trained employees who are transporting a person in custody or on diversion.

(a) The employee shall participate in four hours of training annually. The training curriculum shall include: the management of aggressive behavior, the proper application of mechanical restraint and standards for the proper use of mechanical restraint.

(b) The employee shall be certified in cardiopulmonary resuscitation.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; MHD 10-2000, f. & cert. ef. 7-21-00

309-033-0440

Variance

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept or procedure proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Division review. The Assistant Administrator or designee of the Division shall approve or deny the request for a variance.

(4) Notification. The Division shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Division.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 413.042, 426.060 & 426.235
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 7-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-205-0050; MHD 3-2000(Temp), f. 1-25-00, cert. ef. 1-25-00 thru 7-22-00; Administrative correction 11-17-00

Standards for the Approval of Facilities that Provide Case, Custody and Treatment to Committed Persons in Custody or On Diversion

309-033-0500

Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards for the approval of facilities that provide involuntary care, custody and treatment to persons in protective custody, in custody and on diversion.

(2) Statutory authority. These rules are authorized by ORS 426.395, and 426.005 through 426.395 and carry out the provisions of ORS 426.005 through 426.395.

Stat. Auth.: ORS 413.042 & 426.060 – 426.500
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0000

309-033-0510

Definitions

(1) “Administrator- means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. “Administrator- has the same meaning as “director of the facility- as that term is defined in ORS 426.005. Whenever “administrator- appears it means the administrator or designee.

(2) “Assistant Administrator- means the Assistant Administrator of Addictions and Mental Health Division.

(3) “Clinical record- means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Service Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) “CMHP- means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and

alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(5) “Community hospital- means any hospital that is not a state hospital.

(6) “Court- means the circuit court acting pursuant to ORS Chapter 426.

(7) “Custody- means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233;

(c) A health care facility licensed under ORS Chapter 441 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(8) “Designee- means a QMHP designated by the director or a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody pursuant to ORS 426.233.

(9) “Director- means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. “Director- also means a person who has been authorized by the director to act in the director’s capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(10) “Diversion- means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237.

(11) “Division- means the Addictions and Mental Health Division of the Oregon Health Authority.

(12) “QMHP- means a qualified mental health professional that meets the following minimum qualifications:

(a) Psychiatrist licensed to practice in the State of Oregon;

(b) Physician licensed to practice in the State of Oregon;

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

(e) Graduate degree in psychiatric nursing and licensed in the State of Oregon;

(f) Graduate degree in another mental health-related field; or

(g) Any other person whose education and experience meet, in the judgment of the Division, a level of competence consistent with the responsibilities required by the Division.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232 & 426.236
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0010

309-033-0520

Classes of Facility that Provide Care, Custody or Treatment to Committed Persons or to Persons In Custody or On Diversion

(1) Division to assign classification. The Division shall assign a classification to a facility approved to serve a person committed to the Division under ORS 426.130, or a person in custody pursuant to ORS 426.232, 426.233, or on diversion pursuant to 426.237.

(2) Class 1. A Class 1 facility is a facility that is approved under applicable administrative rules to be locked to prevent a person from leaving the facility, to use seclusion and restraint, and to involuntarily administer psychiatric medication. This class of facility includes:

(a) A state hospital;

(b) A hospital, regional acute psychiatric care facility or other nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion;

(c) A facility which, in the opinion of the Division, restricts the liberty of a person to substantially the same degree as other facilities in this class.

(3) Class 2. A Class 2 facility is a facility that is approved under applicable administrative rules to be locked to prevent a person from leaving the facility. This class of facility includes:

(a) A secure residential facility that is approved under OAR 309-035-0100 through 309-035-0190, Residential Care Facilities for Mentally or Emotionally Disturbed Persons, and that is approved by the Division to be locked to prevent a person from leaving the facility;

(b) A facility which, in the opinion of the Division, restricts the liberty of a person to substantially the same degree as other facilities in this class.

(4) Class 3. A Class 3 facility is a residential facility that is approved under OAR 309-035-0100 through 0309-035-0190, Residential Care Facilities for Mentally or Emotionally Disturbed Persons. A Class 3 facility shall not lock its doors to prevent a person from leaving the facility.

Stat. Auth.: ORS 413.042 & 426.238
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0030

309-033-0530

Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons In Custody and On Diversion

This section establishes rules for approval of hospital and nonhospital facilities which provide service to a committed person or to a person in custody or on diversion.

(1) Approved hospitals and other facilities. Only hospitals and nonhospital facilities, approved by the Division under this rule, shall provide care and treatment services for committed persons or for persons in custody or on diversion.

(2) Application for approval. Approval of hospitals or nonhospital facilities shall be accomplished by submission of a letter of application. If approved, a Certificate of Approval will be issued to the hospital or nonhospital facility to provide such services. This approval shall be reviewed on a biennial basis subject to application of the hospital or other facility and/or review by the Division.

(3) Requirements for approval. In undertaking review of the hospital or nonhospital facility for approval, the Division shall be satisfied that the hospital or nonhospital facility meets one of the following requirements:

(a) Approval to provide seclusion and restraint considered approval to provide services to committed persons and to persons in custody and on diversion. The Division shall approve, without further requirement, hospitals and nonhospital facilities currently approved under OAR 309-033-0700 through 309-033-0740, Standards for the Approval of Community Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion.

(b) Requirements for facilities not approved to provide seclusion and restraint. The Division shall approve a nonhospital facility to serve committed persons and persons in custody and on

diversion if the nonhospital facility is certified as a secure residential facility under Division rules and the nonhospital facility has the following:

(A) Written policies and procedures in place which assure that:

(i) The facility shall not admit a person who may require seclusion or physical restraint.

(ii) A person who develops the need for seclusion and restraint is immediately removed to a hospital or nonhospital facility approved under OAR 309-033-0700 through 309-033-0740, Standards for the Approval of Community Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion.

(iii) Each person admitted to the facility has a physician who is responsible for treating the person during the person's stay at the facility and who examines the person within 24 hours of the person's admission to the facility.

(iv) A staff person shall provide direct care for consumers only when that staff person is trained in the curriculum approved by the psychiatrist or psychiatric nurse practitioner. The staff shall receive the training within the last six months prior to providing direct consumer care.

(v) A staff person shall participate in the training approved by the psychiatrist or psychiatric nurse practitioner quarterly.

(B) A psychiatrist or a licensed psychiatric nurse practitioner, who is employed by the facility or has a contract with the facility, to provide medical oversight of admission policies and procedures, and staff training.

(C) A staff training curriculum which is approved by the psychiatrist or nurse practitioner and includes:

(i) Criteria for the admission of a person who can safely be served by the nonhospital facility;

(ii) Recognition of indicators of violence or assault and criteria for the transfer of person to a more secure facility;

(iii) Indicators of medical problems, identification of medication side effects, and indicators of medical problems and medical crisis; and

(iv) Management of aggressive behavior and de-escalation techniques.

(D) Two qualified mental health associates who are available on-site 24 hours-a-day, seven days-a-week.

(E) Alarmed doors and windows which have been approved by the Division.

(F) A written agreement with a law enforcement agency to respond to emergencies that provides:

(i) Emergency response time within 15 minutes of the nonhospital facility's request.

(ii) Agreement by the law enforcement agency to retake a person who elopes and to return the person to the nonhospital facility or remove the person to a hospital or nonhospital facility approved under OAR 309-033-0700 through 309-033-0740, Standards for the Approval of Community Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion, as directed by the administrator of the nonhospital facility.

(G) Documentation of fire marshal approval to operate as a secure facility.

Stat. Auth.: ORS 413.042, 426.228, 426.232, 426.233 & 426.236
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0040

309-033-0540

Administrative Requirements for Hospitals and Nonhospital Facilities Approved to Provide Services to Persons In Custody

(1) Written policies. Each hospital or nonhospital facility shall have written policies concerning the care, custody, and treatment of persons in custody or on diversion. These policies shall be written to provide for the comfort and safety of the person being provided care and for the safety of the facility staff providing care to that person. These policies shall detail staff responsibilities, person's rights, and emergency procedures. All staff involved in the care of these persons shall be fully familiar with these policies and procedures. These policies shall be reviewed as part of the Division's approval process.

(2) Warning. Each hospital or nonhospital facility shall:

(a) Have a physician, nurse or QMHP give the person the following warning:

"You are being held in this hospital because someone is concerned that you may hurt yourself or other people. Anything the staff of this hospital observes you do or say while you are in custody here may be used as evidence in a court of law to determine whether you should be committed as a mentally ill person. You have a right to legal counsel. If you cannot afford an attorney one will be provided for you by the court.-

(b) Have the warning given at the time of admission and at times when it is determined that the person will reasonably understand the notice, and as often as it is determined necessary to assure that the person has been given an opportunity to be aware of the notice.

(c) Have the warning given to the person in writing, as required by ORS 426.123. An attempt shall be made to have the person sign the written warning. A copy of the signed written warning shall be given to the person and the original shall be kept in the clinical record. The person's inability to sign the written warning or refusal to sign the written warning shall be documented

on the written warning below the place where the person's signature would be normally found, clearly stating the reasons the signature was not obtained. The written warning shall include a place where the person, by making a mark, may request legal counsel.

(3) Notification of next of kin. If the person consents, a physician, nurse or QMHP at a hospital shall make every effort to notify the person's next of kin of the location and condition of the person as required under ORS 426.234.

(4) Notification of the court of hospital hold. The admitting physician, if the person is at a hospital, shall immediately notify the circuit court in writing. The admitting physician shall also immediately notify the director in the county where the hospital is located so that an investigation can be conducted.

(5) Notification of the court of nonhospital hold. The director, if the person is at a nonhospital facility, shall notify, in writing, the circuit court in the county where the person was taken into custody.

(6) Log. Each hospital or nonhospital facility shall maintain a log of persons in custody that includes: name, date of birth, date of admission, type of admission and a notation of the use of restraints.

(7) Posted warning and rights. Each hospital or nonhospital facility shall post a copy of the person's rights in the holding room behind protective unbreakable plastic or in another location clearly visible from the holding room which, at a minimum, states:

(a) The warning described in OAR 309-033-0540;

(b) The person's right to be free from electro-shock therapy or unduly hazardous procedures.

(8) Clinical records. Each hospital or nonhospital facility shall maintain a clinical record which accurately documents the care, custody and treatment of a person in custody. These records shall include:

(a) A copy of the hold form which documents the reasons for the hold, including specific behaviors which indicate the person:

(A) Is dangerous to self or another person; and

(B) Is in need of immediate care, custody or treatment for mental illness.

(b) Documentation that the warning described in OAR 309-033-0540 has been given to the person.

(c) Documentation of the potential effects and the observed effects of any medication administered which may substantially affect the person to prepare for or function effectively at the commitment hearing, signed by the treating physician.

(d) A report of physical examination and relevant laboratory tests.

(e) Daily medical progress notes.

(f) Twenty-four hour nursing notes.

(g) Documentation, signed by the treating physician, of each use of any mechanical restraints and the specific reasons which justify the use.

(h) Documentation of the psychiatric history which, whenever possible, shall include:

(A) History of present illness, including specific prodromal symptoms;

(B) Medical history;

(C) Family history;

(D) Past psychiatric history;

(E) Substance use and abuse history;

(F) History of legal difficulties; and

(G) Social history including current support system.

(i) A report of mental status.

(j) A diagnostic impression.

(k) A treatment plan.

(9) Access to clothing before release of persons in custody. Each hospital or nonhospital facility shall allow the person in custody to have access to his/her clothing before being released to attend the commitment hearing.

Stat. Auth.: ORS 413.042, 426.123, 426.232, 426.233, 426.234 & 426.236
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0050

309-033-0550

Standards for the Approval of Hospitals Detaining Persons In Custody Pending Transport to an Approved Holding Hospital or Nonhospital Facility

(1) Approved hospitals. Only hospitals approved by the Division under this rule may detain a person pending transport pursuant to the provisions of ORS 426.231. A hospital approved under

this rule may transport the person only to a hospital or nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion. Hospitals approved under OAR 309-033-0530 are also approved under this rule to detain a person pending transport and may transport a person to another hospital or nonhospital facility approved under OAR 309-033-0530.

(2) Application for approval. Approval of hospitals shall be accomplished by submission of a letter of application in accordance with administrative rules on letters of approval. If approved, a certificate of approval will be issued to the hospital to provide such services. This approval shall be renewed on a biennial basis subject to the application of the hospital or review by the Division.

(3) Requirements for approval. The director in the county in which the hospital is located shall submit a letter of recommendation for approval on behalf of the hospital. The letter of recommendation shall clearly state that the director and the hospital have a written agreement which includes the following:

(a) The procedures to be followed when a person is detained or transported to another hospital or nonhospital facility, with the parties responsible for performing the procedures clearly identified. The procedures shall state whether or not the hospital is required to give notice to the director prior to the release of the person.

(b) The party or parties responsible for transporting the person to another hospital or nonhospital facility and the means by which such transportation is initiated and authorized.

(c) The services to be provided by the hospital when a person is detained and transported to another hospital or nonhospital, and the payment the hospital is to receive for these services.

(d) The hospital shall have a room which meets OAR 309-033-0720, Application and Requirements for Approval to Provide Seclusion and Restraint, or shall provide an attendant to provide continuous face-to-face monitoring of the person.

(4) Responsibilities of the physician. The physician shall complete a face-to-face examination of the person. Once the physician determines that the person is dangerous to self or any other person and in need of emergency care or treatment for mental illness, the physician shall:

(a) Assure the detention of the person in safe and humane quarters for no longer than 12 hours;

(b) Assure that the person is monitored face-to-face every 15 minutes;

(c) Consult with a physician who has admitting privileges at a receiving hospital or nonhospital facility approved by the Division to determine that the receiving physician:

(A) Agrees that the person appears to be dangerous to self or any other person; and

(B) Consents to receive the person for further evaluation for involuntary emergency care and treatment for mental illness.

(d) If the person is to be sent to the receiving hospital, complete a written statement that states:

(A) The physician has examined the person within the preceding 12 hours;

(B) The reasons the physician has found the person to be dangerous to self or any other person and is in need of emergency care or treatment for mental illness; and

(C) The name of the admitting physician at the receiving hospital who has agreed to transporting the person for further evaluation and possible admission.

(e) Retain a copy of the written statement in the person's clinical record. The original written statement shall accompany the person to the receiving hospital and shall serve as authorization for transport.

(5) Release when person is no longer dangerous. If the physician at the hospital where the person is detained and is awaiting transport believes the person is no longer dangerous to self or any other person, then the physician shall release the person as soon as possible. If the physician cannot locate a receiving hospital where a physician agrees to receive the person for evaluation, then the person shall be released within twelve hours of the time the person was originally detained.

Stat. Auth.: ORS 413.042 & 426.231
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0060

309-033-0560

Variances

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept or procedure proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Division review. The Assistant Administrator or designee of the Division shall approve or deny the request for a variance.

(4) Notification. The Division shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Division.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 8-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-210-0070

Standards for Obtaining Informed Consent to Treatment from a Person and the Administration of Significant Procedures without the Informed Consent
of a Committed Person at Community Hospitals, Nonhospital Facilities, and Residential Facilities Approved by the Division

309-033-0600

Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for community hospitals, nonhospital facilities and residential facilities relating to obtaining informed consent to treatment from a committed person, and for the administration of significant procedures without obtaining the informed consent of a committed person.

(2) Statutory authority. These rules are authorized by ORS 426.385 and 430.041 and carry out the provisions of ORS 426.005 through 426.395.

Stat. Auth.: ORS 413.042 & 426.385
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0000

309-033-0610

Definitions

(1) “Administrator- means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. “Administrator- has the same meaning as “director of the facility- as that term is defined in ORS 426.005(1)(a). Whenever “administrator- appears it means the administrator or designee.

(2) “Assistant Administrator- means the Assistant Administrator of the Addictions and Mental Health Division.

(3) “Clinical record- means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Services Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) “CMHP- means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(5) “Community hospital- means any hospital that is not a state hospital.

(6) “Court- means the circuit court acting pursuant to ORS Chapter 426.

(7) “Custody- means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233(1);

(c) A health care facility licensed under ORS Chapter 431 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(8) “Designee- means a QMHP designated by the director or a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody pursuant to ORS 426.233.

(9) “Director- means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. “Director- also means a person who has been authorized by the director to act in the director’s capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(10) “Division- means the Addictions and Mental Health Division of the Oregon Health Authority.

(11) “Legally incapacitated person- means a person who has been found by the court to be unable to give informed consent to medical treatment and the court has appointed a guardian to make such decisions on the person’s behalf pursuant to ORS 126.127.

(12) “Material risk- means the risk may have a substantial adverse effect on the patient’s psychological and/or physical health. Tardive dyskinesia is a material risk of neuroleptic medication.

(13) “Nurse- means a registered nurse or a psychiatric nurse practitioner licensed by the Oregon Board of Nursing, but does not include a licensed practical nurse or a certified nurse assistant.

(14) “Person- means a consumer of mental health services committed to the Division who is admitted to a community hospital, nonhospital facility or residential facility for care, custody or treatment of mental illness.

(15) “Psychiatrist- means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(16) “Psychologist- means a clinical psychologist licensed by the Oregon Board of Psychologist Examiners.

(17) “QMHP- means a qualified mental health professional that meets the following minimum qualifications:

(a) Psychiatrist licensed to practice in the State of Oregon;

(b) Physician licensed to practice in the State of Oregon;

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

(e) Graduate degree in psychiatric nursing and licensed in the State of Oregon;

(f) Graduate degree in another mental health-related field; or

(g) Any other person whose education and experience meet, in the judgment of the Division, a level of competence consistent with the responsibilities required by the Division.

(18) "Significant procedure- means a diagnostic or treatment modality which poses a material risk of substantial pain or harm to the patient or resident such as, but not limited to, psychotropic medication and electro-convulsive therapy.

(19) "Superintendent- means the chief executive officer of a state hospital, or designee, or a person authorized by the superintendent to act in the superintendent's capacity for the purpose of this rule.

Stat. Auth.: ORS 413.042 & 426.385
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0010

309-033-0620

Obtaining Informed Consent to Treatment From a Person and the Administration of Significant Procedures Without the Informed Consent of a Committed Person

(1) Basic rule for obtaining informed consent to treatment from a person. A person or a guardian, on behalf of a legally incapacitated committed person, may refuse any significant procedure and may withdraw at any time consent previously given to any significant procedure.

(2) Documentation of withdrawal of consent. Any refusal or withdrawal or withholding of consent shall be documented in the person's record.

(3) Exceptions to obtaining informed consent from a person. Personnel of a facility shall not administer a significant procedure to a committed person unless informed consent is obtained from or on behalf of the person in the manner prescribed in OAR 309-033-0620, except as follows:

(a) Administration of significant procedures without informed consent in emergencies (OAR 309-033-0630); and

(b) Involuntary administration of significant procedures with good cause to persons committed to the Division (OAR 309-033-0640).

(4) Capacity of the committed person. Unless adjudicated legally incapacitated for all purposes or for the specific purpose of making treatment decisions, a person shall be presumed competent to consent to, or refuse, withhold, or withdraw consent to significant procedures.

(a) A physician shall deem a person unable to consent to or refuse, withhold, or withdraw consent to a significant procedure only if the person currently demonstrates an inability to compre-

hend and weigh the risks and benefits of the proposed procedure, alternative procedures, or no treatment at all or other information disclosed pursuant to OAR 309-032-0620. Such inability is to be documented in the person's record and supported by documented statement or behavior of the person.

(b) A person committed to the Division shall not be deemed unable to consent to or refuse, withhold, or withdraw consent to a significant procedure merely by reason of one or more of the following facts:

(A) That the person has been involuntarily committed to the Division;

(B) That the person has been diagnosed as mentally ill;

(C) That the person has disagreed or now disagrees with the treating physician's diagnosis; and

(D) That the person has disagreed or now disagrees with the treating physician's recommendation regarding treatment.

(c) If a court has determined that a committed person is legally incapacitated with regard to medical treatment decisions, then consent shall be sought from the legal guardian.

(5) Procedures for obtaining informed consent and information to be given.

(a) The person from whom informed consent to a significant procedure is sought, as required by ORS 677.097, shall be given information regarding:

(A) The nature and seriousness of the committed person's mental illness or condition;

(B) The purpose and method of the significant procedure, its intended outcome and the risks and benefits of the procedure and when neuroleptic medication is prescribed, that tardive dyskinesia is a risk;

(C) Any alternatives that are reasonably available and reasonably comparable in effectiveness; and

(D) Any additional information concerning the proposed significant procedure requested by the person.

(b) The physician intending to administer a significant procedure shall document in the person's chart that the information required in OAR 309-033-0620 was explained and that the person or guardian of a legally incapacitated person or resident explicitly consented, refused, withheld or withdrew consent.

(6) Voluntary consent. Consent to a proposed significant procedure must be given voluntarily, free of any duress or coercion. Subject to the provisions of OAR 309-033-0640, Involuntary Administration of Significant Procedures to Committed Person with Good Cause, and 309-033-

0260, Diversion from Commitment Hearing, the decision to refuse, withhold or withdraw consent previously given shall not result in the denial of any other benefit, privilege, or service solely on the basis of refusing withholding to or withdrawing consent. A voluntary person may be discharged from the facility if offered procedures are refused.

(7) Obtaining consent with respect to legally incapacitated persons. A facility may not administer a significant procedure to a legally incapacitated committed person without the consent of the guardian, except in the case of an emergency.

(8) Reports of progress. The person or the guardian of a legally incapacitated person shall, upon request, be informed of the progress of the person during administration of the significant procedure.

(9) Right to appeal. A person has the right to appeal the application of any provision of these rules as provided in the grievance policies and procedures of the facility. If the committed person is legally incapacitated, the guardian has the right to appeal the application of any provision of these rules by using the grievance procedures.

Stat. Auth.: ORS 413.042 & 426.385
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0030

309-033-0625

Administration of Medication and Treatment without the Informed Consent of a Person in Custody

(1) Hospitals or Nonhospital Facilities Authorized. Only a physician at a hospital or nonhospital facility approved under OAR 309-033-0500 through 309-033-0560 may administer medication and treatment without the informed consent of a person in custody.

(2) What constitutes an emergency. The fact that a person is in custody under the provisions of ORS 426.232 or 426.233 shall not be the sole justification that an emergency exists. An emergency exists if in the opinion of the physician, and either a consulting physician or qualified mental health profession:

(a) Immediate action is required to preserve the life or physical health of the person and it is not practical to obtain informed consent as provided in OAR 309-033-0620; or

(b) Immediate action is required because the behavior of the person creates a substantial likelihood of immediate physical harm to the person, or others in the facility and it is not practical to obtain informed consent as provided in OAR 309-033-0620.

(3) Grounds for the administration of medication and treatment without informed consent. As provided by ORS 426.072(2)(c), a physician shall administer medication and treatment to a person in custody without obtaining prior informed consent, only in the following circumstances:

(a) If an emergency exists as described in OAR 309-033-0625, or

(b) If the physician, in consultation with another physician or qualified mental health profession, the person is unable to give informed consent as described in OAR 309-033-0620.

(4) Procedures and limitations for the administration of medication or treatment without consent. When administering medication or treatment without the informed consent of a person in custody, the physician shall:

(a) Administer medication and treatment in accordance with medical standards in the community;

(b) Not administer electro-shock therapy or unduly hazardous treatment as set forth in ORS 426.072;

(c) Document in the person's record the specific nature of each emergency and the procedure that was used to deal with the emergency, or if the person is unable to give consent, document that fact in the person's record;

(d) If the person is a minor or has a guardian, make a reasonable effort to contact the legal guardian prior to the administration of medication or treatment, but if efforts to contact the guardian are not successful, the physician may only administer medication or treatment in an emergency and shall notify the legal guardian as soon as possible, otherwise the physician shall not administer medication until consent is obtained from the guardian;

(e) Review the medication and treatment with the treatment team within a reasonable period of time after the medicine or treatment is administered without consent and, if applicable, administer medication or treatment designed to correct the behavior creating the emergency;

(f) Not continue to administer medication or treatment after the emergency has subsided or the person has regained the ability to consent to treatment, without obtaining the person's informed consent; and

(g) Immediately proceed as provided in OAR 309-033-0600 through 309-033-0650 if the person who was in custody is committed and the physician believes the person remains unable to give consent and it is necessary to continue involuntary administration of medication or treatment; the physician may only continue the administration of medication or treatment under the provisions of 309-033-0625 for seven days pending a decision under 309-033-0640.

Stat. Auth.: ORS 413.042, 426.072, 426.231 & 426.236
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHS 5-2007, f. & cert. ef. 5-25-07

309-033-0630

Administration of Significant Procedures in Emergencies Without the Informed Consent of a Committed Person

(1) Hospitals or nonhospital facilities authorized. The following facilities that serve committed persons and which administer

significant procedures in emergencies, without obtaining informed consent, shall be subject to the provisions of 309-033-0630:

(a) A hospital or nonhospital facility approved under OAR 309-033-0700 through 309-033-0740, Approval of Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion.

(b) A hospital or nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities To Provide Services to Committed Persons and to Persons in Custody or on Diversion.

(c) Secure residential facilities licensed by the Division, or licensed by the Aging and People with Disabilities Division (APD).

(d) Intermediate care facilities or enhanced care facilities licensed by the SPD.

(2) What constitutes an emergency. An emergency exists if in the opinion of the responsible physician or nurse:

(a) Immediate action is required to preserve the life or physical health of the committed person and it is impracticable to obtain informed consent as provided in OAR 309-033-0620; or

(b) Immediate action is required because the behavior of the committed person creates a substantial likelihood of immediate physical harm to the committed person or others in the facility and it is impracticable to obtain informed consent as provided in OAR 309-033-0620, Procedures for Obtaining Informed Consent and Information to be Given.

(3) Administering a significant procedure. If an emergency exists, the responsible physician or nurse may administer a significant procedure to a committed person without obtaining prior informed consent in the manner otherwise required by these rules, provided:

(a) The physician or designee shall document in the person’s clinical record the specific nature of each emergency and the procedure which was used to deal with the emergency.

(b) If the person is legally incapacitated, the physician or designee shall make reasonable effort to contact the legal guardian prior to the administration of the significant procedure. If contact is not possible, the physician or designee shall notify the legal guardian as soon as possible.

(c) Within a reasonable period of time after an emergency procedure is administered, the treatment team shall review the treatment and, if practicable, implement treatment designed to correct the behavior creating the emergency.

(d) The responsible physician or nurse shall not administer a significant procedure after the emergency situation has subsided, without obtaining informed consent.

Stat. Auth.: ORS 413.042 & 426.236
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0040

309-033-0640

Involuntary Administration of Significant Procedures to a Committed Person With Good Cause

(1) Hospitals or nonhospital facilities authorized. Only the following facilities that serve committed persons shall involuntarily administer significant procedures with good cause under the provisions of 309-033-0640:

(a) A hospital or nonhospital facility approved under OAR 309-033-0700 through 309-033-0740, Approval of Hospitals and Nonhospital Facilities To Provide Seclusion and Restraint to Committed Persons and to Persons in Custody or on Diversion.

(b) A hospital or nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities To Provide Services to Committed Persons and to Persons in Custody or on Diversion.

(c) Secure residential facilities licensed by the Division or licensed by the APD.

(d) Intermediate care facilities or enhanced care facilities licensed by APD which have a variance from APD to provide involuntary medication.

(2) Good cause. Good cause exists to administer a significant procedure to a person committed to the Division without informed consent if, in the opinion of the treating physician, after consultation with the treatment team:

(a) The person is deemed unable pursuant to OAR 309-033-0620 to consent to, refuse, withhold or withdraw consent to the significant procedure.

(b) The proposed significant procedure will likely restore, or prevent deterioration of, the person’s mental or physical health, alleviate extreme suffering, or save or extend the person’s life.

(c) The proposed significant procedure is the most appropriate treatment for the person’s condition according to current clinical practice, and all other less intrusive procedures have been

considered and all criteria and information set forth in OAR 309-033-0620, Procedures for Obtaining Informed Consent and Information to be Given, are considered.

(d) The treating physician has made a conscientious effort to obtain informed consent to the significant procedure from the person.

(3) Independent review. Prior to granting approval for the administration of a significant procedure for good cause to a person committed to the Division, the administrator shall obtain consultation and approval from an independent examining physician.

(a) The administrator shall maintain a list of independent examining physicians and shall seek consultation and approval from independent examining physicians selected on a rotating basis from the list. The independent examining physician shall:

(A) Be a psychiatrist;

(B) Not be in a position to provide primary or on-call care or treatment to the person who is subject of the independent review;

(C) Not be an employee of the facility;

(D) Have been subjected to review by medical staff executive committee as to qualifications to make such an examination; and

(E) Have read and received training from the medical staff regarding the meaning and the application of these rules.

(b) Prior to seeking consultation and approval of an examining physician, the administrator shall provide written notice to the committed person who is subject to the proposed significant procedure without the person's consent.

(4) Independent physician activities. The physician selected to conduct the independent consultation shall:

(a) Review the person's clinical record, including the records of efforts made to obtain the person's informed consent;

(b) Personally examine the person;

(c) Interview the person to determine the extent of the need for the procedure and the nature of the person's refusal, withholding, or withdrawal or inability to consent to the significant procedure;

(d) Consider additional information, if any, presented prior to or at the time of examination or interview as may be requested by the person; and

(e) Make a determination whether the factors required under these rules exist for the particular person or that one or more factors are not present. If the physician determines that the person does not have capacity to give consent to treatment, the physician shall review the proposed significant procedure. The physician shall make his/her determination of capacity, approval or disapproval of the proposed significant procedure to:

(A) The administrator; and

(B) The person to whom a significant procedure is proposed to be administered, with a copy being made part of the person's record.

(5) Administrator determination. The administrator shall approve or disapprove of the administration of the significant procedure to a person committed to the Division based on good cause, provided:

(a) The administrator shall not approve the significant procedure and it shall not be performed when the independent examining physician found that one or more of the factors required by OAR 309-033-0640 were not present or otherwise disapproved of the procedure.

(b) Approval of the significant procedure shall terminate if there is a substantial increase in risk, as determined by a physician, of administering the significant procedure or at any time the person regains capacity to give informed consent/refusal. Approval of the significant procedure shall terminate at the end of the person's commitment but in no case longer than 180 days. Disapproval shall be only so long as no substantial change occurs in the person's condition.

(c) Written notice of the administrator's determination shall be provided to the person and made part of the committed person's clinical records.

(d) A copy of the independent examining physician's report shall be made part of the committed person's clinical record.

(6) Ninety-day right to review. The administrator shall adopt procedures which assure that the committed person may request independent review of the approval once every ninety days after the initial approval. Within 14 days of a verbal or written request from the committed person, the administrator shall initiate an independent review of the approval, as in OAR 309-033-0640.

(7) Transfer of approval. The administrator, or the superintendent of a State hospital, shall transfer the approval of the administration of a significant procedure when a committed person is transferred to another hospital or nonhospital facility described in OAR 309-033-0640.

(a) The administrator, or the superintendent, of the sending hospital or nonhospital facility shall transfer the approval by sending copies of all approval documents to the administrator of the receiving facility.

(b) The administrator, or the superintendent, of the receiving hospital or nonhospital facility shall assure that the treating physician at that facility reexamines the committed person and verifies

that the need for the approval continues to exist as described in OAR 309-033-0620, Procedures for Obtaining Informed Consent and Information to be Given, and 309-033-0640, Good Cause. The receiving hospital or nonhospital facility may administer the significant procedure if the need for the procedure continues in accordance with OAR 309-033-0640, Involuntary Administration of Significant Procedures to a Committed Person with Good Cause.

(c) In no event shall the approval of a significant procedure continue beyond 180 days from the date of the original approval without reestablishing the need for the approval by following the procedures prescribed in OAR 309-033-0640, Involuntary Administration of Significant Procedures to Committed Persons with Good Cause.

(8) Administrative procedures.

(a) Utilization summary. Every four months the administrator shall make a summary of the use of OAR 309-033-0630 and 309-033-0640 that includes:

(A) Each type of proposed significant procedure for which consultation with an independent examining physician was sought;

(B) The number of times consultation was sought from a particular independent examining physician or disposition board for each type of proposed significant procedure;

(C) The number of times each independent examining physician approved and disapproved each type of proposed significant procedure; and

(D) The number of times the approved and disapproved each type of proposed significant procedure.

(b) Outside reviewer's access to summaries. The administrator shall provide a copy of a utilization summary to the federally-mandated advocacy and protection agency for Oregon, which is appointed by the Governor and which currently is the Oregon Advocacy Center, and the Division. The Division may only distribute the report to any other person or organization authorized by the Division which in the opinion of the Assistant Administrator:

(A) Has substantial interest in the advocacy and protection of the rights of persons with mental illness; and

(B) Whose access to the summaries will provide a substantial and material benefit to the citizens of Oregon.

Stat. Auth.: ORS 413.042 & 426.385
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0050

309-033-0650

Variances

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept or procedure proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Division review. The Assistant Administrator or designee of the Division shall approve or deny the request for a variance.

(4) Notification. The Division shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Division.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 413.042 & 426.385
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 9-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-215-0060

Standards for the Approval of Community Hospitals and Nonhospital Facilities to Provide Seclusion and Restraint toCommitted Persons and to Persons in Custody or on Diversion

309-033-0700

Purpose and Scope

(1) This section establishes rules pursuant to ORS 426.072, 426.236, 426.228, 426.232, 426.233 and 426.234, 426.385 for certification of hospitals and facilities which provide care, custody, and treatment to committed persons and to persons in custody or on diversion.

(2) Seclusion or restraint may be used only for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or other individuals.

Stat. Auth.: ORS 413.042, 426.236, 426.385 & 430.021
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0000; MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0710

Definitions

(1) "Administrator" means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs in a nonhospital facility. "Administrator" has the same meaning as "director of the facility" as that term is defined in ORS 426.005(1)(a). Whenever "administrator" appears it means the administrator or his or her designee.

(2) "Authority- means the Oregon Health Authority (OHA).

(3) "Clinical Record" means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Service Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) "CMHP" means the community mental health program which organizes all services for persons with mental disorders or substance use disorders, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(5) "Community Hospital" means any hospital that is not a state hospital.

(6) "Council- means a regional acute care psychiatric facility organization with a mission statement and bylaws, comprised of facility representatives, consumers and family members. The council is advisory to the facility.

(7) "Court" means the circuit court acting pursuant to ORS Chapter 426.

(8) "Custody" means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233(1);

(b) A health care facility licensed under ORS Chapter 431 and certified by the Division, pursuant to 426.231;

(c) A state hospital pursuant to ORS 426.232;

(d) A community hospital pursuant to ORS 426.072 or 426.232; or

(e) A regional acute care psychiatric or non-hospital facility pursuant to ORS 426.072 or 426.233.

(9) "Director" means the community mental health program director who has been authorized by the local mental health authority to direct the CMHP.

(10) "Diversion" means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237(1)(b).

(11) "Division" means the Addictions and Mental Health (AMH) Division of the Oregon Health Authority (OHA).

(12) "Emergency- means, in the opinion of the treating physician, immediate action is required to preserve the life or physical health of a person, or because the behaviors of that person creates a substantial likelihood of immediate physical harm to self, or to others in the facility. The fact that a person is in custody under the provisions or ORS 426.072, 426.232 or 426.233 must not be the sole justification that an emergency exists.

(13) "Hospital or Facility- means the community hospital, regional acute care psychiatric facility, or non-hospital facility eligible for, or presently certified for, the use of seclusion or restraints to committed persons and persons in custody or on diversion.

(14) "NMI" means "Notice of Mental Illness- required, pursuant to ORS 426.070, to be submitted by any two persons, a county health officer or a magistrate to the director and thereafter submitted by the director to the court or, pursuant to 426.234, to be submitted by the physician or the director to the court. Pursuant to 426.070 and 426.234, the court commences proceedings pursuant to 426.070 to 426.130 upon receipt of the NMI.

(15) "Non-Hospital Facility- means any facility, other than a hospital, that is certified by the Authority to provide adequate security, psychiatric, nursing and other services to persons under ORS 426.232 or 426.233.

(16) "Nurse" means a registered nurse or a psychiatric nurse practitioner licensed by the Oregon Board of Nursing, but does not include a licensed practical nurse or a certified nurse assistant.

(17) “P.R.N.- (pro re nata) means that a medication or medical treatment has been ordered to be given as needed.

(18) “Patient Days- means the day of admission plus each additional day of stay, but not the day of discharge, unless it is also the day of admission.

(19) “Peace officer” means a sheriff, constable, marshal, municipal policeman, member of the Oregon State Police or investigator of the Criminal Justice Division of the Department of Justice and such other persons as may be designated by law.

(20) “Physician- means a person who holds a degree of Doctor of Medicine, Doctor of Osteopathy, or Doctor of Podiatric Medicine, if the context in which the term “physician- is used does not authorize or require the person to practice outside the scope of a license issued under ORS 677.805 through 677.840.

(21) “Physician Assistant- means a person who is licensed as such in accordance with ORS 677.265, 677.495, 677.505, 677.510, 677.515, 677.520, and 677.525.

(22) “Psychiatrist” means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(23) “Regional Acute Care Psychiatric Facility- means a facility certified by the Division to provide services for adults as described in OAR 309-033-0850 through 309-033-0890, and is operated in cooperation with a regional or local council. A regional acute care psychiatric facility must include 24 hour per day psychiatric, multi-disciplinary, inpatient or residential stabilization, care and treatment, for adults aged 18 or older with severe psychiatric disabilities in a designated region of the state. For the purpose of these rules, a state hospital is not a regional acute care psychiatric service. The goal of a regional acute care service is the stabilization, control and/or amelioration of acute dysfunctional symptoms or behaviors that result in the earliest possible return of the person to a less restrictive environment.

(24) “Restraint” means any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. Restraint may be used only for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

(25) “Seclusion- is the involuntary confinement of a patient alone in a room or area, from which the patient is physically prevented leaving. Seclusion may be used only for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

(26) “State Hospital” means each campus of the Oregon State Hospital.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110, 426.232, 426.236 & 430.041
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0010; MHS 5-2008, f. & cert. ef. 6-27-08; MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0720

Application, Training and Minimum Staffing Requirements

(1) Only the following facilities shall be certified to use seclusion or restraint:

(a) Community hospitals licensed by the Public Health Division;

(b) Regional acute care facilities for adults certified by the Division pursuant to OAR 309-032-0850 through 309-032-0890; and

(c) Non-hospital facilities certified by the Division pursuant to OAR 309-033-0500 through 309-033-0550.

(2) Applications. Certification for the use of seclusion and restraints must be accomplished by submission of an application, and by the application process described in OAR 309-016. Continued certification is subject to hospital or facility reviews at frequencies determined by the Division.

(3) Requirements for Certification. In order to be certified for the use of seclusion and restraint, the Division must be satisfied that the hospital or facility meets the following requirements:

(a) Medical staffing. An adequate number of nurses, direct care staff, physicians, nurse practitioners or physician assistants shall be available at the hospital or facility, to provide emergency medical services which may be required. For hospitals, a letter from the chief of the medical staff or medical director of the hospital or facility, ensuring such availability, shall constitute satisfaction of this requirement. For non-hospital facilities, a written agreement with a local hospital, to provide such medical services may fulfill this requirement. When such an agreement is not possible, a written agreement with a local physician to provide such medical services may fulfill this requirement.

(b) Direct Care Staff Training. A staff person must be trained and able to demonstrate competency in the application of restraints and implementation of seclusion during the following intervals:

(A) A new staff person must be trained within the six months prior to providing direct patient care or as part of orientation; and

(B) Subsequently on a periodic basis consistent with the hospital or facility policy.

(c) Documentation in the staff personnel records must indicate the training and demonstration of competency were successfully completed.

(d) Trainer Qualifications. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address a person's behaviors.

(e) Training Curriculum. The training required for direct care staff must include:

(A) Standards for the proper use of seclusion and restraints as described in OAR 309-033-0730;

(B) Identification of medication side effects;

(C) Indicators of medical problems and medical crisis;

(D) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion;

(E) The use of non-physical intervention skills;

(F) Choosing the least restrictive intervention based on an individualized assessment of the person's medical, or behavioral status or condition;

(G) The safe application and use of all types of restraint or seclusion used in the hospital or facility, including treaining in how to recognize and respond to sign of physical or psychological distress;

(H) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary;

(I) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by the hospital or facility policies and procedures; and

(J) The use of first aid techniques and certification in the use of cardio-pulmonary resuscitation, including periodic recertification.

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0030; MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0725

Medical Services

(1) A physician must be available 24 hours per day, seven days per week to provide medical supervision of the services provided.

(a) In accordance with state law, those physicians authorized to order seclusion or restraint pursuant to the facility policy, must at minimum have a working knowledge of the hospital policy regarding the use of seclusion and restraint.

(b) A physician must examine a person admitted to the facility within 24 hours of the person's admission.

(2) At least one registered nurse must be on duty at all times.

(3) The facility must maintain a personnel file for each patient care staff which includes a written job description; the minimum level of education or training required for the position; copies of applicable licenses, certifications, or degrees granted; annual performance appraisals; a biennial, individualized staff development plan signed by the staff; documentation of CPR training; documentation of annual training and certification in managing aggressive behavior, including seclusion and restraint; and other staff development and/or skill training received.

(4) Health Care Supervisor. The facility must appoint as Health Care Supervisor a physician, a psychiatric nurse practitioner, a master's level registered nurse or a registered nurse certified by the American Nursing Association. The health care supervisor shall review and approve policies and procedures relating to:

(a) The reporting of indicators of medical problems to a physician; and

(b) Curriculum for the staff training, as identified in these rules.

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0727

Structural and Physical Requirements

(1) The hospital or other facility which provides care, custody and treatment for persons who are considered dangerous to themselves or others shall have available at least one room which meets the following requirements:

(a) The room must be of adequate size, not isolated from regular staff of the facility, and provided with an adequate locking device on all doors and windows.

(b) The door must open outward and contain a port of shatterproof glass or plastic through which the entire room may be viewed from outside and before entering.

(c) The room shall contain no protruding objects, such as doorknobs, towel or clothes bars, hooks, or racks. There shall be no exposed curtains, drapes, rods, or furniture, except a portable bed which can be removed, if necessary. In case of the removal of the bed frame, a fireproof mattress shall be placed on the floor. Beds which are securely fastened to the floor must have no protrusions such as bed posts or sharp corners.

(d) Any windows shall be made of unbreakable or shatterproof glass, or plastic. Non-shatterproof glass shall be protected by adequate detention type screening, such as Chamberlain Detention Screen.

(e) There shall be no exposed pipes or electrical wiring in the room. Electric outlets shall be permanently capped or covered with a metal shield which opens with a key. Ceiling and wall lights shall be recessed and covered with safety-type glass or unbreakable plastic. Any cover, cap or shield shall be secured by tamper-proof screws or other means approved by the Division.

(f) The room shall contain no combustible material, such as matches, lighters, cigarettes, etc. Smoking shall not be allowed in the room, except under direct supervision of staff.

(g) The room shall meet fire, safety, and health standards. If sprinklers are installed, they shall be recessed and covered with a fine mesh metal screening. If pop-down type, sprinklers must have breakaway strength of under 80 pounds. In lieu of sprinklers, a combined smoke and heat detector shall be used. Documentation of the breakaway strength of sprinklers must be on file at the facility.

(2) Bathroom requirements include:

(a) Adequate toilet and sanitary facilities shall be available.

(b) The bathroom shall contain no shower rods, shower curtains, window curtain rods, curtains, or towel rods, unless used only with direct staff supervision.

(c) The bathroom shall not lock from the inside and, if connected to the room, shall be locked when not in use.

(3) No sharp objects, such as razor blades, scissors, knives, nail files, etc., shall be available to the patient, except under direct staff supervision. No poisons or cleaning materials shall be kept in the room or in the bathroom available for the room.

Stat. Auth.: ORS 426.236, 426.385 & 430.041
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0730

Seclusion and Restraint Procedures

(1) Certified facilities shall not use seclusion and restraint except in an emergency and only then subject to the conditions and limitations of these rules.

(2) General procedures.

(a) Only a physician, nurse practitioner, physician assistant or nurse may initiate seclusion or restraint procedures.

(b) Each use of seclusion or restraint shall be monitored and supervised by a physician or a nurse.

(c) A physician responsible for the patient's care must order the use of seclusion or restraint within one hour of the administration of the procedure. This approval must be documented in the person's medical record. The physician's order may occur by the following methods:

(A) Verbally, in person or via telephone;

(B) By Computerized Medical Record; or

(C) By a written order.

(d) Within one hour after the initiation of the seclusion or restraint intervention, the patient must be seen face-to-face by a physician, a registered nurse or physician assistant who has been trained in accordance with these rules.

(e) If the face-to-face evaluation is performed by a registered nurse or physician assistant, the evaluator must consult with the attending physician as soon as possible following the face-to-face evaluation.

(f) The face-to-face evaluation must include the following:

(A) An evaluation of the patient's immediate situation;

(B) The patient's reaction to the intervention;

(C) The patient's medical and behavioral condition; and

(D) The need to continue or terminate the restraint or seclusion

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0040; MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0732

Time Limits

(1) The maximum time limit for each restraint or seclusion order Ã¢â‚¬â€ before consideration of a renewal, and up to a maximum of 24 hours Ã¢â‚¬â€ is as follows:

(a) 4 hours for adults 18 years of age or older;

(b) 2 hours for children and adolescents 9 to 17 years of age; or

(c) 1 hour for children under 9 years of age.

(2) Orders may be renewed according to time limits for a maximum 24 hours verbally, by telephone, facsimile, or thru a computerized medical record. After each 24 hours of continuous restraint or seclusion, and prior to further extension of the restraint or seclusion, an examination and second opinion must occur by a second physician.

(3) The physician responsible for the care of the patient shall examine a person within 24 hours of the administration of seclusion or restraint and the person must be examined by a nurse every two hours until such time as the physician examines the person and either makes new orders for seclusion nor restraint or for releasing the patient from seclusion or restraint. The physician must document reasons for the use of the seclusion or restraint over the physician's signature.

(4) A physician shall not order physical restraint on an as required basis, i.e. a physician shall not make "p.r.n." orders for physical restraint.

(5) No form of restraint shall be used as punishment, for the convenience of staff, or as a substitute for activities, treatment or training.

(6) Medication will not be used as a restraint, but will be prescribed and administered according to acceptable medical, nursing and pharmaceutical practices.

(7) Patients shall not be permitted to use restraint on other patients.

(8) Physical restraint must be used in accordance with sound medical practice to assure the least risk of physical injury and discomfort. Any patient placed in physical restraint shall be protected from self-injury and from injury by others.

(9) 15 Minute Checks:

(a) A patient in restraint or seclusion must be checked at least every 15 minutes.

(b) 15 minute checks include circulation checks, during waking hours adequate range of motion, and partial release of restraint to permit motion and exercise without endangering the patient or staff.

(c) Attention must be paid to the patient's basic personal needs (such as regular meals, personal hygiene and sleep) as well as the person's need for good body alignment and circulation.

(d) Staff must document that the patient was checked and appropriate attention paid to the person's needs.

(e) The patient must be released as soon as the patient is assessed by a nurse, physician, or nurse practitioner to not present imminent dangerousness to themselves or others.

Stat. Auth.: ORS 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0733

Documentation

(1) No later than the end of their work shifts, the persons who obtained authorization and carried out the use of restraint shall document in the person's chart including but not necessarily limited to the following:

(a) The specific behavior(s) which required the intervention of seclusion or restraint;

(b) Less restrictive alternatives used before deciding seclusion or restraint was necessary;

(c) The methods of intervention used and the patient's responses to the interventions; and

(d) Findings and recommendations from the face-to-face evaluation discussed in OAR 309-033-0730(d) through (f) above.

(2) Within 24 hours after the incident resulting in the use of restraint, the treating physician who ordered the intervention must review and sign the order.

(3) Each use of restraint must be reported daily to the health care supervisor.

(4) Any death that occurs while a patient is in seclusion or restraint must be reported to AMH within 24 hours of the death.

(5) Restraint/Seclusion Review Committee. Each facility must have a Restraint/Seclusion Review Committee. The committee may be one formed specifically for the purposes set forth in this rule, or the duties prescribed in this rule may be assigned to an existing committee. The purpose and duty of the Restraint/Seclusion Review Committee is to review and evaluate, at least quarterly, the appropriateness of all such interventions and report its findings to the health care supervisor.

Stat. Auth.: ORS 426.236, 426.385 & 430.021
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0735

Quarterly Reports

(1) Every facility certified under these rules must report to the Division and to the Council within 30 days of each quarter's end, the following information:

(a) The number of seclusion and the number of restraint incidents; and

(b) The number of patient days in the quarter.

(2) The Division must compile the information from all facilities approved under this rule and make available to the public statewide aggregate data. The information may be divided according to facility types.

Stat. Auth.: ORS 426.236, 426.385 & 430.021
Stats. Implemented: ORS 426.005 – 426.309
Hist.: MHS 17-2007(Temp), f. 12-28-07, cert. ef. 1-1-08 thru 6-29-08; MHS 5-2008, f. & cert. ef. 6-27-08: MHS 13-2014, f. & cert. ef. 9-29-14

309-033-0740

Variances

(1) Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept or procedure proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the Council indicating its position on the proposed variance.

(3) The AMH Director, or his or her designee, will approve or deny the request for a variance.

(4) Appeal application. Appeal of the denial of a variance request shall be made in writing to the AMH Director, whose decision shall be final.

(5) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(6) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 426.236, 426.385 & 430.041
Stats. Implemented: ORS 426.005 – 426.395
Hist.: MHD 10-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-220-0050; MHS 13-2014, f. & cert. ef. 9-29-14
Standards for the Denial of Payment for Services to Persons in Custody or on Diversion

309-033-0800

Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures for the denial of payment for persons in custody or on diversion.

(2) Statutory authority. These rules are authorized by ORS 426.241 and 413.042 and carry out the provisions of ORS 426.241.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232, 426.236 & 430.041
Stats Implemented: ORS 426.241
Hist.: MHD 6-1994, f. & cert. ef. 8-24-94; MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0000

309-033-0810

Definitions

(1) “Administrator- means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. “Administrator- has the same meaning as “director of the facility- as that term is defined in ORS 426.005. Whenever “administrator- appears it means the administrator or designee.

(2) “Assistant Administrator- means the Assistant Administrator of the Division.

(3) “Clinical record- means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Services Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) “Community hospital- means any hospital that is not a state hospital.

(5) “Custody- means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233(1);

(c) A health care facility licensed under ORS Chapter 441 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(6) “Director- means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. “Director- also means a person who has been authorized by the director to act in the director’s capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(7) “Diversion- means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237.

(8) “Division- means the Addictions and Mental Health Division of the Oregon Health Authority.

(9) “Psychiatrist- means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(10) “Psychologist- means a clinical psychologist licensed by the Oregon Board of Psychologist Examiners.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232 & 426.236

Stats. Implemented: ORS 426.241

Hist.: MHD 6-1994, f. & cert. ef. 8-24-94; MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0010

309-033-0820

Denial of Payment for Services to Persons In Custody or On Diversion

(1) Assistant Administrator denial. The Assistant Administrator shall deny part or all payment for services for a person in custody or on a diversion only when the Assistant Administrator determines that evidence required by OAR 309-033-0820, Information Payer Must Submit, and the evidence required by OAR 309-033-0820, Clinical Records to be Submitted, does not reasonably support the belief that the person in custody demonstrated:

(a) Mental illness; and

(b) Dangerousness to self or others as evidenced by thoughts, plans, means, actions, history of dangerousness or other indicators of imminent dangerousness which Division believes are within accepted community standards of professional knowledge.

(2) Assistant Administrator consultation with psychiatrist or psychologist. When making a determination under this rule which is primarily based on accepted community standards of professional knowledge, the Assistant Administrator shall consult with a psychiatrist or a psychologist.

(3) Information payer must submit. When making a request for denial of payment the payer responsible for the services provided to the person in custody or on diversion under ORS 426.241 shall submit the following to the Assistant Administrator:

(a) A statement requesting the Division review the appropriateness of the hold or diversion for the purpose of approving denial of part or all payment for services rendered.

(b) An explanation of why the payer believes the services provided to the person in custody or on diversion do not meet criteria described in ORS 426.232, 426.233 or 426.237.

(c) Any documentation which supports the payer's belief that the services provided to the person in custody or on diversion were inappropriate.

(4) Clinical records to be submitted. At the request of the Division, as provided by ORS 426.241(5)(b), the following shall submit clinical records and other documents requested relating to the services in question to the Division:

(a) A hospital or a nonhospital facility approved under OAR 309-033-0530, Approval of Hospitals and Nonhospital Facilities to Provide Services to Committed Persons and to Persons in Custody and on Diversion.

(b) A physician or person providing services to the person in custody or on diversion.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232 & 426.236

Stats. Implemented: ORS 426.241

Hist.: MHD 6-1994, f. & cert. ef. 8-24-94; MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0030

309-033-0830

Variances

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept or procedure proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Division review. The Assistant Administrator or designee of the Division shall approve or deny the request for a variance.

(4) Notification. The Division shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Division.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 413.042, 426.005, 426.060, 426.110(2), 426.232 & 426.236

Stats. Implemented: ORS 426.241

Hist.: MHD 6-1994, f. & cert. ef. 8-24-94; MHD 11-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-225-0040

Standards for the Investigation and Examination of a
Person Alleged to be a Mentally Ill Person

309-033-0900

Statement of Purpose and Statutory Authority

(1) Purpose. These rules prescribe standards and procedures relating to the investigation and examination of a person alleged to be a mentally ill person during the involuntary civil commitment process.

(2) Statutory authority. These rules are authorized by ORS 426.005 through 426.395 and carry out the provisions of ORS 426.005 through 426.395.

Stat. Auth.: ORS 413.042, 426.060 – 426.500

Stats. Implemented: ORS 426.005 – 426.395

Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0000

309-033-0910

Definitions

(1) “Administrator- means the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at nonhospital facilities. “Administrator- has the same meaning as “director of the facility- as that term is defined in ORS 426.005. Whenever “administrator- appears it means the administrator or designee.

(2) “Assistant Administrator- means the Assistant Administrator of Addictions and Mental Health Division.

(3) “Clinical record- means the record required by OAR 309-014-0035, General Standards for Delivery of Community Mental Health Services Elements, documenting the mental health services delivered to clients by a CMHP or subcontractor.

(4) “CMHP- means the community mental health and developmental disabilities program which organizes all services for persons with mental or emotional disturbances, drug abuse problems, mental retardation or other developmental disabilities, and alcoholism and alcohol abuse problems, operated by or contractually affiliated with a local mental health authority operating in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division.

(5) “Community hospital- means any hospital that is not a state hospital.

(6) “Court- means the circuit court acting pursuant to ORS Chapter 426.

(7) “Custody- means the prehearing physical retaining of a person taken into custody by:

(a) A peace officer pursuant to ORS 426.070, 426.228, 426.233;

(b) A peace officer at the direction of the director pursuant to ORS 426.233(1);

(c) A health care facility licensed under ORS Chapter 441 and approved by the Division, pursuant to ORS 426.231;

(d) A state hospital pursuant to ORS 426.180;

(e) A hospital pursuant to ORS 426.070 or 426.232; or

(f) A nonhospital facility pursuant to ORS 426.070 or 426.233.

(8) “Designee- means a QMHP designated by the director or a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody pursuant to ORS 426.233.

(9) “Director- means the community mental health and developmental disabilities program director who has been authorized by the local mental health authority to direct the CMHP. “Director- also means a person who has been authorized by the director to act in the director’s capacity for the purpose of this rule. In the case of the director ordering a peace officer to take a person into custody pursuant to ORS 426.233, the designee shall be a QMHP who is specifically authorized by the county governing body to order persons to be taken into custody.

(10) “Diversion- means the 14 day period of intensive treatment when a director and a psychiatrist certify a person as a mentally ill person pursuant to the provision of ORS 426.237(1)(b).

(11) “Division- means the Addictions and Mental Health Division of the Oregon Health Authority.

(12) “NMI- is the notification of mental illness required, pursuant to ORS 426.070, to be submitted by any two persons, a county health officer or a magistrate to the director and thereafter submitted by the director to the court or, pursuant to ORS 426.234, to be submitted by the physician or the director to the court. Pursuant to ORS 426.070 and 426.234, the court commences proceedings pursuant to ORS 426.070 to 426.130 upon receipt of the NMI.

(13) “Peace officer- means a sheriff, constable, marshal, municipal policeman, member of the Oregon State Police or investigator of the Criminal Justice Division of the Department of Justice and such other persons as may be designated by law.

(14) “Psychiatrist- means a physician licensed as provided pursuant to ORS 677.010 to 677.450 by the Board of Medical Examiners for the State of Oregon and who has completed an approved residency training program in psychiatry.

(15) “QMHP- means a qualified mental health professional that meets the following minimum qualifications:

(a) Psychiatrist licensed to practice in the State of Oregon;

(b) Physician licensed to practice in the State of Oregon;

(c) Graduate degree in psychology;

(d) Graduate degree in social work;

(e) Graduate degree in psychiatric nursing and licensed in the State of Oregon;

(f) Graduate degree in another mental health-related field; or

(g) Any other person whose education and experience meet, in the judgment of the Division, a level of competence consistent with the responsibilities required by the Division.

Stat. Auth.: ORS 413.042, 426.060 – 426.500

Stats. Implemented: ORS 426.005 – 426.395

Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0010

309-033-0920

Certification of Mental Health Investigators

(1) Investigation only by a certified investigator. Only a person certified by the Division shall conduct an investigation of a person alleged to be a mentally ill person as required by ORS 426.070(3)(c) and 426.074.

(2) Certification of a mental health investigator. The Division shall certify as a qualified mental health investigator, for three years or until such time as the Division terminates the certificate, any person who meets the following:

(a) Is recommended by a director for certification as a mental health investigator; and

(b) Is a QMHP, or on January 1, 1988, has been employed by a CMHP as an investigator for a minimum of two years; and

(c) Has established individual competence through training provided by the Division and within 6 months of the training has passed an examination conducted by the Division in the following areas:

(A) The role and duties of an investigator and the process of investigation;

(B) Oregon statutes and administrative rules relating to the civil commitment of mentally ill persons;

(C) Establishing probable cause for mental disorder;

(D) The mental status examination; and

(E) The assessment of suicidality, assaultiveness, homocidality and inability to care for basic needs.

(3) Certification of a senior mental health investigator. The Division shall certify as a senior mental health investigator, for five years or until such time as the Division terminates the certificate, a person who meets the following:

(a) Is recommended by a director for certification as a senior mental health investigator;

(b) Is a QMHP;

(c) Has been certified as a mental health investigator for three years; and

(d) Has completed the training required under OAR 309-033-0920 during the six months prior to application for certification.

(4) Certification of a mental health investigator resident. The Division shall certify as a mental health investigator resident for a non-renewable period of six months, or until such time as the Division terminates the certificate, a person who meets the following:

(a) Is recommended by a director for certification as a mental health investigator;

(b) Is a QMHP;

(c) Has passed an examination conducted by the Division regarding Oregon statutes and administrative rules relating to the civil commitment of mentally ill persons; and

(d) Is supervised by a certified senior mental health investigator. The senior mental health investigator shall review each investigation conducted by the mental health investigator resident and co-sign each investigation report as evidence that the senior mental health investigator believes the report meets OAR 309-033-0940, The Investigation Report.

(5) Qualifications for recertification. The Division may recertify a mental health investigator or a senior mental health investigator who is currently employed by a CMHP, is recommended by the director for recertification and who, during the period of certification, has completed eight hours of training or education in the assessment of mental disorder or the assessment of dangerousness which is approved by the Division.

(6) Residents cannot be recertified. The Division shall not recertify a mental health investigator resident.

(7) Termination of certification. The Division may terminate the certification of a mental health investigator, senior mental health investigator, or a mental health investigator resident when, in the opinion of the assistant administrator:

(a) The person no longer can competently perform the duties required by this rule, or

(b) The person has exhibited a behavior or a pattern of behavior which violates the rights, afforded by statute, of persons being investigated.

Stat. Auth.: ORS 413.042, 426.060 – 426.500

Stats. Implemented: ORS 426.005 – 426.395

Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0030

309-033-0930

Investigation of Person Alleged to Be a Mentally Ill Person

(1) Initiation and timelines for investigation. Upon receipt of an NMI the CMHP shall conduct an investigation of the person to determine probable cause for mental disorder. The person conducting the investigation shall not be the same as the person filing the NMI.

(a) Investigation of NMIs by two persons, a county health officer or a magistrate. At a minimum, if the person can be located, the investigator must contact the person by telephone within three judicial days of the receipt of the NMI by the director.

(A) The investigator shall complete an investigation and submit an investigation report to the circuit court within 15 days of the director's receipt of the NMI.

(B) The investigator may request an extension from the court if a treatment option less-restrictive than involuntary inpatient commitment is actively being pursued or if the person cannot be located.

(b) Investigation of persons in custody. The investigator shall investigate persons in custody in an approved hospital under ORS 426.232 or 426.033 as soon as reasonably possible but no later

than one judicial day after the initiation of the detention and 24-hours prior to the hearing. Whenever feasible, the investigator shall:

(A) Make face-to-face contact with the person within 24 hours of admission to a hospital or nonhospital facility, including weekends; and

(B) Meet with the person one additional time prior to making a recommendation for the court to hold a commitment hearing.

(2) Procedures for the investigation. Only certified mental health investigators, senior mental health investigators or mental health investigator residents shall conduct an investigation of a person.

(a) While conducting an investigation, the investigator shall:

(A) Present photo identification, authorized and provided by the county mental health authority, to the person; and

(B) Explain the reason for the investigation orally and, if doing so would not endanger the investigator, in writing.

(b) Information from relatives. The investigator shall solicit information about the person from person's parents and relatives, whenever feasible.

(c) Disclosure of names. The investigator shall disclose the names of the persons filing the NMI to the allegedly mentally ill person except when, in the opinion of the investigator, disclosure will jeopardize the safety of the persons filing the NMI. The investigator may withhold any information that is used in the investigation report, only until the investigation report is delivered to the court and others as required under ORS 426.074. The investigator may withhold any information that is not included in the investigation report if the investigator determines that release of the information would constitute a clear and immediate danger to any person (see ORS 426.370).

(d) Encourage voluntary services. The director shall attempt, as appropriate, to voluntarily enroll in the least restrictive community mental health services a person for whom an NMI has been filed.

(e) Clinical record required. The director shall maintain a clinical record for every person investigated under this rule. The clinical record shall document to the extent possible the following:

(A) A brief summary of the events leading to the filing of an NMI, the circumstances and events surrounding the interview of the person and the investigator's attempts to engage the person in voluntary mental health services;

(B) Identifying information about the person;

(C) A copy of the NMI;

(D) A copy of the investigation report submitted to the court;

(E) Names, addresses and telephone numbers of family, friends, relatives or other persons who the investigator interviewed for pertinent information. This list shall include the names of the persons filing the NMI with the director; and

(F) Summary of the disposition of the case.

(f) Coordination of services. In the event the person is released or agrees to voluntary treatment, the investigator shall coordinate with the CMHP for the purpose of referral and offering voluntary treatment services to the person as soon as reasonably possible.

(3) Access to clinical records. The investigator shall have access to clinical records of the person being investigated as follows:

(a) When the person is in custody. The investigator shall have access only to clinical records compiled during the hold period. Without valid consent, the investigator shall not have access to clinical records compiled as part of treatment that is provided to the person at any time outside the hold period except as provided by OAR 309-033-0930(3)(b).

(b) When the person investigated is eligible for commitment pursuant to ORS 426.074. The investigator shall have access to any clinical record necessary to verify the existence of the criteria which make the person eligible for commitment pursuant to ORS 426.074.

Stat. Auth.: ORS 413.042, 426.060 – 426.500

Stats. Implemented: ORS 426.005 – 426.395

Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0040

309-033-0940

The Investigation Report

(1) Evidence required in report. The investigator shall include in a report to the court, if relevant or available, evidence and the source of that evidence in the following areas:

(a) Evidence which describes the present illness and the course of events which led to the filing of the NMI and which occurred during the investigation of the person.

(b) Evidence to support or contradict the allegation that the person has a mental disorder.

(c) Evidence to support or contradict the allegation that the person is a danger to self or others, or is unable to provide for basic personal needs and is not receiving such care as is necessary for health and safety.

(2) Documentation of manifestation of mental disorder. The evidence which describes the present illness shall include:

(a) The situation in which the person was found and the most recent behaviors displayed by the person which lead to and support the filing of an NMI;

(b) The sequence of events affecting the person during the investigation period including dates of admission, transfer or discharge from a hospital or nonhospital facility;

(c) Any change in the mental status of the person during the course of the investigation; and

(d) Attempts by the investigator to engage the person in voluntary treatment in lieu of civil commitment and their outcome.

(3) Documentation of mental disorder. Evidence to support or contradict the allegation that the person has a mental disorder shall include the results of a mental status examination and a psychosocial history.

(a) Mental status examination. A mental status examination shall review the presence of indicators of mental disorder in the following areas:

(A) Appearance. Features of the person's dress, physical condition which may indicate the presence of a mental disorder.

(B) Behavior. Features of the person's behavior, movement or rate of speech which may indicate the presence of mental disorder.

(C) Thought content. Features of the content of the person's speech such as delusions and hallucinations which may indicate the presence of a mental disorder.

(D) Thought process. Features of the person's expressed thoughts which may indicate that the person is unable to think in a clear logical fashion and which may indicate the presence of a mental disorder.

(E) Insight. Features of the person's understanding of his/her current mental state which may indicate the presence of a mental disorder.

(F) Judgment. Features of the person's judgment about social situations and dangerous situations which may indicate the presence of a mental disorder.

(G) Cognitive testing. Features of the person's ability to concentrate, ability to remember recent and historical events, ability to use abstract thinking, and ability to use or remember generally known information which may indicate the presence of a mental disorder.

(H) Emotions. Features of the person's emotions, such as being inappropriate to the situation, which may indicate the presence of a mental disorder.

(b) Psychosocial History. A psychosocial history shall discuss the presence of indicators of mental disorder in the following areas:

(A) Psychiatric history.

(i) History of psychiatric or mental health treatment;

(ii) History of commitments for mental disorder including verification from the Division if available; and

(iii) Current participation in mental health treatment.

(B) Family history.

(i) Members of the person's family who have a history of psychiatric or mental health treatment;

(ii) Members of the person's family who have a history of commitment for mental disorder; or

(iii) Reports of family members who appear to have had an untreated mental disorder.

(C) History of alcohol or drug abuse.

(i) History of abusing alcohol or drugs;

(ii) Behaviors which the person may have displayed during the course of the investigation, which are substantially similar to behaviors that indicate the presence of a mental disorder, that may be attributable to the use of alcohol or drugs; or

(iii) If the person appears to have a mental disorder, the effect of the person's current use of alcohol or drugs on behaviors that may indicate the presence of a mental disorder.

(D) History of a loss of function.

(E) Social function.

(F) Personal finances.

(i) Availability of financial resources to provide for basic needs such as food and shelter;

(ii) Use of financial resources to meet needs for food and shelter; or

(iii) Other features of the manner in which the person uses money which would indicate the presence of a mental disorder.

(G) Medical issues.

(i) Medical conditions that may produce behaviors which are substantially similar to behaviors that indicate the presence of a mental disorder; or

(ii) Medical conditions which contribute to the seriousness of a mental disorder which appears to be present.

(4) Documentation of dangerousness and/or inability to provide for basic needs. Evidence to support or contradict the allegation that the person is a danger to self or others, or is unable to provide for basic personal needs and is not receiving such care as is necessary for health and safety shall include the results of an assessment of dangerousness.

(a) An assessment of dangerousness to self shall consider the following areas:

(A) History of thoughts, plans or attempts at suicide;

(B) Presence of thoughts, plans or attempts at suicide;

(C) Means and ability to carry out the plans for suicide;

(D) The potential lethality of the plan;

(E) The probable imminence of an attempt at suicide; and

(F) Available support systems which may prevent the person from acting on the plan.

(b) An assessment of dangerousness to others shall consider the following areas:

(A) History of thoughts, plans, attempts or acts of assaultiveness or violence;

(B) Presence of thoughts, plans, attempts or acts of assaultiveness or violence;

(C) Means and ability to carry out the plans for assaultiveness or violence;

(D) The potential lethality of the plan;

(E) The probable imminence of an attempt at assault or violence; and

(F) Available support systems which may prevent the person from attempting an assault or an act of violence.

(c) An assessment of the person's ability to provide for basic personal needs shall consider the following areas:

(A) History of the person's ability to provide for basic personal needs;

(B) The person's current use of resources to obtain food, shelter, and health care necessary for health and safety;

(C) Behaviors which result in exposure to danger to self or others;

(D) Available support systems which may provide the person care necessary for health and safety; and

(E) If the person appears to lack capacity to care for self, the availability of a guardian who can assure the provision of such care.

(5) Additional report requirements. The investigation report shall also include the following:

(a) The person's consent or objection to contact with specific third parties.

(b) If appropriate and if available from the Division, verification of the person's eligibility for commitment under ORS 426.005(c).

(6) Report availability. The investigation report shall be made available to the facility with custody of the person if the person is committed.

(7) Investigator's responsibilities to the circuit court. The investigator shall file the investigation report with the circuit court twenty-four hours before the hearing and shall appear at the civil commitment hearing.

Stat. Auth.: ORS 413.042, 426.060 – 426.500

Stats. Implemented: ORS 426.005 – 426.395

Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0050

309-033-0950

Certification of Mental Health Examiners

(1) Psychiatrists exempt from certification. A psychiatrist may serve as an examiner as provided by ORS 426.110. Division certification is not necessary for psychiatrists serving as mental health examiners.

(2) Qualifications for certification of persons other than psychiatrists. The Division shall certify, as a qualified mental health examiner for three years or until such time as the Division terminates the certificate, a QMHP who meets all of the following:

(a) Has at least three years clinical experience in the diagnosis and treatment of severely mentally ill adults who suffer primarily from a psychotic disorder;

(b) Presents acceptable written references from two persons who have the above qualifications and can demonstrate direct knowledge of the person's qualifications;

(c) Is recommended by the director to be an examiner in the county; and

(d) Has established individual competence through training provided by the Division in the following areas:

(A) The role and duties of an examiner and the process of examination;

(B) Oregon statutes and administrative rules relating to the civil commitment of mentally ill persons;

(C) Establishing clear and convincing evidence for mental disorder;

(D) The mental status examination; and

(E) The assessment of suicidality, assaultiveness, homocidality and inability to care for basic needs.

(3) Qualifications for recertification. The Division may recertify for three years, or until such time as the Division terminates the certificate of, any mental health examiner who meets the following:

(a) The examiner has been an examiner certified by the Division after July 1, 1988;

(b) The examiner has successfully completed eight hours of training provided by the Division relating to the assessment and diagnosis of mental disorder and, changes in statutes and administrative rules relating to civil commitment; and

(c) The director recommends the person to be an examiner in the county.

(4) Examination. The examiner shall conduct an examination in a manner that elicits the data necessary for establishing a diagnosis and a plan for treatment. Only certified examiners shall conduct an examination of an allegedly mentally ill person.

(5) Termination of certification. The Division may terminate the certification of any mental health examiner when, in the opinion of the assistant administrator:

(a) The person no longer can competently perform the duties required by this rule; or

(b) The person has exhibited a behavior or a pattern of behavior which violates the rights, afforded by statute, of persons being investigated.

Stat. Auth.: ORS 413.042, 426.060 – 426.500

Stats. Implemented: ORS 426.005 – 426.395

Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0060

309-033-0960

Mental Health Examiner's Report to the Court

(1) Examiner assessment of evidence. The examiner shall provide in a report to the court the examiner's opinion whether the evidence supports or contradicts:

(a) The allegation that the person has a mental disorder;

(b) The allegation that the person is a danger to self or others, or is unable to provide for basic personal needs and is not receiving such care as is necessary for health and safety; and

(c) That the person would cooperate with and benefit from voluntary treatment.

(2) Mental status examination and psychosocial history. In addition to considering other evidence presented at the hearing, the examiner shall conduct a mental status examination and a psychosocial history to determine whether the person alleged to be mentally ill has a mental disorder.

(a) Mental status examination. A mental status examination shall include review of the presence of indicators of mental disorder in the following areas:

(A) Appearance. Features of the person's dress, physical condition which may indicate the presence of a mental disorder.

(B) Behavior. Features of the person's behavior, movement or rate of speech which may indicate the presence of mental disorder.

(C) Thought content. Features of the content of the person's speech such as delusions and hallucinations which may indicate the presence of a mental disorder.

(D) Thought process. Features of the person's expressed thoughts which may indicate that the person is unable to think in a clear logical fashion and which may indicate the presence of a mental disorder.

(E) Insight. Features of the person's understanding of his/her current mental state which may indicate the presence of a mental disorder.

(F) Judgment. Features of the person's judgment about social situations and dangerous situations which may indicate the presence of a mental disorder.

(G) Cognitive testing. Features of the person's ability to concentrate, ability to remember recent and historical events, ability to use abstract thinking, and ability to use or remember generally known information which may indicate the presence of a mental disorder.

(H) Emotions. Features of the person's emotions, such as being inappropriate to the situation, which may indicate the presence of a mental disorder.

(b) Psychosocial history. A psychosocial history shall consider the presence of indicators of mental disorder in the following areas:

(A) Psychiatric history.

(i) History of psychiatric or mental health treatment;

(ii) History of commitments for mental disorder including verification from the Division if available; and

(iii) Current participation in mental health treatment.

(B) Family history.

(i) Members of the person's family who have a history of psychiatric or mental health treatment;

(ii) Members of the person's family who have a history of commitment for mental disorder; or

(iii) Reports of family members who appear to have had an untreated mental disorder.

(C) History of alcohol or drug abuse.

(i) History of abusing alcohol or drugs;

(ii) Behaviors the person may have displayed during the course of the investigation which are substantially similar to behaviors that indicate the presence of a mental disorder that may be attributable to the use of alcohol or drugs; or

(iii) If the person appears to have a mental disorder, the effect of the person's current use of alcohol or drugs on behaviors that may indicate the presence of a mental disorder.

(D) History of a loss of function.

(E) Social function.

(F) Personal finances.

(i) Availability of financial resources to provide for basic needs such as food and shelter;

(ii) Use of financial resources to meet needs for food and shelter; and

(iii) Other features of the manner in which the person uses money which would indicate the presence of a mental disorder.

(G) Medical issues.

(i) Medical conditions that may produce behaviors which are substantially similar to behaviors that indicate the presence of a mental disorder; or

(ii) Medical conditions which contribute to the seriousness of a mental disorder which appears to be present.

(3) Assessment of dangerousness and ability to provide basic needs. In addition to considering other evidence presented at the hearing, the examiner shall conduct an assessment of the danger the person represents to self or others and an assessment of the person's ability to provide for basic personal needs.

(a) An assessment of dangerousness to self shall consider the following areas:

(A) History of thoughts, plans or attempts at suicide;

(B) Presence of thoughts, plans or attempts at suicide;

(C) Means and ability to carry out the plans for suicide;

(D) The potential lethality of the plan;

(E) The probable imminence of an attempt at suicide; and

(F) Available support systems which may prevent the person from acting on the plan.

(b) An assessment of dangerousness to others shall consider the following areas:

(A) History of thoughts, plans, attempts or acts of assaultiveness or violence;

(B) Presence of thoughts, plans, attempts or acts of assaultiveness or violence;

(C) Means and ability to carry out the plans for assaultiveness or violence;

(D) The potential lethality of the plan;

(E) The probable imminence of an attempt at assault or violence; and

(F) Available support systems which may prevent the person from attempting an assault or an act of violence.

(c) An assessment of the person's ability to provide for basic personal needs shall consider the following areas:

(A) History of the person's ability to provide for basic personal needs;

(B) The person's current use of resources to obtain food, shelter, and health care necessary for health and safety;

(C) Behaviors which result in exposure to danger to self or other;

(D) Available support systems which may provide the person care necessary for health and safety; and

(E) If the person appears to lack capacity to care for self, the availability of a guardian who can assure the provision of such care.

Stat. Auth.: ORS 413.042, 426.060 – 426.500

Stats. Implemented: ORS 426.005 – 426.395

Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0070

309-033-0970

Variances

(1) Criteria for a variance. Variances may be granted to a facility if there is a lack of resources to implement the standards required in this rule or if implementation of the proposed alternative services, methods, concepts or procedures would result in services or systems that meet or exceed the standards in these rules.

(2) Variance application. The facility requesting a variance shall submit, in writing, an application to the Division which contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept or procedure proposed;

(d) A plan and timetable for compliance with the section of the rule from which the variance is sought; and

(e) Signed documentation from the council indicating its position on the proposed variance.

(3) Division review. The Assistant Administrator or designee of the Division shall approve or deny the request for a variance.

(4) Notification. The Division shall notify the facility of the decision. This notice shall be given to the facility, with a copy to the council, within 30 days of the receipt of the request by the Division.

(5) Appeal application. Appeal of the denial of a variance request shall be made in writing to the Administrator of the Division, whose decision shall be final.

(6) Written approval. The facility may implement a variance only after written approval from the Division. The Intergovernmental Agreement shall be amended to the extent that the variance changes a term in that agreement.

(7) Duration of variance. A variance shall be reviewed by the Division at least every 2 years.

Stat. Auth.: ORS 426.060 – 426.500 & 430.041

Stats. Implemented: ORS 426.005 – 426.309

Hist.: MHD 12-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 309-230-0080