Department of Behavioral Health

TRANSMITTAL LETTER

SUBJECT CONSUMER RIGHTS		
POLICY NUMBER 515.3	DATE AUG 15 2017	TL# 310

Purpose. To establish the Department of Behavioral Health (DBH) policy that promotes the rights of consumers seeking to participate or already participating in DBH community behavioral health services/supports.

Applicability. Department of Behavioral Health (DBH) licensed, certified and/or contracted providers with a human care agreement who provide community-based mental health (MH) and/or substance use disorder (SUD) services and/or supports.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate Behavioral Health Authority (BHA) offices and DBH providers.

Effective Date. This policy is effective immediately.

Superseded Policies. None

Distribution. This policy will be posted on the DBH web site at www.dbh.dc.gov under Policies and Rules. Applicable entities are required to ensure that affected staff is familiar with the contents of this policy.

Tanya A. Royster, MD
Director, DBH

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF BEHAVIORAL HEALTH	Policy No. 515.3	Date AUG 1 5 2017	Page 1
	Supersedes None		

Subject: Consumer Rights

1. **Purpose**. To establish the Department of Behavioral Health (DBH) policy that promotes the rights of consumers seeking to participate or already participating in DBH community behavioral health services/supports.

2. **Applicability**. Department of Behavioral Health (DBH) licensed, certified and/or contracted providers with a human care agreement who provide community-based mental health (MH) and/or substance use disorder (SUD) services and/or supports.

3. **Authority**. "Department of Behavioral Health Establishment Act", D.C. Official Code §§ 7-1141.01 et seq.); 22-A DCMR 3 "Consumer Grievance Procedures", and 22-A DCMR 6319, "Client Rights and Privileges, including Grievances."

4. **Definitions**.

4a. Consumers – refer to individuals who receive mental health and substance use disorder supports and/or services from DBH and contracted providers. Note: The common term used in the substance use disorder (SUD) service delivery systems is "clients" (also, see Exhibits 1 and 2 references to "Consumer").

4b. Cultural competence (see section 5 below) - means the ability of the DBH provider to deliver behavioral health services in a manner that effectively responds to the languages, values, beliefs and practices among the various cultures of consumers[1].

5. **Policy.** It is the policy of DBH to ensure, protect and promote the rights of consumers who are already participating or applying to participate in community behavioral health services and/or supports. DBH and its providers shall demonstrate this commitment by communicating these rights in a culturally competent manner (see section 4b above).

6. **Procedures**. Each provider shall:

6a. Post the Consumer Rights Statement (Exhibit 1) and the contacts below in locations where they are noticeable:

Consumer and Family Affairs Administration (CFAA): (202) 673-4377
Ombudsman Contact Telephone Number: 1 (844) 698-2924

[1] 22-A DCMR 3499.1 "Definitions."

Disability Rights DC at University Legal Services Telephone Number: (202) 547-0198
Consumer Action Network Telephone Number: (202) 842-0001
Long Term Care Ombudsman Telephone Number: (202) 434-2190

6b. Develop an internal consumer rights policy which, at a minimum, follows this DBH policy. The provider's internal written policies and procedures shall be submitted to the DBH Office of Accountability's Certification Division per certification standards for the Mental Health Rehabilitation Services (MHRS) and Substance Use Disorder and Recovery Treatment Providers.

6c. Explain the rights policy to consumers and/or their legal representatives at initial visit or next appointment. A signed copy shall be in a DBH-approved acknowledgment form (last page of Exhibit 1) and shall be maintained in the consumers' records. A consumer's refusal to sign and the reason for not signing shall be documented. Consumers shall have a copy of the signed receipt. Consumers' parents, guardians, family members, personal and/or legal representatives, staff, and those designated by the consumer as significant others (e.g., advocates) shall be provided a copy upon their request.

6d. Inform consumers about their options for resolving a problem, or issue, or dissatisfaction of services/supports and about filing a grievance. If consumers feel that their rights have been violated, limited, or when they are dissatisfied with the services/supports they are receiving, they have the option for an informal negotiation with the provider or exercising their right to file a formal grievance (see section 6e below). Consumers may ask for guidance from CFAA on how to go about informal negotiation with provider.

6e. Advise consumers about the Grievance and Dispute Resolution Procedure (Exhibit 2): (1) Consumers can file a grievance within DBH through the Consumer and Family Affairs Administration (see section 6a above and use Exhibit 3, 4 and 5, or (2) DBH Office of the Ombudsman (see Section 6a above), or (3) with Disability Rights DC at University Legal Services, or (4) Consumer Action Network (see section 6a above), or Long Term Care Ombudsman Telephone Number: (202) 434-2190.

6f. Promote awareness of consumer rights through the distribution and posting of educational materials (e.g., posters and brochures) which follows the Language Access Act of 2004 (D.C. Official Code § 2-1931(2) and § 2-1931(3)) ("the Act").[2]

6g. Ensure that every staff member, including administrative, clerical, and support staff, is knowledgeable about the consumer rights policy.

7. **Compliance and Accountability.** The DBH CFAA shall monitor the implementation of this policy.

[2] The DC Office of Human Rights Language Access Program: Program description • Laws and regulations • Publications • Engagement and awareness campaigns • Contact information

8. **Exhibits**.

Exhibit 1 Consumer Rights Statement

Exhibit 2 Grievance and Dispute Resolution Procedure

Exhibit 3 Consumer Grievance (Form A)

Exhibit 4 Consent to Representation (Form B)

Exhibit 5 Provider Response/Appeal (Form C)

Approved by:

Tanya A. Royster, MD
Director, DBH

Signature **Date** 8/15/2017

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Consumer Rights Statement

This Consumer Rights Statement enumerates the rights that you have when you receive mental health or substance use disorder services/supports from the Department of Behavioral Health (DBH). If you need further explanation of any of these rights, feel free to ask your provider. If the court has said that you are not able to understand these rights, these rights will be explained to your family member or legal representative or anyone you choose. You will be provided a copy (See footnote below for definition of consumer[1] which may also refer to "client").

When you are receiving services from the Department of Behavioral Health (DBH) or any facility that is contracted to provide mental health and/or substance use disorder services/ supports, you have the right to:

1. BE TREATED WITH DIGNITY AND RESPECT AT ALL TIMES. You are valued as a unique individual and shall be treated with consideration and respect for your dignity, autonomy and privacy at all times. Respectful treatment shall be extended to your family members, attorney-in-fact or guardian or personal/legal representatives, and designated significant others (e.g., advocates).

2. BE TOLD WHAT RIGHTS YOU HAVE. You will receive the Consumer Rights Statement during your first visit or next appointment from your provider. These rights will be explained to you in a manner that you can understand. You will be asked to acknowledge your receipt of this information in writing.

3. BE FREE FROM DISCRIMINATION. Mental health and/or substance use disorder services/supports shall be given to you free from discrimination on the basis of race, color, religion, national origin, language, culture, gender, gender identity, sexual orientation, age, marital status, personal appearance, family status and responsibilities, political affiliation, disability, and source of income.

4. BE SAFE FROM HARM. You have the right to be free from physical, emotional, sexual or financial abuse, neglect, harassment, coercion or exploitation when seeking or receiving mental health and/or substance use disorder services/supports.

5. COMPLAIN IF YOU FEEL YOUR RIGHTS HAVE BEEN VIOLATED. If you feel that your rights have been violated, limited, or are not satisfied with the services and/or supports that you are receiving from your provider, you have the option for an informal negotiation or exercising your right to file a formal grievance. The choices for submitting a grievance are as

1 Consumer – refer to a person eligible to receive behavioral health services. Note: The common term used in the substance use disorder (SUD) service delivery systems is "clients").

follows: (1) Consumer and Family Affairs Administration, or (2) DBH Office of the Ombudsman, or (3) with Disability Rights DC at University Legal Services, or (4) Consumer Action Network, or (4) Long Term Care Ombudsman Telephone Number: (202) 434-2190, as applicable.

6. DECIDE WHAT TREATMENT YOU WANT IN ADVANCE. You have the right to make health care decisions, including the right to accept or refuse life-sustaining medical treatment, if such treatment becomes necessary, and the right to execute advanced directives about such medical treatment decisions (e.g., living wills or powers of attorney). Also, you have the right to execute advance instructions about behavioral health treatment preferences. These preferences shall be followed except for good cause.

7. GIVE OR NOT GIVE CONSENT FOR TREATMENT OF YOUR BEHAVIORAL HEALTH OR PHYSICAL HEALTH PROBLEMS. You have the right to receive information about your proposed services and supports, including their purpose, side effects, potential risks and benefits and feasible alternatives. Your informed consent shall be sought for the provision of services and/or supports, unless otherwise required by law. If you are certified as incapacitated to give informed consent, your physician shall seek to obtain consent for the provision of services and support from a family member or personal representative you have authorized release of information, your attorney-in-fact, a person you have designated as your power of attorney or guardian appointed by the court. You may revoke your consent to participate in a treatment or request a review of your services plan at any time.

8. TAKE OR REFUSE TO TAKE MEDICATIONS. You have the right to take or refuse medications, unless otherwise required by law. When seeking informed consent, your provider shall provide you, your personal representative, person you have designated as your power of attorney or guardian appointed by the court, or family member with information about the proposed medication.

9. TREATED IN THE LEAST RESTRICTIVE AND INTEGRATED SETTING. You have the right to receive mental health or substance use services and supports in the least restrictive, barrier-free location, and in most integrated setting appropriate to your individual needs.

10. TAKE PART IN THE DEVELOPMENT OF YOUR TREATMENT/SERVICE PLAN. You have the right to have meaningful input in the development of your service or treatment plan. You may choose to have your family members, personal representative or your attorney-in-fact participate as well. Such treatment or service planning shall include the right to be informed about your condition, legal status and proposed or current services, the risks and benefits of treatments (including medications), therapies or other available alternatives. Services offered to you shall not be conditioned upon agreement to accept another service or support.

11. HAVE INFORMATION ABOUT YOU KEPT PRIVATE. Your health information will not be disclosed without your authorization unless required or allowed by the District and Federal laws, rules or regulations.

12. TALK IN PRIVATE WITH THOSE MENTIONED IN YOUR SERVICE PLAN DURING REASONABLE TIMES. This provision applies to those living in a residential setting (e.g., Community Residential Facility (CRF) or in supported independent living). You

have the right to have space to receive visitors that are included in your treatment or service plan and have no interruptions when talking on the telephone during designated hours.

13. RECEIVE AND SEND MAIL WITHOUT ANYONE ELSE OPENING IT. This provision applies to those living in a residential facility (e.g., CRF or a supported-independent living housing). You have the right to have the opportunities to communicate by sealed and uncensored mail.

14. ASK FOR AND GET A COPY OF YOUR BILL FOR THE SERVCES YOU RECEIVE. You have the right to request and receive an itemized copy of your bill for services rendered, as applicable.

15. RECEIVE SERVICES AND LIVE IN A HEALTHY, SAFE AND CLEAN PLACE. If you are living in place that DBH monitors (e.g., CRF or a supported-independent living housing, treatment facility), you have the right to have DBH inspect these facilities to attest that you are in a safe, sanitary and humane environment.

16. VOTE IN ALL ELECTIONS IF YOU ARE REGISTERED. You have the right to vote/elect your preferred candidates during local and national elections in the jurisdiction in which you are registered.

17. PRACTICE OR NOT PRACTICE YOUR RELIGION. You have the right to engage in or abstain from the practice of religion and freedom from harassment aimed at encouraging you to engage in the religious practices of the provider or other consumers.

18. HAVE A PLACE TO STORE YOUR PROPERTY. If you live in a residential setting (e.g., CRF or in supported-independent living), you shall be provided with a reasonable individual storage space for private use.

19. SAY HOW YOU FEEL ABOUT THE SERVICES YOU RECEIVE. You have the right to participate in a periodic evaluation of mental health and/or substance use services and/or supports; including how providers deliver these services.

CONSUMER RIGHTS STATEMENT

A copy of this document will be given to you, your family member or representative.

Date "Consumer Rights Statement" presented: _____

I acknowledge that this Consumer Rights Statement has been presented and/or has been read to me. I have a signed copy.

Printed Name: _____
Consumer

Signature Date

Printed Name: _____
Witness

Signature Date

Printed Name: _____
Guardian, Family or Representative

Signature Date

Printed Name: _____
Witness

Signature Date

Revised August 2017

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Grievance and Dispute Resolution Procedure

Finding Answers, Improving Relationships (FAIR)

FAIR is the DBH formal grievance process through which you, or someone who represents you, can voice a complaint within the DBH network through the Consumer and Family Affairs Administration (CFAA): (202) 673-4377; Ombudsman: 1 (844) 698-2924: Also, you have the option to initiate a grievance with any of the following: Disability Rights DC at University Legal Services: (202) 547-0198; Consumer Action Network: (202) 842-000; and Long Term Care Ombudsman Telephone Number: (202) 434-2190.

How to file a grievance within the DBH Network

1. Report your grievance orally or in writing. Oral reports will be transferred in writing. The Grievance Form shall be made available to you upon your request from CFAA and shall be completed. Your representative or CFAA may assist you.

2. Submit completed form within six months from the date of the incident to any of the following:

A. Grievance Coordinator of your provider.

B. CFAA, in turn, may refer to the provider involved in the grievance. Note: If the grievance is about a DBH rule or the actions of a DBH employee (e.g., staff at Saint Elizabeths Hospital), you must file the grievance with the CFAA.

Note: A grievance will not be entertained if it complains of a specific action that occurred more than six months prior to the filing of the grievance unless there are extenuating circumstances (§ 304.1, 22-A DCMR, "Consumer Grievance Procedures").

What to expect after grievance is received by Provider

1. The provider shall review and investigate cause of grievance and respond to you within five business days for allegations of abuse and ten business days for other grievances.
2. As much as possible, the provider investigator will contact you for your input within ten business days.
3. DBH shall ensure that the provider has responded before initiating an external review and resolution of the grievance.
4. If you are not satisfied with the response, you have ten business days to appeal through DBH which will refer you for an external review within five business days upon receipt of your request.

External Review

1. DBH shall contract an external reviewer and provide you with a written notice of the method, date and time of the external review, a list of participants, and contact information for the independent peer advocacy program.

2. The external reviewer may hold a fact-finding hearing and issue a written advisory opinion within five days. This time can be extended with consent of all parties. You have a right for representation. In some cases, the reviewer, upon consent of parties, may attempt to mediate towards an agreeable resolution prior to issuing an advisory opinion. In some situations, as chosen by you, the external reviewer may conduct a fact-finding process and issue a written advisory opinion without a hearing. The advisory opinion shall include the following: (a) summary of the evidence, (b) applicable laws and regulations, (c) Findings of Fact, and (d) Conclusion and recommendations.

3. The advisory opinion is submitted to the Director of DBH, provider CEO, with copies to consumer, his/her representatives. Mentioned parties may, within five business days of receipt of this written notice, may provide their reactions to the Director.

4. The DBH Director shall, in writing, accept in full, or in part or reject the recommendations of the external reviewer and set time limits and responsible parties for carrying out any accepted recommendations within ten business days of receipt of the advisory opinion.

5. Any party to a grievance who is dissatisfied with the final determination may request for a fair hearing, pursuant to the DC Administrative Procedure Act and federal regulations.

For assistance, contact:
Consumer and Family Affairs Administration
(202) 673-4377 Fax (202) 671-8049

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

DBH

Consumer Grievance Procedure

A

First Name	M.I.	Last Name	DOB	( ) Male ( ) Female ( ) Prefer to self-describe _____ ( ) Prefer not to say

FORM COMPLETED ON: or TODAY"S DATE	Date Filed with Provider/DBH:	

Provider Where Enrolled:	Provider Filed Against:	FILED AT: (Provider Name)

Mailing Address			
City	State	Zip	Email Address

Telephone 1 ☐ Leave Message OK	Telephone 2 ☐ Leave Message OK

How consumer prefers to be contacted (Circle choice below): Tel. Write Email In Person	Individual Filed Against (If Any)	Does this grievance involve abuse & neglect or denial of service? ☐ Yes ☐ No

Is complaint about failure to comply with earlier grievance decision? ☐ Yes ☐ No	Subject Matter of Grievance (DBH will complete) Code 1 ☐ Code 2 ☐

Summary of Grievance

What does consumer want done?

Please fill out page 2

Describe any previous attempt to resolve the problem:	
☐ Ind. Peer Advocate (C.A.N.)? If so, ID No. ☐	☐ Other Representative (Complete Form B)
The consumer should keep a copy of this form for their records.	

To the Consumer:

1. A copy of this form is proof that you filed your grievance on the date above. Please keep your copy of the form until your grievance is over.
2. Information about your grievance that you provide, or that others provide, may be shared with staff of the Office of Consumer and Family Affairs and with others who respond to the grievance. Information about the grievance will NOT be placed in your clinical record or shared with anyone not involved in the grievance.
3. You cannot be punished or treated unfairly because you filed a grievance.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

DBH

Consent to Representation

B

Information Received by (Name)		FAIR Case No.	
Consumer's First Name	Middle Initial	Consumer's Last Name	
Representative's First Name		Representative's Last Name	
Representative's Mailing Address			
City	State	Zip	Telephone
Email Address		Preferred Method of Contacting Representative (Circle) TELEPHONE WRITE EMAIL DON'T CONTACT	
Relationship to Consumer (Circle One) FAMILY FRIEND IND. PEER ADVOCATE OTHER PEER ADV. STAFF ULS OTHER			

☐ I agree to allow the above person to represent me in filing this grievance and to act as my personal representative for purposes of the privacy laws.

☐ I want my representative to be notified of everything that happens to my grievance.

_____ _____
Signature of Consumer or Guardian Date

☐ Consumer declined to sign this form. Reason: _____

Consumer must sign Authorization to Disclose Form (DBH-HIPAA Form 3). Please give consumer copies of 1) this form, 2) the Authorization Form, and 3) Form A, New Grievance. Please staple the forms together.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

DBH

Provider Response/Appeal

C

IMPORTANT NOTE: The provider uses this form to respond to the grievance. Once the consumer receives the response; the form allows the consumer to either end their grievance or request an appeal; serving two purposes. (This form C replaced Form D)

Consumer's Name	FAIR ID No.	Response Given to Consumer by (Name)	Notification Date to Consumer

Response to Grievance from What Level? **Date of Grievance** **Informal:** **Provider CEO:**	Response is Dated

Text of Response or Outcome (Attach Additional Sheet if Necessary). Specify who worked on the problem and how. **Be sure to include signature of Person who prepared the Response and the date.**

CONSUMER'S DECISION: I have decided to (check one)

☐ End my grievance now. No further action will be taken.

☐ Appeal my grievance to the next level. I understand that I will receive a response to my appeal no later than _____

☐ Wait to decide whether to appeal my grievance. I understand that if I want to appeal I must decide by: _____

For appeals to DBH for Extern

- I ___ am ___ am not willing to meet in the same room with provider staff to discuss the grievance.
- I prefer (select one) ___ mediation, ___ a hearing, ___ no preference (please note that the FAIR program will make the final decision).
- I need the following special accommodation: _____

_____ _____
Signature of Consumer Date

Please provide a copy of this form to the consumer