RHODE ISLAND DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS

Notice of Public Hearing

The Director of the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals has under consideration proposed amendments to the ***Rules and Regulations for the Licensing of Behavioral Healthcare Organizations***. These regulations shall repeal and supersede any prior rules, regulations, and standards relating to the licensure of behavioral healthcare organizations promulgated by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, however named. The purpose of the proposed amendments to the Regulations is to further establish prevailing standards for the licensure and certification of agencies and programs that provide mental health services for adults who are not in the custody of the Department of Children, Youth and Families (DCYF) and/or substance abuse services for children and adults. These regulations are promulgated to ensure that agencies comply with prevailing standards in providing services. They are promulgated in the best interest of the health, safety, and welfare of the public.

In the development of these proposed amendments to the Regulations, consideration was given to the following: (1) alternative approaches; and (2) overlap or duplication with other statutory and regulatory provisions. No alternative approach or duplication or overlap was identified based upon available information.

Notice is hereby given in accordance with the provisions of Chapter 42-35 of the Rhode Island General Laws, as amended, that the Director will hold a public hearing on the above mentioned matter in the **Arnold Conference Center (in the Eleanor Slater Hospital)** at the John O. Pastore Complex in Cranston, Rhode Island **ON TUESDAY, JANUARY 8, 2013 AT 12:00 PM**.

Persons wishing to testify may do so by signing up at the meeting or by submitting written testimony by, **Tuesday, January 8, 2013,** to Heather Daglieri, Esq., Office of Licensure, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, Barry Hall, 14 Harrington Road, Cranston RI 02920 or via email Hdaglieri@bhddh.ri.gov. The public hearing will begin at 12:00 PM and will conclude when the last speaker finishes testimony or at 2:00 PM, whichever occurs first.

For the sake of accuracy, it is requested that statements to be made relative to any aspect of the regulations, including alternative approaches or overlap, be submitted in writing at the time of the hearing or mailed prior to the hearing date to: Heather Daglieri, Esq., Administrator of Licensing, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, Barry Hall, 14 Harrington Road, Cranston, Rhode Island 02920 or via email: HDaglieri@bhddh.ri.gov.

Interested persons may inspect said proposed amendments to the regulations and other related materials on the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals' website at www.bhddh.ri.gov; at the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, 14 Harrington Road, Cranston, Rhode Island, 02920 between the hours of 9:00 a.m. and 3:00 p.m., Monday through Friday; by calling (401) 462-2324 {via RI Relay 711}; or by emailing HDaglieri@bhddh.ri.gov Proposed regulations are also posted on the Rhode Island Secretary of State's website: www.sos.ri.gov

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals is ***accessible to persons with disabilities. If communication assistance (readers /interpreters /captioners) is needed, or any other accommodation to ensure equal participation, please notify the Department at (401) 462-2324 or RI Relay 711 at least three (3) business days prior to the public hearing so arrangements can be made to provide such assistance at no cost to the person requesting.***

Signed this 7th day of December 2012

Craig S. Stenning, Director, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals

State of Rhode Island and Providence Plantations
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Concise Summary of Proposed Technical and Non-technical Amendments to Rules and Regulations For the Licensing of Behavioral Healthcare Organizations

In accordance with the Administrative Procedures Act, Section 42-35-3(a)(1) of the General Laws of Rhode Island, the following is a concise summary of the proposed technical and non-technical amendments:

(1) Amendments to Definitions to further define and refine terms that are used throughout the regulations;

(2) Amendments to ensure that Behavioral Healthcare Organizations licensed by the Department offer enrollment in the Health Information Exchange ("HIE") to each patient and maintain documentation evidencing the offer of enrollment in the treatment record of each individual. If the individual chooses to enroll in the HIE, the organization shall ensure that the individual executes an HIE enrollment form and a Uniform Authorization Form for the disclosure of health information to the HIE.

(3) Amendments to allow flexibility in the governance of an organization by allowing for an advisory board to fulfill a Board of Director's requirements for those entities that are for profit or not for profit chapters of a national organization providing services in Rhode Island.

(4) Amendments to decrease regulatory burden on licensed behavioral healthcare organizations by eliminating the requirement for clinical supervisor validation of assessments and assessment updates performed by licensed staff.

(5) Amendments to ensure that Opioid Treatment Programs check Department of Health's Prescription Monitoring Program for each new admission and at each annual physical.

Rules and Regulations for the Licensing of Behavioral Healthcare Organizations

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS

August 2004

As Amended

September 2004
September 2006
January 2007
(Emergency) September 2009
April 2010
August 2011
December 2012

State of Rhode Island and Providence Plantations

Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Lincoln Chafee
Governor

Craig S. Stenning
Director

BEHAVIORAL HEALTH RECOVERY PRINCIPLES

RECOVERY

Recovery is a journey that results in a person accepting and overcoming the challenges of a disability. Throughout this journey, the person may arrive at meaning, purpose, value, and a comfortable sense of self. Every journey is made up of a different collection of experiences.

Recovery in a major mental illness or addiction to alcohol and other drugs does not usually mean cure of the illness, but adaptation that allows life to go forward in a positive way. Adaptations happen in the individual and in the environment.

Recovery is so deeply personal. Supportive people, especially peers, can help it take root, but none can bestow recovery. It springs from a lighted clearing in the deep woods; it ascends from the healing self.

Each BHDDH-licensed organization/facility providing behavioral health services in Rhode Island shall meet the following Recovery Standards:

- Mission statement of the organization identifies recovery vision as driving the system
- Organization includes people who receive services in all phases of service planning and evaluation
- Primary outcomes identified for each service provided by the organization include measures of recovery
- Leadership of the organization reinforces recovery vision and recovery standards
- Policies and procedures of the organization are compatible with recovery values
- Organization provides access to an array of services so that recovery plans may be effectively individualized
- Organization provides training to improve knowledge, attitudes and skills necessary for all staff to conduct recovery-oriented services.

Organizations shall promote recovery and empowerment by recognizing the uniqueness of each person receiving services and supporting the individual's:

- Expressed desires
- Strengths
- Choices and self-determination
- Self-management of her/his illness
- Direction of her/his treatment plans and service process.

Organizations shall offer services that ensure the opportunity for each person receiving services to attain the following service outcomes:

- An understanding of their behavioral health issue and the recovery process
- A belief in their own recovery
- Improved self-esteem
- Physical well-being
- Supportive relationships with family and peers
- Adequate resources to sustain a good quality of life
- Optimal functioning
- A safe and comfortable living environment
- Self-management of symptoms
- Knowledge of community resources and benefits/entitlements
- Engagement in daily activity that is meaningful to the person, e.g., employment; educational options; hobbies; initiatives of personal interest; supportive, structured activities etc.

Organizations shall ensure that staff who supervise or provide direct services shall demonstrate the following:

- A belief in recovery
- An understanding of recovery as a personal journey that takes time; not a one-time event
- Respect for the uniqueness and autonomy of each individual
- Adequate emotional intelligence to cultivate hope, confidence, and perseverance in persons receiving services
- Capacity to develop a positive, trusting relationship and to work in partnership with others
- An ability to incorporate a person's social and cultural environment into the recovery process
- An understanding of the benefits of mutual peer support in the recovery process.

---- developed by the BHDDH-sponsored Recovery Workgroup. Included are recommendations from the Recovery Focus Groups; Recovery Surveys; Recovery Discussions at licensed behavioral healthcare organizations; and excerpts from works by William A. Anthony and Patricia E. Deegan.

PREFACE

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals staff, along with persons served, advocates and providers in the Rhode Island Behavioral Healthcare community, have designed these rules, regulations, and standards. They have been designed with the needs of people uppermost in mind and they are intended to be flexible and responsive enough to allow for the continued development of innovative behavioral healthcare supports and services.

These Behavioral Healthcare Rules, Regulations, and Standards supersede any and all prior rules, regulations, and standards relating to the Licensing of Facilities and Programs Providing Mental Health Services promulgated pursuant to Rhode Island General Laws sections 40.1-24-1 *et seq*., 40.1-24.5 *et seq*., 40.1-8.5 *et seq*., Rules and Regulations for the Licensing of Substance Abuse Facilities promulgated pursuant to Rhode Island General Laws section 40.1-1-13(11) *et seq*., Rules Pertaining to the Definition of Mental Health Professional promulgated pursuant to Rhode Island General Laws section 40.1-5-3 *et seq.* and 40.1-5-7 *et seq.*, Rules and Regulations for the Community Mental Health Services Act promulgated pursuant to Rhode Island General Laws section 40.1-8.5 *et seq.*, Amendment to Rules and Regulations and Standards for the Licensing of Mental Health Facilities and Programs – Licensing of Supervised Apartments promulgated pursuant to Rhode Island General Laws sections 40.1-24-1 *et seq*., 40.1-24.5 *et seq*., 40.1-8.5 *et seq*., and Rhode Island Community Mental Health Medicaid Procedure Manual promulgated pursuant to Rhode Island General Laws section 40.1-S.4-11, 42 CFR440.BO(d),42CFR 440.16.

These Behavioral Healthcare Rules, Regulations and Standards have been promulgated to ensure that basic statutory requirements for serving persons in need of behavioral healthcare are met; and to ensure that organizations providing behavioral healthcare services promote the empowerment and recovery of the individuals they serve.

In order to comply with these rules, regulations, and standards, the behavioral healthcare organization must present sufficient evidence that the physical plant meets safety standards; the staff is adequate in number and properly trained to carry out the goals of the program; and that the overall philosophy, objectives, and services are responsive to the needs of those served and are consistent with the mission statement of the Department and with the Behavioral Healthcare Recovery Principles.

The issuance of a Behavioral Healthcare license requires compliance with these rules, regulations and standards and authorizes the licensee to establish programs and services. Under no circumstances does such a Behavioral Healthcare license commit the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals or the State to any funding of any facility, program, or organization.

Pursuant to the provisions of Rhode Island General Laws section 42-35-3, the following were given consideration in adopting these regulations: (a) alternative approaches to the regulations; (b) duplication or overlap with other state regulations; and (c) significant economic impact on small business or any city or town. No alternative approach was

identified; nor was any duplication or overlap identified. The protection of the health safety and welfare of the public necessitates the adoption of these Regulations despite any economic impact, which may be incurred as the result of the adoption of these Regulations.

STATUTORY AUTHORITY FOR LICENSING

Authority for these rules, regulations and standards is found in RI General Laws section 40.1-24-1 *et seq*., Rhode Island General Laws section 40.1-24.5-1 *et seq*., Rhode Island General Laws section 40.1-8.5 *et seq*., Rhode Island General Laws section 40.1-1-13(11) *et seq*., and Rhode Island General Laws section 40.1-5-1 *et seq.*

APPLICABILITY

These rules, regulations and standards apply to all facilities, programs and organizations that provide mental health services for adults who are not in the custody of the Department for Children, Youth, and Families (DCYF) and/or substance abuse services for children and adults.

Except for the following:

1. Health Care Facilities licensed by the Rhode Island Department of Health pursuant to Rhode Island General Laws section 23-17-1 *et seq.*

2. Sheltered Care Facilities licensed by the Department of Health pursuant to Rhode Island General Laws section 23-17.4-1 *et seq*

3. Facilities, programs, and agencies licensed by the Rhode Island Department for Children, Youth, and Families pursuant to Rhode Island General Laws section 42-72-5(8).

4. Facilities, programs, or organizations already licensed or certified by any appropriate state agency, pursuant to Rhode Island General Laws.

5. Organized ambulatory care facilities owned and operated by professional service corporations as defined in Rhode Island General Laws section 7-5.1-1 *et seq.* (the "Professional Service Corporation Law").
6. A private practitioner's (physician, dentist, or other health care provider) office.

7) Group of practitioners' offices (whether owned and/or operated by an individual practitioner, alone or as a member of a partnership, professional service corporation, organization, or association).

All references within these rules and regulations are incorporated by reference and have the same force and effect as if promulgated herein.

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals shall report substantial violations of any and all applicable statutes, Rules, or Regulations to the appropriate state or federal department, agency, or authority.

Questions regarding applicability of these rules to particular facilities, programs, or organizations should be addressed to the Director of the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

LICENSE REQUIRED

No person or governmental unit, acting severally or jointly with any other person or governmental unit, shall establish, conduct, or maintain a facility, program, or organization as defined in these Rules, Regulations and Standards without a license, pursuant to Rhode Island General Laws section 40.1-24-1(h).

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Part I: Licensing Procedures and Definitions

Section 1.0 Definitions

The following words and terms shall have the assigned meanings throughout these rules and regulations unless a specific context clearly indicates otherwise:

1.1 ***"Administer"*** means the direct application of a medication, whether by injection, inhalation, ingestion, or any other means, to the body of an individual by (1) a licensed and authorized agent and under his or her direction, or (2) by the individual at the direction and in the presence of the licensed and authorized agent.

1.2 ***"Administrative Discharge"*** means the process by which an organization discontinues all services and closes the treatment record of a person served when the person is not participating in treatment or adhering to his or her treatment contract.

1.3 ***"Admission"*** means an organization's decision, after conducting an initial biopsychosocial assessment, to offer services to a person and includes opening a treatment record for the person, orienting him or her to the organization, and assigning his or her treatment to an appropriate staff person or team. Individuals shall be admitted to the organization no later than their third consecutive face-to-face clinical service.

1.4 ***"Adverse event or incident"*** means any sudden or unexpected occurrence that:

A. Takes place on the premises of the organization

--- or ---

B. Is the result of or can be linked to treatment or services provided by the organization

--- and ---

C. Causes or has the potential to cause any physiological or psychological injury or death to any person served, a staff person, or a visitor to the organization.

"Serious" as defined in the Definition Section of the Licensing Procedure & Process for Facilities & Programs Licensed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, means any injury or harm that requires more than immediate on-site first aide; and/or that involves the response of public emergency services.

1.5 ***"Advocate"*** means a (1) legal guardian or (2) an individual acting in support of or on behalf of a person in a manner consistent with the interests of the person.

1.6 ***"Affiliation Agreement"*** means a signed, written understanding among two or more organizations that describes how they will work together to benefit persons served by the organizations.

1.7 ***"Aftercare Plan"*** means a post-treatment plan that is designed to maintain and enhance recovery.

1.8 ***"Aggregate"*** means to combine standardized data and information.

1.9 ***"ANCC"*** means the American Nurses Credentialing Center.

1.10 ***"ASAM-PPC"*** means the American Society of Addiction Medicine-Patient Placement Criteria for the Treatment of Substance-Related Disorders.

1.11 ***"Assessment"*** means the process of testing, gathering biopsychosocial information, and making a diagnostic judgment to determine an individual's behavioral health status and need for services, conducted by a qualified staff person.

1.12 ***"Aversive Techniques"*** are those requiring the deliberate application of discomforting, painful or noxious stimuli (that would be so to the average person) to achieve their effectiveness.

1.13 ***"Behavioral Health Acute Stabilization Unit"*** (***BH-ASU)*** is a hospital diversion and step down unit for Rhode Island residents 18 years of age or older who are experiencing a psychiatric and/or substance abuse related crisis. This unit will provide on-going assessment and observation, crisis intervention and psychiatric, substance and co-occurring treatment.

1.14 ***"Behavioral Health Issue"*** means any of the symptoms that are caused by either a mental illness, substance abuse/dependence or a combination of both.

1.15 ***"Behavioral Healthcare"*** is the umbrella term that encompasses all mental health and substance use related assessment, treatment, prevention, and support services.

1.16 ***"Behavioral Healthcare Organization"*** means a public or private establishment primarily constituted, staffed, and equipped to deliver mental health and/or substance abuse services to the general public.

1.17 ***"Behavioral Management"*** means any intervention or treatment that utilizes positive reinforces and/or restrictions to help an individual receiving services to develop and/or strengthen recovery-oriented behaviors and to address and correct treatment targeted behaviors.

1.18 ***"Behavioral Management Plan"*** means an agreement negotiated with the person served, and as appropriate, family member or guardian, in which mutually acceptable behavioral goals and interventions are specified.

1.19 ***"Best Practice Standards"*** mean principles of care that reflect the type and implementation of service recommended by research, professional literature, and professional experience.

1. 20 ***"Board"*** means the Board of Directors of the organization and/or the advisory board of a behavioral healthcare organization that is (a) a for profit entity or (b) a not for profit entity that is part of a national organization providing services in Rhode Island.

1.21 ***"Case management"*** means services that are provided to assist a person in gaining access to medical, social, educational, and other support services essential to meeting basic human needs and treatment goals.

1.22 ***"Certified Co-Occurring Disorder Professional"*** (*CCDP*) is a credential issued by the Rhode Island Board for Certification of Chemical Dependency Professionals. ~~A person who has earned the CCDP credential has a minimum BA/BS in Behavioral Science, 200 clock hours Co-Occurring specific education, including 6-hours Ethics, 6,000 hours Co-Occurring Disorder specific work experience, 200 hours appropriate supervision, and pass the ICRC CCDP written examination.~~ The requirements for this credential are established and recognized by the International Certification & Reciprocity Consortium (IC&RC).

1.23 ***"Certified Co-Occurring Disorder Professional – Diplomate"*** (*CCDP-D*) is a credential issued by the Rhode Island Board for Certification of Chemical Dependency Professional. ~~A person who has earned the CCDP-D credential has a minimum Master Degree in Behavioral Science, 140 clock hours Co-Occurring specific education, including 6-hours Ethics, 2,000 hours Co-Occurring Disorder specific experience, 100 clock hours clinical supervision, and pass the ICRC CCDP written exam.~~ The requirements for this credential are established and recognized by the IC&RC.

1.24 ***"Change in operator"*** means a transfer of the authority of the Board of Directors, by the Board of a BHO, to any other person or group of persons (excluding delegations of authority to the medical or administrative staff of the organization).

1.25 ***"Change in owner"*** means:

A. When an organization is a partnership: the removal, addition, or substitution of a partner that results in the new partner acquiring a controlling interest in the organization.

B. When an organization is an unincorporated sole proprietorship: the transfer of the title and property to another person.

C. When an organization is a corporation:

1. A sale, lease, exchange, or other disposition of all, or substantially all, of the property and assets of the corporation.

2. A merger of the corporation into another corporation.

3. The consolidation of two (2) or more corporations resulting in the creation of a new corporation.

D. When an organization is a for profit corporation: any transfer of corporate stock that results in a new person acquiring a controlling interest in such corporation.

E. When an organization is a non-profit corporation: any change in membership that results in a person acquiring a controlling vote in such corporation.

1.26 ***"Clinical Screening"*** means the process via telephone of gathering demographic and clinical information when an individual is potentially in need of or requests services from a BHO. The screening is conducted to determine the person's level of risk and the type of service needed, as well as, the person's eligibility for a particular service.

1.27 ***"Clinical supervision"*** means to instruct, direct, monitor, and be accountable for staff in their performance of providing treatment and services to the persons served.

1.28 ***"CMHC"*** also known as a CMHO**,** means a private, non-profit community mental health center organization designated by the Director of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) to provide behavioral healthcare services in a specified geographical area according to RI General Law section 40.1-8.5-1 *et seq.*

1.29 ***"Collateral"*** means an individual who collaborates with or supports a person served.

1.30 ***"Community Psychiatric Supportive Treatment" (CPST)*** is a service provided to individuals, their families, and other collaterals by mental health staff in accordance with an approved treatment plan, for the purpose of ensuring the individual's stability and assisting with his or her recovery, by monitoring and providing the treatment and interventions necessary for the individual to manage illness symptoms and to deal with overall life situations.

1.31 ***"Community Residence"*** means a facility that operates twenty four (24) hours a day to provide room, board, supervision and supportive services to three (3) or more people who have developmental, mental and/or substance related disabilities.

1.32 ***"Community Support Professional"*** means a person who has been certified to provide community support services by fulfilling all the requirements of the Rhode Island Community Support Professional Training and Certification Program.

1.33 ***"Community Support Program"*** means an organized group of behavioral healthcare treatment, support, and rehabilitation services designed to help adults (not in the custody of DCYF), who have serious mental illness, function effectively in their communities.

1.34 ***"Complaint"*** is a formal, written request for further review of an unresolved concern or an allegation against a licensed organization or provider regarding an alleged violation of ethical standards**,** regulations, or law.

1.35 ***"Concern"*** is an issue that is perceived as interfering with a person receiving adequate treatment.

1.36 ***"Continuing Care"*** means providing services according to a treatment plan that ensures that an individual receives the level of care he or she needs at any given time.

1.37 ***"Counseling"*** means interacting with an individual to evaluate and treat a mental health and/or substance abuse issue. This type service may include individual, family, and group therapy provided to the person served and significant others, according to the person's treatment plan.

1.38 ***"Courtesy dosing"*** means the provision of medication to an individual by a licensed Opioid Treatment Program that is not the individual's usual or customary treatment site.

1.39 ***"Crisis Intervention"*** means short-term emergency services. Emergency and crisis shall be used interchangeably in these regulations.

1.40 ***"Crisis Stabilization"*** means continuing services until the unhealthy symptoms and behaviors associated with an emergency are alleviated.

1.41 ***"Data Definitions"*** mean the identification of the data to be used in analysis.

1.42 ***"Department"*** means the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

1.43 ***"Director"*** means the Director of the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).

1.44 ***"Disaster"*** means any event that causes major upheaval or turmoil in a community, such as floods, fires, earthquakes, transportation accidents, violent acts, or other events causing mass casualties, with one result being that many citizens require related support, comfort, and assistance.

1.45 "***Dispense"*** means the preparation, administration, or delivery of a medication pursuant to the lawful order of a licensed healthcare provider.

1.46 ***"Distribute"*** means to deliver a medication, other than by administering or dispensing.

1.47 ***"Division of Behavioral Healthcare Services" (DBHS)*** means the unit within BHDDH that is responsible for mental health and substance abuse treatment and prevention services.

1.48 ***"DSM"*** means the Diagnostic and Statistical Manual of Mental Disorders.

1.49 ***"Endemic"*** means the habitual presence of an infection within a geographical area; may also refer to the usual prevalence of a given disease within such an area.

1.50 ***"Epidemic"*** means an outbreak in a community or region of a group of infections of similar nature, clearly in excess of normal expectancy and derived from a common or propagated source.

1.51 ***"Evidence-Based Practice"*** is an intervention or service for which there is strong research demonstrating effectiveness in assisting persons to achieve desired outcomes.

1.52 ***"Facility"*** means the physical plant where programs and services are provided-and /or overseen, or could be provided, and as defined in Rhode Island General Laws section 40.1-24-1.

1.53 ***"Family"*** means an individual who plays a significant role in the life of the person served. This may include an individual who is not legally related to the person. This individual is often referred to as a "significant other".

1.54 ***"Family Psychoeducation"*** is an evidence-based practice that provides families and significant support persons the information required for them to develop increasingly sophisticated skills to effectively support their family member's recovery.

1.55 ***"Full-time equivalent" (FTE)*** means the number of hours designated by an organization that constitutes a standard workweek for that organization.

1.56 ***Harm Reduction"*** means a set of practical strategies that reduce the negative consequences of substance use, incorporating a spectrum of strategies for safer use, to managed use, to abstinence. Harm reduction strategies address the conditions of use and the use itself.

1.57 ***"Health Information Exchange"* or *"HIE"*** means the system operated, or to be operated, by the RHIO under state authority allowing for the statewide electronic mobilization of confidential health information, regulated by Rhode Island General Laws § 5-37.7-1, et seq. and the Department of Health regulations relating to the HIE.

1.5~~7~~8 ***"HIV"*** means human immunodeficiency virus and all HIV-related viruses, as defined by the Centers for Disease Control.

1.5~~8~~9 ***"Individual" or "Individual served"*** means a person who receives behavioral healthcare services or is assessed to need behavioral healthcare services based on the results of an initial assessment. The term "person served" shall be synonymous herein with the term "individual".

1.~~59~~60 ***"Informed Consent"*** means the permission given by a person who has the legal capacity to give consent to or to authorize treatment. Such person:

A. Is situated as to be able to exercise free power of choice without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other form of constraint or coercion; and

B. Has been given sufficient information about the risks and benefits of the proposed treatment or procedure and the elements involved to be able to make a knowledgeable and enlightened decision.

1.6~~0~~1 ***"Investigation"*** means a systematic review and search for facts. It is objective in nature and is intended to identify facts, sequence and chronology of events, active failure(s), latent failure(s) and assessment of risk as pertinent to a specific adverse event. An investigation may be undertaken as a result of a complaint, an adverse event or incident report, or other information that comes to the attention of the Department or the organization.

1.6~~1~~2 ***"Leaders"*** are those individuals who set expectations, develop plans, and implement processes to assess and improve the quality of the organization's governance, management, clinical, and support functions.

1.6~~2~~3 ***"Legally Competent"*** means all persons in Rhode Island who are 18 years or older are presumed legally competent to direct their own personal and financial affairs unless determined otherwise by a court in accordance with Rhode Island General Laws section 33-15-1 *et seq.*

1.6~~3~~4 ***"Licensed Chemical Dependency Professional"*** means a person who is licensed in Rhode Island to provide, under supervision, chemical dependency or substance abuse services.

1.~~64~~65 ***"Licensed Chemical Dependency Clinical Supervisor"*** means a person licensed in Rhode Island to provide and to supervise chemical dependency or substance abuse services.

1.6~~5~~6 ***"Licensed Clinician or Practitioner"*** means a person licensed in Rhode Island to provide, under supervision, behavioral healthcare services, within the scope of the individuals license.

1.6~~6~~7 ***"Licensed Independent Clinician or Practitioner"*** means any individual who is permitted by law to provide behavioral health services without direction or supervision, within the scope of the individual's license.

1.6~~7~~8 ***"Medical detoxification"*** means the medical management of the physiological and psychological symptoms of withdrawal from alcohol and/or another drug of abuse that is provided in a hospital or free standing, appropriately equipped setting.

1.6~~8~~9 ***"Medically supervised withdrawal"*** within an Opioid Treatment Program means a gradual withdrawal of the treatment agent using decreasing doses in such a manner that a zero dose of the treatment agent is achieved over a period of time, as determined by the physician, in conjunction with the person served.

1.~~69~~ 70 ***"Mental Health Psychiatric Rehabilitative Residence"*** (***MHPRR)*** is a licensed residential program with no more than sixteen (16) beds which provides 24-hour staffing in which clients receive a wide range of care management, treatment, psychiatric rehabilitation and individual care services.

1.7~~0~~1 ***"Minor/child"*** means any person less than eighteen years of age who is not emancipated.

1.7~~1~~2 ***"Opioid Treatment Program"*** means a service that administers or dispenses an approved medication as maintenance or detoxification treatment to a person dependent on opiates. It provides, when appropriate or necessary, a comprehensive range of medical and rehabilitative services; is approved by the State authority and the Substance Abuse and Mental Health Services Administration (SAMHSA); and is registered with the Drug Enforcement Administration to use opiate replacement therapy for the treatment of opiate dependence.

1.7~~2~~3 "***Orientation"*** means a process to provide initial information about the BHO and its services to persons served and to staff of the organization. For staff, orientation includes an assessment of their competence relative to their job responsibilities and the organization's mission, vision, and values.

1.7~~3~~4 ***"Outcome"*** means the result(s) of the performance or the non-performance of a function or process.

1.~~74~~75 ***"Outpatient detoxification"*** means the medical management, provided through outpatient services, of the physiological and psychological symptoms of withdrawal from alcohol and/or another drug of abuse, to insure that medical or psychological complications do not develop.

1.7~~5~~6 ***"Peer support"*** means individual or group interactions conducted by persons receiving services, or their families or significant others, for the purpose of providing emotional support, sharing experiences in coping with problems, and developing a network of supportive people outside the formal behavioral healthcare service system.

1.7~~6~~7 ***"Physical examination"*** means an examination by a duly licensed physician, nurse practitioner, or physician assistant that shall include physical evaluation for possible cardiopulmonary, hepatic, neurological, or infectious conditions. It should also include a tuberculin skin test unless there is documented evidence of such a test within the previous six months.

1.7~~7~~8 ***"Pre-Crisis Treatment Plan"*** means a plan developed with the person served that specifies interventions to be used to manage any potential behavioral health crisis that the individual may experience.

1.7~~8~~9 ***"Premises"*** means a tract of land and the buildings thereon where direct services are provided.

1.~~79~~80 ***"Primary Provider"*** means the staff person who is responsible for ensuring that the treatment plan of the person served is formulated and implemented.

1.8~~0~~1 ***"Priority Population"*** means individuals eligible for specific services based on eligibility criteria set by the Department.

1 8~~1~~2 ***"Program"*** means a planned structured service delivery system structured to provide specific components that are responsive to the needs of the persons served.

1.8~~2~~3 ***"Provider"*** means a person or organization that manages or delivers clinical and/or support services.

1.8~~3~~4 "***Provisional Chemical Dependence Professional***" (PCDP) is a credential issued by the Rhode Island Board for Certification of Chemical Dependency Professional. ~~A person who has earned the PCDP credential require1-year/2000 clock hours supervised work experience, and has completed 140 clock hours of education (70-hours must be substance abuse specific and the remaining may include 70 hours in counselor training), including 36 hours of required course work.~~

1.~~84~~85 ***"Provisional Certified Co-Occurring Disorder Professional"*** (PCCDP) is a credential issued by the Rhode Island Board for Certification of Chemical Dependency Professional. ~~A person who has earned the PCCDP credential has an Associates Degree in Behavioral Science or a non-degree, and has a minimum of 2,000 hours Co-Occurring specific training, a minimum of 140 hours Co-occurring specific education (70-hours addiction and 70-hours mental health), 150 clock hours appropriate supervision (with 10-hours in each domain), with no exam.~~

1.8~~5~~6 ***"Recovery"*** means a process of overcoming both physical and psychological symptoms and/or behaviors associated with a mental illness or a dependence on a drug or drugs of abuse.

1.8~~6~~7 ***"Recovery Principles"*** are the values, developed by consumers and providers in the Rhode Island behavioral healthcare system, that guide the implementation of a recovery-oriented service system.

1.8~~7~~8 ***"Register"*** means the process used by an organization to record sufficient demographic and clinical data to identify an individual who has received an initial face-to-face clinical service and has not been admitted to the organization.

1.8~~8~~9 ***"Rehabilitation Service"*** means a service specifically tailored to assist a person to improve physical, psychosocial, and vocational functioning.

1.~~89~~90 ***"Residential Services"*** means a type of service providing 24-hour care, treatment, and support in a setting other than a hospital.

1.9~~0~~1 ***"Restraint"*** means restricting the movement of the whole or a portion of a person's body as a means of controlling a person's physical activity to protect the person or others from injury.

1.~~90.1~~91.1 ***"Chemical or Pharmacological Restraint"*** means medication that is given for the emergency control of behavior when the medication is not standard treatment for the individual's medical or psychiatric condition.

1.~~90.2~~91.2 ***"Mechanical Restraint"*** means the use of an approved mechanical device that restricts the freedom of movement or voluntary functioning of a limb or a portion of a person's body as a means to control his or her physical activities.

1.~~90.3~~91.3 ***"Physical Restraint"*** means the use of approved physical interventions or "hands on" holds to prevent an individual from moving his or her body to engage in a behavior that places him or her or others at risk of physical harm. Physical restraint does not include the use of "hands on" approaches that occur for extremely brief periods of time and never exceed more than a few seconds duration and are used for protective purposes.

1.9~~1~~2 **"*Rhode Island Consumer System of Care*"** is a recovery-focused model that allows consumers to receive individualized care selected from a menu of services provided by a licensed Rhode Island Behavioral Healthcare Provider. The basic principles of this model consist of empowering consumers and family to participate in treatment, and access to the necessary services to meet treatment needs. In this system, consumers are provided with levels of care in response to clinical needs and presentation. It is expected that consumers will transition between levels of care in response to progress in recovery, attainment of goals, need for more intensive treatment, and/or client choice.

1.9~~2~~3 ***"Seclusion"*** means retention, for any period of time, of an individual alone in a locked room, or a space from which the individual may not freely exit or from which the individual believes he or she may not exit.

1.9~~3~~4 ***"Service Area"*** means the geographical area designated by the Director that forms the boundaries within cities and towns for each community mental health center.

1.~~94~~95 ***"Services"*** are individually planned interventions intended to reduce or ameliorate the symptoms of mental disorders or substance dependence or abuse through treatment, training, rehabilitation, or other supports.

1.9~~5~~6 ***"Shall"*** means an obligation to act is imposed.

1.9~~6~~7 ***"Significant others"*** are individuals who are important to the person served, as identified by the person served.

1.9~~7~~8 ***"Staff"*** means any employee, intern, trainee, independent contractor, or volunteer performing a service or activities for the organization and for meeting the needs of individuals served for which competent performance is expected.

1.9~~8~~9 ***"Stakeholder"*** means individual served, provider, payor, accreditation entity, applicable regulator, advocate, and/or community served.

1.~~99~~100 ***"State Opioid Treatment Authority"*** is the Department of BHDDH.

1.10~~0~~1 ***"Supported Employment"*** means a type of service whereby an individual receives assistance in obtaining and maintaining work in competitive, integrated environments chosen by the individual.

1.10~~1~~2 ***"Supported Employment Professional"*** means a person who has been certified to provide supported employment services by fulfilling all the requirements of the Rhode Island Supported Employment Professional Training and Certification Program.

1.10~~2~~3 ***"Treatment" or "Care"*** means a set of individually planned interventions, training, rehabilitation, or supports that help an individual work toward his or her recovery goals and to obtain or maintain an optimal level of functioning, to reduce the effects of disability or discomfort, or to ameliorate symptoms, undesirable changes or conditions specific to physical, mental, behavioral, or social functioning.

1.10~~3~~4 ***"Validate"*** means to verify or substantiate.

Section 2.0 General Requirements

2.1 An organization that wishes to provide behavioral healthcare services may apply for a Behavioral Healthcare Service License for any of the following service categories.

2.1.1 General Outpatient Services

2.1.2 Services for Persons with Co-Occurring Mental Health and Substance Use Disorders: Integrated Co-Occurring Treatment

2.1.3 Medication and Laboratory Services

2.1.4 Case Management Services

2.1.5 Community Psychiatric Supportive Treatment

2.1.6 Intensive Outpatient Services

2.1.7 Community Integration Services

2.1.8 Supported Housing Services

2.1.9 Residential Services

A. Behavioral Health Acute Stabilization Unit or BHASU

2.1.10 Outpatient Detoxification Services

2.1.11 Medical Detoxification Services

2.1.12 Opioid Treatment Programs

2.2 A Behavioral Healthcare Organization (BHO) that is designated by the Director as a Community Mental Health Center (CMHC), according to Rhode Island General Laws section 40.1-8.5-1 *et seq*., shall apply for a BHO/CMHC License and is required to provide the CMHC services identified below and may, in addition to the CMHC services, apply to provide any of the BHO services listed in 2.1:

2.2.1 24-hour emergency service

2.2.2 Crisis intervention and stabilization services for adults who reside in the designated service area of the CMHC and who do not have a current private behavioral healthcare provider

2.2.3 Emergency assessment and crisis intervention for individuals who present in crisis in the service area of the CMHC but reside in another service area

2.2.4 Assessment and treatment services for adults who reside in the CMHC's service area to include, but not be limited to, services for:

A. Individuals who meet the eligibility criteria for Community Support Services

B. Individuals discharged from psychiatric inpatient treatment

C. Persons who are being assessed for or have been diagnosed with a co-occurring mental health disorder and substance abuse or dependence.

2.2.5 Emergency assessment and crisis intervention for individuals being considered for admission to mental health inpatient facilities designated by the Department, to determine the appropriateness of such admission

2.2.6 Community Support Programs as described in Section 39 of these Regulations.

2.2.7 Assertive Community Treatment (RIACT) and / or intensive outpatient treatment for persons eligible for Community Support Services who are in need of intensive treatment.

2.3 An organization, not designated as a CMHC, that was approved by the Director to provide RIACT-I services and/or a Community Support Program prior to the promulgation of these regulations, may apply to provide such service(s).

2.4 A license addendum shall list the licensed services, the population to be served, the specific locations where services are provided, and any license stipulations. For residential services, the license shall specify the number of persons each location may serve.

2.5 A license to operate an Opioid Treatment Program requires:

A. Registration with the Rhode Island Department of Health

B. Registration with the Drug Enforcement Administration

C. Compliance with all applicable Rhode Island Behavioral Healthcare Regulations

D. Accreditation by an accrediting organization approved by the Substance Abuse and Mental Health Services Administration (SAMHSA).

E. Compliance with all applicable federal regulations

2.6 In accordance with the provisions of Rhode Island General Laws section 21-28-3.21 (entitled "Operation of Treatment and Rehabilitation Programs for Drug Dependent Persons"): The administering or dispensing directly, but not prescribing, of any controlled substance listed in any schedule to a drug dependent person for the purpose of continuing his or her dependence upon such drugs in the course of conducting an authorized clinical investigation in the development of a treatment and rehabilitation program for drug dependent persons, shall be deemed to be within the meaning of the term "in the course of professional practice," provided:

A. That approval is obtained prior to the initiation of the program by submission of an application therefore to proper federal authorities and in addition thereto,

B. That a license to operate the program within Rhode Island be obtained from the Director of the Rhode Island Department of Health.

2.7 A CMHC may apply to the Department for designation as a Health Home Provider. The Department shall only approve a CMHC's request to be designated as a Health Home Provider if the Department determines that a CMHC meets the certification standards as required by the Department.

Section 3.0 Rules Governing Practices and Procedures

3.1 All hearings and reviews required pursuant to these rules and regulations shall be held in accordance with the provisions of Rhode Island General Laws section 42-35-1 *et*

seq. and the Department's Rules and Regulations Governing the Practices and Procedures before the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

Part II: Organization and Management

Section 4.0 Leadership and Organization Planning

4.1 The organization shall operate in accordance with all applicable local, state and federal laws, rules, and regulations.

4.2 Each organization shall have an organized Board of Directors that functions as its governing body and that is ultimately responsible for:

4.2.1 Program and fiscal management and operation of the organization

4.2.2 Assurance of the quality of treatment and services

4.2.3 Compliance with all federal, state, and local laws, and regulations pertaining to organizations, and the Regulations herein.

4.2.4 Each BHO that is either (a) a for profit entity or (b) a not for profit entity that is part of a national organization providing services in Rhode Island shall have an advisory board that meets all of the requirements of a board of directors as mandated in these regulations.

4.3 The Board of Directors shall provide appropriate personnel, physical resources, and equipment to facilitate the delivery of behavioral health treatment services during established hours of operation.

4.4 The Board of Directors of each organization shall include persons who have currently or formerly received behavioral health services (age 18 or older), family members of persons who have received behavioral health services, and persons living or working in the primary community served by the organization or in the service area of the CMHC.

4.5 The Board of Directors shall adopt by-laws, or an acceptable equivalent, defining the ethical standards and the responsibilities for the governance of the operation and performance of the organization.

4.6 The Board of Directors shall designate an administrator who shall be operationally responsible for:

4.6.1 The management and operation of the organization

4.6.2 Compliance with rules, regulations, standards, and policies pertaining to the health and safety of persons served

4.6.3 Planning, organizing, and directing activities as may be delegated by the Board of Directors.

4.7 A written plan shall define the mission, vision, and values for the organization as well as strategic, operational, program-related, and other plans and policies to achieve them.

4.7.1 The mission, vision, and values of the organization shall reflect a recovery orientation.

4.8 Planning shall address all of the organization's treatment, services, and organizational functions that are described in these regulations.

4.9 The leaders shall communicate the organization's mission, vision, values, and plan to all staff of the organization and to persons served.

4.10 Services shall be designed through the collaboration of the organization's leaders with persons served, leaders of the various communities served by the organization, and other provider organizations.

4.10.1 Each CMHC shall develop and maintain collaborative relationships with the emergency departments and psychiatric units of local and other applicable hospitals.

4.11 The planning process provides a framework for setting performance improvement priorities and identifies how priorities are adjusted in response to unusual or urgent events.

4.12 The scope of services provided by each program or service of the organization is defined in writing and is approved by the organization's leaders.

4.12.1 All services shall be organized and delivered according to evidence-based and best practice standards and guidelines, when available.

4.13 Administrative leaders, clinical leaders, other appropriate staff, and persons served shall have the opportunity to participate in the organization's decision-making structures and processes.

4.14 The leaders shall develop programs to promote staff recruitment, retention, development, and continuing education.

Section 5.0 Financial Management

5.1 The organization shall develop an annual operating budget and long-term capital expenditure plan in collaboration with representatives from the appropriate disciplines and organizational units, at least as required by applicable law and regulation.

5.1.1 A strategy to monitor the implementation of the plan shall be included.

5.2 The Board of Directors shall approve the annual operating budget and the long-term capital expenditure plan.

5.3 The organization's financial plan shall include:

5.3.1 An authorized budget with a review of financial performance at least quarterly

5.3.2 Provisions for meeting the needs of individuals served and producing the desired outcomes

5.3.3 Attention to long-term financial solvency

5.3.4 Attention to continuity of services

5.3.5 Identification of the sources of funding for the operations of the organization.

5.4 The budget review process shall:

5.4.1 Consider the appropriateness of the organization's plan for providing treatment and services to meet the needs of individuals served and their recovery.

5.4.2 Include representatives from every appropriate clinical and administrative discipline and category of management.

5.5 The BHO shall contract with an independent certified public accountant to conduct an annual audit of the organization's financial statements.

5.6 The organization shall secure insurance to:

5.6.1 Cover damage, injury, or loss of life caused by fire, accident, or any other dangers that might occur during the operation of the organization;

5.6.2 Protect the personal funds of residents in the residential programs of the organization;

5.6.3 Provide liability coverage for all vehicles owned, leased or operated by the organization.

5.7 If the organization is responsible for funds belonging to the persons served, there are procedures that address:

5.7.1 The identification of such funds;

5.7.2 Accountability of the organization for any expenditure of such funds;

5.7.3 The expenditure or investment of such funds only with the consent of the person served or, if appropriate, his or her legal representative;

5.7.4 Ensuring that if the funds of the person served are invested, that the interest earned accrues to the person served;

5.7.5 Access by the person served, or his or her legal representative, to the records of his or her funds.

Section 6.0 Direction of Services

6.1 The leadership of the organization promotes the recovery vision and incorporates the Recovery Principles in the operation of the organization.

6.1.1 The leadership of each program or service is responsible for developing and implementing policies and procedures that guide the provision of service and the recovery and wellness of persons served.

6.2 The leadership of each program or service is responsible for integrating the program or service into the primary functions and goals of the organization.

6.3 The leadership of each program or service is responsible for coordinating and integrating programs and services with other organizational units.

6.4 The leadership of each program or service is responsible for overseeing continuous assessment and improvement of the quality of treatment and services, and involving persons served in the design and evaluation of services.

6.5 The leadership of each program or service is responsible for ensuring that the defined rights and responsibilities of persons served and of staff are enforced.

6.6 The leadership of each program or service is responsible for reviewing and acting on reports and recommendations from committees, programs, services, and from persons served.

6.7 Responsibility for administrative and clinical direction is defined in writing.

6.7.1 A qualified professional with appropriate clinical training and experience is responsible for the clinical direction of treatment and service delivery.

Section 7.0 Leadership's Role in Performance Improvement

7.1 The leaders ensure that processes and activities most important to treatment and service outcomes are continuously and systematically measured, assessed, and improved throughout the organization.

7.2 Leaders and managers participate in cross-organizational performance improvement activities, as appropriate to their responsibilities.

7.3 Responsibility for acting on performance improvement recommendations is assigned and defined in writing.

7.4 The organization shall have a formalized and structured adverse event/incident review and analysis function. Such function shall operate in accordance with all of the Department's requirements relating to the review, analysis, and reporting of adverse events/incidents. (Refer to Appendix III)

7.4.1 Leaders of the organization shall ensure that the incident review and analysis function serves to improve the organization's service system.

7.5 Leaders shall ensure that the processes for identifying and managing adverse events are defined and implemented. These processes shall include, but shall not be limited to:

7.5.1 Creation of a process for the reporting of adverse events through established channels within the organization, and to external agents in accordance with law and regulation.

7.5.2 Documentation of a risk-reduction strategy and action plan that includes measurement of the effectiveness of the process and the system improvements implemented to reduce risk.

7.6 The leaders allocate sufficient resources for assessment and improvement of the organization's governance, managerial, clinical and support processes.

7.7 The leaders evaluate their organization's effectiveness in improving performance.

Section 8.0 Human Resources

8.1 The organization shall recruit, manage and retain personnel who support and promote the mission of the organization and reflect the community it serves.

8.2 The organization shall have a policy that reflects its philosophy regarding substance abuse by the staff of the organization.

8.3 The organization shall develop and implement policies and procedures that address the hiring, promotion and termination of staff.

8.4 Clinical and administrative leaders shall define, for their areas of responsibility, the qualifications and competencies of staff needed to fulfill the organization's mission.

8.4.1 Staff qualifications shall be commensurate with job responsibilities and applicable licensure, law, regulation, registration and/or certification.

8.5 A person's employment or volunteer activity shall be contingent upon the organization obtaining all of the following:

8.5.1 Primary source verification of the person's education and training;

8.5.2 Verification of the person's current licensure and/or certification, when applicable;

8.5.3 Evidence of the person's knowledge and experience for assigned responsibilities; and

8.5.4 A report of the person's current Bureau of Criminal Identification (BCI) Record.

A. In the event that the report contains disqualifying information, the Board of Directors of the organization shall make and document a judgment regarding the employment of the prospective employee. Such judgment shall be based upon consideration by the Board of Director's of whether the disqualifying information indicates that the employment could endanger the health or welfare of persons served by the organization.

8.6 The organization shall have a policy that requires employees to report to the organization any changes in the status of their BCI subsequent to their hire by the organization.

8.7 If the organization uses volunteers, trainees, or interns, these individuals:

8.7.1 Are appropriately supervised; and

8.7.2 Meet the qualifications comparable to employed staff if they are providing professional services, unless the individual is receiving training as part of an educational or professional licensure requirement.

8.8 The organization has a written plan on cultural diversity. The plan includes, at a minimum:

8.8.1 The recruitment and retention of personnel who reflect the cultural diversity of the communities in which the BHO provides services.

8.8.2 A provision for recruiting leadership that is culturally representative of the individuals served by the organization.

8.8.3 The availability of staff or interpreters to address the communication needs of persons served.

8.9 The organization has a policy and procedure to address requests by persons served for a change of provider, clinician or service.

Section 9.0 Staff Competency and Training

9.1 The organization has a mechanism for receiving regular feedback from staff to help create an environment that promotes self-development and learning.

9.2 An orientation process provides initial training and information for all staff, including volunteers.

9.3 The organization ensures that each staff person, during orientation and as needed, receives adequate training regarding the rights of persons served and the Concern and Complaint Resolution Procedure.

9.4 The organization provides training to improve knowledge, attitudes and skills necessary for staff to conduct recovery-oriented services.

9.5 The organization continuously collects and aggregates data about patterns and trends in staff competence to identify and respond to staff learning needs.

9.6 The organization conducts an annual job performance evaluation for each staff member directly employed by the organization. The evaluation includes, at a minimum:

9.6.1 An assessment of job performance in relation to the required skills and the expectations set forth in the job description;

9.6.2 An assessment of performance objectives established in the last evaluation period;

9.6.3 Establishment of objectives for the next evaluation period;

9.6.4 A documented review of the evaluation with the staff person;

9.6.5 Documentation of the results of the evaluation maintained in the staff person's file.

9.7 The organization has a process designed to determine the competence of licensed independent practitioners.

9.8 The competence of providers who are not licensed independent practitioners is determined by initial assessment and periodic reassessment. At a minimum, the following criteria shall be used to assess the competence of the staff person.

9.8.1 Current and applicable licensure, certification or registration;

9.8.2 Continuing education or training related to the staff person's job;

9.8.3 Satisfactory performance of essential job tasks as assessed by the staff person's supervisor.

9.9 All staff providing direct services who are not licensed independent practitioners shall receive clinical supervision on an ongoing basis.

9.9.1 All professionally licensed staff who provide a clinical or medical service, and are not independent practitioners, except nurses in an OTP who have no counseling responsibilities, shall receive a minimum of four (4) hours of clinical supervision per month (pro-rated for part-time clinicians), that shall consist of no less than one (1) hour of individual supervision. Each month the remaining three (3) hours of clinical supervision may be in a group setting.

A. Participation in case study discussions led by a clinical supervisor, as defined in Regulation 9.10, may qualify as group clinical supervision.

9.9.2 All direct service staff who do not have a professional license, except those who work the third shift in a residential program, shall receive a minimum of four (4) hours of clinical supervision per month (pro-rated for part-time direct service staff) of which at least two (2) hours shall be individual clinical supervision. Each month the remaining two (2) hours of documented clinical supervision may be in a group setting.

A. Participation in case study discussions led by a clinical supervisor, as defined in these Regulations, may qualify as group clinical supervision.

9.9.3 Direct service staff who work the third shift in a residential program shall receive a minimum of one (1) hour of clinical supervision each month, at least thirty (30) minutes of which shall be individual clinical supervision.

9.9.4 All clinical supervision shall relate to the service the staff person is providing.

9.9.5 All clinical supervision shall be documented.

9.10 Unless specified otherwise in these regulations, staff providing clinical supervision shall have, at a minimum, the following qualifications with education, license, and experience relevant to the service they are supervising:

9.10.1 Licensed Independent Practitioner

--- or ---

9.10.2 Licensed Chemical Dependency Clinical Supervisor

--- or ---

9.10.3 Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professional – "Diplomate" (CCDP-D) or Certified Co-Occurring Disorder Professional, and who has completed a Department approved course in clinical supervision

--- or ---

9.10.4 Clinician with relevant Master's Degree and license and, at least, two (2) years full time experience providing relevant behavioral health services.

--- or ---

9.10.5 Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or, at least, two (2) years full time experience providing relevant behavioral health services.

9.11 Each professionally licensed staff person employed by an organization shall have a current license to practice in Rhode Island.

9.12 Within an organization, no less than fifty percent (50%) of staff providing direct therapeutic substance abuse services shall:

9.12.1 Hold a Rhode Island license in a behavioral health clinical specialty with a certification in chemical dependency from a nationally recognized entity whose certification criteria include clinical experience, clinical supervision, and an examination, that are substantially similar to the requirements of the Rhode Island Board for Licensing of Chemical Dependency Professionals (the Department reserves the right to disqualify such certification for cause)

--- or ---

9.12.2 Shall be Licensed Chemical Dependency Professionals.

--- or ---

9.12.3 Shall be Certified Co-Occurring Disorder Professional or Certified Co-Occurring Disorder Professional-Diplomate.

9.12.4 The remaining fifty percent (50%) shall be actively engaged in the process of meeting the requirements above and shall be supervised as stated in these Regulations.

9.13 Within an organization no less than fifty percent (50%) of staff whose primary function is to provide direct services to adults receiving Community Support Services, who are not otherwise certified or licensed practitioners, shall be certified as a Rhode Island Community Support Professional.

9.13.1 The remaining fifty percent (50%) shall be actively engaged or enrolled, within twelve (12) months of hire, in training leading to a relevant license or certification.

9.14 Within an organization, no less than fifty percent (50%) of staff whose primary function is to provide vocational or employment services to adults receiving Community Support Services shall:

9.14.1 Have a relevant Master's Degree, or a certificate as a career development facilitator

--- or ---

9.14.2 Have Rhode Island certification as a Supported Employment Professional.

9.14.3 The remaining fifty percent (50%) shall be actively engaged or enrolled, within eighteen (18) months of hire, in training leading to a relevant degree or certification.

9.15 Each organization shall develop and maintain a written professional development plan that shall detail the staffing requirements described in these Regulations. At a minimum the plan shall describe the following:

9.15.1 Current clinical staff;
9.15.2 Resources needed to comply with these Regulations;
9.15.3 Timeline for meeting the requirements.

9.16 Upon the adoption and effective dates of these Regulations, an employee who does not meet the qualifications specified here for the particular position he or she holds shall be considered a qualified employee under these Regulations for as long as he or she continues to fulfill the responsibilities of that specific position in the organization.

Section 10.0 Management of the Environment of Care

10.1 The organization shall plan for and provide a safe, accessible, effective and efficient environment consistent with its mission, services, and applicable federal, state, and local laws, codes, rules, and regulations. The organization shall have processes for:

10.1.1 Conducting risk assessments that proactively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on individuals served, staff, and public safety;

10.1.2 Reporting and investigating all incidents to include property damage or injury that affects individuals served, staff, or visitors;

10.1.3 Ongoing hazard surveillance, including relevant product safety recalls;

10.1.4 The examining of safety issues by appropriate organizational representatives.

10.2 The organization shall plan~~s~~ for and implement~~s~~ a plan for the safety of staff and persons served.

10.2.1 Safety policies and procedures shall be distributed, practiced, and enforced.

A. Reviews shall be conducted annually.

10.2.2 At all sites owned, rented or leased by the organization First Aid equipment and supplies are in a designated location and readily available to personnel during all hours of operation.

10.2.3 The organization shall implement~~s~~ policies and procedures to prevent the misuse and abuse of drugs at all sites owned, rented or leased by the organization.

10.2.4 When services are provided off site, the organization shall:

A. Have a policy addressing the safety of personnel
B. Provide training related to potential risks.

10.2.5 The organization shall designate individuals to oversee development, implementation and monitoring of safety management.

10.3 The premises of all the facilities of the organization shall be sanitary, in good repair, free from accumulation of combustible debris and waste material and free from offensive odors.

10.4 Smoking shall be prohibited in all buildings owned by the organization, in all building space rented or leased by the organization, except residential apartments, and in all vehicles owned, rented, or leased by the organization.

10.5 The organization shall develop and implement a plan for managing hazardous materials and wastes that is consistent with applicable law and regulation.

10.6 The organization shall develop and implement an emergency management plan that addresses the four (4) phases of emergency management activities: mitigation, preparedness, emergency response, and restoration/recovery. The emergency management plan shall provide processes for:

10.6.1 Identifying specific procedures in response to a variety of disasters based on a hazard vulnerability analysis performed by the organization.

10.6.2 Notifying the Department and other relevant external authorities of emergencies. For purpose of this licensing section, emergencies are defined as any and all of the following:

A. Disruption of normal service delivery.

B. Any natural or man-made event that adversely impacts, or could potentially adversely impact, the operation of the organization's delivery of services, facility or community served.

C. Any event that necessitates mutual aid assistance from other behavioral health organizations to maintain operations.

10.6.3 Documenting mitigation actions to be taken by the organization to lessen the severity and impact of any potential disaster.

10.6.4 Documenting performance standards for disaster responses that identify staff skill levels and knowledge of their individual role in the organizations emergency preparedness management program.

10.6.5 Identifying the staff responsible for covering all necessary staff positions and for implementing emergency management activities at each facility.

10.6.6 Notifying internal staff of the procedures and modes of communication to be used.

10.6.7 Identifying back up internal and external means of communication.

10.6.8 Managing space, supplies, and security.

10.6.9 Evacuating all facilities in the event that the environment of care cannot support adequate care and treatment.

10.6.10 Conducting at least two (2) drills annually that test emergency management procedures in response to:

A. A natural disaster, e.g. hurricane, flood, blizzard
B. A man-made disaster, e.g. explosion, building fire, bio-chemical terrorist act, etc.

10.6.11 Conducting evacuation drills at each treatment facility on each shift at least annually.

10.6.12 Record all drills and document corrective action taken.

10.6.13 Accessing information on persons served that may be needed in a disaster

10.6.14 Provide an orientation and education program for personnel who participate in implementing the emergency management plan.

10.6.15 Communicating emergency plans to all personnel and to persons served, as appropriate.

10.6.16 Defining and integrating the organization's role with community and state emergency response agencies.

10.6.17 Provide supportive measures and debriefing assistance for staff who participate in implementing the emergency plan.

10.6.18 Conducting an annual evaluation of the objectives, scope, performance, and effectiveness of the emergency management plan.

10.7 The organization shall develop and implement a fire prevention plan that is consistent with all laws and regulations.

10.8 The organization shall have equipment appropriate to the needs of the persons served and personnel for fire detection and suppression.

10.9 If fire safety approval for a building in which the organization provides services is withdrawn or restricted, the organization shall notify the Department orally within twenty four (24) hours and in writing within forty eight (48) hours of the withdrawal or restriction.

10.10 If a building is structurally renovated or altered after the initial fire safety approval is issued, the organization shall submit, from the appropriate fire safety authority, the new fire safety approval or written certification that a new fire safety approval is not required.

10.11 At all sites that are owned, rented leased or operated by the organization, fire exit drills shall be conducted and documented:

10.11.1 At least quarterly in non-residential facilities.
10.11.2 At least one (1) per shift per quarter in residential facilities.

10.12 Fire drill documentation shall be maintained and shall include:

10.12.1 Name of person conducting drill;
10.12.2 Date and time of drill;
10.12.3 Amount of time taken to evacuate the building
10.12.4 Type of drill (obstructed or unobstructed);
10.12.5 Record of problems and steps taken to correct them.

10.13 The organization shall develop and implement a plan to monitor, test and inspect all utilities and equipment, including medical equipment.

10.14 Safety self-inspections conducted by the organization shall:

10.14.1 Occur twice each year;
10.14.2 Occur at all sites owned, rented, or leased by the organization;
10.14.3 Be documented, to include:

A. Identification of areas inspected
B. Corrective actions taken in response to deficiencies cited.

10.15 The organization shall have a process for identifying and implementing violence prevention measures.

10.16 To the extent permitted by law, weapons shall be prohibited at the licensed site(s), except when carried by licensed security personnel.

10.17 The organization shall establish an environment that meets the needs of individuals served, promotes their rights, and respects their human dignity.

10.17.1 The organization shall display the Rights of Persons Served and the Concern and Complaint Resolution Procedure, specified in these Regulations, in conspicuous places, such as waiting rooms and common areas, in all buildings where services are provided by the organization.

A. Information about how to obtain copies shall be included in the posted material.

10.17.2 Waiting or reception areas shall be comfortable and adequately accommodate visitors and individuals served.

10.18 Restrooms shall be available and accessible for staff and individuals served.

Section 11.0 Management of Information

11.1 The organization shall plan and design information management processes to meet internal and external information needs.

11.1.1 The BHO shall have and maintain the ability to report data in an electronic fashion to the Department for such purposes as the Department deems necessary, or as is required by other funding or oversight entities.

11.1.2 The BHO shall establish and maintain records and electronic data in such a manner as to make uniform the system of periodic reporting required by the Department.

11.1.3 Organizations shall provide all requested information, either routine or non-routine, as specified by the Department.

11.1.4 All information and data shall be maintained and transmitted in a manner consistent with state and federal privacy and confidentiality statutes and regulations.

11.2 Records and information shall be protected against loss, destruction, tampering, and unauthorized access or use.

11.3 Uniform data definitions and data capture methods shall be used whenever possible.

11.5 The transmission of data and information shall be timely and accurate.

11.6 The format and methods for disseminating data and information shall be standardized, whenever possible.

11.7 There shall be an organized system for disseminating information to appropriate stakeholders.

11.8 Adequate integration and interpretation capabilities are provided. The information management process, whether electronic or manual shall:

11.8.1 Coordinate the collection of information;
11.8.2 Organize data;
11.8.3 Interpret and clarify data;
11.8.4 Generate and provide access to longitudinal data;
11.8.5 Link clinical and non-clinical data over time and among all treatment settings;
11.8.6 Link internal and external information sources;
11.8.7 Link organizational data and management literature.

11.9 The organization shall define, capture, analyze, transform, transmit and report individual-specific data and information on treatment or service processes and outcomes.

11.10 The organization shall offer enrollment in the HIE to each patient and maintain documentation evidencing the offer of enrollment in the treatment record of each individual. If the individual chooses to enroll in the HIE, the organization shall ensure that the individual executes an HIE enrollment form and a Uniform Authorization Form for the disclosure of health information to the HIE attached as Appendix IV.

11.1~~0~~1 The organization shall maintain a treatment record for every individual assessed, treated or served and incorporate information from subsequent contacts with the individual.

11.1~~1~~2 Only authorized individuals shall make entries in treatment records, as specified in organization policies.

11.1~~2~~3 Unless otherwise required under applicable state regulation or statute, the treatment record of adult service recipients shall be maintained for a minimum of six (6) years post discharge from the organization. The records of minors, who have received

substance abuse services, shall be maintained for a minimum of six (6) years after the date he or she reaches age eighteen (18).

11.1~~3~~4 Each treatment record shall contain the following basic information and all other relevant information specified in these Regulations:

11.~~13.1~~14.1 The Individual's:

A. Name;
B. Address;
C. Date of birth;
D. Sex;
E. Race or ethnic origin;
F. Education;
G. Marital status;
H. Employment;
I. Spiritual beliefs and practices;
J. Legal status;
K. The name and phone number of any legally authorized representative;
L. Dates of admission and discharge;
M. Information about the person to contact in the event of an emergency, including such person's name, address and telephone number;
N. Evidence of known advance directives, when applicable;
O. Evidence of informed consent;
P. Any referrals and communications made to external or internal service providers and to community agencies;
Q. Information on any unusual occurrences;
R. Documentation of individual, family or guardian consent for all services, refusal to consent or withdrawal of consent~~;~~
S. Enrollment in the HIE.

11.14 Every treatment record entry shall be dated and signed with the author's full name and credentials.

11.15 The treatment record or computer system shall alert authorized users when portions of the record are filed elsewhere.

11.16 A random sample of treatment records shall be reviewed at least quarterly for completeness, accuracy, and timely completion of all necessary information, and compliance with the documentation standards in these regulations.

11.17 In the event the organization ceases operation the organization shall maintain a written policy regarding proper transfer or disposal of records consistent with local, state and federal laws.

Section 12.0 Surveillance, Prevention and Control of Infection

12.1 The organization shall use a coordinated process to reduce the risks of infection in individuals served and in staff.

12.2 The organization shall have in place processes to reduce the risks of endemic and epidemic infections in individuals served and in staff. These processes shall address:

12.2.1 Prevention
12.2.2 Surveillance
12.2.3 Identification
12.2.4 Control of infection

12.3 Infections acquired or brought into the organization shall be reported to the appropriate staff and public health authorities, as required by state and federal regulation.

12.4 The organization's infection control program shall be designed to reduce the risks and decrease the rates of epidemiological significant infections.

12.5 Management shall support the infection control program and ensure adequate data analysis, assessment and interpretation of findings.

Section 13.0 Performance Improvement

13.1 Each organization shall develop an annual written performance improvement plan that identifies the organization's performance goals and priorities for the year. The organization shall:

13.1.1 Outline at least one (1) specific improvement goal for Parts II through VI of these Regulations and for each major program operated by the organization;

13.1.2 Monitor the implementation of the plan and make adjustments as needed;

13.1.3 Prepare an annual written management summary that reports on the extent to which the annual performance improvement plan was achieved;

13.1.4 Present the plan and the management summary to its Board of Directors.

A. Board actions relative to the plan shall be recorded in the minutes of the Board.

13.2 The organization shall have a written description of the organization's ongoing systematic approach to Performance Improvement that:

13.2.1 Applies to the entire program(s) and is based upon a consistent approach;

13.2.2 Relates to the overall mission and strategic plan for the organization;

13.2.3 Is a collaborative and interdisciplinary effort;

13.2.4 Describes how data is collected, analyzed, displayed, communicated and used to improve work processes and/or service outcomes;

13.2.5 Describes how the organization's Board of Directors and senior management shall participate in and support performance improvement;

13.2.6 Describes the mechanism(s) for stakeholder participation in the activities of improvement;

13.2.7 Identifies priorities for improvement through the process of data collection and analysis;

13.2.8 Addresses both internal work processes and service outcomes;

13.2.9 Undergoes no less than annual review and revision.

13.3 The organization shall use performance measures and data collection to monitor its performance and to identify and prioritize opportunities for improvement.

13.3.1 Data shall be collected on what the organization considers to be critical processes and outcomes;

13.3.2 Data collection shall be prioritized based upon mission-critical functions, services provided, and populations served;

13.3.3 Data shall be collected to monitor improvements;

13.3.4 Data shall be collected as required by contract and/or specific Department priorities.

13.4 Serious adverse events shall undergo intensive analysis with root causes identified. Actions designed to prevent the same or a similar event from recurring shall be identified and implemented.

Section 14.0 Research

14.1 In the event that research, experimentation, or clinical trials involving human subjects is to be conducted, the organization must adhere to the following guidelines and to all applicable state and federal laws and regulations.

14.1.1 A proposal outlining the research, experimentation, or clinical trial must be submitted to the organization's Research Review Committee. The proposal shall include:

A. The purpose of the study, and its relation to the mission statement and values;

B. A description of the benefits expected;

C. A description of the potential discomforts and/or risks that could be encountered;

D. A full explanation of the procedures to be followed;

E. The criteria for inclusion and exclusion;

F. The process to be used to explain the procedures to the subject of the study, experiment, or clinical trial;

G. The authorization form to be used;

H. The method of addressing privacy, confidentiality, and safety.

14.1.2 The authorization form shall include all of the elements in 14.1.1 and:

A. The name and credentials of the person who supplied the information;

B. The signature and date of such person;

C. The process for the subject to withdraw at any point, without compromising his or her access to the organization's services.

14.1.3 If research is proposed in connection with a university or college, the organization shall be required to provide documentation verifying that the research has been reviewed by the university's human subject review committee.

14.1.4 Upon completion of the research, the organization shall ensure that actions are taken to alleviate, to the extent possible, any confusion, misinformation, stress, physical discomfort or other harmful consequences that may have arisen with respect to any participant's right to privacy, confidentiality and safety.

Part III: Rights, Responsibilities, and Ethics

Section 15.0 Rights of Persons Served and Responsibilities of Behavioral Healthcare Organizations

A fundamental responsibility of the organization is to ensure the protection and promotion of the rights of the persons served. This means that an organization actively asserts the individual's rights and does not wait for the individual to claim a right. The culture and operation of the organization shall reflect a belief in recovery, collaboration with persons served and the interdependence of treatment, service delivery and organizational ethics. The organization in embracing the philosophy of empowerment and recovery shall ensure that the following rights are clearly evident throughout its operation.

15.1 The organization shall maintain a written statement of rights for individuals receiving services and those requesting services.

15.1.1 Individuals requesting services shall have the right to receive a clinical screening.

15.2 The organization shall display in a conspicuous place(s) in all buildings where services are provided by the organization, a copy of the Rights of Persons Served as defined in these Regulations (to include waiting rooms; in facilities where there is no waiting room they shall be displayed in the public/common area).

15.2.1 The posted rights shall contain information on how an individual may obtain a copy of the Rights of Persons Served.

15.3 Each person served shall receive a written statement of his or her rights that shall contain, at a minimum, the following rights:

15.3.1 To be informed of his or her rights during admission or orientation to the organization, whenever the organization makes a change in the rights of persons served and upon the verbal or written request of the individual.

A. Receipt of this information shall be documented in the clinical record and validated by the signature of the person served. If the person is unable or unwilling to sign such shall be recorded.

15.3.2 To express a concern or complaint about services, staff or the operation of the organization:

A. The person served shall be informed of the organization's Concern and Complaint Resolution Procedure during orientation to the organization, whenever there is a change in the procedure, and upon the verbal or written request of the individual; and

B. Receipt of this information shall be documented in the treatment record and validated by the signature of the person served. If the person is unable or unwilling to sign, such shall be recorded.

15.3.3 To be encouraged and assisted throughout treatment to exercise his or her rights without fear of discrimination, restraint, interference or recrimination.

15.3.4 To be informed of his or her rights and to receive services in a language and manner he or she understands.

15.3.5 To not have services denied for any discriminatory reason, including race, religion, gender, sexual orientation, ethnicity, age, disability or source of financial support.

15.3.6 To receive the following information about the organization upon admission or during orientation and upon verbal or written request throughout the course of treatment:

A. Accreditation status
B. Discharge policies
C. Areas of treatment specialization
D. Hours of operation
E. Emergency contact procedures
F. Concern and Complaint Resolution Procedure
G. General services provided by the organization
H. The rights of persons served.

15.3.7 To receive a copy of the organization's statement regarding the responsibilities of persons served.

A. Before being asked to leave a program or service for not fulfilling the responsibilities of such program or service the person shall receive the following:

1. Assistance in resolving issues;
2. Assistance in accessing alternative services;
3. Written notification of the pending discharge and the individuals rights of appeal.

15.3.8 To be provided information about the cost of services proposed and those rendered to the person served and to his or her family.

A. To be provided, upon request, information regarding charges billed to, and payments made by, an insurance company on his or her behalf.

15.3.9 To receive, upon request, information about the credentials, training, professional experience, treatment orientation and specialization of providers and their supervisors.

15.3.10 To treatment and services that are considerate and respectful of the individual's values and beliefs.

15.3.11 To privacy, security and confidentiality of information.

15.3.12 To be provided treatment and services in an environment free of abuse, neglect, mistreatment, financial exploitation and any other human rights violation.

15.3.13 To be protected from all coercion.

15.3.14 To be informed about what to expect during the treatment process.

15.3.15 To be informed about, and to participate in, decisions regarding treatment and services and to receive, at least, the following information to facilitate informed decision-making:

A. Current diagnoses;

B. Proposed interventions, treatment, services and medications;

C. Potential benefits, risks, and side effects of proposed interventions, treatment, services and medications;

D. Potential risks if treatment is not provided;

E. Limitations on confidentiality;

F. Ongoing progress/status regarding treatment goals and objectives;

G. Significant alternative medications, treatments, services or interventions, when appropriate;

H. The right, to the extent permitted by law, to refuse interventions, treatment, services or medications;

I. Projected discharge date and plan.

15.3.16 To individualized treatment and services, including:

A. Provision of services within the most integrated setting appropriate for the individual.

B. An individualized treatment or service plan that promotes recovery.

C. Ongoing review and mutually agreed upon adjustments of the treatment or service plan.

D. Competent, qualified and experienced staff to supervise and to carry out the individual's treatment or service plan.

15.3.17 To be present and actively participate in the design of his or her own treatment plan and in all periodic reviews and to choose people to assist in the development and monitoring of the plan.

15.3.18 To be offered a copy of the treatment plan.

15.3.19 To request a review of the treatment plan at any time during treatment.

15.3.20 To seek an independent opinion from a mental health or substance abuse professional, of his or her choice, regarding treatment and services.

15.3.21 To request a change of provider, clinician or service. If the request is denied the individual shall receive a written explanation.

15.3.22 To be given reasonable notice of and the reasons for, any proposed change in the staff responsible for the individual's treatment or service.

15.3.23 To object to any changes in treatment, services or personnel, and the right to a clear written explanation if such objection cannot be accommodated.

15.3.24 To refuse any treatment, procedure or medication, to the extent permitted by law and to be advised of the potential risks and impact on his or her treatment process.

15.3.25 To be referred to an alternate service, program or treatment setting if he or she is better served at a different level of care.

15.3.26 To be present and participate in planning aftercare activities and referrals to other services he or she may need.

15.3.27 To provide authorization, or refuse to provide authorization for the release of confidential information to family members and/or others.

A. To provide authorization, or refuse to provide authorization, for family members and others to participate in his or her treatment.

15.3.28 To access his or her record in compliance with applicable state and federal laws.

15.3.29 To be given information regarding his or her pertinent legal rights relative to the Representative Payee process, when applicable.

<u>15.3.30</u> <u>To be offered enrollment in the HIE.</u>

15.4 Each individual, asked to participate in a research project, shall receive full explanations of the following, in a language and manner that promotes the opportunity for informed choice and authorization:

15.4.1 The reason the person is being asked to participate in this particular research;

15.4.2 The treatment being proposed;

15.4.3 Elements of the proposed treatment that are considered experimental research or a clinical trial;

15.4.4 The benefits to be expected;

15.4.5 The potential discomforts and risks;

15.4.6 Alternative services that might benefit him or her;

15.4.7 The procedures to be followed, especially those that are experimental in nature;

15.4.8 Methods of addressing privacy, confidentiality and safety;

15.4.9 The right to refuse to participate in any research project without compromising his or her access to the organization's services. Refusal to participate may occur at any time during the research process.

Section 16.0 Rights of Persons Served in Residential Programs

16.1 Programs that provide twenty-four (24) hour care shall develop and implement policies and procedures that address the rights of the persons served as described in Sections 15 and 16 of these Regulations.

16.2 No resident admitted to any community residence shall be deprived of any constitutional, civil or legal right solely by reason of admission pursuant to Rhode Island General Laws section 40.1-24.5-5. In addition to the rights of persons served noted in Section 15 of these Regulations, each resident is entitled to the following rights without limitation:

16.2.1 To privacy and dignity.

16.2.2 To communicate by sealed mail or otherwise with persons of the resident's choosing.

16.2.3 To be visited privately at all reasonable times by his or her personal physician, attorney or clergy.

16.2.4 To vote and participate in political activity with, as needed, reasonable assistance in registering and voting.

16.2.5 To be employed at a gainful occupation insofar as the resident's condition permits.

A. No resident shall be required to perform labor that involves the essential operation and maintenance of the community residence or program or the regular care and supervision of other residents. Residents may be required to perform labor involving normal housekeeping and home maintenance functions as documented in their individualized treatment plans or as delineated in the community residents' rules and regulations.

16.2.6 To attend or not attend religious services.

16.2.7 Residents have the right to access the Mental Health Advocate and to have assistance, when desired and necessary, to implement this right.

16.3 Except to the extent that the residential program director determines that a limitation or a denial of any of the following rights would be in the resident's best interests and, further, unless the director documents the good cause reasons for the denial or limitations in the resident's individualized treatment plan, the resident shall be entitled to the following:

16.3.1 To keep and use one's own personal possessions;

16.3.2 To have reasonable access to a telephone to make and receive private calls;

16.3.3 To keep and be allowed to spend a reasonable sum of one's own money for consumer purchases;

16.3.4 To have opportunities for physical exercise and outdoor recreation;

16.3.5 To have reasonable, prompt access to current newspapers, magazines and radio and television programming;

16.3.6 To receive visitors of one's own choosing at reasonable times. Posted reasonable visiting hours must be maintained in each community residence.

16.4 The following shall apply when any of the rights listed in 16.3 are restricted.

16.4.1 Reasons for the restriction must be explained to the resident.

16.4.2 The resident's treatment plan shall address ways for the resident to gain or regain the restricted right(s).

16.4.3 Restrictions shall be as limited as possible and should not occur if there is an alternative, less restrictive way for the individual to participate in the program and attain his or her treatment goals.

16.4.4 All restrictions shall be reviewed by the treatment team and the program administrators within thirty (30) days of implementation and at least quarterly thereafter.

16.4.5 At the resident's request, information about such restrictions shall be forwarded to family members.

16.5 Every effort shall be made by the organization to give a prospective resident an opportunity to visit the Behavioral Healthcare Organization's residential program prior to admission. The prospective resident shall participate in making the decision regarding his or her admission.

16.6 Individuals served in a twenty-four (24) hour setting who want spiritual support or services shall have reasonable access to them. Access to spiritual support or services shall not infringe on the rights of other residents.

Section 17.0 Confidentiality

17.1 All persons served have the right to have their records kept confidential pursuant to the applicable federal and state laws and regulations.

17.1.1 Each organization shall at all times protect the privacy of persons served and shall comply with all the requirements of the applicable state and federal confidentiality statutes and regulations.

17.1.2 Each organization shall develop policies and procedures in accordance with all state and federal laws and regulations with respect to the privacy and confidentiality of the records and identity of persons served.

17. 2 Each person served shall have the right to have access to his or her treatment record upon request:

17.2.1 The person's access to the treatment record shall include access to records included therein that were received from third parties and any information or documentation relied upon by the organization to develop a diagnosis and a treatment plan.

17.2.2 When a person served requests access to his or her treatment record, the organization shall provide the person with its written policy and procedure outlining the process by which such treatment record can be accessed. This policy and procedure shall include the following:

A. Persons served, upon review of their records, shall be informed of their right to disagree with information contained therein and to have a statement of disagreement included in their records.

1. A process and/or a form, developed by the organization to record such statement of disagreement, shall be available to persons served; and assistance to prepare such form shall be provided upon request.

17.3 If or when a person served authorizes the release of his or her treatment record, the organization shall inform him or her that he or she may revoke such authorization at any time.

17.4 Each organization shall provide training for all staff on its policies and procedures with respect to the privacy and confidentiality of treatment records and health care information.

17.5 An organization's violation of any state or federal confidentiality statute or regulation shall result in a licensing action by the Department.

Section 18.0 Protection of Rights: Human Rights Officers

18.1 Each organization shall designate and empower at least one person employed by or affiliated with the organization to serve as a Human Rights Officer (HRO). The HRO must, to the extent possible, have no duties that may conflict with his or her responsibilities as a Human Rights Officer and the organization must ensure that the HRO is given the time and resources to perform his or her human rights responsibilities. The name of the HRO and the method for contacting her or him shall be given to all persons served and shall be posted in a conspicuous place, such as waiting rooms and/or other common/public places, at all sites where services are provided by the organization.

18. 1.1 Individuals selected to fulfill the responsibilities of a HRO must have satisfactorily completed a HRO training program approved by the Department and, at a minimum, must meet the following qualifications:

A. Ability to serve as an advocate for all persons served while working cooperatively and effectively with staff;

B. Knowledge and skills to conduct investigations;

C. Capacity to perform responsibilities in an impartial manner.

18.1.2 The responsibilities of the HRO include the following:

A. Ensuring that persons served are informed of their rights and given opportunities to receive education regarding their rights;

B. Providing ways for persons served to have an opportunity to discuss and ask questions about their rights;

C. Training all staff, during orientation, regarding the rights of persons served, as defined in these regulations;

D. Assisting persons served to exercise their rights;

E. Monitoring the implementation of human rights regulations throughout the organization;

F. Fulfilling all HRO responsibilities specified in the Concern and Complaint Resolution Procedure.

18.1.3 The above responsibilities shall be included in the HRO's position description and his or her performance relative to these responsibilities shall be evaluated at least annually.

Section 19.0 Concern and Complaint Resolution Procedure

19.1 Each organization shall have a concern and complaint resolution policy with an accompanying procedure. The policy and procedure shall conform, at a minimum, to the following standards:

19.1.1 This policy and procedure shall apply to persons receiving services and to former recipients of services.

19.1.2 At each step in the process, every attempt shall be made to address the concern or the complaint and to resolve the issue in a quick and equitable manner that is without discrimination or recrimination.

19.1.3 The policy shall include a provision for informing the individual of his or her right to:

A. Immediately contact an advocate of his or her choice

B. Contact the Department, if the person perceives an imminent danger or fears retaliation.

19.1.4 A process shall be developed and implemented to record and track complaints.

19.1.5 Complaint documents shall be filed, maintained, and analyzed.

19.1.6 A process shall be developed for forwarding complaint materials to the Department when a complaint remains unresolved and an appeal is initiated.

19.1.7 All organization staff shall be trained during orientation and as needed, on the concern and complaint resolution policy and procedure with emphasis on the skills necessary to address concerns so that an early and equitable resolution is achieved.

19.1.8 Documentation of this training shall be maintained in each employee's personnel file.

19.2 Each organization shall implement a process to address concerns and complaints that includes, at a minimum, the following practices:

19.2.1 The individual may express a concern or a complaint to any organization staff member or may enlist the assistance of an advocate to do so.

A. The individual shall be offered a copy of the organization's Concern and Complaint Resolution Procedure that details the steps in the process.

19.2.2 The staff member providing assistance to the individual shall make every attempt to resolve an expressed concern.

19.2.3 When a concern is not resolved, such concern shall be considered a formal complaint and the individual shall be offered assistance in writing and submitting the complaint to the HRO and in accessing an advocate, if requested.

19.2.4 All complaints shall be forwarded to the organization's designated Human Rights Officer (HRO).

A. The complaint shall be logged by the HRO, according to the organization's procedures.

B. Within four (4) business days of making a formal complaint, the individual shall receive written and verbal confirmation of the HRO's receipt of the complaint.

19.2.5 Within five (5) business days or less of the receipt of the complaint, the HRO shall make an attempt at early resolution.

A. If the issue is resolved, a report noting the resolution, shall be forwarded to the program staff person designated by the organization.

19.2.6 If the issue is not resolved, the HRO shall investigate the complaint by gathering the facts and by speaking with the people involved and/or those with collateral information.

A. The investigation shall be completed within fifteen (15) business days or less from the date of the HRO's receipt of the complaint.

B. If the issue is resolved, a report noting the resolution shall be forwarded to the designated department or staff person.

19.2.7 If the complaint is not resolved, the individual shall be informed of his or her right to appeal to the Department. If the individual exercises this right, assistance shall be offered. The individual shall be reminded of his or her option to choose an advocate and assistance with contacting an advocate shall be offered.

Section 20.0 Organization Ethics

20.1 Professional staff shall adhere to both the Code of Ethics of their respective disciplines and the organization's Code of Ethical Conduct.

20.2 The organization's written Code of Ethical Conduct shall address ethical issues in the management and provision of services and in the implementation of clinical practices.

20.2.1 Ethical standards for all staff, including volunteers and consultants, shall include but shall not be limited to the following:

A. Staff shall use accurate and respectful language in all communications to and about persons served.

B. Staff are prohibited from engaging in or promising to engage in a personal, scientific, professional, financial, or other relationship, that is outside the professional relationship sanctioned by the organization, with persons currently or formerly served by the organization.

C. Staff shall not take advantage of any professional relationship or exploit others for their personal, religious, financial, political, or business interests.

20.3 The organization's policies and procedures shall reflect ethical practices for marketing, admission, transfer and billing.

20.4 The organization's Code of Ethical Conduct shall address the provision of appropriate care without consideration of financial resources.

20.5 The organization's Code of Ethical Conduct shall include a policy regarding gifts, goods, or services given to or received from persons served.

20.6 The Code of Ethical Conduct shall be posted in a conspicuous place(s) in all buildings where services are provided and shall be communicated to all personnel and to all persons served during orientation to the organization and shall be available upon verbal or written request.

20.7 Training regarding the Code of Ethical Conduct shall be provided to all staff, volunteers.

20.7.1 A record of this training shall be maintained by the organization.

20.8 The organization shall have a written policy and procedure to address any violation of the Code of Ethical Conduct.

20.9 All staff and volunteers affiliated with the organization shall sign a copy of the Code of Ethical Conduct to indicate that they understand their responsibility to abide by these standards.

20.9.1 Documentation shall be maintained in the individual's personnel file.

20.10 The organization shall not take retaliatory or punitive action against any employee or person served for his or her report of a possible or perceived violation of any rule, regulation, standard, or statute committed by the organization or by an employee of the organization.

Section 21.0 Behavioral Management

21.1 Aversive techniques are prohibited in all Behavioral Healthcare Organizations.

21.2 Behavioral management procedures require the consent of the person served.

21.2.1 Persons served and, as appropriate their families shall participate in selecting behavior management interventions.

21.3 The organization shall develop and implement written policies and procedures that describe the use and the monitoring of behavioral management interventions. These policies and procedures must be consistent with applicable federal and state regulations and incorporate the following standards.

21.3.1 The organization shall require a positive approach to behavior management.

21.3.2 Behavioral management may be implemented and enforced only as interventions that are:

A. Agreed to by the person served;
B. Are part of the person's overall treatment plan.

21.3.3 The least restrictive alternative shall be used in selecting a behavior management intervention.

21.3.4 Behavioral management goals and objectives must be integrated with the individual's other treatment goals and objectives and be in accordance with written policies and procedures that govern service expectations, treatment goals, safety and security.

21.3.5 When the organization serves as representative payee for the person served, the person's benefits may not be used as reinforcers or restrictions in a behavioral management agreement.

21.3.6 A behavioral management agreement that is part of the person's treatment plan shall document:

A. The behaviors that are the target of the plan;

B. The methods to teach appropriate expression of the targeted behavior or alternative adaptive behavior;

C. The procedures to be used;

D. How often, under what circumstances, and by whom the plan will be implemented;

E. The intended result of the behavioral management interventions.

21.3.7 Other individuals served by the organization shall not be requested or assigned to carry out any element of the person's behavioral management plan.

21.3.8 Prohibited interventions include but are not limited to the following:

A. Corporal punishment;

B. Fear-eliciting procedures;

C. Denial of any basic need such as shelter, essential clothing and an adequate, nutritional diet; and

D. Denial of the person's legal rights.

21.4 All behavioral management plans shall be developed, implemented, and monitored by employees or contractors trained in behavioral management.

21.5 The person served has the right to withdraw, at any time, his or her agreement to an element, or to all elements, in a behavioral management agreement or plan and to be advised of the potential risks and impact on his or her treatment process.

21.6 The organization shall identify, educate, and approve those staff who will be responsible for the development and implementation of behavioral treatment plans.

21.7 Policies and procedures shall specify the mechanism for monitoring the use of behavioral management.

21.8 Policies and procedures related to behavioral management shall be available to persons served, and as appropriate, to their families, guardians, and advocates.

Section 22.0 Seclusion and Restraint

22.1 Chemical restraint and mechanical restraint, as defined in these Regulations, are prohibited in all Behavioral Healthcare Organizations.

22.1.1 The organization shall have a written policy that prohibits chemical restraint and mechanical restraint, and describes the method of communicating this to all staff.

22.2 Seclusion and physical restraint as defined in these Regulations may be used only when there is an imminent risk of danger to an individual or others and no other safe and effective intervention is possible. Nonphysical interventions are the first choice as an intervention, unless safety issues demand an immediate physical response.

22.2.1 When seclusion or physical restraint is used, it shall be applied in a manner that minimizes the possibility of physical injury or mental distress to the individual.

A. Only approved physical restraining procedures that have been developed by a nationally recognized organization shall be used.

B. Only staff who have been trained in the use of restraint and seclusion and have been authorized by the organization shall initiate the use of restraint or seclusion.

C. The individual shall be removed from seclusion or restraint as soon as the threat of harm has been safely minimized.

D. The room used for seclusion shall provide a safe environment with adequate ventilation and lighting and observational availability for staff.

E. Trained personnel shall continuously monitor a person in seclusion.

22.2.2 The force used in physical restraint shall not exceed the minimum force required to limit the person's movement.

22.2.3 The frequency and duration of seclusion or physical restraint shall be the minimum required to prevent or remedy emergency situations.

A. Written and verbal orders for the use of seclusion or restraint shall be time limited, not to exceed four (4) hours for an adult or one (1) hour for a child or adolescent.

22.2.4 The safety, dignity, and privacy of each individual who experiences seclusion or restraint must be maintained to the greatest extent possible.

22.2.5 As early as feasible in the process, the individual shall be made aware of the rationale for seclusion or restraint and the behavior criteria for discontinuation.

22.2.6 If an individual repeatedly requires physical restraint, the program director shall initiate a review of the person's treatment needs to evaluate:

A. Whether the person may require a revised treatment plan;

---or---

B. May need a different treatment setting

22.3 A licensed independent practitioner who has been trained and qualified in the use of restraint and seclusion shall:

22.3.1 Supply a verbal or written order for seclusion or physical restraint within one (1) hour after initiation of the procedure.

22.3.2 Shall conduct a face to face evaluation of the person served within one(1) hour of the order for seclusion or restraint. This evaluation shall be documented in the person’s record.

22.4 When the individual has consented to have the family kept informed of his or her treatment and the family has agreed to be notified, staff shall promptly attempt to contact the family to inform them of the seclusion restraint.

22.5 A trained and qualified staff person shall conduct an assessment of the person in seclusion or restraint every fifteen (15) minutes.

22.6 The individual and, if appropriate, the individual's family, shall participate with staff who were involved in the episode in a debriefing about each episode of restraint. The debriefing shall include:

22.6.1 Identifying what led to the incident and what could have been handled differently;

22.6.2 Ascertaining that the individual's physical well-being, psychological comfort, and right to privacy were addressed;

22.6.3 Counseling the individual involved for any trauma that may have resulted from the incident;

22.6.4 Modifying the individual's treatment plan and/or treatment setting, when indicated;

22.6.5 Documenting all of the above in the person's treatment record.

22.7 The use of seclusion or restraint must be recorded in the individual's treatment record by a staff member who was present at the time of the restraint.

22.7.1 Documentation shall include:

A. The name, position and credentials of staff who initiated the procedure, who gave the order, who received the order, who conducted the evaluation and all others involved in the procedure.

B. The clinical justification for the procedure.

C. The inadequacy of less restrictive interventions that were attempted first.

D. The time and duration of the procedure.

E. Reports of the fifteen (15) minute assessments.

F. Care provided to the person served during the procedure.

G. Any injuries sustained and treatment to the person served or to staff.

H. Notification of the family, as appropriate.

22.8 The leaders of the organization shall establish safe and therapeutic environments that reduce and eliminate the need for seclusion or restraint.

22.9 The organization shall have a policy that states its position on the use of seclusion and restraint.

22.9.1 Such policy shall address the prevention of the use of seclusion and restraint and shall include procedures that guide the use of each.

22.10 The leaders shall communicate the organization's policy on the use of seclusion and restraint to all staff that have direct care responsibility.

22.11 The organization shall ensure that all direct care staff have received training in prevention, de-escalation techniques and early intervention to minimize the use of seclusion and restraint.

22.12 Only staff who have been trained and assessed as competent in the application of seclusion and restraint shall be authorized to initiate such procedures.

22.12.1 Training shall include de-escalation techniques, safe physical management, and how to monitor and continually assess for earliest release.

22.12.2 Training shall be conducted by individuals who are certified in restraint and de-escalation techniques.

22.13 Every use of seclusion or restraint shall be recorded and reported as an adverse event.

22.13.1 The organization shall collect data on the use of seclusion and restraint in order to monitor and improve its performance.

PART IV: Clinical Screening and Biopsychosocial Assessment

Section 23.0 Clinical Screening

Clinical screenings are telephone interviews conducted with a person who is requesting services or one who is potentially in need of services. The purpose of the screening is to assess the acuteness, type, and level of service needed and to determine if the organization is able to provide the requested or needed service or if referral to another provider is warranted. The screening process shall be conducted in a sensitive, respectful manner.

23.1 The clinical screening process shall, at a minimum, include:

23.1.1 Identifying and addressing the immediate and urgent needs of the person;

23.1.2 Determining the need for assessment or treatment either by the organization or by referral to another provider or organization;

23.1.3 Eliciting information from significant others when necessary and available;

23.1.4 Scheduling a face-to-face appointment with the person whenever sufficient information is not available through the telephone screening;

23.1.5 Documenting all requests for services and the dispositions.

23.2 The organization has written policies and procedures describing the clinical screening process that:

23.2.1 Define the roles and responsibilities associated with the clinical screening function;

23.2.2 Require gathering and documenting, at a minimum, the following information to determine and to prioritize the type and level of service needed and the appropriate service provider:

A. Demographic information

B. The reason the person or the referring agent is contacting the organization

C. Sufficient information about the person's physical, psychological, and social functioning;

D. The person's immediate need for basic necessities;

E. The person's use of alcohol and other drugs;

F. Risk factors, including suicidal or homicidal ideation or behaviors, to determine the need for emergency or urgent care.

23.2.3 Guidelines for referring individuals for services within and outside the organization and for confirming the status of referrals.

23.3 Clearly written criteria for scheduling appointments and for admission shall be established, and include:

23.3.1 Criteria to prioritize the scheduling of appointments;

23.3.2 Criteria for admitting persons for services;

A. In determining an individual's initial and ongoing eligibility for any service, an organization may not discriminate against an individual based on the following factors:

1. The individual's past mental illness or substance use diagnosis;
2. Medications prescribed to the individual in the past or present;
3. The presumption of the individual's inability to benefit from treatment;
4. The individual's level of success in prior treatment episodes.

23.3.3 The staff person(s) responsible for making decisions regarding scheduling and admitting persons for services;

23.3.4 Criteria for denying services;

23.3.5 Criteria for referring to other providers.

23.4 When a person is found to be eligible for the organization's services, but not in need of immediate or crisis-related services, an appointment shall be scheduled with reasonable promptness. If the organization lacks the resources to schedule an appointment within six weeks (6) of the screening date, the organization shall refer the individual to another appropriate provider.

23.5 When the screening results in a person not being offered services by the organization the following procedures, at a minimum, shall be implemented:

23.5.1 The person is informed that he or she may speak with the screening supervisor if he or she states his or her situation has not been adequately understood.

23.5.2 The person is informed of the reasons for not being offered services by the organization.

23.5.3 Recommendations are provided for alternative services and referral sources, as appropriate.

23.5.4 The person is informed that concerns or complaints may be directed to the Department.

23.5.5 The organization maintains documentation of these actions.

23.6 Staff conducting clinical screenings shall have access to current information about referral resources that have been approved by the organization.

23.7 The organization shall ensure that staff supervising and conducting clinical screenings shall, at a minimum, have the following qualifications:

23.7.1 The clinical supervisor shall meet the requirements defined in regulation 9.10;

23.7.2 A telephone screening clinician shall have demonstrated, to the satisfaction of the clinical supervisor of the service, that he or she has the knowledge and skill to competently perform the responsibilities of the screening service.

Section 24.0 Biopsychosocial Assessment

The process of the initial assessment and the preliminary treatment plan shall maximize opportunities for the clinician to gain an understanding of the person and for the person served to access the most appropriate services.

24.1 An assessment of the individual's physical and psychological status and social functioning shall be conducted for each person who is evaluated for admission to the organization.

24.1.1 The organization shall register, according to the organization's protocol, each person who receives an assessment service and is not yet admitted to the organization.

24.1.2 Individuals shall be admitted to the organization no later than their third face-to-face clinical service within one treatment episode.

24.1.3 Through the assessment process, the following shall be determined and documented:

A. The treatment needs and expectations identified by the person served;
B. The type and level of treatment to be provided;
C. The need for specialized medical or psychological evaluations;
D. The need for the participation of the family or other support persons;
E. The staff person (s) and/or program to provide the treatment.

24.2 Assessment documentation shall be organized to reflect the two (2) aspects of completing an assessment: gathering the data base information and formulating the integrated summary.

24.2.1 The data base information shall consist of materials, facts, and clinical observations about the individual's strengths, functioning, and biopsychosocial needs.

24.2.2 The integrated summary shall be formulated through analysis and synthesis of the data base information.

24.3 The following information about the person served shall be recorded:

24.3.1 Age;
24.3.2 Gender;
24.3.3 Education;
24.3.4 Employment;
24.3.5 Ethnicity;
24.3.6 Financial status;
24.3.7 Military service history;
24.3.8 Living arrangement;
24.3.9 Advanced directives, when applicable.

24.4 The following data base information shall be recorded by the clinician conducting the assessment:

24.4.1 Presenting issues and current stressors identified by the individual;

24.4.2 Psychological characteristics and mental status exam, that includes:

A. History of and current behaviors associated with risk taking and life threatening ideation and actions.

24.4.3 History of and current behaviors associated with substance abuse, gambling, and other addictions, to include the following, as appropriate:

A. Age of onset;
B. Duration;
C. Amount, frequency, and patterns of use or involvement;
D. Withdrawal symptoms;
E. Consequences of use or involvement.

24.4.4 Previous behavioral health treatment history including diagnoses, type of treatment, and outcome;

24.4.5 Trauma history;

24.4.6 Medical history and current medical conditions with name, address, and phone numbers of current physicians;

24.4.7 Medications prescribed at time of assessment and during the previous six months, if available;

24.4.8 Drug allergies, idiosyncratic reactions, and/or other adverse effects;

24.4.9 Sexual history;

24.4.10 Family and personal relationships;

24.4.11 Social development and functioning;

24.4.12 Personal strengths, preferences for and objections to specific treatments, and service expectations identified by the individual;

24.4.13 Functional evaluations of language, self-care, daily living skills, visual-motor, and cognitive functioning, when indicated;

24.4.14 Recreational activities and interests;

24.4.15 Spiritual beliefs;

24.4.16 Legal issues;

24.4.17 A family history relative to substance abuse/dependency, trauma, and mental illness;

24.4.18 Source and type of psychosocial services currently provided by other organizations;

24.4.19 Other issues, such as nutrition, that may be appropriate for treatment.

24.5 For organizations that provide substance abuse services to minors, the data base portion of the assessment shall additionally include information about the following:

24.5.1 Age-appropriate behaviors

24.5.2 Peer group functioning

24.5.3 Cognitive functioning, physical status, and developmental and learning disabilities, if indicated

24.5.4 School functioning

24.5.5 Expectations of family or guardian.

24.6 Each biopsychosocial assessment shall include an integrated summary that analyzes and synthesizes the findings of the data base assessment. Formulation of the integrated summary shall include:

24.6.1 A description of the person that includes his or her strengths, aspirations, and concerns related to the proposed treatment.

24.6.2 Formulation and prioritization of the issues for treatment and a description of the factors that contribute to each issue.

24.6.3 Clinical judgments regarding both positive and negative factors likely to affect the person's course of treatment and clinical outcomes.

24.6.4 Multiaxial DSM diagnosis, written and coded.

24.6.5 For persons assessed in need of substance abuse services, the assessment summary shall include recommendations for a level and type of service based on current ASAM-PPC criteria

24.6.6 Preliminary treatment plan.

A. Individualized goals and service needs with consideration of the individual's expectations and desires.

24.7 The preliminary treatment plan, based on the data base information and integrated summary shall be developed that includes, at a minimum, the following:

24.7.1 Prioritized issues to be addressed at this stage of treatment.

24.7.2 Person's strengths relevant to addressing each treatment issue.
24.7.3 Disposition of each primary issue.
24.7.4 Identification of preliminary treatment goals and interventions.

A. Person responsible and date to be completed shall be documented for each intervention.

24.8 The preliminary treatment plan shall be formulated as part of the assessment and shall suffice up to the fourth clinical service or thirty (30) days after the assessment, whichever comes last. Unless other requirements are designated for a specific program, a more comprehensive treatment plan, developed according to the regulations in Section 25, shall be required for individuals receiving services beyond thirty (30) days or four (4) clinical sessions.

24.9 Review and update of the assessment is an ongoing process. Updates must be documented in response to the following situations:

24.9.1 Significant changes in the individual's clinical condition, overall condition, or life situation;
24.9.2 Frequent use of crisis intervention services;
24.9.3 Changes in level of care;
24.9.4 Transfer between treatment programs;
24.9.5 When requested by person served;
24.9.6 When objectives are met or expected to be met.

24.10 24.10 At least once every twelve (12) months, a review and update of the assessment information and the integrated summary shall be documented. This review/update must be reviewed and validated with the signature of the clinical supervisor within fourteen (14) days of completion. This validation is not required for documents created by licensed clinical staff.

24.11 Assessment reviews and updates shall be conducted in face-to face interviews with the individual.

24.12 For individuals receiving long-term services, the biopsychosocial assessment shall be rewritten in its entirety, at least every sixty (60) months. This reassessment must be reviewed and validated with the signature of the clinical supervisor within fourteen (14) days of completion. This validation is not required for documents created by licensed clinical staff.

24.13 Unless specified otherwise in these Regulations staff conducting initial biopsychosocial assessments shall, at a minimum, have the following qualifications with education and experience relevant to the service they are providing:

24.13.1 Licensed Independent Practitioner

--- or ---

24.13.2 Master's Degree with license to provide relevant behavioral health service or with one (1) year post Master's Degree full time experience providing behavioral health services

--- or ---

24.13.3 Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or with one (1) year post RN license full time experience providing behavioral health services

--- or ---

24.13.4 Licensed Chemical Dependence Clinical Supervisor

--- or ---

24.13.5 Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professional-Diplomate;

--- or ---

24.13.6 Certified Co-Occurring Disorder Professional with no less than one (1) hour of individual clinical supervision each month;

---or---

24.13.7 Provisional Chemical Dependency Professional or Provisional Certified Co-Occurring Disorders Professional with no less than two (2) hours of individual clinical supervision each month;

---or ---

24.13.8 Master's Degree staff working toward licensure-and individuals enrolled in Master's Degree programs working towards Provisional Chemical Dependency Professional, or Provisional Certified Co-Occurring Disorders Professional certification, - with no less than one (1) hour of individual clinical supervision per week and additional supervision as required by their respective training or licensing programs.

Part V: Treatment Documentation

The process of clinical documentation shall maximize the active involvement of the person served and shall promote the individual's efforts toward recovery. There shall be evidence that the person's strengths and preferences, his or her needs, issues, challenges, and diagnoses are identified in the biopsychosocial assessment and are considered throughout the person's treatment.

Section 25.0 Treatment Plan

25.1 Based on the biopsychosocial assessment, a goal-oriented, individualized treatment plan shall be developed and implemented with each person served.

25.1.1 The treatment planning process shall identify and incorporate the unique needs, expectations, and characteristics of the person served into an appropriate, personalized, and comprehensive plan.

25.1.2 A major goal of each treatment plan shall be the promotion of the individual's efforts toward recovery.

25.2 The responsibility for the overall development and implementation of the treatment plan shall be assigned to a member of the professional staff who has the clinical skills and experience to provide the indicated services. This staff member shall be clearly identified in the plan.

25.3 The organization shall develop and implement policies and procedures that promote the participation of individuals served and their identified support persons in treatment planning sessions. Such policies and procedures shall include, but shall not be limited to the following:

25.3.1 The treatment plan shall include the signature of the person served or a statement that the person is unwilling or unable to sign.

25.3.2 If the person served does not participate in the treatment planning process and /or is unwilling or unable to sign the treatment plan, the primary provider shall initiate actions to minimize obstacles and encourage participation. All actions taken shall be documented in the person's treatment record.

25.4 The treatment plan shall contain the following elements:

25.4.1 The written and coded multi-axial DSM diagnoses demonstrating a clear connection between the diagnoses, the data and integrated summary documented in the assessment, and the goals and interventions identified on the treatment plan.

25.4.2 A written statement of each issue that needs to be addressed. Each issue statement shall include identification of the person's strengths that shall contribute to his or her achieving the treatment goals associated with the issue.

25.4.3 Long term goal(s) identified by the person served that are recovery-oriented.

25.4.4 Short term goals formulated by the person served and the treatment team as stepping-stones to the long term goal(s). Short term goal statements shall be:

A. Outcome oriented;

B. Measurable;

C. Realistic;

D. Congruent with the person's values;

E. Consistent with the person's point of view and written in terms the person understands;

F. Linked logically and directly with the assessment and the prioritized treatment issues;

G. Linked to symptom reduction, and to living, learning, and work activities, as appropriate.

25.4.5 Interventions developed to attain each Short Term Goal shall clearly and specifically indicate:

A. Concise measurable treatment;

B. Services, tasks, or support that will help the individual attain his or her goals within the time frames established;

C. Consideration of ASAM-PPC guidelines, when relevant;

D. When and with what frequency each intervention will occur;

E. The person(s) who will perform each intervention;

F. Timeframes based on the projected length of time to review progress or to accomplish each specific goal and intervention.

25.4.6 The criteria to be met for treatment to be completed or for the person to exit the service or program.

25.5 The treatment plan for individuals with both substance abuse and mental health diagnoses shall include treatment goals and interventions that address issues relative to both diagnoses in an integrated dual-diagnosis treatment approach as described in Section 32 of these regulations.

25.6 Treatment plans for individuals who have a representative payee shall include treatment goals and interventions designed to help the individual manage his or her own finances.

25.7 The treatment plan shall include referrals for services that are not provided by the organization and are necessary for the attainment of the individual's treatment goals.

25.7.1 The status of the referred services shall be described in progress notes with outcomes recorded on the treatment plan and in treatment plan reviews.

25.8 The treatment plan shall be signed by the primary provider and, unless the primary provider meets the qualifications in Regulation 9.10, shall be validated with the signature of the clinical supervisor of the specific service or program. Each staff person's credentials and the date shall be clearly documented with the signature.

25.8.1 Validation shall be recorded no later than two (2) weeks after completion of the plan.

25.8.2 The treatment plans of individuals receiving services in a CMHC residential or assertive community treatment program require the signature of a psychiatrist.

25.9 A new treatment plan shall be developed at least once every twelve (12) months.

Section 26.0 Treatment Plan Review

26.1 Goals and interventions indicated in the treatment plan shall be reassessed and modified as necessary, and at each of the following events:

26.1.1 Upon changes in the individual's condition or level of care;
26.1.2 At the time of the individual's admission to a specific service or program;
26.1.3 At the time of an internal transfer between programs;
26.1.4 When an intervention is completed or a goal attained;
26.1.5 When an intervention is not helping the individual attain the desired outcome;
26.1.6 Upon the individual's frequent use of crisis intervention services;
26.1.7 When an individual refuses services or makes him or herself unavailable for services;
26.1.8 At the request of the person served.

26.2 Unless a different requirement is specified for a particular service or program, within the sixth month after the effective date of the individual's treatment plan, the entire plan shall be reviewed, including those goals and interventions that were changed or added during the six (6) month period.

26.2.1 For General Outpatient Services Clients receiving only Medication Services prescribed by a Psychiatrist, the psychiatrist's progress notes can be used for the treatment plan review. Progress notes are to be standardized as in Section 27.0 of these regulations and detailed regarding client's current course of treatment.

26.3 The person served and support persons (when authorized by the person served) shall be involved in all reviews and revisions of the treatment plan. The requirements documented in Regulation 25.3 shall apply to treatment plan reviews.

26.4 The results of the review must be specifically referenced in the treatment plan and shall be:

26.4.1 Documented on the treatment plan itself

--- or ---

26.4.2 Documented on a supplement to the treatment plan that is clearly labeled "Treatment Plan Review"

--- or ---

26.4.3 Documented in a detailed progress note that is clearly labeled "Treatment Plan Review".

26.5 The treatment plan review requires documentation of an evaluation process that includes:

26.5.1 Identifying the reason for the review and the period of time covered;

26.5.2 Gathering information from the person served about his or her perception of the treatment process and plans for continued treatment;

26.5.3 Determining if a treatment goal has been attained;

26.5.4 Identifying the factors driving or hindering goal attainment;

26.5.5 Determining the effectiveness and outcome of each treatment intervention;

26.5.6 Considering the treatment plan's responsiveness to the person's strengths, abilities, needs, preferences, and satisfaction;

26.5.7 Reviewing progress notes;

26.5.8 Considering ways the therapeutic alliance may be enhanced;

26.5.9 Updating, adding, deleting, or revising issue statements, goals, and interventions based on information gained during the course of treatment and the treatment review process.

26.6 Treatment plan reviews shall be signed and validated according to requirements specified in Regulations 25.3 and 25.8.

Section 27.0 Progress Notes

27.1 The person's current status and progress relative to the treatment plan and the treatment process shall be documented as progress notes in the treatment record.

27.1.1 Progress notes shall be recorded according to a standard charting format.
27.1.2 Progress notes shall be legibly handwritten, typed, or entered electronically.
27.1.3 Each progress note shall be maintained in chronological order in the person's treatment record.

27.2 Unless a periodic note is authorized for a specific program, a progress note shall be recorded for each service contact with a person served or a collateral.

27.3 Progress note documentation shall include the following information, recorded either manually or electronically:

27.3.1 The clinician or administrative support person shall record:

A. Name of person served
B. Name of person providing the service
C. Location of service
D. Type of service
E. Date and time of service

27.3.2 The clinician shall record:

A. Duration of service

B. Objective and subjective observations, that include any changes in the person's condition, and services rendered during the service contact with the individual

C. The individual's response to treatment and the response of significant others to the individual's treatment, as appropriate.

D. A clinical assessment, based on the observations and information gathered during the service contact, that includes:

1. The current functioning of the person

2. Evaluation of risk factors

3. The effectiveness of interventions with revisions to treatment plan and rationale noted, when indicated

4. Progress toward treatment goals and efforts toward recovery.

E. Formulation of a plan for specific services or interventions based on the assessment of the person during the service contact.

F. Signature of the full name of the clinician providing and recording the service including his or her credentials and date.

27.4 The following shall also be recorded in progress notes:

27.4.1 Information about the individual's participation in the treatment process;

A. Discussions pertinent to the informed decision making process, and the decisions made by the individual served.

27.4.2 Efforts to engage and/or to contact individuals who:

A. Are in need of treatment but are difficult to contact or to maintain connected to treatment

B. Are at risk for discontinuing critical behavioral health services.

27.4.3 Requests for and reports of special consultations or evaluations and documentation of review by appropriate staff;

27.4.4 Telephone conversations with the person served or with collaterals;

27.4.5 Professional communications regarding the person served;

27.4.6 Cancelled and missed appointments.

27.5 Progress notes shall provide documentation of relevant events occurring during the individual's course of treatment.

Section 28.0 Discharge Summary and Aftercare Plan

28.1 An aftercare plan shall be developed in partnership with the individual before a planned discharge. The aftercare plan shall include:

28.1.1 Services to be accessed following discharge;
28.1.2 Activities to sustain the progress made during treatment;
28.1.3 A crisis plan for the individual to follow after discharge, when indicated.

28.2 At the time of the person's discharge from services, a summary shall be formulated that records the most significant information regarding the individual's treatment from the time of first contact until services have ended. The discharge summary shall include the following:

28.2.1 Circumstances of the discharge;
28.2.2 Presenting issues;
28.2.3 Current multiaxial DSM diagnoses, both written and coded;
28.2.4 All significant findings relevant to the person's treatment and recovery;
28.2.5 Course and progress of treatment;
28.2.6 Outcomes in relation to the identified issues, goals, and treatment;
28.2.7 Recommendations and referrals for further services, if indicated.

28.3 The discharge summary shall be completed no later than fifteen (15) working days after the individual's discharge from the organization.

28.3.1 When the individual is available, he or she shall be offered a copy of the aftercare plan.

28.4 When a person served is not participating adequately in a particular service or program, the director of such service or program may discharge the person from the program or the organization only when the following conditions have been met:

28.4.1 The program staff have worked with the person to resolve issues, made appropriate changes in his or her treatment plan, and have documented such efforts.

28.4.2 The program staff have assisted the person to access alternative services.

28.4.3 The person has been given written notice of the pending discharge and has been informed of his or her right to appeal the decision.

28.5 The individual served shall be discharged from the organization and the treatment record closed if there has been no attempted contact by the individual or scheduled appointments for thirty (30) days, unless:

28.5.1 Without services, the individual is at risk for relapse, hospital level care, incarceration, or homelessness.

A. In the above situation, staff shall make and shall document intensive efforts to engage the person in appropriate services.

28.5.2 The person is prescribed medication by the organization.

A. The physician or prescribing nurse must authorize the discharge of all individuals for whom he or she prescribes medication.

28.5.3 The individual has been receiving Community Support Services and is scheduled to be incarcerated for one (1) year or less.

A. The organization shall continue to advocate for the individual to receive appropriate treatment while incarcerated and shall assist with the individual's return to the community.

28.5.4 A specific program has other requirements.

28.6 When a person served does not participate in a planned discharge, prior to the organization processing an administrative discharge and closing the person's treatment record, the organization shall:

28.6.1 Provide the individual written notice of the pending discharge from treatment and the closure of his or her treatment record.

28.6.2 Provide information on how to access emergency services and the conditions, if any, of future care from the discharging organization.

28.7 After discharge, follow-up contacts shall be provided as required by specific programs or by state law.

28.8 The organization is responsible for implementing any additional clinical documentation requirements listed under specific programs or services described in these Regulations.

Part VI: Services and Programs

Each service and program shall adhere to all of the standards in these regulations unless a regulation documented in the section of a particular service or program specifies otherwise.

Section 29.0 Emergency, Crisis Intervention, and Crisis Stabilization Services

Behavioral health emergency, crisis intervention, and crisis stabilization services are immediate and short-term behavioral healthcare interventions provided to individuals experiencing an emergency or crisis situation. These services continue until the crisis is stabilized or the individual is safely transferred or referred for appropriate stabilization and/or ongoing treatment.

29.1 All licensed organizations are required to provide, or make available, directly or through referral, crisis intervention and stabilization services for the individuals they serve. In addition to the individuals they serve, all CMHC's are required to operate a crisis intervention and stabilization program for adults who reside in the CMHCs designated service area and who do not have a current behavioral healthcare provider.

29.1.1 Organizations shall ensure that emergency services are available via telephone and /or face-to-face evaluation twenty-four (24) hours a day, seven (7) days a week.

29.2 Organization crisis programs and services shall establish policies and protocols that, at a minimum, describe the following:

29.2.1 Admission, treatment, and discharge criteria

29.2.2 Physician or nurse-approved protocols for the provision of emergency medical and emergency behavioral healthcare

29.2.3 Guidelines for the internal and external transfer, referral, and follow-up care of persons served, to include referrals for physical and medication evaluations

29.2.4 The process for accessing internal and external resources

29.2.5 Procedures for the involvement of significant others during emergency situations.

29.3 The following assessment information, as appropriate to the person served and the specific crisis, shall be gathered and documented:

29.3.1 Presenting issue(s);

29.3.2 Mental status;

29.3.3 Level of risk for suicidal, homicidal, or other dangerous behaviors;

29.3.4 History and current use of alcohol and other drugs to include consideration of current state of intoxication and need for immediate medical intervention;

29.3.5 Psychiatric history;

29.3.6 Trauma history;

29.3.7 Relevant family history;

29.3.8 Current medications;

29.3.9 Drug allergies, idiosyncratic reactions, and/or other adverse effects;

29.3.10 Medical conditions;

29.3.11 Legal status;

29.3.12 Name, and phone number of treating physician(s);

29.3.13 Information from significant others and from current providers when appropriate and available;

29.3.14 Diagnostic formulation;

29.3.15 Treatment recommendations and dispositions.

29.4 The organization shall register, according to the organization's protocol, each person whose initial face-to-face clinical service is an emergency or crisis assessment.

29.5 Crisis stabilization services, provided after crisis intervention services, shall require a crisis stabilization treatment plan, formulated with the person served, that includes, at a minimum, the following:

29.5.1 Multiaxial DSM diagnoses;
29.5.2 Presenting issues for treatment;
29.5.3 Identification of the person's strengths to assist him or her to attain the desired recovery goals;
29.5.4 Stabilization/relapse prevention goals and interventions;

29.5.5 Plan for treatment after stabilization;
29.5.6 Criteria for transfer or discharge.

29.6 Policies and procedures shall be developed and implemented that address the provision of services for individuals who:

29.6.1 Refuse treatment;
29.6.2 Fail to keep scheduled appointments;
29.6.3 Are unable to or do not follow their treatment plans;
29.6.4 Engage in threats or acts of violence;
29.6.5 Exhibit behavior disruptive to program functioning.

29.7 The implementation of crisis intervention services in CMHC's shall include, but shall not be limited to, the following:

29.7.1 An accessible phone line for emergency contacts shall be established and the organization shall ensure that a qualified clinician responds within ten (10) minutes of notification from an answering service or from a non-professional staff person.

29.7.2 The CMHC shall have procedures for transferring to a hospital individuals experiencing a medical or psychiatric emergency.

29.8 "Mental Health Professional" as defined by the Mental Health Law means a psychiatrist, psychologist, clinical social worker, psychiatric nurses, mental health counselor and other such persons, as may be defined by rules and regulations promulgated by the director.

29.8.1 BHDDH Rules and Regulation further defines "Qualified Mental Health Professional" (QMHP) as an individual with a minimum of a Master's Degree in a clinical practice or a license as a Registered Nurse and have a minimum of thirty (30) hours of supervised face-to-face emergency services contact experience as a psychiatric emergency service worker in Rhode Island.

A. Such experience may be gained through employment with a CMHC or a Licensed Hospital conducting emergency psychiatric assessment for individuals under consideration for admission to a department designated inpatient mental health facility.

B. Each CMHC and Licensed Hospital performing psychiatric emergency services triage shall provide the Director of BHDDH with an annual up-to-date list of QMHPs including supervisors for its twenty four (24) hour emergency service who meet the qualifications stated in 29.8.1.

29.8.2 Each CMHC shall employ, either directly or on a consultation basis, the services of one (1) or more psychiatrists to provide twenty-four (24) hour medical back up.

29.8.3 CMHC crisis intervention staff must have knowledge of the appropriate use of community resources, crisis intervention techniques, and procedures for involuntary hospitalization (inpatient and outpatient).

29.9 Unless meeting the previous definition of a QMHP or specified otherwise in these Regulations, organization staff providing emergency and crisis intervention and stabilization services shall have the qualifications listed in Regulation 24.13. These services do not include evaluation and assessment for Psychiatric Inpatient admission.

29.10 Each CMHC and Licensed Hospital performing psychiatric emergency service triage shall provide the Director of BHDDH with all required QMHP application materials and recommendations for consideration and approval.

Section 30.0 Medication and Laboratory Services

Medications are often an essential component of treatment, helping to maximize the functioning of persons served while reducing targeted symptoms. All medication services must be coordinated with a person's psychosocial interventions and be an integral part of his or her recovery-oriented treatment plan. This section applies to organizations that provide any of the following medication services: prescribing, ordering, dispensing, or administering medications.

30.1 The organization shall establish and implement policies and procedures that guide the safe and effective use of medication. These policies and procedures, at a minimum, shall address the following:

30.1.1 Ordering, procuring, storing, controlling, prescribing, preparing, dispensing, and documenting medications according to law and regulation;

30.1.2 Distribution and administration of controlled medications, including documentation and record keeping required by law;

30.1.3 Proper storage, distribution, and control of investigational medications and those in clinical trial;

30.1.4 Qualification of "as needed" prescriptions or orders and times of dose administration;

30.1.5 Process and documentation of informed consent;

30.1.6 Control and distribution of sample drugs;

30.1.7 Distribution of medications to individuals at home visits, therapeutic outings, and at discharge;

30.1.8 Procurement, storage, control, and distribution of prepackaged medications obtained from an outside source when no on-site pharmacy service exists;

30.1.9 Process for handling medication errors;

30.1.10 Actions to follow when drug reactions and other emergencies related to the use of medications occur;

30.1.11 Involuntary and administrative discharges of persons who are prescribed medications by the organization's medical staff.

30.2 An individual who is receiving medication shall be seen at least quarterly by the prescribing physician or prescribing nurse, unless the physician or nurse documents that longer intervals are clinically appropriate.

30.2.1 For each meeting with the person served, the prescribing physician or prescribing nurse shall document the following in the person's record:

A. All medications he or she prescribes, renews, or discontinues at the meeting shall be recorded according to medical practice standards.

B. The reason for prescribing, continuing, or discontinuing a medication.

C. Any changes in medications or protocol.

D. The effectiveness of a continued medication.

E. Any signs or reports of side effects.

F. The treatment, if necessary, to address or prevent side effects.

G. Discussion with the person regarding risks and benefits of medications recommended or prescribed at the meeting.

H. Comments by the person served regarding his or her response to medication and, when indicated, the person's request to change or discontinue a medication.

I. All other medications that the person is currently taking shall be reviewed and those that are new shall be documented, to ensure that the combination of medications is reasonable and safe.

30.3 Verbal orders may be given, received and transcribed only by qualified, licensed medical staff employed by the organization.

30.3.1 Each verbal order shall be recorded, dated and identified by the names and credentials of the individuals who gave it and received it.

30.3.2 The person who gave the verbal order must sign it the next day he or she is working at the organization.

30.4 Medications shall not be used for the convenience of a program, or as a reward, or for the behavioral control or punishment of persons served.

30.5 To minimize opportunities for error, medications shall be provided for persons served in the most ready-to-administer form possible in accordance with best practice guidelines of a particular program or service.

30.6 Medications provided to persons served shall be properly and safely labeled using a professional, standardized method.

30.7 Medications shall be administered as prescribed and only by persons authorized by state law to administer medications.

30.8 Medications shall be given only to the individuals for whom the medications are prescribed.

30.8.1 In Opioid Treatment Programs, responsible adults may be approved to pick-up the medication of a person served who, for medical reasons, is incapable of physically accessing the site of the program.

30.9 Medication that is administered by or at the organization shall be administered in accordance with the following provisions:

30.9.1 Persons served shall administer their own oral medications, unless contraindicated for therapeutic reasons.

30.9.2 As needed, persons served shall receive training in the self administration of medications and this training shall be documented in the person's clinical record.

30.9.3 The assistance that non-medically licensed staff may provide to a person served shall be limited to reminding the person to take the medication and giving the person the opportunity to take the medication at the prescribed time.

30.9.4 For each dose of medication that is administered, the following information shall be documented:

A. The name, strength, and dose of the medication;

B. The time the medication was administered;

C. How the medication was administered, if other than orally;

D. The signature of the person who administered the medication or such person's ID when an automated dosing system is used.

30.9.5 Whenever a prescribed medication has not been administered or taken as ordered:

A. The prescribing physician or nurse shall be notified in accordance with acceptable medical practice.

B. Notation of the missed medication and the reason for it shall be documented on the medication form.

30.10 Medications shall be administered only in accordance with a current medication order.

30.10.1 When a medication is administered at an organization site, a copy of the current medication order must be available at the site of the administration.

30.10.2 All medication orders shall be maintained in the individual's treatment record.

30.11 The following information regarding medications is provided to persons served, to program staff, and, as appropriate, to family members.

30.11.1 The risks associated with each medication;
30.11.2 The intended benefits;
30.11.3 Potential side effects;
30.11.4 Contraindications;
30.11.5 Procedures to be taken to minimize risks and side-effects;
30.11.6 A description of the clinical signs that indicate a medication may need to be discontinued;
30.11.7 The rationale for each medication;
30.11.8 Alternatives to the use of medications, as appropriate;
30.11.9 Alternative medications, as appropriate;
30.11.10 The proper storage of medications;
30.11.11 The availability of financial supports and resources to assist the persons served with handling the costs associated with medications, when indicated.

30.12 Physicians and nurses shall involve the person served in decisions related to his or her use of medications.

30.13 Prescribed medication shall be accounted for in accordance with local, state, and federal laws. Any theft, loss, spillage, or error in administration of a medication shall be reported to the administrator of the organization.

30.13.1 The Department shall be notified of any adverse event involving medications.

30.14 Organizations that provide substance abuse services shall have policies and procedures for drug testing. These policies shall be made available to the persons served and shall include the following:

30.14.1 Individuals may, at their own expense, have drug tests confirmed.

30.15 Opioid Treatment Programs shall comply with:

30.15.1 42 CFR, Part 8 (DHHS/SAMHSA, DEA Regulations);
30.15.2 Rhode Island General Laws section 5-19-1 *et seq*. (Pharmacy Statute); and
30.15.3 Rhode Island State Methadone Authority requirements, and all applicable RI General laws.

30.16 Opioid Treatment Programs (OTPs) shall use only opioid replacement treatment medications that are approved by the Food and Drug Administration and the Cosmetic Act (21 U.S.C. 355) for use in the treatment of opioid addiction.

30.17 Clinical laboratories provided on the premises of the organization shall be licensed by the state subject to the provisions of Rhode Island General Laws section 23-16.2 *et seq*. Testing not performed on the premises shall be performed by facilities licensed in accordance with Rhode Island General Laws section 23-16.2 *et seq.*, or by a hospital laboratory in accordance with Rhode Island General Laws section 23-17-1 *et seq*.

30.18 All organizations shall provide HIV and Hepatitis C information and offer a referral for HIV testing for persons served who engage in related high-risk behaviors.

30.18.1 All testing pursuant to this section, conducted by an organization, shall be performed in accordance with Rhode Island General Laws section 23- 6-17 and 18, except where federal confidentiality laws (42 CFR, Part 2) may supersede. The identity of the individuals tested under this section shall be maintained only at the site where the sample is drawn, and shall not be released except as otherwise provided.

30.18.2 Each person who is offered a test and counseling shall be provided with an "Informed Consent Form" (in accordance with Rhode Island General Laws section 23-6-13) which he or she shall sign and date in acknowledgment of the offer.

30.18.3 All persons tested under this section shall be provided pre test and post test counseling in accordance with regulations adopted by the Department of Health (DOH) and by Rhode Island General Laws section 23-6-17. All persons providing the pre and/or post test counseling must have completed

the training provided by the DOH Office of Sexually Transmitted Disorders and HIV or an equivalent course.

30.19 The physician or designee shall document in the treatment record the referral for treatment and follow-up of each person identified with HIV, Hepatitis B, C, or Tuberculosis infection.

30.20 Regulations in this section shall not be construed as encompassing all regulations pertaining to the handling of medications. Organizations must comply with all applicable state and federal laws.

Section 31.0 General Outpatient Services

General Outpatient treatment programs provide an array of services that include but are not limited to individual, group and family counseling, and education. These programs offer comprehensive and coordinated diagnostic, clinical, and educational services that may vary in intensity level according to the needs of the individual served.

31.1 Organizations providing General Outpatient Services shall develop and implement policies and procedures describing:

31.1.1 Admission, continuing care, and discharge criteria
31.1.2 Evidence-based (when available) and best practice standards for services provided to include Co-Occurring.

31.2 General Outpatient Programs (GOP) shall provide or shall have the capacity to arrange for the following behavioral health services:

31.2.1 Biopsychosocial Assessment
31.2.2 Psychotherapy
31.2.3 Counseling
31.2.4 Psychiatric Evaluation
31.2.5 Medication treatment and review
31.2.6 Psychological Assessment
31.2.7 Psychoeducation
31.2.8 Twenty-four (24) hour crisis services

31.3 In the General Outpatient Programs of Community Mental Health Centers, community psychiatric supportive services shall be provided for individuals assessed in need of, and eligible for, those services.

31.4 For individuals with co-occurring disorders, mental health and substance abuse services shall be provided in an integrated manner according to the evidence-based practice standards in Section 32 of these Regulations.

31.5 Services shall be coordinated with other relevant health, rehabilitation, social and support services.

31.6 Organizations operating General Outpatient Programs shall maintain evening and/or weekend appointment hours adequate to meet the needs of persons served and, at a minimum, four (4) appointment hours shall be available one (1) evening per week or one (1) weekend day.

31.7 The supervisor of GOP services shall meet the qualifications defined in Regulation 9.10.

31.8 Staff providing GOP services shall, at a minimum, have the qualifications listed in Regulation 24.13.

Section 32.0 Services for Persons with Co-occurring Disorders: Integrated Co-Occurring Treatment

32.1 Organizations shall organize their services so that individuals with co-occurring substance abuse and mental health service needs receive treatment in an integrated manner.

32.1.1 The organization shall develop and implement policies and procedures that ensure that persons with co-occurring disorders receive services according to evidence-based practice standards.

32.2 The following elements shall be in place in any specialized treatment program that serves individuals with co-occurring mental health and substance-related disorders.

32.2.1 Persons with co-occurring disorders shall receive services from staff with knowledge, skills, and qualifications to provide both mental health and substance abuse services.

A. Fifty percent (50%) of direct care staff will meet the following qualifications: CCDP-D, CCDP, or dual licensure in both Mental Health and Addictions.

32.2.2 Psychoeducational components of treatment shall address both disorders.

32.2.3 A psychiatrist shall be available on site or through consultation.

32.2.4 When applicable, medication management shall be integrated into the treatment plan.

32.2.5 Interventions to treat both disorders shall be included in the person's individualized treatment plan.

32.2.6 All interventions shall be consistent with and determined by the individual's stage of treatment or stage of readiness to change.

32.2.7 Group treatment shall be specifically designed to address both mental health and substance abuse issues.

32.3 The following elements, in addition to the above, shall be in place in any treatment program that serves individuals with co-occurring disorders who receive Community Support Services.

32.3.1 Individuals shall receive integrated services from a staff person who has the knowledge and skills to treat both disorders or from a multidisciplinary team that consists of two or more clinical staff who have the knowledge and skills to treat both disorders (e.g. CCDP-D, CCDP, or an individual dually licensed in both Mental Health and Addictions).

32.3.2 Comprehensive services, to include residential options, assertive community treatment, and supported employment services, shall be available and accessible for persons receiving integrated dual diagnosis treatment.

32.3.3 Individuals shall receive services on a long-term basis with the intensity modified according to level of need and degree of recovery.

32.3.4 Outreach to the person served and to members of his or her support network shall be conducted, as needed, to maintain the person's connection to services and to assist him or her to access community resources.

32.3.5 Counseling services shall be provided to help the person manage his or her symptoms and to pursue recovery with a lifestyle free from alcohol and other drugs.

32.3.6 Services shall include social support interventions to strengthen the person's social environment.

32.3.7 Family members and significant others, as appropriate, shall be provided education about both disorders.

32.3.8 To prevent relapse, individuals shall receive assistance to participate in self-help programs in the community.

32.3.9 Specific interventions to promote the individual's physical health shall be included in each person's treatment plan.

Section 33.0 Case Management and Community Psychiatric Supportive Treatment

Case management services provide the supportive assistance an individual needs to attain the goals of his or her behavioral health treatment plan and to access medical, social, educational, and other services essential to meeting basic human needs.

Community psychiatric supportive services provide goal-oriented and individualized treatment for the persons served through assessment, planning, treatment, support, linkage, advocacy, coordination, and monitoring activities. The intensity and frequency of the service, as well as its location, is based on the individual needs of the person. These services may be provided by individual staff or by teams who, through a supportive relationship(s), promote the individual's recovery.

33.1 Organizations offering case management and/or community psychiatric supportive treatment shall ensure that the following services are available and provided according to the specific needs and choices identified in the individualized treatment plan of the person served:

33.1.1 Assistance necessary for the person to attain the goals of his or her individualized plan for recovery.

33.1.2 Ongoing assessments and review of supports and services to ensure the continuing availability of required services.

33.1.3 Counseling, support, and treatment services identified in the person's individualized treatment plan.

33.1.4 Assistance in further developing the competencies the person needs to increase his or her social support network and to minimize social isolation and withdrawal brought on by behavioral health issues.

33.1.5 Assistance in the development and implementation of a plan for accessing benefits and entitlements and for assuring income maintenance.

33.1.6 Assistance with securing and maintaining employment in an appropriate setting.

33.1.7 Assistance with engaging in personally meaningful activities, to include educational pursuits and volunteer work.

33.1.8 Assistance in developing and maintaining tobacco, alcohol, and other drug-free lifestyle.

33.1.9 Assessment of current housing situation and cost and assistance in accessing and maintaining safe and affordable housing.

33.1.10 Assistance in accessing necessary health care.

33.1.11 Assistance in developing the skills to self-manage his or her illness.

33.1.12 Assistance in accessing needed self-help and peer support services.

33.1.13 Assistance in learning specific skills and abilities related to effectively functioning in each major life area.

33.1.14 Assistance in locating and effectively utilizing all necessary community services in the medical, social, legal, and behavioral health areas and ensuring that all services are coordinated.

33.1.15 Development of a pre-crisis treatment plan and assistance in crisis intervention and stabilization as needed.

33.1.16 Coordination with other providers to monitor the person's health status, medical conditions, and his or her medications and potential side effects.

33.2 Staff shall provide or help the individual access the services identified in the person's individualized treatment plan.

33.3 Families, significant others, and collaterals shall participate in case management and CPST services with the written authorization of the person served.

33.4 When the person is in need of, but avoiding treatment, outreach is conducted to encourage the person's participation in treatment.

33.5 All case management and CPST services are carried out in partnership with the person served.

33.6 All staff providing case management and CPST services shall receive training regarding the community resources relevant to the people they serve.

33.7 Staff providing CPST shall, at a minimum, be a Registered Nurse or have an Associate's Degree in a human service field.

33.8 Clinical supervisors of case management or CPST services shall have, at a minimum,

33.8.1 Qualifications listed in regulation 9.10

---- or ----

33.8.2 Bachelor’s Degree in a relevant human service field and have a minimum of three (3) years full time experience providing behavioral health services to the population served.

Section 34.0 Intensive Outpatient Services

Intensive Outpatient Services are interventions of greater frequency and intensity than General Outpatient or routine Community Support Services that are provided to individuals at risk of a relapse or an escalation of their illness.

34.1 Organizations providing intensive outpatient services shall, at a minimum, develop and implement policies and procedures describing:

34.1.1 Admission, continuing care, and discharge criteria

34.1.2 Best practice standards for services provided

34.1.3 Mechanisms for providing services in the frequency and intensity appropriate to an individual's needs and treatment goals.

34.2 ASAM-PPC guidelines shall be considered when providing services for persons with substance abuse and/or dependence diagnoses.

34.3 The regulations in 34.3 apply to intensive outpatient (IOP) substance abuse treatment programs:

34.3.1 A minimum of nine (9) hours per week of skilled treatment services shall be provided for each person served.

A. Individuals shall participate in no less than one (1) individual counseling session per week and in a group counseling session on a daily basis unless such participation is deemed detrimental to the individual or to others in the group.

B. Services beyond the minimum shall be provided in amounts, frequencies, and intensities appropriate to the individual's needs and treatment goals.

C. When mental health services are needed, they shall be provided in an integrated manner with substance abuse services.

34.3.2 The initial treatment plan for each person served shall be developed within fourteen (14) days of his or her admission to the program. (If an individual has been referred from an inpatient-residential rehabilitation service, the referring agency's treatment plan may be utilized on a preliminary basis.)

A. Treatment plans shall be reviewed at least weekly during the individual's enrollment in the program, and revised as goals are accomplished or new treatment issues arise. Such reviews shall be documented in the progress notes and on the treatment plan.

34.3.3 An interdisciplinary team of addiction treatment professionals shall staff the IOP.

A. Program staff shall have sufficient cross-training to understand the signs and symptoms of mental disorders and to understand and explain the uses of psychotropic medications and their interactions

with substance-related disorders (e.g. CCDP-D, CCDP, or an individual dually licensed in both Mental Health and Addictions).

34.4 CMHC's shall ensure that intensive outpatient services are available, as needed, for all persons served.

Section 35.0 Rhode Island Assertive Community Treatment (RIACT-I)

RIACT-1 is an intensive outpatient program that provides a comprehensive range of rehabilitation and support interventions to persons with severe and persistent mental illness to enable them to live autonomous, safe, and healthy lives in their natural community environments. Many individuals served in this program have co-occurring substance abuse disorders, are homeless, or are involved with the judicial system.

35.1 Criteria for eligibility for RIACT-I services shall be determined by the Director.

35.1.1 The RIACT-I program shall be available, as needed, to all individuals who meet the eligibility criteria.

35.1.2 The BHO shall have the eligibility criteria clearly stated in the RIACT-I Program's written policies and procedures.

35.2 RIACT-I services shall not be time limited.

35.2.1 Discharge from the RIACT-I Program shall occur when a person served:

A. Moves outside of the team's geographic area of responsibility.

1. In such cases, the RIACT-I Team shall arrange for the transfer of mental health service responsibility to a provider in the service area to which the individual is moving, whether that be in Rhode Island or out-of-state. The RIACT-I program shall maintain contact with the individual until this service transfer is implemented.

B. Demonstrates an ability to function in all major role areas (work, social, and self-care) without requiring assistance from the program.

1. This shall be determined by both the person served and program staff.

C. Requires a more intensive level of service.

35.2.2 Documentation of all discharges shall be in accordance with all applicable rules and Regulations herein.

35.3 Each RIACT-I program shall have the organizational ability to provide a staff-to-person served ratio of at least one (1) full-time staff person (excluding psychiatry) to no more than ten (10) persons served.

35.4 To be certified as a RIACT-I program, the program shall employ a minimum of ten (10) and a maximum of sixteen (16) full-time equivalent staff persons (plus psychiatry).

35.5 The following minimal staffing configuration must be met in each RIACT-I program:

35.5.1 Full-time Team Leader who serves as the clinical supervisor of the team and has had prior supervisory experience or training and, at a minimum, one (1) of the following qualifications:

A. Master's Degree in a behavioral health field with at least one (1) year full-time experience treating the population served
--- or ---
B. Registered nurse with a minimum of two (2) years full-time experience treating the population served
--- or ---
C. Individual in a relevant Master's Degree program who shall complete work on such degree within one (1) year of appointment and has at least two (2) years full-time experience treating the population served.
---or---
D. Certified Co-Occurring Disorder Professional-Diplomate

35.5.2 Full or part-time Psychiatrist to provide at least five (5) hours of psychiatric services per week for every thirty (30) persons served.

A. The psychiatric services shall include face-to-face contact with persons served, consultation to team staff, participation in regularly scheduled treatment planning meetings, and participation in, on average, two (2) daily organizational meetings per week

35.5.3 At least two (2.0) FTE registered nurses. A Team Leader who is a registered nurse cannot replace one of these two (2) FTE's.

35.5.4 One (1) or more staff designated for the role of employment specialist. Qualifications for this position are:

A. A relevant Master's Degree or a certificate as a career development facilitator
--- or ---
B. A relevant Bachelor's Degree with at least one (1) year full-time experience in a program or environment providing supported employment or related services for individuals with a physical or mental disability
--- or ---

C. A relevant Associate's Degree with at least two (2) years full-time experience in a program or an environment providing supported employment or related services for individuals with a physical or mental disability.

D. Supported Employment Professional Certification may replace one (1) year of experience in the above qualification requirements

35.5.5 At least fifteen percent (15%) of the program staff shall be qualified as Substance Abuse Specialists. Minimum qualifications for these positions are:

A. Master's Degree in mental health or a related field and at least one (1) year full-time experience providing substance abuse treatment
--- or ---
B. Licensed Chemical Dependency Professional (LCDP), or Certified Co-Occurring Disorder Professional-Diplomate, or Certified Co-Occurring Disorder Professional;
--- or ---
C. Provisional Chemical Dependency Professional working toward license as a Chemical Dependency Professional or Provisional Certified Co-Occurring Disorders Professional working towards Co-Occurring Disorder Professional, in compliance with the requirements as written by the Rhode Island Board for Certification of Chemical Dependency Professionals.

35.5.6 All remaining staff shall have achieved at least an Associate's Degree in a human service field.

35.5.7 At least seventy-five percent (75%) of the total non-medical positions in 35.5.1, 35.5.4, 35.5.5, and 35.5.6, shall have a Bachelor's Degree in a human service field.

35.5.8 At least twenty percent (25%) of the total staff in 35.5.1, 35.5.3, 35.5.4, 35.5.5, and 35.5.6, shall also have at least a Master's Degree in a mental health or related field (e.g., social work, psychology, rehabilitation counseling, nursing, occupational therapy, chemical dependency).

35.6 At least eighty percent (80%) of the total staff in 35.5.1, 35.5.3, 35.5.4, 35.5.5, and 35.5.6, shall be full-time employees of the program. Any part-time employees shall work no less than half-time in the program.

35.7 Programs that have a total number of persons served requiring a staff configuration that exceeds ten full-time positions shall increase the number of supervisory, psychiatry, nursing, employment, and other staff positions commensurate with the requirements outlined in 35.5.

35.8 The RIACT-I program shall be available to provide treatment, rehabilitation, and support services seven (7) days per week, 365 days a year and shall operate a minimum of twelve (12) hours per day on weekdays and eight (8) hours per day on weekends and holidays.

35.9 During all off-hour periods, RIACT-I program staff who are experienced in the program and skilled in crisis intervention procedures, shall be on-call and available to respond to persons served by telephone or in person, as needed, in the event that the existing emergency services program cannot respond. RIACT-I staff are expected to handle all crisis calls during all times that the program is operating.

35.9.1 Psychiatric back-up shall also be available during all off-hour periods. If availability of the RIACT-I program psychiatrist during all hours is not feasible, alternative psychiatric back-up must be arranged.

35.10 The RIACT-I program shall have the capacity to provide multiple contacts per day or per week to persons served who are experiencing severe symptoms and/or significant problems in daily living.

35.10.1 The RIACT-I program shall have the capacity to increase the service intensity for a person served within hours of his or her status requiring it. In such cases, supplemental services may be provided through arrangements with the emergency services program of the organization.

35.11 Each person served in the RIACT-I program shall receive at least one (1) hour of service each week within a total of, at least, eight (8) hours of service each month. If this requirement is not met, an explanation must be documented in the person's treatment record.

35.12 The RIACT-1 Team shall provide seventy-five percent (75%) of service contacts in the community, in non-office, non-facility-based settings and shall maintain records to verify this level of service provision.

35.13 Each person served shall be assigned an Individual Treatment Team (ITT) comprised of specific staff members who have the appropriate range of clinical and rehabilitation skills to meet the individual's recovery needs.

35.13.1 Each ITT shall include a primary clinician, the psychiatrist, a registered nurse, and other staff (usually 2-3) assigned according to the expertise required to assist the individual in attaining his or her treatment goals.

35.14 Each person entering the program shall have an introductory meeting with the team psychiatrist within fourteen (14) business days prior to admission or five (5) business days after admission to the program. The purpose of this meeting is:

35.14.1 To identify urgent issues that need to be addressed;

35.14.2 To gather information that will form the basis of the psychiatric assessment and be used to provide clinical guidance to the team while the comprehensive assessment is being completed.

35.15 The Team Leader or designee, who meets the qualifications in 35.5.1, shall conduct an initial assessment and develop a thirty (30) day treatment plan at the time of the person's admission to the RIACT-1 Program.

35.16 A comprehensive biopsychosocial assessment shall be completed within thirty (30) days after the person's admission and shall be conducted in the following manner:

35.16.1 Each assessment area shall be completed by RIACT-I staff with the skill and knowledge to address the area being assessed.

35.16.2 All available information, including but not limited to, self-reports, reports of family members and other significant parties, and written summaries from other agencies shall be considered.

35.17 Reviews, updates, and subsequent assessments shall be conducted by members of the ITT.

35.18 An individualized treatment plan shall be developed for each person served.

35.18.1 The treatment plan shall be developed at a treatment planning meeting attended by an appropriate mix of RIACT-1 staff working that day, including, at least, the primary provider; psychiatrist; team leader; representatives from each of the major disciplines, including nursing, vocational, and substance abuse; and any other team member providing significant service to the individual.

35.18.2 The person served shall be invited to participate in the Treatment Planning Meeting and shall be provided the support needed for him or her to actively engage in the planning process.

A. With the permission of the person served, RIACT-I staff shall also involve other pertinent agencies and members of the person's family and social network in the formulation of the treatment plan.

B. The completed treatment plan shall be validated by the signatures of the person served, the team psychiatrist, and the team leader or his or her designee who meets the qualifications of 35.5.1.

C. If the person served does not participate in the Treatment Planning Meeting, the following must be documented in the individual's treatment record:

1. The reason for the person not participating
2. How the person's preferences are represented on the treatment plan.

35.19 A Pre-Crisis Treatment Plan shall be developed with each person served.

35.20 Each RIACT-I team shall have the capability to provide the following services according to the personal needs and goals identified in each individual's treatment plan.

35.20.1 Clinical case management/community psychiatric supportive services.

35.20.2 Twenty-four (24) hour per day crisis intervention and stabilization services (the team may utilize the organization's emergency program).

35.20.3 Individual supportive therapy with a goal toward the individual's self-management of his or her illness and recovery.

35.20.4 Medication prescription, administration and monitoring

A. Individuals shall be seen by the team psychiatrist at least once every three (3) months.

35.20.5 Integrated Dual Diagnosis Treatment, as described in Section 32 of these Regulations, for all individuals with substance abuse treatment issues.

35.20.6 Supported Employment services as described in Section 36 of these Regulations

35.20.7 Services to assist the individual to regain or attain skills of daily living

35.20.8 Social, interpersonal relationship, and leisure-time skill training

35.20.9 Support services to assist individuals to access community resources

35.20.10 Family psycho education services as described in Section 40 of these Regulations.

35.21 The team shall maintain a written Daily Log. The Daily Log shall provide a roster of all persons currently served by the team, as well as brief documentation of any service contacts which have occurred during the last twenty four (24) hours, and a concise, behavioral description of each person's daily status.

35.22 The team shall maintain a written Weekly Contact Schedule containing all planned service contacts that staff must carry out to enable each person served to achieve the goals and objectives in his or her treatment plan. The time, date, defined interventions, and staff assigned shall be specified for each contact on the schedule.

35.22.1 A central file of all Weekly Contact Schedules shall be maintained.

35.23 On a daily basis, the team shall develop a written Daily Team Assignment Schedule that lists all planned contacts transferred from the Weekly Contact Schedule.

35.24 Each team shall conduct an organizational clinical staff meeting five (5) days per week. These meetings shall be held at regularly scheduled times according to a schedule established by the Team Leader and shall occur during the weekdays when maximum numbers of staff are present.

35.24.1 The meeting shall begin with a review of the Daily Log, which updates staff on the service contacts from the prior day and provides a systematic means for the team to assess the day-to-day progress and status of each person served.

35.24.2 The meeting shall include a review of the Daily Team Assignment Schedule to cover the period until the next clinical staff meeting. During the meeting, the Team Leader or designee shall assign staff to carry out the interventions scheduled to occur during that period.

35.24.3 The meeting shall also be used as a formal opportunity to revise treatment plans as needed; plan for emergency/crisis situations; and add service contacts to the Daily Team Assignment Schedule per the revised or crisis treatment plans.

35.25 Each RIACT-I Program shall develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services that complies, at a minimum, with all applicable supervision requirements in these Regulations. The Team Leader and/or designee(s), who meet the qualifications in 35.5.1, shall assume responsibility for supervising and directing all RIACT-I Program services. This supervision and direction shall be documented and shall consist of:

35.25.1 Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with persons served in regularly scheduled or crisis meetings to assess the staff member's performance, give feedback, and/or model alternative treatment approaches.

35.25.2 Regular meetings with individual staff to address issues that cannot be successfully addressed during the daily and treatment planning meetings or during the side-by-side sessions, to develop personnel goals, and to conduct employee evaluations.

35.26 The program shall maintain an up-to-date policies and procedures manual that contains these RIACT-I Regulations and complies with all other appropriate state and federal regulations.

Section 36.0 Rhode Island Assertive Community Treatment-II (RIACT-II)

RIACT-II is a service that integrates a wide range of services including Community Psychiatric Supportive Treatment; Psychiatric Services; and Individual Placement and

Support Services into a single, self-contained program unit. The service is similar to, but less intensive than, RIACT-I.

36.1 All individuals who meet current DBH criteria for Community Support Services are eligible for RIACT-II services. Individuals who both qualified for and received CSP services under the definition in place prior to the date of the implementation of the current definition are also eligible.

36.1.1 The RIACT-II program shall be available, as needed, to all individuals who meet the eligibility criteria.

36.1.2 The BHO shall have the eligibility criteria clearly stated in the RIACT-II Program's written policies and procedures along with a written description of their assessment and assignment process for referring a client for RIACT-II or another CSP service.

36.2 RIACT-II services shall not be time limited.

36.2.1 Discharge from the RIACT-II Program shall occur when a person served:

A. Moves outside of the team's geographic area of responsibility.

1. In such cases, the RIACT-II Team shall arrange for the transfer of mental health service responsibility to a provider in the service area to which the individual is moving, whether that be in Rhode Island or out-of-state. The RIACT-II program shall maintain contact with the individual until this service transfer is implemented.

B. Demonstrates an ability to function in all major role areas (work, social, and self-care) without prompting or monthly contact.

1. This shall be determined by both the person served and program staff.

C. Requires a more intensive level of service.

36.2.2 Documentation of all discharges shall be in accordance with all applicable Rules and Regulations herein.

36.3 Each RIACT-II program shall have the organizational ability to provide a staff-to person served ratio of at least one (1) full-time staff person (excluding psychiatry) to no more than eleven (11) persons served.

36.4 To be certified as a RIACT-II program, the program shall employ a minimum of eleven (11) and a maximum of fourteen (14) full-time equivalent staff persons (plus psychiatry). At least eighty percent (80%) of the total program staff shall be full-

time employees of the program. Any part-time employees, with the exception of psychiatry, shall work no less than half-time in the program.

These certification requirements may be temporarily waived during program start-up.

36.5 The following minimal staffing configuration must be met in each RIACT-II program:

36.5.1 Full-time Team Leader who serves as the clinical supervisor of the team and has had prior supervisory experience or training and, at a minimum, one (1) of the following qualifications:

A. Master's Degree in a behavioral health field with at least one (1) year full-time experience treating the population served
--- or ---
B. Registered nurse with a minimum of two (2) years full-time experience treating the population served
--- or ---
C. Individual in a relevant Master's Degree program who shall complete work on such degree within one (1) year of appointment and has at least two (2) years full-time experience treating the population served
---or---
D. Certified Co-Occurring Disorder Professional-Diplomate

E. This individual may not fill any other specified capacity on the team except to serve as a primary Community Treatment Specialist (CTS).

36.5.2 Full or part-time Psychiatrist to provide at least four (4) hours of psychiatric services per week for every 30 persons served.

A. The psychiatric services shall include face-to-face contact with persons served, consultation to team staff, participation in regularly scheduled treatment planning meetings, and participation in, on average, two (2) daily organizational meetings per week.

B. It is strongly recommended that the psychiatrist be on-site 5 days a week. If this is not possible, the psychiatrist must be on-site for a minimum of 3 days per week and the agency must provide a mechanism to secure psychiatric back-up on the other days. In this context, "on-site" means physically located within the RIACT-II program area.

C. All efforts are to be made to avoid fragmentation of care when the primary psychiatrist is not present or available for treatment issues. In order to maintain continuity of care, the psychiatrist involved with the individual must attend regularly scheduled treatment planning meetings.

36.5.3 At least eighteen percent (18%) of the program staff shall be registered nurses. A Registered Nurse functioning as Team Leader or in any other specialty role may not be counted towards the eighteen percent (18%).

36.5.4 At least twenty-eight percent (28%) of the program staff shall be designated as Rehabilitation Specialists. Rehabilitation staff may not function as either a Clinical Specialist or a Substance Abuse Specialist. Qualifications for this position are:

A. A relevant Master's Degree or a certificate as a career development facilitator
--- or ---
B. A relevant Bachelor's Degree with at least one (1) year full-time experience in a program or environment providing supported employment or related services for individuals with a physical or mental disability
--- or ---
C. A relevant Associate's Degree with at least two (2) years full-time experience in a program or an environment providing supported employment or related services for individuals with a physical or mental disability.

D. Supported Employment Professional Certification may replace one (1) year of experience in the above qualification requirements

36.5.5 The rehabilitation staff shall receive additional supervision from a senior rehabilitation staff person (MA level) who may also, at the discretion of the provider, coordinate rehabilitation services for all Community Support Program clients.

36.5.6 One of the Rehabilitation Specialists must function in the role of a Community Integration Specialist. This individual is expected to have extensive knowledge about community resources and skills in assessing and addressing clients' social needs.

In addition to her/his general rehabilitation responsibilities, the Community Integration Specialist is expected to serve as a resource to other team members in ensuring that the following community integration goals are incorporated into each client's treatment plan according to the client's individual choice, strengths, and needs:

A. Identification of and participation in community activities;

B. Development of a natural support system;

C. Attainment of good communication and relationship-building skills;

D. Access to peer support and psycho-educational group services.

E. All clients for whom employment is appropriate as jointly determined by the client and program staff must have vocational/employment goals in their treatment plans.

36.5.7 At least eighteen percent (18%) of the program staff shall be qualified as Substance Abuse Specialists. One of these staff members must be a Licensed Chemical Dependency Professional (LCDP) or be an LCDP with a Master's Degree or certified as a Co-Occurring Disorder Professional-Diplomate or a Co-Occurring Disorder Professional. Minimum qualifications for the other position within this specialty position shall be:

A. Master's Degree in mental health or a related field and at least one (1) year full-time experience providing substance abuse treatment
--- or ---
B. Licensed Chemical Dependency Professional (LCDP), or Certified Co-Occurring Disorder-Diplomate, or Certified Co-Occurring Disorder Professional.
--- or ---
C. Provisional Chemical Dependency Professional working towards licensure as a Chemical Dependence professional, or Provisional Certified Co-Occurring Disorders Professional working towards Co-Occurring Disorder Professional Certification, in compliance with the requirements as written by the Rhode Island Board for Certification of Chemical Dependency Professionals

36.5.8 One Master's level team member shall have adequate experience and skill to function as a Clinical Specialist who shall provide psychotherapy services, assist with family psychosocial/educational programming, and serve as CTS for those clients who present complex treatment needs. This individual may not assume any other specialty role except that of a CTS for an appropriate number of clients.

36.5.9 At least twenty-eight percent (28%) of the total program staff shall also have at least a Master's Degree in a mental health or related field (e.g., social work, psychology, rehabilitation counseling, nursing, occupational therapy, chemical dependency).

36.5.10 All remaining staff shall have achieved at least a Bachelor's Degree in a human service field; a high school degree with 2 years experience related to their specific job functions, or be a Registered Nurse.

36.5.11 Programs that have a total number of persons served requiring a staff configuration that exceeds eleven full-time positions shall increase the number of supervisory, psychiatry, nursing, employment, and other staff positions commensurate with the requirements outlined in 135.5.

36.6 Minimum/maximum primary Community Treatment Specialist responsibilities shall be assigned according to the following guidelines:

Position	Primary CTS Clients
Team Leader	1-5
RN	1-10
Rehabilitation Specialist	1-7
Substance Abuse Specialist	1-14

36.7 The RIACT-II program shall be available to provide treatment, rehabilitation, and support services six (6) days per week and shall operate a minimum of ten (10) hours per day on weekdays and four (4) hours per day on weekend days. Holiday hours shall be covered through emergency services with at least one RIACT-II staff person available for consultation. Program hours should be adjusted so that staff are available when needed by the client, particularly during the early evening hours.

36.8 During all off-hour periods, RIACT-II program staff who are experienced in the program and skilled in crisis intervention procedures, shall be on-call and available to respond to requests by the existing catchment area crisis intervention staff in the event that the specialized knowledge of the team is required. RIACT-II staff are expected to handle all crisis calls during all times that the program is operating.

36.8.1 Psychiatric back-up shall also be available during all off-hour periods. If availability of the RIACT-II program psychiatrist during all hours is not feasible, alternative psychiatric back-up must be arranged.

36.9 The RIACT-II program shall have the capacity to provide multiple contacts per day or per week to persons served who are experiencing severe symptoms and/or significant problems in daily living.

36.9.1 The RIACT-II program shall have the capacity to increase the service intensity for a person served within hours of his or her status requiring it. In such cases, supplemental services may be provided through arrangements with the emergency services program of the organization.

36.10 Each person served in the RIACT-II program shall receive a total of at least four (4) hours of service each month, preferably, but not necessarily, provided at the rate of one (1) hour per week. If the overall four (4) hour minimum is not met, an explanation must be placed in the person's record.

36.10.1 Each client shall receive at lease one face-to-face psychiatric contact every 3 months, exclusive of those provided during the assessment and treatment planning process.

36.11 The RIACT-II Team shall provide sixty-five percent (65%) of service contacts in the community, in non-office, non-facility-based settings and shall maintain records to verify this level of service provision.

36.12 Each person served shall, within one week of admission to the program, be assigned an Individual Treatment Team (ITT) comprised of specific staff members who have the appropriate range of clinical and rehabilitation skills to meet the individual's recovery needs.

36.12.1 Each ITT shall include the primary Community Treatment Specialist, psychiatrist, a Registered Nurse, and a Rehabilitation Specialist. An additional Master's or senior level clinician *or* substance abuse specialist may be assigned according to the expertise required to assist the individual in attaining his or her treatment goals.

The composition of this team may be modified during the start-up period with prior approval of DBH.

36.13 Each person entering the program shall have an introductory meeting with the team psychiatrist for a psychiatric evaluation. This requirement may be waived at the discretion of the Provider for clients moving from RIACT-I to RIACT-II or if the RIACT-II MD has already completed a psychiatric assessment on the client for another program within the last 180 days which addresses all required components.

36.13.1 Although the requirement for a new complete psychiatric evaluation might be waived, the client should still be seen by the physician within the first 60 days and prior to the initial treatment planning meeting.

36.14 The Team Leader, or a designee who meets the qualifications in 135.5.1, shall conduct an initial assessment and develop a sixty (60) day treatment plan at the time of the person's admission to the RIACT-II Program.

For clients moving from RIACT-I to RIACT-II, a current RIACT-I assessment, in conjunction with a consultation with RIACT-I staff, may be used to develop the 60-day treatment plan.

36.15 A comprehensive bio-psychosocial assessment shall be initiated upon the person's entrance to the program with the initial assessment completed within sixty (60) days of admission. Comprehensive information shall continue to be gathered and documented on an ongoing basis with review and updates completed within sixty (60) days after the person's admission and shall be conducted in the following manner:

36.15.1 Each assessment area shall be completed by RIACT-II staff with the skill and knowledge to address the area being assessed.

36.15.2 The bio-psychosocial assessment shall meet all requirements of the RRS.

36.15.3 Reviews, updates, and subsequent assessments shall be conducted by members of the ITT.

36.15.4. For clients moving from RIACT-I to RIACT-II, a current RIACT-I assessment may be used to meet the initial assessment requirement.

36.16 An individualized treatment plan that is in compliance with all of the requirements of the RRS shall be developed for each person served.

36.16.1 The treatment plan shall be developed at a treatment planning meeting attended by an appropriate mix of RIACT-II staff working that day, including, at least, the primary CTS; psychiatrist; team leader; representatives from the major disciplines, including nursing, rehabilitation, and substance abuse; and any other team member providing significant service to the individual.

The composition of this group may be modified at the discretion of the Provider if representatives from the major disciplines are not present during the start-up period.

36.16.2 The person served shall be invited to participate in the Treatment Planning Meeting and shall be provided the support needed for him or her to actively engage in the planning process.

A. With the permission of the person served, RIACT-II staff shall also involve other pertinent agencies and members of the person's family and social network in the formulation of the treatment plan.

B. The completed treatment plan shall be validated by the signatures of the person served, the team psychiatrist, and the team leader or his or her designee who meets the qualifications of 135.5.1.

C. If the person served does not participate in the Treatment Planning Meeting, the following must be documented in the individual's treatment record:

1. The reason for the person not participating
2. How the person's preferences are represented on the treatment plan.

36.17 A Pre-Crisis Treatment Plan meeting all of the requirements of the RRS shall be developed with each person served.

36.18 Each RIACT-II team shall have the capability to provide the following services according to the personal needs and goals identified in each individual's treatment plan.

36.18.1 Clinical case management/community psychiatric supportive services.

A. Each client shall have a designated Community Treatment Specialist (CTS) who will be responsible for developing and maintaining a strong therapeutic relationship with the client on an ongoing basis whether the client is in the hospital, in the community, or involved with other agencies (e.g., a correctional facility).

36.18.2 Twenty-four (24) hour per day crisis intervention and stabilization services. While the team may utilize the organization's emergency services program after hours, a team member should be available for consultation as necessary.

36.18.3 Individual supportive therapy with a goal toward the individual's self-management of his or her illness and recovery.

A. All new admissions to the team may be allowed to complete any current course of time-limited, disorder-specific therapy for up to 12 visits after admission. This therapy must have begun prior to team admission and the results of same must be integrated into the RIACT-II treatment plan and progress notes.

B. In rare instances, it is permissible for the team to refer a current client out of the program for disorder-specific therapy in unique areas that the team would not be expected to have expertise in (e.g. eating disorders, DBT, etc.). These referrals must be clearly documented in the client record which must also comprehensively address the integration of team and specialty treatment.

36.18.4 Medication prescription, administration and monitoring

A. All RIACT II staff shall assess and document the client's mental illness symptoms and behavior in response to medication and shall monitor for medication side effects on a routine basis as a result of their day-to-day contacts.

36.18.5 Integrated Dual Diagnosis Treatment, as described in Section 32 of these Regulations, for all individuals with substance abuse treatment issues.

36.18.6 Community Integration Services including, but not limited to Supported Employment, Supported Education and Psychiatric Rehabilitation as described in Section 36 of these Regulations

A. It is permissible to refer a client out to ORS services if necessary in order to facilitate reaching an employment/vocational goal.

36.18.7 Family psycho-education services as described in Section 40 of these Regulations

36.19 The team shall maintain a written Daily Log. The Daily Log shall provide a roster of all persons currently served by the team, as well as brief documentation of any service contacts which have occurred during the last twenty four (24) hours, and a concise, behavioral description of each person's daily status.

36.20 The team shall maintain a written Weekly Contact Schedule containing all planned service contacts that staff must carry out to enable each person served to achieve the

goals and objectives in his or her treatment plan. The time, date, defined interventions, and staff assigned shall be specified for each contact on the schedule.

36.20.1 A central file of all Weekly Contact Schedules shall be maintained.

36.21 On a daily basis, the team shall develop a written Daily Team Assignment Schedule that lists all planned contacts transferred from the Weekly Contact Schedule.

36.22 Each team shall conduct an organizational clinical staff meeting five (5) days per week. These meetings shall be held at regularly scheduled times according to a schedule established by the Team Leader and shall occur during the weekdays when maximum numbers of staff are present.

36.22.1 At least one meeting per week shall begin with a review of the entire Daily Log, which updates staff on the service contacts from the prior day and provides a systematic means for the team to assess the day-to-day progress and status of each person served by the team.

The remaining meetings may, at the discretion of the Team Leader, review only the clients who received services on the prior day and those who are scheduled for services on the day of the meeting.

36.22.2 The meeting shall include a review of the Daily Team Assignment Schedule to cover the period until the next clinical staff meeting. During the meeting, the Team Leader or designee shall assign staff to carry out the interventions scheduled to occur during that period.

36.22.3 The meeting shall also be used as a formal opportunity to revise treatment plans as needed; plan for emergency/crisis situations; and add service contacts to the Daily Team Assignment Schedule per the revised or crisis treatment plans.

36.22.4 All available staff must be physically present for the weekly comprehensive meeting. Staff may be allowed to telecommute for the remaining meetings at the discretion of the Team Leader.

36.23 Rehabilitation Specialists shall meet weekly at which time they will share information about clients; do group case review and problem solving; and receive group supervision by a senior rehabilitation specialist and the RIACT-II team leader

36.24 Each RIACT-II Program shall develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services that complies, at a minimum, with all applicable supervision requirements in these Regulations. The Team Leader and/or designee(s), who meet the qualifications in 135.5.1, shall assume responsibility for supervising and directing all RIACT-II Program services. This supervision and direction shall be documented and shall consist of:

36.24.1 Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with persons served in regularly scheduled or crisis meetings to assess the staff member's performance, give feedback, and/or model alternative treatment approaches.

36.24.2 Regular meetings with individual staff to address issues that cannot be successfully addressed during the daily and treatment planning meetings or during the side-by-side sessions, to develop personnel goals, and to conduct employee evaluations.

36.25 The program shall maintain an up-to-date policies and procedures manual that contains these RIACT-II Regulations and complies with all other appropriate state and federal regulations.

Section 37.0 Community Integration Programs & Services

Community Integration Services (CIS) are designed to help persons with behavioral health needs to optimize their personal, social, and vocational competency in order to live successfully in the community. Included are services presently known as Vocational Rehabilitation, Psychosocial Rehabilitation, Supported Employment, Supported Education, and other community-based rehabilitation services. Community Integration Services may be provided as a separate program within an organization, or as core services and interventions provided as an integral component of another established program, (e.g., RIACT, Residential, Clubhouse, etc.). The persons served are active partners in all aspects of such programs and the services are designed around their needs and desires and are responsive to their expectations.

37.1 Organizations providing community integration services shall operate such services according to the following standards:

37.1.1 Services shall be specifically designed to promote and support an individual's engagement in meaningful activity and supportive relationships.

37.1.2 The services and programming shall be designed to foster and facilitate an individual's recovery.

37.1.3 The services shall be delivered as 1-to-1 (one (1) staff person with one (1) individual served) and/or within structured and unstructured group formats. Individuals shall be given a choice of available service delivery options.

A. Documentation of structured and unstructured group services in CIS shall be recorded for each person served in a per contact or monthly progress note.

37.1.4 The individual's community integration goals shall be established during the individualized treatment planning process.

A. An individual's community integration goals and interventions shall be coordinated with all other services he or she receives and shall be included in his or her comprehensive treatment plan.

B. The rehabilitation goals and objectives shall be updated/changed as needed, with reviews of the plan conducted at least every six (6) months.

37.1.5 Services shall be provided by specially trained and qualified staff, who, as part of the individual's clinical treatment team, share an equal responsibility in the treatment planning process.

37.1.6 Assignment of primary case management or CPST responsibilities to CIS staff shall be avoided, when possible, in order to maintain focus on the provision of community integration services.

37.1.7 Services shall be provided during hours that best serve each individual's needs.

37.2 The specialized assessment for Community Integration Services shall, at a minimum, include a detailed description of the individual's:

37.2.1 Interests and aspirations
37.2.2 Preferences
37.2.3 Experiences
37.2.4 Resources
37.2.5 Strengths
37.2.6 Limitations
37.2.7 Goals

37.3 Supported Employment Services shall adhere to the core values of the Rhode Island Supported Employment Elements in Appendix I.

37.4 Supported Employment Services shall, at a minimum, include the provision of:

37.4.1 Job seeking skills training;
37.4.2 Job development and job matching services;
37.4.3 Job coaching;
37.4.4 Follow-along supports;
37.4.5 Benefits counseling;
37.4.6 Referral to the Office of Rehabilitation Services;
37.4.7 Career counseling and training;
37.4.8 Referral to other community resources that provide employment assistance;
37.4.9 Planning for transportation necessary to gain or keep employment.

37.5 Supported Education Services shall, at a minimum, assist an individual with the following:

37.5.1 Planning for, and applying to GED and post-secondary educational programs and opportunities;
37.5.2 Researching and applying for financial aid;
37.5.3 Accessing the disability services of the educational institution;
37.5.4 Planning for transportation necessary for attaining educational goals;
37.5.5 Implementing follow-along supports to include on-site and/or off-site supports
37.5.6 Referral to other community organizations that will support the individual's educational goals.

37.6 Psychosocial /Psychiatric Rehabilitation Services shall, at a minimum, support, facilitate, and/or provide the following services for persons served:

37.6.1 Opportunities for participation in social/leisure activities to minimize social isolation and withdrawal brought on by behavioral health issues.

37.6.2 Activities and services that promote the establishment and maintenance of peer relations and supports.
37.6.3 Skill training that helps sustain successful community integration.
37.6.4 Referral to and support of participation in community organizations and activities.

37.7 The organization shall ensure that staff providing community integration services shall, at a minimum, have the following qualifications:

37.7.1 The supervisor or manager shall have a relevant Master's Degree with, at least, two (2) years experience or a relevant Bachelor's Degree with, at least, three (3) years experience in a program and/or environment that provides community integration services or services that are related to the above mentioned service elements.

37.7.2 Direct service staff shall have the qualifications described in 9.13 or 9.14, of these regulations, that are applicable to their specific positions and responsibilities.

Section 38.0 Rhode Island Consumer System of Care

The Rhode Island Consumer System of Care is a recovery-focused model that allows consumers to receive individualized care selected from a menu of services provided by a licensed Rhode Island Behavioral Healthcare Provider. The basic principles of this model consist of empowering consumers and family to participate in treatment, and access to the necessary services to meet treatment needs. In this system, consumers are provided with levels of care in response to clinical needs and presentation. It is expected that consumers

will transition between levels of care in response to progress in recovery, attainment of goals, need for more intensive treatment, and/or client choice.

Consumers from the Community Support Program will be served in this system of care. **This includes all current** CSP consumers and new consumers identified as eligible through the use of the current BHDDH CSP eligibility criteria

BHDDH has adopted the Medicaid Waiver Levels of Care framework to organize the system of care. The Levels of Care are Lowest (Recovery and Prevention), High and Highest.

38.1 Lowest Level of Care: Recovery and Prevention Services:

38.1.1 Consumers appropriate for this level of service are those who may live independently or with minimal supports in the community. Services include supportive psychotherapy/counseling and/or psychiatric medication review.

38.1.2 Consumers in this level of care can be assessed for transition to primary care providers for follow up services. Providers shall continue to respond to these consumers' needs on a consultation basis.

38.1.3 Services may consist of the following based on the individual consumer's needs:

A. Brief counseling
B. Medication Services
C. Supported Employment Services
D. Education Supported Services
E. Minimal Case management of approximately 3-4x's per year.
F. Peer Support Services
G. Available NAMI Support Services

38.1.4 Given current data and trends, it is expected that a MAXIMUM of 15% of all CSP clients will be served in this level of care. The Division of Behavioral Health must receive notice and justification for any deviation from this target.

38.2 High Level of Care

38.2.1 Consumers appropriate for this level of care are those with moderate impairments resulting in a course trajectory that manifests the following:

A. Difficulty securing basic needs
B. Difficulty in carrying out home management tasks
C. Difficulty with employment
D. Difficulty in self-care, grooming, procurement of medical, legal and housing assistance.

38.2.2 Within this level of care consumers are considered to be at moderate risk and should maintain the same primary staff member(s) as their needs

change. The type and intensity of the service provided will vary depending upon the consumers' needs.

38.2.3 Services may include the following based on the consumer's needs:

A. Symptom assessment, illness management and individual supportive therapy to help consumers cope with and gain mastery over symptoms and impairments. (i.e, CBT)
B. Counseling
C. Crisis assessment and intervention
D. Crisis diversion/stabilization programs
E. Medication Services
F. Substance Abuse Services
G. Activities of Daily Living
H. Supported Employment Services
I. Education Supported Services.
J. Social, interpersonal relationships
K. Structuring time and leisure
L. Family psychoeducation
M. Case management to access legal, financial, money management, housing, transportation, etc.
N. Psychiatric Rehabilitation Services
O. Peer Support Services
P. Available NAMI Support services

38.2.4 Given current data and trends, it is expected that most CSP clients will be served in this level of care, approximately 50%. The Division of Behavioral Health must receive notice and justification for any deviation from this target

38.3 Highest Intensity Community Specialty Services

38.3.1 Consumers appropriate for this level of care are defined as having persistent and severe impairments resulting in extreme/marked limited abilities that require brief intermittent or long term interventions to keep behaviors/symptoms from resulting in negative consequences.

38.3.2 The following also more specifically defines this population:

A. Inability to consistently perform routine daily activities i.e. maintain personal hygiene, meeting nutritional needs, or caring for personal business affairs.

B. Inability to consistently maintain a safe living situation (repeated evictions, loss of hosing or no housing) or recognize and avoid common dangers or hazards to self or possessions.

C. Inability to consistently manage self with others (extreme isolation or destructive behavior to self and others).

D. Inability to consistently be employed or carry out the homemaker role (e.g. household meals, washing clothes, budgeting or childcare tasks and responsibilities).

E. Co-Occurring substance use disorder of significant duration or coexisting mental retardation.

F. High risk or recent history of criminal justice involvement (arrest or incarceration).

G. Require daily contacts for assessment, crisis intervention and medication management.

Additionally, the person may have one of the following:

A. High risk for hospital admission or readmission.

B. Prolonged inpatient days (more than 90 days within on calendar year).

C. Repeated (more than three (3) episodes per calendar year) criminal justice involvement.

D. Referred from an inpatient detoxification unit and documented history of co-occurring treatment.

E. Repeated crisis stabilization

38.3.3 Services may include the following based on the consumer's needs:

A. Symptom assessment, illness management and individual supportive therapy to help consumers cope with and gain mastery over symptoms and impairments. (i.e, CBT)
B. Counseling
C. Crisis assessment and intervention
D. Crisis diversion/stabilization programs
E. Medication Services
F. Substance Abuse Services
G. Activities of Daily Living
H. Supported employment Services
I. Education Supported Services.
J. Social, interpersonal relationships
K. Structuring time and leisure
L. Family psychoeducation
M. Case management to access legal, financial, money management, housing, transportation, etc.
N. Psychiatric Rehabilitation Services
O. Peer Support Services

P. Available NAMI Support Services

38.3.4 Given current data and trends, it is expected that a MINIMUM of 35% of CSP clients will be served in this level of care. The Division of Behavioral Health must receive notice and justification for any deviation from this target

A. Clients service in this level will include MHPRR funded services.

38.3.5 This type of service will be able to respond 7 days per week and provide access to 24 hour emergency/crisis intervention services.

38.3.6 Hours are to expand past normal business hours and include weekends and holidays to meet the needs of all clients in all levels of care.

38.4 MHPRR Service within the Highest Level of Care

38.4.1 Eligible consumers are defined as having persistent and severe impairments resulting in extreme persistent disabilities. MHPRR services consist of Residential Services as defined by section 39.0 of the Rules and Regulations for the Licensing of Behavioral Healthcare Organizations. The population consists of consumers who require on-site supervision and support to monitor their activities of daily living skills (ADLS) addressing basic needs such as budgeting, meal preparation, grocery shopping, medication management, and overall coordination and monitoring of their medical and psychiatric treatment needs.

38.4.2 Services may include the following based on the consumer's needs:

A. Symptom assessment, illness management and individual supportive therapy to help consumers cope with and gain mastery over symptoms and impairments. (i.e, CBT)
B. Counseling
C. Crisis assessment and intervention
D. Crisis diversion/stabilization programs
E. Medication prescription administration
F. Substance Abuse Services
G. Activities of Daily Living
H. Supported employment
I. Education supported services.
J. Social, interpersonal relationships
K. Structuring time and leisure
L. Family psychoeducation
M. Case management to access legal, financial, money management, housing, transportation, etc.
N. Psychiatric Rehabilitation Services
O. Peer Support Services
P. Available NAMI Support Services

38.4.3 BHDDH reviews all requests for additional MHPRR residential services.

38.4.4 BHDDH maintains a priority list for MHPRR residential admission.

38.5 Level of Care Process

38.5.1 All relevant forms approved by BHDDH will be used to evaluate levels of care on admission and on 6 month treatment plan reviews. These forms will be used to evaluate appropriateness for the current level or the need to transition to a new level of care.

38.6 Level of Care Standards:

38.6.1 Services within each level of care will provide an integrated treatment approach consistent with the consumer's recovery-focused treatment plan.

38.6.2 Providers will practice elements and principles of evidence based practices including, but not limited to: Individual Placement and Support (IPS), Family Psychoeducation, Assertive Community Treatment (ACT), Co-Occurring Integrated Treatment and Illness Management and Recovery.

38.6.3 Consumers will have access to all of the provider's menu of services to include but not be limited to counseling, substance abuse, case management, supported and transitional employment, nursing, family psychoeducation, psychiatry/medication services etc..

38.6.4 Consumer to staff ratios for each level of care will be submitted to BHDDH and reviewed at liaison meetings.

38.6.5 Staff within each level of care is to have meetings that are utilized to review consumers' needs, those at risk and discussion of consumers to be scheduled that day if needed.

38.6.6 Each level of care will accept all eligible referrals.

38.6.7 Providers will not develop waiting list for the levels of care.

38.6.8 Levels of care will have the flexibility to accept consumers to programs prior to a completion of a full psychiatric evaluation or any internal paperwork requirements that would interfere with a consumer being assigned to a level of care or type of service.

38.6.9 Any CSP consumer with an active or possible DSM Substance Abuse or dependence diagnosis will be assessed by a substance abuse specialist using the ASAM PPC for treatment guidelines. Best practices (i.e. stages of change, motivational interviewing, co-occurring integrated treatment) are to be utilized in the provision of substance abuse treatment.

38.6.10 All CSP consumers will be assumed to have the potential for competitive employment and will be actively engaged in supported employment services unless: they meet age criteria for retirement and choose not to work, or it is documented clearly in a vocational assessment utilizing the principles of the IPS model that the client is not able to work, or the client is competitively employed. In all of these instances there needs to be clear documentation in a vocational assessment that supported employment services are not required.

38.7 Staffing/Competency

38.7.1 Each level of care will have a team leader(s) who serves as the clinical supervisor. Supervisory experience or training at a minimum has one (1) of the following qualifications:

A. Master's Degree in a behavioral health field with at least one (1) year full-time experience treating the population served
--- or ---
B. Registered nurse with a minimum of two (2) years full-time experience treating the population served
--- or ---
C. Individual in a relevant Master's Degree program who shall complete work on such degree within one (1) year of appointment and has at least two (2) years full-time experience treating the population served.
--- or ---
D. Certified Co-Occurring Disorder-Diplomate
--- or ---
E. Upon the adoption and effective dates of these Regulations, an employee who does not meet the qualifications specified here for the particular position he or she currently holds shall be considered a qualified employee under these Regulations for as long as he or she continues to fulfill the responsibilities of that specific position in the organization (BHC 9.16).

38.7.2 Staff competency, training and supervision will follow standards described in Section 9.

38.7.3 Consumers are to have access to all services and qualified staff as described in Section 9.

38.7.4 Consumers will have access to care from qualified staff that can respond with case management or emergency assessment/evaluation 7 days per week.

38.7.5 All providers will have a staff or staff members scheduled 7 days per week to respond to consumers who require a case management or an emergency assessment, regardless of the "Level of Care" defined within this Section.

38.7.6 Record documentation will follow all regulations as identified by the Rules and Regulations for the Licensing of Behavioral Healthcare Organizations (Sections 23 - Section 28.0 are to be followed).

38.7.7 Any consumer who is receiving medication shall be seen at least quarterly by the prescribing physician or prescribing nurse, unless the physician or nurse documents that longer intervals are clinically appropriate. All medication and laboratory services will follow Section 30.

Section 39.0 Supported Housing Services

Supported Housing services assist individuals and families to obtain and/or maintain affordable, safe housing when they may otherwise have difficulty in doing so. The following regulations apply to all CMHC Community Support Programs and to all other organizations that provide supported housing services.

39.1 Organizations that provide supported housing services shall establish and implement policies and procedures to ensure that, at a minimum, the following functions are addressed.

39.1.1 Persons served are assisted in accessing apartments of their choice that are subsidized or affordable according to the person's income.

39.1.2 A community support professional or case manager is designated to assist the individual with his or her community living needs, to include, at least:

A. Overcoming barriers to tenancy;
B. Relationships with neighbors;
C. Relationship with landlord;
D. Adherence to lease requirements;
E. Health and safety issues.

39.1.3 The organization shall assign at least one (1) staff person the responsibility of coordinating with owners and/or property managers to promote the resolution of tenant/landlord disputes and to coordinate lease compliance issues. The name and phone number of this person shall be readily available to persons served.

39.1.4 Persons receiving supported housing services shall include in their individualized treatment plans all services he or she needs to sustain successful housing and to attain recovery.

A. Treatment plan reviews shall be conducted to determine if the intensity of supports is sufficient to assist the individual in maintaining his or her housing.

Section 40.0 Residential Services

Residential programs operate twenty-four (24) hours a day, seven (7) days per week providing services and supervision to designated populations. Services promote recovery and empowerment and enable individuals to improve or restore overall functioning. These regulations apply to all behavioral health programs that provide twenty-four (24) hour supervised housing and treatment.

40.1 Each residential program shall have on-site policies and procedures that describe admission, continuing care, and discharge criteria specific to the type of residential setting.

40.2 An initial assessment, indicating the need for twenty-four (24) hour supervised care, shall be completed for each person admitted to the program.

40.3 A Psychiatric Rehabilitative Residence Personal Care Checklist (Appendix II) shall be completed within seven days of an individual's admission to a mental health residential program.

40.3.1 The assessment shall include all areas outlined in the Checklist and shall be conducted by staff with specific skills and knowledge in the area being assessed.

40.3.2 The Checklist shall be authorized and signed by the treating psychiatrist.

40.3.3 Areas on the Checklist that require assistance or monitoring shall be addressed on the individual's treatment plan.

40.4 A physical health assessment, including a medical history and physical examination, shall be completed by a qualified medical, licensed, independent practitioner, within one (1) week after admission to a residential program.

40.4.1 If a comprehensive medical history and physical examination have been completed within thirty (30) days before admission to the program, a durable, legible copy of this report may be used in the treatment record as the physical assessment, but any changes to the individual's condition must be recorded at the time of admission.

40.5 Within seven (7) days of admission, a comprehensive treatment plan shall be completed with each resident and, as appropriate, his or her family.

40.5.1 The treatment plans and treatment plan reviews of each resident of a mental health residential program must be signed by the psychiatrist who is treating the resident.

40.6 Each supervised apartment residential program shall serve no more than three (3) residents per apartment unit and each resident shall have his or her own, individual

bedroom. The supervised apartments shall be comprised of no more than twelve (12) apartment units excluding any single apartment unit designated as a "staff apartment" and/or office space. The configuration of units, in total, shall serve no more than twelve (12) individuals.

40.6.1 All apartment units must be either in the same building and/or same apartment complex and/or same condominium association and/or same contiguous block.

40.6.2 A staff person must be able to be present in any individual apartment unit within five (5) minutes of receiving an alert or a request regarding a resident of an apartment. This includes third shift "sleep over" staff if they are utilized by the program.

40.6.3 All apartment units shall have an accessible working telephone.

40.6.4 Each supervised apartment program shall implement smoking regulations that include the following:

A. Smoking shall be strongly discouraged in any sleeping room.

B. Staff shall strongly encourage that smoking be limited to only one (1) area of each apartment unit.

C. Ashtrays of noncombustible material and safe design shall be provided where smoking occurs.

D. Metal containers with self-closing cover devices into which ashtrays may be emptied shall be provided and readily available where smoking occurs.

E. Each resident who smokes shall receive special smoking fire safety instruction and this instruction shall be documented in the resident's treatment record.

40.6.5 Reasonable accommodations and individually tailored support services shall be made available to all residents in supervised apartment programs including, but not limiting to the following.

1. The provision of specialized safety equipment such as irons, stoves, and other equipment that shut off when unattended.

2. The availability of one to one (1:1) staffing for periods of time when a resident is in crisis.

40.6.6 All buildings that house supervised and residential apartment programs shall meet the requirements of the applicable standards of the Rhode Island Fire Safety Code.

40.7 The service elements offered by a residential program shall include but not be limited to the provision of or linkage to the following based on each resident's individualized treatment plan:

40.7.1 Behavioral health therapeutic and rehabilitative services necessary for the resident to attain recovery
40.7.2 Individual, group, and family counseling
40.7.3 Medication prescription, administration, education, cueing and monitoring
40.7.4 Educational activities (appropriate to age and need)
40.7.5 Behavioral Management
40.7.6 Menu planning, meal preparation, and nutrition education
40.7.7 Skill training regarding health and hygiene
40.7.8 Budgeting skills training and/or assistance
40.7.9 Crisis intervention
40.7.10 Community and daily living skills training
40.7.11 Community resource information and access
40.7.12 Transportation
40.7.13 Social skills training and assistance in developing natural social support networks
40.7.14 Vocational/ Employment services
40.7.15 Coordination with the resident's medical care providers
40.7.16 Cultural/Spiritual Activities
40.7.17 Aftercare/follow-up services
40.7.18 Limited temporary physical assistance, as appropriate

40.8 In addition to essential services each residential program must provide the following for its residents:

40.8.1 A homelike and comfortable setting, that provides the individual adequate space for personal belongings

40.8.2 Opportunities to participate in activities not provided within the residential setting

40.8.3 Regular meetings between the residents and program personnel

40.8.4 A daily schedule of activities

40.8.5 Provisions for review of the individual's treatment goals and progress of these goals

40.8.6 Sleeping arrangements based on individual need for group support, privacy, or independence, as well as, the individual's gender and age

40.8.7 Provisions for external smoking areas, quiet areas, and areas for personal visits

40.8.8 Required training for residents and staff in safety drills, infection control policies, and risk management procedures.

40.9 In accordance with the needs of the individual served, good standards of personal hygiene are taught and maintained, with due regard for privacy.

40.10 All residential programs shall be staffed on-site, twenty-four (24) hours per day, seven (7) days per week as long as there are residents physically present. Staff may be situated in a central location in an apartment program. In all cases, a staff person must be able to be present in any room or apartment unit within five (5) minutes in response to any alert or request regarding a resident.

40.11 During all hours of operation in all residential programs, there are provisions for the availability of at least one (1) individual trained in basic First Aid and in cardiopulmonary resuscitation (CPR).

40.12 Residential facilities shall have policies and procedures that insure compliance with all federal and state laws and regulations pertaining to accessibility, health, fire, and safety.

40.12.1 Residential programs shall maintain the appropriate documentation regarding the testing, maintenance, and monitoring of such laws and regulations.

40.13 Each residential program shall have written policies and procedures for the evacuation of all residents in the event of a fire or other emergency that includes, but is not limited to, the following:

40.13.1 Each residential program shall conduct a test to determine each resident's ability to evacuate the premises within two (2) minutes.

A. Each potential resident shall be tested before he or she is admitted to the program, or within the first 48-hours in the case where an individual is referred from a detoxification or prison setting,

B. Each resident shall be tested at least quarterly. The test may be conducted as part of a fire drill.

C. The tests shall be documented in the resident's record, or in an on-site program record for all residents. The documentation shall include:

1. Name of resident;
2. Type of assistance, if any required;
3. Time required to evacuate from the resident's sleeping quarters;
4. Date and time of the test;
5. Name and title of the person who conducted the test.

D. In the following manner, each resident shall be classified according to his or her ability to evacuate the premises within two (2) minutes in the event of a fire or other emergency:

1. Does not require physical assistance, supervision, or instruction.
2. Does not require physical assistance but does require supervision or instruction.
3. Requires physical assistance.

40.13.2 At least one (1) fire exit drill per shift per quarter shall be conducted in each residential program. At least fifty percent (50%) of such drills shall be obstructed drills, as defined by the state fire/safety regulations.

40.13.3 All program staff shall have fire safety training annually that includes training in the program's emergency evacuation plan.

A. This training shall be documented in each staff person's personnel record.

40.13.4 Each resident shall be trained in, and shall practice, the proper actions to take in the event of a fire. This training shall include actions to take in the event the primary escape route is blocked.

A. This training shall be documented in each resident's treatment record or in a program report for all residents that is kept on site at the residential program.

40.13.5 All smoke detectors shall be checked at least four (4) times per year to ensure their proper operation.

40.14 Substance abuse residential programs shall:

40.14.1 Provide the level and type of service needed by each resident following ASAM-PPC guidelines.

40.14.2 Provide at least five (5) hours per week of individualized, professionally directed treatment for each resident.

40.14.3 Offer family counseling and education services on an as-needed basis.

40.15 Clinical Supervisors of residential staff shall have at a minimum, the qualifications listed in 33.8

40.16 Direct service staff in residential programs shall have, at a minimum, the following qualifications relevant to the service they are providing: at least, a license as a Registered Nurse or an Associate's Degree in Human Service field or a combination of education and prior work or life experience that the organization determines is comparable.

40.16.1 Residential programs promoting their services as a specialty program with co-occurring disorders must have an appropriate ratio or qualified mental health and substance abuse personnel.

40.17 Residential programs that provide substance abuse services shall maintain a written cooperative agreement with a detoxification facility.

40.18 A minimum of two (2) follow-up contact attempts shall be made within six (6) months of each person's discharge from a residential program. (RIGL Section 40.1-24-19).

40.19 Documentation of both successful and unsuccessful follow-up contacts shall be recorded in the treatment record. This documentation shall include at least the following:

40.19.1 Date and time of contact or attempted contact;
40.19.2 Summary of contact (summary of the client's progress or regression);
40.19.3 Reason for unsuccessful contact (if applicable);
40.19.4 Plan for future follow-up contacts (if applicable);
40.19.5 Signature of staff person making the contact.

Regulations 40.20 through 40.25 apply only to Substance Abuse Residential Programs that Serve Minors.

40.20 Substance Abuse residential programs that serve minors shall provide staffing that allows for constant adult supervision at all times and includes the following:

40.20.1 Awake staff coverage twenty-four (24) hours per day

40.20.2 Direct care staff to resident ratio is at least one to ten (1:10) when residents are awake and one to twenty (1:20) when residents are asleep.

40.21 Residential programs that serve minors for more than thirty (30) days, shall provide, or arrange through school districts, an academic and physical education program for each minor within fourteen (14) days of his or her admission.

40.22 Residential facilities and treatment services for minors shall be separate from those provided for the adult population, except for the following minors:

40.22.1 Pregnant minors;
40.22.2 Children of adults undergoing residential treatment.

40.23 Parental consent shall be required for all minors treated in substance abuse residential programs, except as otherwise provided by Rhode Island General Laws section 14-5-4.

40.24 Programs providing services to minors shall comply with Rhode Island General Laws section 11-9-13 pertaining to the purchase, sale, or delivery of tobacco products to persons under the age of eighteen (18).

40.25 Residential programs shall have a written policy regarding staff responsibilities when a minor is absent without permission. The policy shall include:

40.25.1 Immediate notification of the parent(s) or legal guardian(s)

40.25.2 Notification of the proper legal authorities after the minor is absent for twenty-four (24) hours

40.25.3 Documentation in the minor's treatment record of the elopement and of the appropriate notifications as they were completed.

Regulations 40.26 through 40.35 apply only to the Behavioral Health Acute Stabilization Unit.

40.26 **Purpose**: The Behavioral Health Acute Stabilization Unit (BHASU) is a hospital diversion and step down unit for Rhode Island residents eighteen (18) years of age or older who are experiencing a psychiatric and/or substance abuse related crisis. This unit will provide assessment and observation, crisis intervention and treatment for psychiatric, substance abuse and co-occurring treatment.

40.27 **Capacity:** The unit must have access to a minimum of ten (10) beds located in one facility. The maximum capacity that can be located in one facility is sixteen (16) beds.

40.27.1 Ideally, there should be no more than two (2) clients in one (1) room. Exceptions to this policy require prior approval by BHDDH and are limited to allowing one (1) room to have three (3) clients.

40.27.2 A program must have the capacity to supervise clients individually in a room if clinically necessary.

40.28 **Admission Criteria:**

A. Individuals must be eighteen (18) years of age or older and a resident of Rhode Island.

B. Individuals must have the capacity to safely stay in an unlocked facility.

C. Individuals must voluntarily agree to be admitted into the unit.

D. Individuals must be medically stable and receive medical clearance for the transfer by both the referring facility and the BHASU when referred by an emergency room or if being stepped down from an inpatient facility. Disputes regarding medical clearance must be resolved at the physician level.

E. Referrals will only be accepted through an emergency room, or an inpatient facility or a Rhode Island Licensed Behavioral Healthcare provider.

40.29 **Exclusion Criteria:** Clients exhibiting one (1) or more of the following may be excluded from the program at the discretion of the BHASU Program Director.

A. Acute substance intoxication

B. Acute psychosis with evidence of impaired judgment or lack of impulse control as evidenced by psychiatric symptoms of command hallucinations or delusional thinking;

C. Acute mania impairing judgment and impulse control;

D. Gross functional impairment due to vegetative signs of depression such as remaining in bed all day, deterioration of cognitive ability and inability to perform self care;

E. Assaultive ideation, evidenced by threats and likelihood to harm, kill or injure others;

F. Assaultive behaviors evidenced by threats and/or restraining orders combined with the likelihood to act on those behaviors;

G. Active self-injurious behaviors such as head banging, lacerating wrists, and threatening to elope from the unit;

H. Recent suicide attempt with a continued threat or plan to act on suicidal ideation

I. A determination that the client's physical condition is too compromised for the unit to handle despite medical clearance at the point of the original evaluation. This determination must be made at the physician level and documented at the Unit. All refusals based on this item must be reported to BHDDH within forty-eight (48) hours with full documentation being forwarded to the Department upon request.

40.30 Proposed **Length of Stay:** Length of stay will be individualized based on each individual's service needs. A typical stay for diversion programs of this nature is 3-7 days and exceeds fourteen (14) days only on rare occasions.

40.31 **Discharge Criteria:** Clients may be discharged if one (1) or more of the following criteria are met:

A. Treatment issues identified in the treatment plan are resolved;

B. The individual is unable to be safely managed at the unit due to increased severity and intensity of symptoms;

C. The individual is in need of acute medical treatment requiring a hospital setting;

D. The individual is in need of hospital level of care to safely manage the symptoms of detoxification and/or withdrawal;

E. Physical aggression towards staff or other residents;

F. Self abusive behavior, unable to be managed in the unit;

G. Involvement in criminal/antisocial activity while in the program, i.e. stealing, drug use, possession or distribution, threats or intimidating behavior towards others;

H. Crisis is stabilized and client can be referred to less intensive treatment.

40.32 Admission Procedures: The Unit will have the capacity to accept admissions 24-hours a day, seven (7) days a week (24/7). The initial referral will come by phone directly to a person who is either located on site at the unit or is available by phone with direct access to the unit. Delays in dealing with a referral are not expected unless multiple referrals are made simultaneously.

A. The initial phone screening must be supervised by a Licensed Independent Clinician or Practitioner who shall have overall clinical responsibility for the screening process.

B. Upon completion of the phone screening, the unit must have the capacity to finalize the disposition with the referral source within sixty minutes.

C. Once admission is accepted, transportation issues are the responsibility of the inpatient facility/ER and may be billed under Medicaid fee-for-service using standard allowable codes. Unaccompanied transportation by a taxi cab may not be utilized.

D. The Unit RN will contact the referring emergency room to receive the nurse-to-nurse report prior to receiving the admission. The Unit RN will request copies of all pertinent medical information regarding the client including lab work, toxicology results, etc.

E. Individuals will receive a medical pre-screening or physical examination by the unit RN immediately upon arrival at the unit,

F. Once cleared by the unit RN, individuals will undergo a safety check including a trauma-informed search of the client and any belongings that the client brings with them at the time of admission unless clinically contraindicated. The search must be conducted by two (2) unit staff, be culturally sensitive, and include efforts to maximize the information given to the patient; maximize client choice

wherever possible; assume a collaborative and respectful stance; and minimize coercion. A decision to bypass the safety search based on clinical grounds must be authorized by Licensed Independent Clinician or Practitioner supervising the admission.

G. A Licensed Independent Clinician or Practitioner will conduct an initial assessment within 24-hours of admission and collaborate with the individual and treatment team to develop a treatment plan. This assessment should take into consideration any findings of the triage assessment and, if conducted upon the client's arrival to the unit, may replace same.

H. Clients must also receive an orientation to the program, a copy of the Client Rights form, and be informed of all program policies and procedures on admission.

40.33 **Staffing:** The program must be staffed 24/7. This includes on-site coverage at all times by nurses, counselors, and care managers, as well as access to a psychiatrist available to respond within thirty (30) minutes.

40.33.1 The program must have on-site scheduled psychiatry time as required by the client mix at any given time.

40.33.2 Clinical supervisors of residential staff shall have, at a minimum, the qualifications listed in 33.8

40.33.3 All staff providing direct services who are not Licensed Independent Clinicians or Practitioners shall receive clinical supervision on an ongoing basis, as specified under BH Regulation 9.9

40.33.4 During all hours of operation in all residential programs, there are provisions for the availability of at least one (1) individual trained in basic First Aid and in cardiopulmonary resuscitation (CPR).

40.33.5 Required training for staff includes: safety drills, infection control policies, and risk management procedures.

40.34 **Program Description of Services:**

40.34.1 **24 Hour Crisis Services:** All staff will be trained in risk assessment and crisis intervention services. Upon arrival to the program, individuals are to receive a face-to-face initial triage review by a Licensed Independent Clinician or Practitioner to assess acuity, risk status, and client level of need for the interim period prior to a full assessment and development of an initial treatment plan.

4034.2 **Hospital Step Down Services:** The unit must offer step-down services for clients who do not require inpatient hospitalization or detox but who require further stabilization before returning to the community.

40.34.3 **Care Management Services:** Every client on the unit will have an identified care manager. The care manager is responsible for the coordination of care while the client is on the unit and also for insuring that the client has appropriate follow-up appointments upon discharge.

40.34.4 **Psychiatry Services**: The unit must have a psychiatrist available 24/7 to respond to medication orders and any medical concerns. The psychiatrist must also be scheduled to be on-site at the program for psychiatric assessments and medication reviews as required by the specific client mix at any given time.

40.34.5 **Medication Services:** An RN is to be on-site 24/7 for the administration and monitoring or medication.

40.34.6 **Inpatient Psychiatric and Medical Admissions:**

A. The unit will have a staff member meeting the requirements of the Mental Health Law on site 24/7 to facilitate inpatient psychiatric admission from the unit site to an inpatient facility if required.

B. The unit will also have an RN on-site 24/7 to facilitate transfers for medical admissions.

40.34.7 **Evidence Based Co-occurring Treatment Services:** Services will be offered that are evidenced based for individuals with co-occurring treatment needs. Interventions to treat both disorders are to be listed in the treatment plan and implemented by staff with knowledge, skills and qualifications to provide both mental health and substance abuse services.

40.34.8 **Group and Individual Counseling**: All individuals have access to participate in group and or individual counseling as indicated by their treatment needs and treatment plan.

40.34.9 **Discharge Planning:** All individuals will have a discharge plan, which shall be started within 24-hours after admission.

A. Follow up appointments are not to exceed 48 hours for the first

B. Appointment and 14 days for a follow up medication appointment.

C. Individuals are not to simply be given phone numbers to contact as follow-up.

D. Individuals referred to homeless shelters will have scheduled follow up appointments with providers and will also make attempts to have releases signed so that coordination of care between the unit and the homeless shelter can occur.

E. Transportation issues are to be resolved and documented in the individual's record describing how the individual will attend the first appointment. (i.e. family member, self, public transit, staff to transport etc).

F. All discharge plans will be documented and approved by a licensed practitioner of the healing arts.

40.34.10 **Family Psychoeducation and Supportive Services:** Services are available to family members to be involved in treatment planning and discharge meetings. Education, information, and support is to be provided to family members.

40.35 **Residential Regulations not applicable for BHASU**

A. 40.3 - 40.11
B. 40.14 - 40.19

Section 41.0 Community Support Programs

41.1 Each CMHC is required to develop and implement a Community Support Program (CSP) that provides comprehensive services for individuals who need intensive and/or long-term services to attain recovery.

41.2 All CSP services shall be provided in partnership with the person served.

41.3 All CSP services shall assist each person served to attain self-management of his or her illness and recovery.

41.4 Eligibility criteria for CSP services shall be determined by the Director.

41.5 Every CSP shall have written admission, continuing care, and discharge criteria for each service component within the program.

41.6 The organization shall ensure that individuals who meet the eligibility criteria for CSP are afforded access to services without a waiting period for those services.

41.7 The following services shall be provided, directly or by referral, in each CSP:

41.7.1 Biopsychosocial Assessment;
41.7.2 Individual, family, and group counseling and psychotherapy;
41.7.3 Case management/CPST;

41.7.4 Psychiatric evaluation and medication prescription, education, and management;
41.7.5 Integrated Co-Occurring Treatment;
41.7.6 Assertive Community Treatment and/or Intensive Outpatient Treatment;
41.7.7 Family Psychoeducation Services;
41.7.8 Community Integration Services;
41.7.9 Supported Housing;
41.7.10 Residential Services;
41.7.11 Crisis intervention and stabilization;
41.7.12 Peer Support.

41.8 Service providers in the CSP program shall represent, at a minimum, the following disciplines:

41.8.1 Psychiatrists;
41.8.2 Licensed Social Workers, Licensed Mental Health Counselors, or Licensed Marriage & Family Therapist;
41.8.3 Registered nurses;
41.8.4 Licensed Chemical Dependency Professionals, Certified Co-Occurring Disorder Professional-Diplomate, or Certified Co-Occurring Disorder Professional;
41.8.5 Rehabilitation counselors;
41.8.6 Certified Community Support Professionals;
41.8.7 Certified Supported Employment Professionals.

41.9 A staff person, responsible for overseeing all of the individual's services, shall be assigned for each person receiving CSP services.

41.10 A Pre-Crisis Treatment Plan shall be developed and reviewed at least every six (6) months for each person receiving CSP services.

41.11 Individuals with both substance abuse and mental health service needs shall receive integrated ~~dual diagnosis~~ co-occurring treatment.

Section 42.0 Family Psychoeducation

Family Psychoeducation (FPE) services shall be an integral part of every Community Support Program (CSP). Family Psychoeducation is an evidence-based practice that provides families and significant support persons the information required for them to develop increasingly sophisticated skills to effectively support their family member's recovery.

42.1 The organization shall develop and implement policies and procedures that define its Family Psychoeducation Program. These policies shall include but not be limited to the following:

42.1.1 Method of presenting the benefits of FPE to each person receiving CSP services;

42.1.2 Method of informing families of the opportunity to participate in FPE;

42.1.3 The FPE formats available at the organization (single family, multi-family group, etc.,);

42.1.4 The training and qualifications of staff designated to facilitate FPE.

42.2 The elements that shall be operationalized in every FPE include:

42.2.1 The person served, together with his or her family, shall be involved throughout the FPE process.

42.2.2 Families, with the informed consent of the person served, shall be involved as members of the treatment team on a long-term basis.

42.2.3 The family's expectations of the treatment program and their hopes for their family member shall be explored.

42.2.4 Education about the illness of the person served and about general coping skills shall be provided to the person and his or her family.

42.2.5 Problem-solving exercises shall be conducted with the person served and his or her family to address individual issues caused by the illness.

42.2.6 A pre-crisis treatment plan shall be developed with the person served and his or her family.

42.2.7 Staff shall be flexible in meeting the needs of the family and the person served.

Section 43.0 Outpatient Detoxification Services

This section applies to all outpatient detoxification services except opioid maintenance/detoxification programs.

43.1 Each Outpatient Detoxification Program shall have written policies and procedures that include, but are not limited to, the following:

43.1.1 Individuals may be admitted to the program after the program physician conducts a complete physical examination that includes the required blood work and determines the individual to be:

A. Physiologically in need of detoxification from alcohol or other drugs according to current ASAM-PPC criteria

B. At minimal risk for severe withdrawal syndrome.

43.1.2 A biopsychosocial assessment shall be completed and documented within seventy-two (72) hours of an individual's admission to the program.

43.1.3 An initial treatment plan addressing short-term detoxification goals shall be completed within seventy-two (72) hours of an individual's admission.

43.1.4 The program shall have a written policy that documents an affiliation agreement with a community hospital to provide support services in case of a medical emergency related to detoxification.

43.2 Each outpatient detoxification program shall establish medical protocols, under the direction and with the approval of the program's medical director, that shall include, but not be limited to, the following:

43.2.1 Written detoxification protocols shall be established for each substance for which the program provides detoxification services.

43.2.2 Medical protocols shall be implemented by a program physician or other authorized, licensed, medical staff.

43.2.3 All medication shall be administered and dispensed according to individualized treatment plans and medical protocols.

43.3 To ensure that the appropriate rehabilitative services are provided, the person served shall be assigned a primary counselor who will follow the client's progress during detoxification. Such assignment shall be documented in the treatment record.

43.4 All medical, nursing, and counseling staff shall have training in, and have the ability to recognize, medical conditions associated with trauma, illness, and detoxification.

43.5 Each program shall have a designated medical director who has the responsibility for supervising all medical services and who shall be licensed to practice medicine in Rhode Island.

43.6 A registered nurse shall be on site to provide services to individuals who are receiving outpatient detoxification services.

Section 44.0 Medical Detoxification Services

44.1 Medical detoxification programs shall develop and implement policies and procedures that include, but are not limited to, the following:

44.1.1 The program shall have established written admission, continuing care, and discharge criteria.

44.1.2 The program shall have a written agreement with a hospital for transferring individuals in cases of medical emergencies.

44.1.3 There shall be a written physician-approved detoxification protocol or standing detoxification orders for each substance for which the program provides a detoxification service.

44.1.4 There shall be a written policy to address individuals leaving detoxification treatment against the advice of staff. The policy shall include:

A. The person served shall be informed, both verbally and in writing, of the risks of leaving treatment prematurely.

B. The individual shall be provided a list of possible withdrawal danger signs particular to his or her detoxification protocol.

C. The person shall sign an "Against Medical Advice Form".

D. The signature shall be witnessed by a staff member.

1. If the client refuses to sign the "Against Medical Advice Form" the organization staff shall document this on the aforementioned form and sign the form.

44.2 Staffing shall provide twenty-four (24) hour awake on-site care and the program shall be open seven days a week. Adequate staffing levels shall be maintained to admit, treat, and discharge individuals.

44.3 A complete medical history and physical examination shall be performed and documented on each individual within twenty-four (24) hours of admission.

44.4 A biopsychosocial assessment shall be completed and documented within seventy-two (72) hours of admission. Assessments may be reviewed, revised, and updated if the person is readmitted within one (1) year of the first admission.

44.5 An initial individualized treatment plan addressing short-term detoxification goals shall be completed within seventy-two (72) hours of admission. This plan shall be documented in the client's treatment record.

44.6 To ensure that the appropriate rehabilitative services are provided, the person served shall be assigned a primary counselor who will follow the person's progress during detoxification.

43.6.1 Programs shall make every effort, when clinically appropriate, to assign the same counselor if the person is readmitted.

44.7 Staff shall provide a planned regimen of twenty-four (24) hour professionally directed evaluation, care, and treatment services, to include the administration of prescribed medications by medical staff.

44.8 Persons served shall remain in a medical detoxification program for the period of time determined and documented as medically necessary by the program's physician.

44.9 Medical specialty, psychological, psychiatric, laboratory, and toxicology services shall be available within the program or through consultation or referral.

44.10 The program shall have on staff a supervising physician who has responsibility for oversight of all medical and pharmaceutical procedures.

44.11 The program shall have a designated registered nurse, with at least two (2) years full-time experience in substance abuse treatment, who shall be responsible for the general supervision of the nursing staff.

44.12 There shall be no less than one (1) licensed nurse per twenty-five (25) individuals being treated in a detoxification program. One (1) registered nurse shall be on-site in the program at all times.

44.13 All counseling staff in the program shall be licensed chemical dependency professionals or shall be working toward licensure.

44.14 All nurses shall receive annual training in the medical management and supervision of detoxification from alcohol and other drugs. Documentation of such training shall be retained on file and be available for review.

44.15 The program shall conduct on-site training and education for clinical and support staff. The training shall include, but not be limited to, the following:

44.15.1 Appropriate screening protocols and procedures

44.15.2 Use of ASAM-PPC placement and treatment criteria

44.15.3 Medical aspects of substance use, abuse, and withdrawal, especially as it pertains to the acute care setting

44.15.4 Pharmacology in the detoxification program setting

44.15.5 Discharge or continuum of care

44.15.6 Early interventions for individuals at high risk during intoxication and withdrawal

44.15.7 Non-violent crisis intervention

44.15.8 Management of the individual with suicidal ideation.

Section 45.0 Opioid Treatment Programs

This section applies to all public or private opioid treatment and maintenance programs. These programs must also comply with all applicable sections of the General Regulations and with 42 CFR Part 8 (DHHS/SAMHSA, DEA Regulations), and Rhode Island General Laws section 21-28-1 *et seq.* (Uniform Controlled Substance Act), Rhode Island General Laws section 21-28.2-1 *et seq.* (Drug Abuse Control Act), Rhode Island General Laws section 21-28.3-1 *et seq.* (Drug Abuse Reporting System), Rhode Island General Laws section 5-19-1 *et seq*. (Pharmacy Statute), and Rhode Island State Methadone Authority. Programs shall reference the State Methadone Treatment Guidelines/ TIP1 (Treatment Improvement Protocol Series/CSAT) and Buprenorphine Treatment Guidelines.

45.1 Opioid treatment programs (OTPs) shall use only opioid replacement treatment medications that are approved by the Food and Drug Administration, and the Cosmetic Act (21 U.S.C. 355) for use in the treatment of opioid addiction.

45.2 All federal laws and regulations that pertain to the handling of any opioid replacement medication shall apply in these regulations.

45.3 All opioid treatment programs shall be open seven (7) days per week – or have the capacity to arrange for dispensing medication(s) to clients on Sundays or Holidays should the program be closed or have reduced hours. Any such closure or reduction in clinic hours would require pre-approval by the State Opioid Treatment Authority. A closure request or a request to reduce clinic hours shall be made in writing to the State Opioid Treatment Authority.

45.4 Each OTP shall have written policies and procedures describing admission requirements that shall include:

45.4.1 Documentation of a one (1) year history of opioid addiction for persons eighteen (18) years of age and over. Exceptions may be granted by the program physician for applicants who have been released from prison or from chronic care facilities, are HIV positive, are pregnant, and/or have previously been treated for opioid addiction.

45.4.2 For individuals under eighteen (18) years of age, the program must verify a minimum of two (2) prior short term detoxifications or drug free treatment episodes in a twelve (12) month period and must obtain parental or legal guardian's consent.

45.4.3 No person under sixteen (16) years of age may be admitted to an opioid treatment program unless the program has received prior written approval of the admission from the State Methadone Authority.

45.4.4 All women of childbearing potential shall be tested for pregnancy:

A. Before admission to an OTP
B. Before any detoxification or medially supervised withdrawal is initiated.
C. Medical staff shall document test results in the woman's treatment record.

45.4.5 A physical health assessment, including a medical history and physical examination, shall be completed within the first twenty-four (24) hours of a person's admission to the program.

A. This assessment shall include: an assessment of the possibility of: infectious diseases, including HIV, TB, Viral Hepatitis and sexually transmitted diseases; pulmonary, liver, and cardiac abnormalities; dermatological and neurological consequences of addiction; and possible concurrent surgical problems.

B. The assessment shall include laboratory tests, the results of which must be returned no later than fourteen (14) days after admission. The licensee shall ensure that such laboratory tests are completed by licensed facilities which shall comply with all applicable federal and state laboratory licensure and certification requirements. The laboratory tests shall include the following:

1. Tests to determine liver function;
2. Complete blood count and lipid panel; and
3. Screening test for syphilis.

C. If the Medical Director determines that laboratory tests are not clinically indicated at the time of admission, this justification shall be documented in the patient record.

D. Programs are required to check Department of Health's Prescription Monitoring Program for each new admission.

45.4.6 All persons served shall have a drug test upon admission. A specimen positive for opiates is not necessary for admission to an OTP, if other criteria, such as the following, have been satisfied.

A. Individual meets the DSM diagnostic requirements for opiate dependence.
B. Individual is clearly at risk for relapse while receiving services in an abstinence-based program.

45.4.7 Prior to an individual's admission to an OTP, the following information shall be entered into the Department's Substance Abuse Database Central Registration System:

A. The individual's initials (first, middle, last)
B. Date of birth
C. Last four (4) digits of the person's Social Security number
D. Anticipated date of admission
E. Gender.

45.4.8 If the Central Registry is inoperable, prior to admitting any individual, the program shall contact each of the other OTPs in Rhode Island to verify that the individual is not receiving services from another OTP.

A. The documentation of these contacts shall be noted in the individual's treatment record and the OTP shall submit the individual's data to the Central Registry as soon as it is operable.

45.4.9 In emergencies, the program medical director or other qualified physician shall make the clinical judgment as to when opioid treatment is initiated.

45.5 Each OTP shall forward to the Central Registry daily reports on admissions, transfers, and discharges.

45.6 The OTP shall have written policies and procedures regarding drug testing that shall include but not be limited to the following:

45.6.1 All drug testing screen results shall be documented in the person's treatment record.

45.6.2 Required drug tests include screening for the following substances: opiates, methadone, cocaine, benzodiazepines, and substances prevalent in the community as determined by the OTP and the Department. Any additional drug tests ordered at the discretion of the program shall be specific to the individual's treatment needs.

45.6.3 The OTP drug testing policy and procedure shall be approved by the designated State Methadone Authority.

45.6.4 Random drug testing shall be conducted as clinically indicated, but no less than eight (8) times/year while an individual remains in treatment.

45.6.5 Specimens shall be collected in a manner that minimizes falsification and shall be stored in a secure place to avoid substitution.

45.6.6 Testing facilities shall be licensed in Rhode Island pursuant to Rhode Island General Laws section 23-16.2-1 *et seq.* and qualified to do drug testing.

45.6.7 Results of drug testing shall not be used in a punitive manner, but rather, shall serve as one factor in making treatment decisions.

45.6.8 Each OTP shall have its own protocol regarding the increased frequency of drug testing.

45.7 A physician shall determine, and document in writing, the initial dose and schedule to be followed for each individual admitted to the OTP.

45.7.1 Initial doses of methadone shall not exceed thirty (30) milligrams and the total dose for the first twenty four (24) hours shall not exceed forty (40) milligrams, unless the program physician documents in the individual's treatment record that forty (40) milligrams did not suppress opiate abstinence symptoms.

45.7.2 The initial dose and schedule for each person shall be communicated to the licensed medical staff supervising the dispensing of any opioid replacement treatment medication.

45.7.3 Individuals transferring from one OTP to another may receive their daily dose as ordered by the transferring physician after medical personnel at the transferring OTP verify the dose to medical personnel at the new OTP.

45.7.4 Before the initial dose is dispensed, the individual shall complete all screening and admission procedures, except in an emergency or in a courtesy dosing situation, which shall be documented in the treatment record.

45.8 The OTP shall develop and implement the following drug dispensing and administering procedures:

45.8.1 A standardized method that includes the use of identification by photograph shall be implemented to properly identify each individual before any opioid replacement treatment medication is dispensed. A dose shall not be administered or dispensed until an individual is identified and assessed to be medically and clinically appropriate.

45.8.2 The prescribed drugs shall only be administered and dispensed by licensed professionals authorized by law to do so.

45.8.3 Each opioid replacement treatment medication used by the program shall be administered and dispensed in accordance with its approved product labeling.

A. Dosing and administration decisions shall be made by a program physician familiar with the most up-to-date product labeling. Any decision to deviate from the labeling must be documented in the individual's record, along with the rationale for that decision.

45.8.4 The dosage to be dispensed shall be verified with the current dosage ordered. Ingestion shall be observed and documented by the person who administered the opioid replacement treatment medication.

45.8.5 Methadone shall be dispensed in oral form in one dose per container when liquid form is dispensed and in a multiple dose container when tablets are used. Buprenorphine shall be dispensed in sub-lingual tablets.

45.8.6 Pregnancy testing shall be performed monthly for women receiving buprenorphine.

45.8.7 A person's medication may be withheld when the OTP medical staff determines that administration of the dose would not be medically safe based on an assessment of the person.

A. The person shall be informed of the reason for withholding the medication.

B. The person shall be referred for medical treatment indicated.

1. The assessment and all subsequent actions shall be documented in the person's treatment record.

45.9 The OTP shall have a written policy describing procedures to be implemented when a person served needs "Courtesy Dosing" while enrolled in an approved treatment program.

45.9.1 Arrangements for "Courtesy Dosing" shall be made in advance, consistent with federal standards.

45.10 An initial treatment plan shall be completed within the first thirty (30) days of each person's admission to the OTP.

45.10.1 Treatment plans shall be reviewed, revised, and updated every six (6) months.

45.10.2 A new treatment plan shall be developed at least once every twelve (12) months.

45.11 Medical care, including referral for necessary medical service, and evaluation and follow-up of patient complaints must be compatible with current and accepted standards of medical practice. All patients must receive a medical examination at least annually. All other medical procedures performed at the time of admission shall be reviewed by the medical staff on an annual basis, and all clinically indicated tests and procedures shall be repeated. Medical staff shall record the results of this annual medical examination and review of patient medical records in each patient's record. Programs are required to check the Department of Health's Prescription Monitoring Program at each annual physical.

45.12 Rehabilitative counseling services (individual, group, and family) shall be provided by OTP staff and shall be consistent with the individual's treatment plan.

45.13 The type and number of counseling sessions received by each individual in the program shall be based on a clinical assessment of the person's service needs and goals as formulated in the person's treatment plan. Minimum requirements for the scheduling of counseling sessions are as follows:

45.13.1 A minimum of one (1) hour of individual counseling must be provided monthly (in one (1) or two (2) sessions) and shall be documented in the individual's treatment record for the first year of treatment.

45.13.2 Individuals admitted to long-term detoxification services must receive at least two (2) hours of individual counseling each month. Individuals admitted to short-term detoxification services must receive a minimum of four (4) hours of individual counseling each month.

A. Following an individual's detoxification, medical and clinical staff shall determine and document in the person's treatment plan, the type and frequency of counseling necessary.

45.13.3 After the first year of treatment, each person who is participating in group counseling, on at least a monthly basis, shall receive a minimum of one (1) hour of individual counseling every ninety (90) days.

45.13.4 Each individual, who is not participating in group counseling, shall receive at least one (1) hour of individual counseling every thirty (30) days.

45.13.5 An individual who has initiated medically supervised withdrawal shall be re-evaluated to determine the frequency of his or her counseling sessions and that evaluation and subsequent changes to the individual's treatment

shall be documented in his or her record.

45.14 When an individual is transferred to another program within the organization, the individual's treatment record with completed, up-to-date documentation shall be transferred to the receiving program.

45.15 When an individual is transferred to another organization, copies of the following information from the individual's treatment record shall be provided to the receiving organization:

45.15.1 Dosing schedule
45.15.2 Laboratory work and toxicology
45.15.3 Current treatment plan
45.15.4 Discharge summaries

45.16 OTP's shall develop policies and procedures that ensure compliance with federal and state regulations before take-home medication privileges are granted. In addition, prior to advancement to a new take-home phase, programs are required to check the Department of Health's Prescription Monitoring Program. The policies and procedures shall, at a minimum, include the following:

45.16.1 The following treatment schedule shall be implemented:

A. At least a two (2) month probationary period with daily doses of medication ingested under appropriate supervision. During this time the individual must satisfactorily meet all requirements of the program. In the event that a program is closed on a Sunday or Holiday during a patient's two (2) month probationary period, if the patient meets the criteria established by the program and approved by the State Opioid Treatment Authority, the patient may receive one (1) take-home during this period. Written closure requests to the State Opioid Treatment Authority (as required in section 45.3 of these regulations) shall also include written detailed plans containing: patient inclusion/exclusion criteria, patient notification, diversion control, a documented history of take-home safety, and the submission of exception requests. Documentation of appropriateness shall be noted in the patient record.

B. During the first ninety (90) days of take-home privileges, the take-home supply shall be limited to a single dose each week. The individual shall ingest all other doses under appropriate supervision.

C. During the second ninety (90) days, the take-home supply shall be limited to two (2) doses per week.

D. During the third ninety (90) days, the take-home supply shall be limited to three (3) doses per week with no more than two (2) consecutive days supply of medication.

E. After one (1) year the individual may be permitted to reduce attendance to two (2) visits weekly and may be given no more than three (3) consecutive days supply of medication.

F. After two (2) years, the individual may be permitted to reduce program attendance to once weekly and may receive no more than six (6) days take-home supply of medication.

G. After three (3) years, the individual may be permitted to reduce program attendance to two (2) visits monthly and receive no more than a fourteen (14) day supply of medication.

H. After four (4) years, the individual may be permitted to reduce program attendance to once monthly. OTPs are required to inform the State Opioid Treatment Authority of all individuals advanced to this take-home phase.

45.16.2 In an emergency situation or severe illness, individuals may be given up to ten (10) days supply of medication based on the judgment of the OTP physician.

45.16.3 Prior to the initiation of take-home privileges, the following shall be confirmed and documented:

A. The individual shall receive instructions regarding safety. Such instructions shall include but not be limited to, child safety measures and the storage of medications.

B. The individual shall obtain an agency approved locked box for storage of take-home medication.

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45.16.4 Take-home containers shall be labeled with the following:

A. Individual's name;
B. Name and amount of medication;
C. Directions for use, including route of administration;
D. Date issued and date medication is to be taken;
E. Program name and address;
F. Program's telephone number.

45.16.5 Childproof caps shall be used on all take-home bottles of opioid replacement medication.

45.16.6 The OTP physician shall document in the treatment record the rationale for authorizing take-home privileges.

45.16.7 The individuals shall return all take-home containers on their next day of Program attendance. Prior to the person's receiving his or her subsequent dose, bottles shall be inspected to ensure that they are coming from the appropriate person during the appropriate time-period.

45.16.8 The agency shall have a policy regarding the non-return of take-home bottles that includes the interventions to be taken. Should there be a violation of this policy, the documentation required for each incident shall include the following:

A. The person's treatment history at the agency

B. Reason for damage to the label on the container or the person's inability to produce the container

C. Number of repeated occurrences.

45.16.9 Take-home privileges are not allowed during long or short-term opioid detoxification.

45.16.10 Take-home privileges may be revoked by the OTP physician with the rationale documented in the person's treatment record.

45.16.11 Individuals may contest a revocation of take-home privileges through the Concern and Complaint Resolution Procedure.

45.16.12 An OTP must maintain a Diversion Control Plan to ensure quality care while minimizing the diversion of an opioid replacement medication from treatment to illicit use. The plan shall include, but not be limited to, the following:

A. Clinical and administrative continuous monitoring
B. Problem identification, correction, and prevention
C. Accountability to the person and to the community

45.16.13 When buprenorphine is given as a take-home medication, the medically indicated formulation shall be used.

45.17 Each OTP shall have policies and procedures regarding the discontinuation of any opioid replacement medication that include, at a minimum, the following:

45.17.1 The OTP physician shall approve all requests for voluntary withdrawal from an opioid replacement medication.

45.17.2 All withdrawal schedules shall be determined on an individual basis and each individual's progress shall be monitored by OTP staff.

A. Withdrawal schedules shall adhere to proper medical guidelines without consideration of financial concerns.

45.17.3 Written procedures that address the involuntary discharge from treatment shall include, but not be limited to the following:

A. At the inception of treatment, each person served shall be informed of his or her responsibilities associated with the program, including the policies related to involuntary withdrawal. The person shall be reminded of these policies and procedures at the time of an impending involuntary discharge.

B. Criteria shall be established for the involuntary withdrawal of treatment.

C. The OTP physician shall establish the withdrawal schedule in accordance with sound medical treatment and ethical considerations.

D. Dosage reduction schedules shall be individualized. No standardized dosage reduction schedule shall be established.

E. Withdrawal schedules shall be carefully monitored by all clinical personnel within the program.

F. When on-site withdrawal is determined to not be suitable for an individual, OTP staff shall assist the individual to transfer to another OTP.

45.17.4 Opioid treatment programs shall develop a written procedure establishing standards for "against medical advice" withdrawal. The withdrawal schedule shall be determined on an individual basis and completed under observation of the OTP staff.

45.17.5 Individuals who have completed a voluntary withdrawal from an opioid replacement treatment medication shall be eligible for aftercare counseling through outpatient services.

45.17.6 Individuals who have successfully completed the medically supervised withdrawal or detoxification phase and are being transferred to an outpatient program at the same organization, shall be transferred to the OTP's aftercare status in the Client Information System at the Division of Behavioral Healthcare Services no later than seven (7) days after the

person's last dose.

45.17.7 Individuals who complete a medically supervised withdrawal shall be given priority for re-admission within thirty (30) days of leaving treatment.

45.18 A program shall not admit a person for more than two (2) detoxification treatment episodes in one (1) year. Individuals with two (2) or more unsuccessful detoxification episodes shall be evaluated by the OTP physician for other forms of treatment.

45.19 In addition to the security requirements of the DEA Regulations Governing Narcotic Treatment Programs (Parts 1301 - 1307 and 42 CFR part 2) and Rhode Island General Laws section 21-28-1 *et seq.* ("Controlled Substance Act"), the following requirements must be met:

45.19.1 Access to electronic alarm areas where drug stock is maintained shall be limited to a minimum number of authorized personnel. Each employee shall have his or her own individual code, which shall be erased upon the employee's termination. A list shall be maintained that identifies all persons with access to the stock/safe and dispensing station and the type of access each has.

45.19.2 All stored controlled substances (powdered, liquid, tablet and reconstituted) shall be clearly labeled with the following information:

A. Name of substance;
B. Strength of substance;
C. Date of reconstitution;
D. Lot number;
E. Reconstituted expiration date or manufacture date, whichever is earlier.

45.19.3 All stored poured doses shall have the following information:

A. Name of substance;
B. Strength of substance;
C. Date of reconstitution;
D. Lot number;
E. Reconstituted expiration date or manufacture date.

45.19.4 Containers shall be kept covered and stored in the appropriate locked safe with access limited through an electronic alarm system that conforms with the DEA requirements of 21 CFR Part 21, Section 1301.71.

45.19.5 Following the initial opioid replacement treatment medication inventory at each OTP, an authorized licensed staff member shall conduct a bi-annual written inventory and document the results. The record is to be maintained

for a period of two (2) years. The inventory shall contain:

A. Name and address of the OTP;
B. Date of inventory;
C. Opening or closing of business day;
D. Quantity of opioid replacement treatment medications on hand, amount used, and amount received;
E. Total of all medications accounted for;
F. Signature of person performing the inventory and a co-signature.

45.19.6 The Department shall be notified of any occurrence of theft, suspected theft, or any loss of any opioid replacement treatment medication. The form, authorized by the Department for reporting adverse events/incidents, shall be completed for each occurrence and shall be sent to the Rhode Island BHDDH, along with a photocopy of DEA form 106.

45.19.7 OTPs shall have quality control procedures to track and trend all spillages of any medication.

45.19.8 The disposal of unused controlled substances shall be done in accordance with procedures provided by Federal DEA Regulations (Part 1307.21) and the Rhode Island Department of Health.

45.20 To ensure that appropriate rehabilitative and nursing services are provided, the Program Director of the OTP or his or her designee, shall assign the treatment of persons served according to best practice standards.

45.21 Each OTP shall have a designated medical director who has the responsibility for administering all medical services. He or she shall be licensed to practice medicine in Rhode Island, have Department of Health Controlled Substance Registration and be DEA registered.

45.21.1 The medical director or other authorized OTP physician shall assume the following responsibilities:

A. Evaluate each person to determine and to document his or her current physiological opioid addiction
B. Conduct the required physical evaluation and document the medical history for each person served
C. Ensure that the appropriate laboratory studies have been performed
D. Document and sign or counter-sign all medical orders
E. Review and sign treatment plans at least annually.

45.22 Each OTP shall have a registered nurse who shall be responsible for the general supervision of the nursing staff. The nurse shall participate in at least two (2) trainings per year in the area of substance abuse.

45.23 All pharmacists employed by an OTP shall be licensed in Rhode Island and must be authorized by the organization to dispense all opioid replacement treatment medications used by the program.

45.24 No less than fifty percent (50%) of staff providing direct therapeutic services shall have the qualifications listed in Regulation 9.12.1 or 9.12.2.

45.25 Medical, social, educational, and other services essential to meeting the basic human needs of persons served may be provided by case managers.

45.25.1 Case managers in OTPs are not required to have or work toward the qualifications listed in Regulation 9.12.

APPENDIX I

SUPPORTED EMPLOYMENT

INDIVIDUAL PLACEMENT AND SUPPORT (IPS) ELEMENTS

1. **Integration of rehabilitation services with mental health treatment**. Employment specialists, as members of the mental health service team, share in the decision-making and have equal status with other service providers on the team. The entire team is expected to assist clients with their rehabilitation goals. Team members share client information in a purposeful manner in relation to the client's treatment plan.

2. **Rehabilitation unit**. Rehabilitation staff functions as a unit rather than a group of individual practitioners. They have group supervision, share information, and help with each other's cases.

3. **Open Enrollment (Zero exclusion criteria).** There are no eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, etc. All clients are informed about rehabilitation services and encouraged to participate. The treatment team is expected to assist all clients to engage in work or other constructive activities of their choice. Clients are always eligible for services, even though they may not actively participate at a given point in time.

4. **Ongoing work-based assessment.** Assessment is an ongoing process of gathering information about the client's interests and skills. It is based on personal history and work experiences rather than formal tests. Through the assessment process, clients and staff identify the type of work and environment for which the client is best suited.

5. **Individualized rapid search for gainful employment**. Staff doesn't wait for test results, but take the client's lead in finding a good-fit job as quickly as possible. The individual client's preferences, skills, needs, and process of recovery dictate the timeline.

6. **Individualized job search**. Employer contacts are based on client preferences and needs, rather than the job market.

7. **Diversity of jobs developed**. Employment specialists provide job options that are diverse and in different settings in response to individual client choices.

8. **All job experiences are viewed positively as part of the recovery process.** All jobs are viewed as positive learning experiences on the path of vocational growth and development. For example, clients will receive supportive counseling following an involuntary termination from employment and the appropriateness of the placement will be reviewed.

9. **Competitive jobs prioritized**. Mainstream jobs with permanent status are prioritized rather than sheltered or time- limited jobs. All options, including education and training, are considered according to each client's individual interests and skills.

10. **Follow-along supports**. Individualized follow-along supports are provided to employer and client on a time-unlimited basis. Clients are provided ongoing assistance with career development, to include education and training, even after they are working. Social, as well as, vocational needs are addressed. Opportunities for peer support are facilitated.

11. **Community-based services**. Most *v*ocational services are provided in community settings other than mental health service agencies.

12. **Assertive engagement and outreach**. Employment Specialists take the initiative in engaging and maintaining contact with clients.

based on evidence-based practices:
PACT and IPS

APPENDIX II: PERSONAL CARE CHECKLIST

Psychiatric Rehabilitative Residence Individual Care Checklist
Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Client Name: _____ Residence Admit Date: _____

This checklist must be completed within 7 days of the individual's admission to the program and at least every six (6) months thereafter. It is the responsibility of the provider to ensure that a current checklist, either completed or countersigned by a physician, is maintained in the client's record at all times. An incomplete or outdated checklist may be cause for disallowances under the Mental Health Medicaid Program.

This checklist is not an exhaustive listing of all of the care that the client requires and is not meant to serve as a replacement for a comprehensive set of assessments as required in the Check the box that most closely describes the client's status with regard to each item at the current time. Use the space at the end of page 2 for additional comments if necessary. You must have one and only one check for each item.

Service Name/Description	**No Assistance Needed**	**Needs Counseling/ Monitoring**	**Needs Some Direct Supervision**	**Needs Substantial Supervision**
PERSONAL HYGIENE/APPEARANCE				
Hair Care–Regular shampooing, brushing, combing.				
Facial Maintenance–Use of makeup, dental care, shaving.				
Clothing and Dressing–Cleaning, ironing, sewing, storage, coordination of colors and style, purchasing within budget, dress appropriate for weather and age.				
Personal Cleanliness–Keeping self and area clean.				
DIETARY MANAGEMENT				
Proper meal preparation.				
Proper meal planning.				
Food shopping.				
Food storage and handling.				
Maintenance of special diet if required.				
Appropriate eating skills and habits.				
HOUSEHOLD MANAGEMENT				
Using laundry facilities, caring for clothes.				
Changing/making bed on a regular basis.				
Maintaining clean, safe and appropriate kitchen.				
Maintaining clean, safe, appropriate bedroom.				
Maintaining clean, safe and proper common areas.				
Caring for own possessions				

Client Name: _____

Service Name/Description	No Assistance Needed	Needs Counseling/ Monitoring	Needs Some Direct Supervision	Needs Substantial Supervision
FINANCIAL MANAGEMENT				
Money management and banking.				
Bill paying and record keeping.				
OTHER ASSOCIATED TASKS				
Self medication (understanding purpose; taking as prescribed; recognizing and dealing with side effects; symptom recognition and management)				
Use of physical healthcare services.				
Use of dental services.				
Recognizing and avoiding common dangers (e.g. fire, electrical shock, traffic, etc.)				
Use of community resources (e.g. Public transportation)				
PSYCHOSOCIAL/INTERPERSONAL				
Establishing meaningful activities and relationships in normative community settings.				
Productive use of leisure time.				
Relating to friends, neighbors, and other community members effectively and appropriately.				
Demonstrating appropriate levels of assertiveness and self–esteem.				
CLIENT RIGHTS/AUTONOMY				
Contributing productively to the development and modification of program policies and procedures.				
Undertaking activities to increase personal living skills and independence.				
Accessing and participating in self–help, mutual support, and/or advocacy organizations as appropriate.				
Exercising personal choice and control in key life domains (e.g. Selection of roommates, relationships, program activities, etc.)				
COMMENTS AND RECOMMENDATIONS				
(Continue comments and recommendations on next page)				

Client Name: _____

(Comments and recommendations continued)

Completed By: Name (Print): _____

Signature: _____

Date: _____

If not completed by physician, physician countersignature:

Name (Print): _____

Signature: _____

Date: _____

APPENDIX III - CONFIDENTIAL REPORT OF INCIDENT - SEPTEMBER 2009
DIVISION OF BEHAVIORAL HEALTHCARE SERVICES

Organization:_____ Date and Time of Incident_____

Mental Health: ___Group Home ___CSP ___GOP
___ Hospital Inpatient ___ Hospital Emergency Department

Substance Abuse: ___Detoxification ___ Residential ___Outpatient
___Opiate Treatment ___ Intensive OP ___ Women's Day Treatment

Individual Involved: _____ Client _____ Staff _____ Visitor

Full Name **AND** MHSIP ID/CIS #: _____

Diagnosis: _____ DOB: _____

Location of Incident: (Include address): _____

Nature of Incident: (Mark "X")

1. _____ Unexpected Death
2. _____ Suicide
3. _____ Suicide Attempt
4. _____ Mistreatment
5. _____ Assault/Battery
6. _____ Client Abuse
7. _____ Client Neglect
8. _____ Serious Injury
9. _____ Serious Medication Error
10. _____ Serious Medication Reaction
11. _____ Missing/ Diverted Medication
12. _____ Environmental Emergency/Serious Equipment Failure
13. _____ Major Theft
14. _____ Fire
15. _____ Elopement
16. _____ Finding of Serious Staff Misconduct
17. _____ Other (specify) _____

Entities Notified: (Mark "X")

1. _____ Police - State/Local (Circle)
2. _____ Fire Department
3. _____ Rescue Squad (treatment related)
4. _____ Physician
5. _____ Other (specify)_____

Is follow-up necessary? ___ Yes ___ No
If "Yes", is an investigation underway? ___ Yes ___ No

If "Yes", anticipated date of completion**:** _____

Describe in a **legible attachment** the incident; initial findings; and preliminary actions taken. Include all pertinent data including the date on which the client last received services, provider name, the client's mental/physical status at the time, and any risk assessment data collected as well as the type of services provided during the last 3-months of treatment.

_____ _____ _____
Signature of Person Reporting Date Contact Phone #

_____
Name Printed Title

Submit this form within 48 hours to: ~~Barbara Petrarca,~~ Division of Behavioral Healthcare,
PRIOR TO FAXING, PLEASE CALL 401-462-3291 FAX: 401-462-1564
Send a copy to: The Office of Standards and Licensure, ~~Attn: Nancy Court~~
Address for all reports: BHDDH, Barry Hall, 14 Harrington Road, Cranston, RI 02920

Appendix IV Uniform Authorization Form

Authorization for Use & Disclosure of Protected Health Information (PHI)

Name: _____ Date of Birth _____

Address: _____

City: _____ State: _____ Zip code: _____

I am enrolled in CurrentCare and wish for my health information to be disclosed to CurrentCare for providing me with treatment and/or coordination of care purposes. I hereby authorize _____ to **disclose** all of my health information, including my information relating to alcohol and substance abuse, mental or behavioral health, HIV/AIDS, genetic diseases or tests, and sexually transmitted diseases, to: **Rhode Island Quality Institute** as the administrator and operator of the Rhode Island statewide health information exchange CurrentCare.

I understand that my records are protected under federal and Rhode Island laws and regulations, and cannot be disclosed without my written consent, except as otherwise specifically provided by law. I understand that I may revoke (cancel) this authorization at any time and I must do so in writing at the address below. I understand that any revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not be effective until it is actually received and processed. I understand that signing this authorization is voluntary. I understand that pursuant to my CurrentCare enrollment form, my PHI may be re-disclosed only to the health care providers to whom I have given authorization to access my PHI and who acknowledge that they are treating me and need access to my PHI to treat me.

I understand that my PHI contains information involving treatment for alcohol or drug abuse, and are also protected under the federal regulation 42 CFR Part 2, and any disclosure of my information to CurrentCare by my substance abuse treatment provider will include a notification that CurrentCare may not redisclose my substance abuse treatment records without my consent, which shall be given only through my CurrentCare enrollment form.

Further, information released with this authorization will not be given, sold, transferred or in any way disclosed to any other entity unless authorized by law, without my further written consent.

This consent shall expire one (1) year from the date of this form unless otherwise specified below, or earlier terminated in writing by patient.

Specify Date (less than one year): _____

Signature of Patient / Legal Representative _____ Relationship to Client _____ Date _____

If patient has a legal guardian or is an emancipated minor, request copies of the legal documentation.

Signature of client if under 18

Signature _____ **Date:** _____

Facility Correspondence Address and Telephone Number: