

ALABAMA DEPARTMENT OF MENTAL HEALTH
SUBSTANCE ABUSE SERVICES
ADMINISTRATIVE CODE

CHAPTER 580-9-44
PROGRAM OPERATIONS

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580-9-44-.01 Definitions.

(1) Abstinence - Non-use of any addictive psychoactive substance.

(2) Abuse - The willful infliction of physical pain, injury, or mental anguish or the willful deprivation of services necessary to maintain mental and physical health.

(3) Activity - The execution of a task or action (a group or individual session) by an individual.

(4) Activity Therapy - Structured, object-oriented music, dance, art, social, or play therapeutic activities conducted, not for recreational purposes, by a qualified substance abuse professional to assist a client in developing or enhancing psychosocial competencies, to alleviate emotional disturbances, to change maladaptive patterns of behavior, and/or to assist in restoring the individual to a level of functioning capable of supporting and sustaining recovery.

(5) Addiction - A primary, chronic neurobiological disease, with genetic, psychosocial and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

(6) Administer - The direct application of a prescription drug by ingestion or any other means to the body of a client by a licensed practitioner, or by the client at the direction of, or in the presence of, a practitioner.

(7) Admission - That point in an individual's relationship with an organized treatment service when the placement assessment process has been completed and the individual placed in a level of care of the treatment program.

(8) Adolescent - An individual aged 13-18. The term also frequently applies to young adults aged 18-21, whose needs dictate admissions to adolescent programs.

(9) Advocacy - To advocate for, protect and advance the legal, human and service rights of people.

(10) Aftercare - The component of a treatment program which assures the provision of continued contact with the client following the termination of services from a primary care modality, designed to support and to increase the gains made to date in the treatment process. Aftercare plan development should start prior to discharge, but is not implemented until discharge.

(11) Aftercare Plan - A written plan that specifies goals to be achieved by a client and/or family involved in the aftercare of the client.

(12) Alcoholism - A general but diagnostic term, usually used to describe alcohol dependence, but sometimes used more broadly to describe a variety of problems related to the use of beverage alcohol.

(13) Ambulatory Detoxification - Detoxification that is medically monitored but that does not require admission to an inpatient medically or clinically monitored or managed setting.

(14) Ancillary Services - Non-substance use related services such as legal, vocational, employment, public assistance, childcare and transportation that may either be essential or incidental to a client's recovery.

(15) ASAM Placement Criteria - ASAM Placement criteria means the most current edition/set of placement criteria for substance abuse patient/clients published by the American Society of Addiction Medicine.

(16) Assertive Community Treatment (ACT) - Active outreach to persons, usually with serious and persistent mental illness, who need a support system that facilitates living and

functioning adequately in the community. ACT involves comprehensive services designed to engage and retain patients in treatment and assist them in managing daily living, obtaining work, building and strengthening family and friendship networks, managing symptoms and crises and preventing relapse.

(17) Basic Living Skills - Scheduled interventions conducted under the supervision of a qualified substance abuse professional to train and assist a client in reestablishing the ability to perform and manage fundamental tasks required for daily living.

(18) Behavioral Health Field - A broad array of mental health, substance use, habilitation and rehabilitation services that are utilized to individuals with substance use disorders. The field includes the areas of psychology, social work, counseling and psychiatric nursing.

(19) Behavioral Health Screening - A structured interview process conducted by a qualified substance abuse professional, utilizing the DMH/SASD uniform assessment tool, for the purpose of identifying an individual's presenting needs and establishing a corresponding recommendation for placement in an appropriate level of care.

(20) Case Management - The activities guided by a client's service plan which brings agencies, resources and people together within a planned framework of action toward the achievement of established treatment goals.

(21) Central Registry - A system which is used by two (2) or more providers to share information about clients who are applying for or presently involved in detoxification or maintenance treatment using methadone or other opiate replacements, for the purpose of preventing the concurrent enrollment of clients with more than one OMT provider.

(22) Certification - The process by which DMH or SASD determines that a provider is qualified to provide treatment or prevention services under applicable State and Federal standards.

(23) Chemical Dependency - A generic term relating to psychological or physical dependency, or both, on one or more psychoactive substances.

(24) Chemical Restraint - Is the use of any drug to manage a client's behavior in a way that reduces the safety risk to the client or others or to temporarily restrict the client's freedom of movement and is not a standard treatment dosage for the client's medical or psychiatric condition.

(25) Child/Adolescent - The period of life of an individual up to the age at which one is legally recognized as an adult according to state or provincial law. (CARF)

(26) Child Sitting Services - Care provided for children of clients in treatment during the same time period as the specific occurrence of the parent's treatment.

(27) Client - An individual who receives treatment for alcohol or other drug problems. The terms "client" and "patient" sometimes are used interchangeably, although staff in medical settings more commonly use "patient" while staff of non-medical residential or outpatient settings refer to "clients".

(28) Clinically Managed Services - Services directed by non-physician addiction specialists rather than medical personnel. They are appropriate for individuals whose primary problems involve emotional, behavioral or cognitive concerns, readiness to change, relapse, or recovery environment and whose problems with intoxication/withdrawal or biomedical are minimal or can be managed through separate arrangements for medical services.

(29) Clinical Supervision - Intermittent face-to-face contact, provided on or off the site of a service, between a clinical supervisor and treatment staff to ensure that each client has an individualized counseling plan and is receiving quality care.

(30) Consultation - A discussion of the aspects of a particular client's circumstance with other professionals to ensure comprehensive and quality care for the client that is consistent with the objectives of the client's treatment plan, or is used to make adjustments to the client's treatment plan.

(31) Continuous Assessment - The term includes but is not limited to review of the individual service plan, client progress reports, etc. The information gained from continuous assessment is used to match an individuals' need with the appropriate setting, care level and intensity. It is also used to determine an individuals' need for continued stay, discharge, or transfer to another level of care.

(32) Continuing Care - A course of treatment identified in a service plan designed to support the process of recovery that is provided at a frequency sufficient to maintain recovery. The treatment provided is flexible and tailored to the shifting needs of the client and his and her level of readiness to change.

(33) Co-Occurring Disorders - Concurrent substance use and mental health disorder found in a single individual. Both conditions are such that they may also exist alone but there is no implication as to one disorder being primary. Other terms used to describe COD include: dual diagnosis, dual disorders, mentally ill chemically addicted (MICA), chemically addicted mentally ill (CAMI), mentally ill substance abusers (MISA), mentally ill chemically dependent (MICD), coexisting disorders, co-morbid disorders, and individuals with co-occurring psychiatric and substance symptomatology (ICOPSS).

(34) Continued Stay, Transfer, and Discharge Criteria - Criteria used after the initial assessment to monitor progress during a treatment episode and decide on Level of Care.

(35) Counselor - A member of the clinical staff working in a program who is licensed or certified and whose primary duties consist of conducting and documenting services such as counseling, psycho-educational groups, psychosocial assessment, treatment planning and case management.

(36) Crisis Intervention - Services that respond to a client's needs during acute episodes that may involve physical distress, imminent relapse and danger to self and others.

(37) Crisis Planning - A process of developing necessary resources to appropriately address and respond to acute needs of a client to include assessing for suicide and homicide ideations or plans.

(38) Criteria - Written rules, measures, or factors that help assessors determine where to place a client in care.

(39) Dependence - Used in three different ways: (a) physical dependence is a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist; (b) psychological dependence is a subjective sense of need for a specific psychoactive substance, either for its positive effects or to avoid negative effects associated with its abstinence; and (c) one category of psychoactive substance use disorder.

(40) Detoxification - The deliberate withdrawal of a person from a specific physiological addicting substance in a safe and effective manner.

(41) Detoxification Rating Scales - As needed documentation. For example: clinical institution, withdrawal, assessment (CIWA); clinical opiates withdrawal scale (COWS), etc.

(42) Developmental Delay, Prevention Activities, Dependent Child - Structured activities provided by an appropriately credentialed professional for children of clients in treatment, during the same time period as the specific occurrence of the parent's treatment. These services function to foster healthy psychological, emotional, social and intellectual development of the child.

(43) Diagnostic Criteria - Prevailing standards which are used to determine a client's mental and physical condition relative to their need for substance abuse services, such as those which are described in the current Diagnostic and Statistical Manual of Mental Disorders.

(44) Didactic Group - Groups that are designed to teach or lecture.

(45) Discharge Planning - The process, beginning at admission of determining a client's continued need for treatment services and developing a plan to address ongoing client recovery needs once the client has been discharged from a level of care.

(46) Discharge Summary - A written narrative of the client's treatment record describing the client's accomplishments and problems during treatment, reasons for discharge and recommendations for further services.

(47) Discharge/Transfer Criteria - During client assessment, problems and priorities are identified as justifying treatment at a particular level of care. Discharge/Transfer Criteria describe the degree of resolution of those problems and priorities and are used to determine when a client can be treated at a different level of care or discharged from treatment. The appearance of new problems may require services that can be provided effectively only at a more or less intensive level of care. This level of function and clinical severity of a client's status in each of the six dimensions is considered in determining the need for discharge or transfer.

(48) Documentation - Provisions of written, dated and authenticated evidence (signed by person's name and title) to substantiate compliance with standards (e.g. minutes of meetings, memoranda, schedules, notices, announcement).

(49) Drug Intoxication - Dysfunctional changes in physiological functioning, psychological functioning, mood state, cognitive process, or all of these, as a consequence of consumption of a psychoactive substance; usually disruptive, and often stemming from central nervous system impairment.

(50) DSM - The most current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. References to DSM may be construed to mean the most current edition of the International Classification of Diseases (ICD-10) when appropriate.

(51) Dual Diagnosis - Refers to the client who has signs and symptoms of concurrent substance-related and mental disorders. Other terms used to describe such co-occurring disorders include, co-occurring disorders, dual disorders, mentally ill chemically addicted (MICA), chemically addicted mentally ill (CAMI), mentally ill substance abusers (MISA), mentally ill chemically dependent (MICD), coexisting disorders, comorbid disorders, and individuals with co-occurring psychiatric and substance symptomatology (ICOPSS).

(52) Dual Diagnosis Capable (DDC) - Treatment programs that address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning are described as "Dual Diagnosis Capable" DDC. Such programs have arrangements in place for coordination and collaboration with mental health services. They can provide psychopharmacologic monitoring and psychological assessment and consultation, either on site or through coordinated consultation with off site providers. Program staff are able to address the interaction between mental and substance related disorders and their effect on the client's readiness to change- as well as relapse and recovery environment issues- through individual and group program content. Nevertheless, the primary focus of DDC programs is the treatment of substance-related disorders.

(53) Dual Diagnosis Enhanced (DDE) - Describes treatment programs that incorporate policies, procedures, assessments, treatment and discharge planning processes that accommodate patients who have co-occurring mental and substance related disorders. Mental health symptom management groups are incorporated into addiction treatment. Motivational enhancement therapies specifically designed for those with co-occurring mental and substance-related disorders are more likely to be available (particularly in out-patient settings) and, there is close collaboration or integration with a mental health program that provides crisis backup services and access to mental health case management and continuing care. In contrast to Dual Diagnosis Capable services, Dual Diagnosis Enhanced services place their primary focus on the integration of services for mental and substance-related disorders in their staffing, services and program content.

(54) Early Intervention - Services that explore and address any problems or risk factors that appear to be related to the use of alcohol and other drugs and that help the client to recognize the harmful consequences of inappropriate use. Such individuals may not appear to meet the diagnostic criteria for a substance use disorder, but require early intervention for education and further assessment.

(55) Emergency Service - A network of services that provides all persons having acute problems related to alcohol and other drug use and abuse readily available diagnosis and care, as well as appropriate referral for continuing care after emergency treatment.

(56) Exploitation - An unjust or improper use of another person or their resources for one's own profit or advantage or for the profit or advantage of another person.

(57) Evidence-Based Practice - An approach to mental health care practice in which the clinician is aware of the evidence that bears on his/her clinical practice, and the strength of that evidence.

(58) Failure (as in a treatment failure) - Lack of progress and/or regression at any given level of care. These situations warrant a reassessment of the treatment plan, with modifications of the treatment approach. Such situations may require changes in the treatment plan at the same level of care or transfer to a different (more or less intensive) level of care to achieve a better therapeutic response. Sometimes used to describe relapse after a single treatment episode- an inappropriate construct in describing a chronic disease or disorder.

(59) Family - Individuals as defined by law, or significant others that claim relationship to the client. A person's immediate relatives and/or significant others. A term used to describe a person's parents, spouse, siblings, extended family, guardians, legally authorized representatives, or significant others as identified by the person served. (CARF)

(60) Family Counseling - A treatment plan focused on intervention involving a client, his/her family unit and/or significant others, and a mental health/substance abuse professional. Treatment is designed to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder that interferes with a client's personal, familial, vocational, and/or community adjustment.

(61) Flow Sheets - A term usually associated with the field of nursing; Documentation that is required for a patient that assesses their entire day. Components of a flow sheet include:

- (a) The Master Treatment Problem (MTP Problem).
- (b) Risk Assessment.
- (c) Medication Compliance and Response.
- (d) Subjective & Objective Data.
- (e) Physical Assessment- Review of Systems.
- (f) Pain Assessment.
- (g) Intervention/Education.
- (h) Response to Intervention.
- (i) Additional Information.

(62) Follow-up - A process used by a treatment provider that will periodically assess the progress of a client who has completed treatment services.

(63) Governing Authority - The individuals or group that provides direction, guidance, and oversight, approves decisions specific to the organization and its services. The chief executive or agency director reports to this authority.

(64) Grievance - A written expression of dissatisfaction which may or may not be the result of an unresolved complaint.

(65) Group Counseling - The application of counseling techniques which involve interaction among members of a group consisting of at least three (3) clients but not more than fifteen (15) with a minimum of one (1) counselor for every fifteen (15) clients.

(66) Health Education - A service prescribed to modify assessed alcohol and/or drug use, cognitive, behavioral, emotional, social, and/or psycho-physiological factors relevant to and affecting the client's physical health problems. This service is provided for individuals who have established illnesses or symptoms.

(67) HIV Early Intervention Services - Appropriate pretest counseling for HIV and AIDS. Testing individuals with respect to such disease, including tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease. Also, appropriate post-test counseling and therapeutic measures.

(68) Human Service Needs Assessment (HSNA) - An assessment of specific human service needs of a client. The systematic determination of the specific needs of each client. Its' purpose is to comprehensively define the scope of services and the client's functional levels to develop an individualized case management case plan. It clearly describes the client's strengths and problem areas. The following key elements make up the HSNA: family relationship, housing, vocational/educational, recreational, transportation, social support, physical, financial and spiritual.

(69) Individualized Counseling - Counseling designed to meet a particular client's needs, guided by a treatment plan that is directly related to a specific, unique client assessment.

(70) Individualized Service Plan - The ongoing process by which a clinician and the client identify and rank problems, establish agreed upon goals and decide on the treatment process and resources to be utilized.

(71) Intake - The process of collecting and assessing information to facilitate admission of an individual into a substance abuse treatment program.

(72) Intake Service - A structured interview process conducted by a trained clinician for the purpose of identifying and evaluating a client's continued need for treatment or care after diagnostic interview examination, admission and implementation of the initial treatment plan, in a specific level of care.

(73) Intensive Case Management - A comprehensive community service that includes evaluation, outreach and support services, usually provided on an outpatient basis. The case manager (management team) advocates for the client with community agencies and arranges services and supports. The case manager may also teach community living and problem-solving skills, model productive behaviors and the client becomes self-sufficient.

(74) Intensive Outpatient Treatment - An organized service delivered by addiction professionals or addiction-credentialed clinicians, which provides a planned regimen of treatment, consisting of regularly scheduled sessions within a structured program, for a minimum of nine (9) hours of treatment per week for adults and six (6) hours of treatment per week for adolescents.

(75) Interdisciplinary Staff - A group of clinicians trained in different professions, disciplines, or service areas (such as physicians, counselors, psychologists, social workers, nurses and certified substance abuse counselors), who function interactively and interdependently in conducting a client's diagnostic interview examination, service plan and treatment services. There must be close interaction and integration among the disciplines to ensure that all members of the team interact to achieve team goals.

(76) Intervention - A planned interaction with an individual who may be dependent on one or more psychoactive substances, with the aim of making a full assessment, overcoming denial, interrupting drug-taking behavior, or inducing the individual to initiate treatment. Includes activities and strategies that are used to prevent or impede the development or progression of substance abuse problems.

(77) Length of Service - The number of days for inpatient care or units/visits for outpatient of service provided to a patient, from admission to discharge, at a particular level of care.

(78) Level of Care - The term refers to broad categories of patient placement, which encompass a range of clinical services such as early intervention, detoxification, or Opioid Maintenance Therapy services and levels of care such as intensive outpatient treatment or clinically managed medium intensity residential treatment.

(79) Level of Function - An individual's relative degree of health and freedom from specific signs and symptoms of a mental or substance-related disorder, which determine whether the individual requires treatment.

(80) Licensed Independent Practitioner - An individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. In Alabama such individuals include: MD, DO, licensed psychologist, licensed professional counselor, licensed certified social worker, licensed marriage and family

therapist, Master's level nurse in psychiatric nursing, certified registered nurse practitioner, and physician assistant.

(81) Linkage - Established connections and networks with a variety of agencies, companies and persons in the community that provides linkage that is facilitated between the client and service provider. (CARF)

(82) Long-term Detoxification Treatment - Detoxification treatment for a period of more than thirty (30) days but less than one-hundred eighty (180) days.

(83) Medical Director - A physician licensed under Alabama law who has been designated to oversee all medical services of a provider and has been given the authority and responsibility for medical care delivered by a provider. This includes ensuring the program is in compliance with all federal, state and local laws and regulations regarding the medical treatment of addiction to an Opioid drug.

(84) Medically Managed Treatment - Services that involve daily medical care, where diagnostic and treatment services are directly provided and/or managed by an appropriately trained and licensed physician.

(85) Medically Monitored Treatment - Services that are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists and other health care professionals and technical personnel, under the direction of a licensed physician. Medical monitoring is provided through an appropriate mix of direct patient contact, review of records, team meetings, twenty-four (24) hour coverage by a physician, and quality assurance programs.

(86) Medical Monitoring - Evaluation, care and treatment by medical personnel who are licensed for clients whose substance abuse and related problems are severe enough to require intensive inpatient treatment using an interdisciplinary team approach.

(87) Medical Necessity - Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are consistent with:

- (a) The diagnosis and treatment of a condition.
- (b) The standards of good medical practice.
- (c) Required for other than convenience.

(d) The most appropriate supply or level of service.

When applied to inpatient care, the term means: that the needed care can only be safely given on an inpatient basis.

(88) Medically Managed Service - Services provided or directly managed by a physician.

(89) Medically Monitored Service - Services provided under the direction and supervision of a physician. The physician may or may not directly administer care to the client.

(90) Medication Administration - The direct administration of prescribed medication, as according to assessed needs stipulated in a client's service plan, and observation of the client's intake of the medication by mouth.

(91) Medication Assistant Certified Worker (MAC Worker) - Unlicensed worker that performs basic strategies in assisting with the medication administration process. Must have successfully completed the twenty-four (24) hour MAC 1 & 2 educational program and received a score of ninety (90) or above on the MAC test.

(92) Medication Assistant Supervisor Nurse (MAC Nurse) - A registered nurse (RN) or licensed practical nurse (LPN) with a valid Alabama license and employed or contracted by an agency/program certified by the ADMH. Must complete the seven (7) hours training program for MAS nurses and receive a score of ninety (90) or above on the MAS test.

(93) Medication Assistance Train-the-Trainer Registered Nurse (MATT RN) - Must be a MAS registered nurse with at least one (1) year of community service. Must also receive additional training beyond the MAS requirement and receive a score of ninety (90) or above on the MATT test.

(94) Medication Destruction Record - What it is and what is contained in it.

(95) Medication Management - The practice of prescribing and/or dispensing medication by qualified personnel. (CARF)

(96) Medication Monitoring - Face-to-face contact between the client and rehabilitative services, or a child and adolescent services/adult protective services professional, pharmacist, RN, or LPN for the purpose of reviewing the overt physiological effects of psychotropic medications; monitoring compliance with dosage instructions; instructing the client

and/or caregivers of expected effects of psychotropic medications; assessing the client's need to see the physician; and recommending changes in the psychotropic medication regimen.

(97) Mental Health Consultation - A service aimed at assisting other service agency providers or independent practitioners in providing appropriate services to an identified Medicaid client by providing clinical consultation. Key service functions include written or oral interaction in a clinical capacity in order to assist another provider to meet the specific treatment needs of an individual client and to assure continuity of care to another setting.

(98) Modality - A specific type of treatment (technique, method, or procedure) that is used to relieve symptoms or induce behavior change. Modalities of addiction treatment include, for example, detoxification or antagonist medication, motivational interviewing, cognitive behavioral therapy, group therapy, social skills training, vocational counseling and self/mutual help groups.

(99) Monitoring - The interaction between the area authority or county program and a provider of public services regarding the functions set forth in the standards.

(100) Motivational Enhancement and Engagement Strategies - A patient-centered counseling approach for initiating behavior change by helping patients to resolve ambivalence about engaging in treatment and stopping substance use. This approach employs strategies to evoke rapid and internally motivated change in the patient, rather than guiding the patient stepwise through the recovery process. (Adopted from Principles of Drug Addiction Treatment-A Research Based Guide, National Institute on Drug Abuse, 1999).

(101) Neglect - The willful act of withholding or inadequately providing shelter, food, hydration, clothing, medical care and good hygiene.

(102) Non-Violent Crisis Intervention - A process of interrupting an action or behavior that is harmful to an individual through the use of techniques that require limited force or action.

(103) Nurse Delegation Program (NDP) - A general term that refers to the entire system that allows non-licensed persons to assist licensed nursing professionals in the administration of medications in a residential treatment setting.

(104) Opioid Agonist Treatment Medication - A prescription medication, such as methadone, Buprenorphine or other substance scheduled as a narcotic under the Federal Controlled Substances Act (21 U.S.C. Section 811) that is approved by the U.S. Food and Drug Administration for use in the treatment of opiate addiction or dependence.

(105) Opioid Maintenance - The dispensing of methadone for more than one-hundred eighty (180) days in the treatment of an individual for dependence on opiates.

(106) Outpatient Service - An organized non-residential service, delivered in a variety of settings, in which addiction treatment personnel provide professionally directed evaluation and treatment of substance-related disorders. Usually fewer than nine (9) hours.

(107) Overdose - The inadvertent or deliberate consumption of a dose much larger than that either habitually used by the individual or ordinarily used for treatment of an illness, and likely to result in a serious toxic reaction or death.

(108) Parenting Skills Development - A structured face-to-face encounter facilitated by a trained clinician for the purpose of enhancing the parenting competency of individuals who are parents of dependent children, and who have a substance use disorder. This service may include interactive activities involving the parents' children.

(109) Partial Hospitalization - A generic term encompassing day, night, evening and weekend treatment programs that employ an integrated, comprehensive and complementary schedule of recognized treatments. Commonly referred to as "day treatment." A partial hospitalization program does not need to be attached to a licensed hospital.

(110) Patient - An individual receiving alcohol/other drug treatment. The terms "client", "patient" and "client" sometimes are used interchangeably and refer to the individual who has completed the screening, behavioral health screening and diagnostic interview examination process and is receiving substance abuse treatment services.

(111) Peer Counseling Services - The provision of scheduled interventions by a certified peer counselor, who is in recovery from a substance use or co-occurring substance use and mental illness disorder, to assist a client in the acquisition and exercise of skills needed to support recovery. Services may include activities that assist clients in accessing and/or

engaging in treatment and in symptom management, promote socialization, recovery, and self-advocacy, and provide guidance in the development of natural community supports and basic daily living skills.

(112) Performance Improvement - A formal method of evaluating the quality of care rendered by a provider and is used to promote and maintain an efficient and effective service delivery system. Performance improvement includes the use of a quality assurance process to ensure that problems, when they occur are corrected appropriately and in a timely manner.

(113) Pharmacotherapy - Any treatment of persons served with medications, including methadone or opiate replacement therapies.

(114) Physical Restraint - The direct application of physical force to a client without the client's permission to restrict his or her freedom of movement.

(115) Placement Assessment - An interview with the person served to collect information related to his/her history and needs, preferences, strengths and abilities in order to determine the diagnosis, appropriate services and/or referral. (Modified CARF)

(116) Prevention - Social, economic, legal, medical and/or psychological measures aimed at minimizing the use of potentially addicting substances, lowering the dependence risk in susceptible individuals, or minimizing other adverse consequences of psychoactive substance use. Primary prevention consists of attempts to reduce the incidence of addictive diseases and related problems in a general population. Secondary prevention aims to achieve early detection, diagnosis and treatment of affected individuals. Tertiary prevention seeks to diminish the incidence of complications of addictive diseases.

(117) Program - A generalized term for an organized system of services designed to address the treatment needs of patients.

(118) Progress Note - Written entries made by clinical staff in the client record that document progress or lack thereof toward meeting treatment plan objectives, and which generally address the provision of services, the client's response to those services, and significant events. Progress notes also include documentation of those events and activities related to the client's treatment.

(119) Psychiatric Seclusion - The involuntary confinement of a client alone in a room, from which the client is prevented from leaving for a prescribed period of time in order to control or limit his/her dangerous behavior.

(120) Psychoeducation - Individualized instruction and training of the persons served to increase their knowledge and understanding of their psychiatric diagnoses, prognoses, treatment and rehabilitation in order to enhance their acceptance of these psychiatric disabilities, increase their cooperation and collaboration with treatment and rehabilitation, improve their coping skills, and favorably affect their outcomes. Such education should be consistent with the individual plans and be provided with the knowledge and support of the interdisciplinary teams. (CARF)

(121) Qualified Case Manager - An individual that possesses a Bachelor of Science degree in a behavioral health field or in nursing and have successfully completed training in a case management curriculum approved by DMH to provide case management services to the identified population being served.

(122) Qualified Interpreter:

(a) Spoken Language Interpreters must be able to interpret expressively and receptively using specialized vocabularies between two persons speaking two languages.

(b) Sign Language Interpreters must meet the expectations of the Spoken Language Interpreter plus be eligible to work in Alabama as specified in Section 34, Chapter 16 of the Code of Alabama, i.e. they must obtain Interpreter licensure.

(123) Qualified Person - Any person qualified under applicable law or professional requirement where they exist to perform any function authorized under these rules. Where professional qualifications are not imposed under other law, these rules may permit persons to act as specifically authorized.

(124) Qualified Physician - Is a Psychiatrist or a licensed physician who has been granted privileges to order seclusion or restraint.

(125) Qualified Registered Nurse - Is one who has successfully completed a DMH approved psychiatric management course and who as at least one (1) year psychiatric nursing experience. A Registered Nurse who has been granted privileges to implement seclusion or restraint.

(126) Qualified Substance Abuse Professional I (QSAP I) - An individual licensed in the State of Alabama as a Professional Counselor, Certified Social Worker, Psychiatric Clinical Nurse Specialist, Psychiatric Nurse Practitioner, Marriage and Family Therapist, Clinical Psychologist, Physician's Assistant, Physician and meets the other qualifications as specified in the standards themselves.

(127) Qualified Substance Abuse Professional II (QSAP II) - An individual who holds a master's or bachelor's degree from an accredited college or university in Psychology, Social Work, Community Rehabilitation, Pastoral Counseling, Family Therapy, or other behavioral health areas that requires equivalent clinical course work and who meets the other qualifications as specified in the standards themselves.

(128) Qualified Substance Abuse Professional III (QSAP III) - An individual who has a bachelor's degree from an accredited college or university in Psychology, Social Work, Community Rehabilitation, Pastoral Counseling, Family Therapy, or other behavioral health area that requires equivalent clinical course work and; who has a minimum of two (2) years full-time paid employment experience providing direct treatment or care for individuals who have substance-related disorders, under the supervision of a QSAP I, and holds a substance abuse counselor certification.

(129) Readiness to Change - An individual's emotional and cognitive awareness of the need to change, coupled with a commitment to change. When applied to addiction treatment it describes the patient's degree of awareness of the relationship between his/her alcohol or other drug use or mental health problems and the adverse consequences of such use, as well as the presence of specific readiness to change personal patterns of alcohol and other drug use.

(130) Recovery Support Services - A range of non-clinical services provided to facilitate the process of recovery from substance use disorders and to promote wellness. These services may be provided prior to, during and after treatment for individuals and their families who have been assessed as having a need for such.

(131) Referral - The establishment of a link between a client and another service by providing client authorized documentation to the other service of the client's need and recommendations for treatment services, and includes follow-up within a given time span as to the disposition of the recommendations.

(132) Relapse - Recurrence of psychoactive substance-dependent behavior in an individual who has previously achieved and maintained abstinence for a significant period of time beyond withdrawal.

(133) Relapse Prevention - Services designed to support the recovery of the individual and to prevent the recurrence of substance abuse.

(134) Resident - A patient in one of the clinically managed, residential levels of care.

(135) Residential Detoxification - Detoxification that is medically monitored and requires admission to a Clinically Managed or Medically Monitored Detoxification Program.

(136) Restraint:

(a) Any manual method used or physical or mechanical device, material, or equipment attached or adjacent to a client's body that he or she cannot easily remove or that restricts freedom of movement or normal access to one's body.

(b) A drug used to control a client's behavior when that drug is not a standard treatment for the client's condition.

(c) The use of physical, mechanical, chemical, or other means to temporarily subdue an individual or otherwise limit a person's freedom of movement. (CARF)

(137) Seclusion - The use of a secure, private room designed to isolate a client who has been determined by a physician to pose an immediate threat of physical harm to self or others. Seclusion refers to the placement of a client alone in any room from which the client is physically prevented from leaving.

(138) Screening - A process involving a brief review of a person's presenting problem to determine the person's appropriateness and eligibility for substance abuse services and the possible level of services require.

(139) Sentinel Event - Is an unexpected occurrence involving a child/adolescent receiving treatment for a psychological or psychiatric illness that results in serious physical injury, psychological injury, or death (or risk thereof).

Serious Incident/Critical Incident - The occurrence or set of events inconsistent with the routine operation of an approved

treatment facility, or the routine care of a client. Serious incidents, sometimes referred to as critical incidents, include but are not necessarily limited to the following:

- (a) Adverse drug events.
- (b) Self destructive behavior.
- (c) Deaths and injuries (including automobile accidents) to the client, client family, staff, and visitors.
- (d) Medication errors.
- (e) Neglect or abuse of a client.
- (f) Fire.
- (g) Unauthorized disclosure of information.
- (h) Damage to or theft of property belonging to a client or an approved treatment facility.
- (i) Other unexpected occurrences.
- (j) Or events potentially subject to litigation.

A serious incident may involve multiple individuals or results.

(141) Service Plan - A written plan of services, developed by the clinician in conjunction with the client, that addresses the individualized needs of the client through devising plans for services that offer reasonable promise of success and are consistent with the abilities and circumstances of the client. The Service Plan is reviewed regularly by the clinician and client to assess its continued viability and effectiveness while respecting the client's input and freedom of choice.

(142) Setting - A specific place in which treatment is delivered. Settings for alcohol/other drug treatment include hospitals, methadone clinics, community mental health centers and prisons or jails.

(143) Severity of Illness - Specific signs and symptoms for which a patient requires treatment, including the degree of impairment and the extent of a patient's support networks.

(144) Short-term Detoxification Treatment -Detoxification treatment for a period not in excess of thirty (30) days.

(145) Sign Language Interpreter - The provision of sign language or interpreter services for clients enrolled in a specified level of care by appropriately credentialed professionals.

(146) Smoking Cessation - A structured face-to-face encounter provided by trained personnel to assist individuals enrolled in a specific level of care in efforts to stop smoking.

(147) Staffing/Case Review - A regularly scheduled review of client's treatment goals which involve the client's primary clinical staff person and other persons involved in the implementation of the treatment plan.

(148) Staff Member - A person who is directly employed by an organization on either a full- or part-time basis. (CARF)

(149) Stages of Change - This refers principally to the work of Prochaska and DiClemente, who described how individuals progress and regress through various levels of awareness of a problem, as well as the degree of activity involved in behavior. While their original work studied individuals who changed from smokers to non-smokers, the concept of stages of change subsequently has been applied to a variety of behaviors.

(150) Standards - Specifications representing the minimal characteristics of an alcohol and other drug abuse treatment program, which are acceptable for the licensing of a program.

(151) State Opioid Treatment Authority - The Director, or designee, of the State of Alabama DMH Substance Abuse Division's Treatment Services or its successor.

(152) Substance Abuse - Harmful use of a specific psychoactive substance. The term also applies to one category of psychoactive substance-related disorders. While recognizing that "abuse" is part of present diagnostic terminology, ASAM recommends that an alternative term be found for this purpose because of the pejorative connotations of the word "abuse".

(153) Substance Abuse Service Provider - Any entity or person. A public agency, a private for-profit or not-for-profit agency, a person who is in private practice and a hospital either licensed or exempt from licensure that has obtained certification through DMH/SASD to provide substance abuse services at any of the SASD approved levels of care.

(154) Substance Dependence - Marked by a cluster of cognitive, behavioral and psychological symptoms indicating that

the individual continues to use alcohol or other drugs despite significant related problems. The cluster of symptoms can include tolerance, withdrawal or use of a substance in larger amounts or over a longer period of time than intended; persistent desire or unsuccessful efforts to cut down or control substance use; a great deal of time spent in activities related to obtaining or using substances or to recover from their effects; relinquishing important social, occupational or recreational activities because of substance use; and continuing alcohol or drug use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by such use.

(155) Substance Use Disorders - Include Substance Dependence and Substance Abuse, according to the specific diagnostic criteria given in DSM IV. Substance Use Disorders are one of two subgroups ('substance dependence' and 'substance abuse') of the broader diagnostic category of Substance-Related Disorders. In the ASAM PPC-2R, the specific subgroup or disorder is used in the diagnostic criteria for admission to certain levels of care.

(156) Supportive Counseling - Not considered therapy but is provided to clients, or victims, to help them discuss feelings relating to domestic violence, sexual assault or abuse, and other issues that maybe negatively affecting their well-being. It is used to help them identify their strengths and to re-develop feelings of self-worth. The client's spouse, parents, or other family members may also receive supportive counseling which provides them with an outlet to verbalize their feelings and to develop viable plans for action.

(157) Support Services - Those readily available to the program through affiliation, contract or because of their availability to the community at large (example: 911). They are used to provide services beyond the capacity of the staff of the program and which will not be needed by patients on a routine basis or to augment the services provided by staff.

(158) The Levels of Care:

(a) Level 0.5: Early Intervention: A service for a group of individuals who, for a known reason, are at risk of developing substance-related problems, or for those for whom there is not yet sufficient information to document a substance use disorder. (ASAM PPC-2R).

(b) Level I: Outpatient Treatment: Organized services that may be delivered in a variety of settings. Includes professionally directed services provided by addiction

or mental health personnel that include evaluation, treatment and recovery services. These services are provided in regularly scheduled sessions and follow a defined set of policies and procedures or medical protocols. (ASAM PPC-2R)

(c) Level II: Intensive Outpatient Treatment/Partial Hospitalization: An organized outpatient service that delivers treatment services during the day, before or after work or school, in the evenings, or on the weekends. Includes programs that essentially provide education and treatment components while allowing clients to apply their newly acquired skills within "real world" environments. These programs have the capacity to arrange for medical and psychiatric consultation, psychopharmacological consultation, medication management and 24-hour crisis services. (ASAM PPC-2R)

(d) Level III: Residential/Inpatient Treatment: Encompasses organized services provided by addiction and mental health personnel who provide a planned regimen of care in a twenty-four (24) hour live-in setting. Such services adhere to defined policies and procedures. They are located in permanent facilities where clients reside safely. They are staffed for twenty-four (24) hour coverage and self-help groups are available on-site. There are five types of programs located at this level:

1. Level III.01: Transitional Residential Program
2. Level III.1: Clinically Managed Low Intensity Residential Treatment
3. Level III.3: Clinically Managed Medium Intensity Residential Treatment
4. Level III.5: Clinically Managed High Intensity Residential Treatment
5. Level III.7: Medically Monitored Inpatient Treatment (ASAM PPC-2R)

(e) Level IV: Medically Managed Intensive Inpatient Treatment: These programs provide a planned regimen of twenty-four (24) hour medically directed evaluation, care and treatment of mental and substance-related disorders in an acute care inpatient setting. They are staffed by addiction-credentialed physicians, psychiatrists and clinicians. Services at this level are delivered under a defined set of policies and procedures and have permanent facilities that include inpatient beds. Level four programs provide care to clients whose mental and substance-related problems are so severe that they require primary biomedical, psychiatric and nursing care. Treatment is

provided twenty-four (24) hours a day and the full resources of a general acute care hospital or psychiatric hospital are available. Treatment is specific to SA or MI disorders but the skills of the interdisciplinary team and the availability of support services allow the conjoint treatment of any co-occurring biomedical condition that needs to be addressed. (ASAM PPC-2R)

(159) Timeout - The restriction of a client for a period of time to a designated area from which the client is not physically prevented from leaving for the purpose of providing the client an opportunity to regain self-control.

(160) Tolerance - A stage of adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug's effects over time.

(161) Transfer - Movement of the client from one level of service to another, within the continuum of care. The change may take place at the same location or by physically moving the client to a different site for the new level of care.

(162) Transfer Summary - A written justification of the circumstances of the transfer of a client from one component to another or from one provider to another.

(163) Transitional Hold - A brief physical restraint of an individual that may be face-down for the purpose of quickly and effectively gaining physical control of that individual, or prior to transport to enable the individual to be transported safely.

(164) Transitional Residential Treatment - Services directed by persons who specialize in addictions treatment. They are appropriate for persons whose primary problems involve emotional, behavioral or cognitive concerns, readiness to change, relapse potential and recovery environment dictates that these issues can be addressed through arrangements for clinical/medical services with the appropriate living situation.

(165) Transportation - Agency provided non-emergency services utilized to transport a client to and from treatment or care, and to and from community-based organizations and activities during the course of treatment or care, as identified in the individual's service plan.

(166) Treatment - The application of professional planned, merged, administered, and/or monitored evidenced-based/best practices and procedures to identify, stabilize, minimize, or alleviate the harmful consequences of

substance related disorders and to restore impaired health and functionality relative to the disorders.

(167) Treatment Program - Any program that delivers alcohol and/other drug abuse treatment services to a defined client population.

(168) Treatment Staff - The group of personnel of the alcohol and other drug abuse treatment program, which is directly involved in client care or treatment.

(169) Waiver - The voluntary relinquishment or surrender of some known right or privilege. Waivers are given in writing, listing clearly and unambiguously the full knowledge of what is being waived. They are developed specifically for a particular right, duty, or privilege and cannot be used or applied to other essential functions of a job or activity. All waivers are signed by the appropriate authority.

(170) Youth - A person between six (6) and eighteen years (18) of age. (CARF)

(171) Meaning of the verbs in the Standards: Attention is drawn to the use of the words "shall", "should", and "may" in the SASD Standards:

(a) "Shall" is the term used to indicate a mandatory statement, the only acceptable method under these present standards.

(b) "Should" is the term used to reflect the most preferable procedure, yet allowing for the use of effective alternatives.

(c) "May" is the term used to reflect an acceptable method that is recognized but not necessarily preferred.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New: Filed: July 22, 1992. **Extended:**

September 30, 1992. **Extended:** December 31, 1992. **Certified:**

March 30, 1993. Effective May 5, 1993. **Repealed and New Rule:**

Filed November 19, 2003; effective December 24, 2003. **Repealed**

and New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.02 Personnel. It will be incumbent on the Board of Directors of each organization/agency to develop the

qualifications for the position of Executive Director. This is a full-time position.

(1) Qualified Treatment Personnel. The entity shall employ qualified and trained personnel to ensure the health, safety, and well-being of its clientele, and to support efficient utilization of its resources.

(a) The entity shall develop, maintain, and document implementation of written policies and procedures to ensure that all personnel meet and remain current on credentials required for certification, licensure, and for job performance and service delivery as specified by these rules.

(b) Clinical Director. Each entity providing treatment services shall employ a Clinical Director, who shall be responsible, in conjunction with the Executive Director, for the quality and appropriateness of clinical services within the entity's treatment program(s). The Clinical Director:

1. Shall possess, at a minimum, a master's degree from a nationally or regionally accredited university or college in psychology, social work, counseling, psychiatric nursing, or other behavioral health area with requisite course work equivalent to that of a degree in counseling, psychology, social work, psychiatric nursing, and a minimum of three years post master's relevant clinical experience; and

2. Meet the qualifications of a licensed or certified QSAP I; or.

3. Shall be a licensed physician who has completed an approved three-year residency in psychiatry.

4. Shall provide or appropriately arrange for clinical supervision for all qualified staff assigned to the agency.

(c) Program Coordinator. Each respective level of care provided by the entity shall be under the supervision of a Program Coordinator who meets the requirements of a QSAP I or QSAP II and the following criteria as written:

1. Manage the day-to-day operations of the respective level of care.

2. Ensure that the level of care is provided in accordance with the rules established, herein, and in accordance with the goals and objectives established for this service by the governing authority.

3. Meet the qualifications set forth in these rules for the respective level of care.

4. Meet the following criteria:

(i) A Program Coordinator supervising one (1) level of care at a single location may carry a caseload that does not exceed fifteen (15) individuals.

(ii) A Program Coordinator may supervise multiple levels of care operating in one (1) location, but may not concurrently carry a caseload.

(iii) A Program Coordinator may supervise one (1) level of care operating in multiple locations, but may not concurrently carry a caseload.

(iv) A Program Coordinator may supervise multiple levels of care operating in multiple locations, but may not concurrently carry a caseload.

(v) A Program Coordinator carrying a caseload may not function as a Clinical Supervisor.

(d) Qualified Substance Abuse Professionals (QSAP). The entity shall utilize qualified substance abuse professionals, to provide treatment for individuals with substance related disorders.

1. QSAP I. A Qualified Substance Abuse Professional I (QSAP I) shall consist of:

(i) An individual licensed in the State of Alabama as a:

(I) Professional Counselor, Graduate Level Social Worker, Psychiatric Clinical Nurse Specialist, Psychiatric Nurse Practitioner, Marriage and Family Therapist, Clinical Psychologist, Physician's Assistant, Physician; or

(ii) An individual who:

(I) Has a master's Degree or above from a nationally or regionally accredited university or college in psychology, social work, counseling, psychiatric nursing, or other behavioral health area with requisite course work equivalent to that of a degree in counseling, psychology, social work, or psychiatric nursing, and

(II) Has successfully completed a clinical practicum or has six month's post master's clinical experience; and

(III) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. which shall be obtained within thirty (30) months of date of hire.

(iii) A QSAP I is authorized to provide services as delineated in the most recent version of the ADMH Substance Abuse Services Billing Manual as published and maintained by ADMH.

2. QSAP II. A Qualified Substance Abuse Professional II (QSAP II) shall consist of:

(i) An individual who:

(I) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and

(II) Is licensed in the State of Alabama as a Bachelor Level Social Worker; or

(III) Has a Bachelor's Degree from a nationally or regionally accredited college or university in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and

(IV) Holds a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium.

(ii) A QSAP II is authorized to provide services as delineated in the most recent version of the ADMH Substance Abuse Services Billing Manual as published and maintained by ADMH.

3. QSAP III. A Qualified Substance Abuse Professional III (QSAP III) shall consist of:

(i) An individual who:

(I) Has a Bachelor's Degree from a nationally or regionally accredited university or college in psychology, social work, community, rehabilitation, or pastoral counseling, family therapy, or other behavioral health area that requires equivalent clinical course work, and

(II) Participates in ongoing supervision by a certified or licensed QSAP I for a minimum of one (1) hour individual per week until attainment of a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, or Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. which shall be obtained within thirty (30) months of hire.

(ii) A QSAP III is authorized to provide services as delineated in the most recent version of the ADMH Substance Abuse Services Billing Manual as published and maintained by ADMH.

4. Qualified Paraprofessionals(QPP). A qualified paraprofessional shall have the following minimum qualifications:

(i) A high school diploma or equivalent, and

(ii) One (1) year of work experience directly related to job responsibilities and

(iii) Concurrent participation in clinical supervision by a licensed or certified QSAP I.

(iv) A QPP is authorized to provide services as delineated in the most recent version of the ADMH Substance Abuse Services Billing Manual as published and maintained by ADMH.

5. Peer Support Specialist. A peer support specialist must meet the following minimum qualifications:

(i) Certified by ADMH as a Certified Recovery Support Specialist (CRSS) within six (6) months of date of hire, and

(ii) Concurrent participation in clinical supervision by a licensed or certified QSAP I.

(iii) A Peer Support Specialist is authorized to provide services as delineated in the most recent edition of the ADMH Substance Abuse Services Billing Manual as published and maintained by ADMH.

6. Students who are completing a graduate degree from a regionally accredited university or college in psychology, counseling, social work, or psychiatric nursing may conduct direct services under the following conditions:

(i) The student is in a clinical practicum that is part of an officially sanctioned academic curriculum.

(ii) The student receives a minimum of one (1) hour per week of direct clinical supervision (face to face) from a licensed or certified QSAP I.

(iii) Any written clinical documentation generated by the student must be reviewed and signed by the supervising clinical staff member.

(3) Staff Development. The entity shall develop, maintain, and document implementation of written policies and procedures that establish a staff development and training program for all employees, students, and volunteers. This program shall include, at a minimum, the following requirements:

(a) Annual Training: During each calendar year, the entity shall provide training for each employee that addresses the following topics:

1. Crisis intervention.
2. Management of disruptive behavior.
3. Suicide prevention/intervention.
4. Confidentiality and privacy of client information.
5. Cultural competency relative to the program's target population.

6. Infectious disease prevention and management, to include at a minimum: TB, HIV/AIDS, Sexually Transmitted Diseases and Hepatitis.

7. Program policies and procedures.
8. DMH Administrative Code specific to level(s) of care.

(b) First Aid/Cardiopulmonary Resuscitation (CPR) Training. All staff of each substance abuse prevention, treatment, and recovery support program shall obtain, within one

(1) month of hire, and continuously, thereafter, current certification in First Aid and CPR.

(4) An individual who met the requirements of the Administrative Code 580-9-44-2 Personnel effective March 2012 and was employed prior to the approval of these rules shall be in good standing.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New: Filed: July 22, 1992. **Extended:** September 30, 1992. **Extended:** December 31, 1992. **Certified:** March 30, 1993. **Effective:** May 5, 1993. **Repealed and New Rule:** Filed January 26, 2012; effective March 1, 2012. **Amended:** Filed January 8, 2018; effective February 22, 2018.

580-9-44-.03 Client Rights. The entity shall develop, maintain, and document implementation of written policies and procedures that demonstrate how the organization protects and promotes clients' welfare, the manner in which clients are informed of these protections, and the means by which these protections are enforced, which shall include, at a minimum, the following specifications:

(1) The entity's policies and procedures governing the rights of clients shall adhere to all applicable federal, state, and local laws and regulations.

(2) The entity shall be able to document and demonstrate through implementation of its policies and procedures that, at a minimum, each client has the following rights:

(a) To considerate, respectful, humane, adequate, and appropriate care from all employees of the agency, at all times, under all circumstances.

(b) To receive accurate, easily understood information at all times during every aspect of service delivery.

(c) The option to give or withhold informed consent:

1. Prior to the provision service delivery by the entity and

2. Prior to participation in research projects.

(d) To receive a copy of any informed consents authorized.

(e) To be informed of the person who has primary responsibility for the client's care.

(f) To participate fully in all decisions related to treatment and care provided by the entity.

(g) To be provided with appropriate information to facilitate decision making regarding treatment.

(h) To the provision of services in a manner that is responsive to and respectful of the client's unique characteristics, needs and abilities.

(i) To the development of a unique service plan formulated in partnership with the program's staff, and to receive services based upon that plan.

(j) To the availability of an adequate number of competent, qualified, and experienced professional clinical staff to ensure appropriate implementation of the client's service plan.

(k) To the provision of care as according to accepted clinical practice standards within the least restrictive and most accommodating environment possible.

(l) To be informed of the nature of possible significant adverse effects of the recommended treatment, including any appropriate and available alternative treatments, services, and/or providers.

(m) To express preferences regarding the selection of service provider(s).

(n) Service delivery that is absent of:

1. Physical abuse.
2. Sexual abuse.
3. Harassment.
4. Physical punishment.
5. Psychological abuse, including humiliation.
6. Threats.
7. Exploitation.

8. Coercion.

9. Fiduciary abuse.

(o) To report without fear or retribution, any instances of perceived abuse, neglect, or exploitation.

(p) To use a grievance and appeal process for dispute resolution.

(q) To provide input into the entity's service delivery processes through client satisfaction surveys and other avenues provided by the governing body.

(r) To be informed of all fees associated with treatment for which payment will be due from the client, and the consequences of nonpayment of required fees.

(s) To receive services in a safe and humane environment.

(t) To privacy, both inside and outside the program setting.

(u) To be informed of any potential restriction of rights that may be imposed.

(v) To be informed of the parameters of confidentiality.

(w) To be informed of all program rules and client responsibilities prior to initiation of care, and the consequences of non-compliance.

(x) To be informed of client rights at the time of admission, both verbally and in writing.

(3) The entity shall develop, maintain, and document implementation of written policies and procedures that:

(a) Describe the mechanisms utilized for implementation and protection of client rights, which shall include at a minimum:

1. Informing the client of his/her rights at the time of admission in a manner understood by the client, and as needed throughout the service delivery process.

2. Providing the client with a copy of the rights, in a medium that the client understands, at admission and documenting this process in the client's service record.

3. Prominently posting copies of the rights throughout the facility in which services are provided.

(b) Identify and govern implementation of program rules, which shall:

1. Be appropriate relative to the population served and the level of care provided.

2. Be confined to those rules that are needed to ensure order, safety, and promote client and staff wellness.

3. Not be overly restrictive in their scope or consequence.

4. Not be applied arbitrarily or capriciously.

5. Not use involuntary withdrawal of medication or discharge from the program, unless all other means of ensuring order, safety, or wellness have been attempted, documented in the service record, and exhausted.

6. Provide clear guidelines relative to client visitation, telephone use privileges, and receipt of mail.

7. Govern the use of seclusion and restraint.

8. Govern any situation resulting in planned or unplanned restriction of client rights that shall include, at a minimum:

(i) Identify personnel authorized to initiate rights restrictions.

(ii) A process for regularly evaluating:

(I) Any restrictions placed on the rights or privileges of persons served.

(II) The purpose or benefit of any type of restriction.

(III) Methods to reinstate restricted or lost privileges and rights.

(iii) Documentation of the restriction entered in the clinical record and signed by the program director.

(c) Describe the methods by which the client may review his/her clinical record.

(d) Describe use of special equipment, such as two-way mirrors and/or audio/visual equipment, which at a minimum includes a requirement for the client's written informed consent for participation, and specification of:

1. The mechanism by which audio/visual content will be destroyed.
2. The time parameters in which destruction will take place.
3. Govern client participation in any research or study using human subjects, to include at a minimum, the following specifications:

(i) A description of the process utilized by the entity to adhere to all governmental regulations, including, Title 45 CFR (Code of Federal Regulations) Part 46. {1} Institutional Review Boards.

(ii) The process utilized to ensure adherence to professional ethics.

(iii) The process by which the governing body:

(I) Is informed of the research or study proposing utilization of the entity's clientele.

(II) Grants and provides documentation of authorization of the research or study.

(e) Describe the process utilized to obtain client authorizations for release of confidential, private, or other protected information.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.04 Abuse And Neglect.

(1) The entity shall develop, maintain, and document compliance with policies and procedures to protect each client's

right to be free from physical and mental abuse, exploitation, or neglect. At a minimum, these policies and procedures shall:

(a) Affirm and safeguard the rights of each client pursuant to all applicable federal, state, and local laws and 580-9-44-.03.

(b) Ensure that prompt action is taken to prevent the potential of further abuse while an investigation is in process.

(c) Provide for an immediate and thorough investigation of all allegations of abuse, exploitation, or neglect by trained, experienced personnel delegated with all necessary authority. The status of all investigations shall be reported to the executive director of the program or his or her designated representative on a continuous basis.

(d) Establish reasonable and appropriate corrective action, including education, training, and disciplinary action for any program-affiliated individual who has been found responsible for abuse, exploitation, or neglect of clients. All criminal violations shall be reported to the Office of the Attorney General, State of Alabama, or the local district attorney for consideration of further legal action.

(e) Establish a process whereby the program's administrators, professionals, direct-care staff, and volunteers receive informational material and training on client rights and on prevention of client abuse, exploitation, and/or neglect. The entity shall maintain documentation that verifies:

1. Each new staff member is provided with opportunities to establish a working knowledge of client rights and prevention of abuse, exploitation, and neglect.

2. Training addressing client rights, neglect, exploitation, and abuse is provided on an ongoing basis for all staff.

(2) The entity shall report all cases of suspected client abuse, neglect, and/or exploitation to the Mental Illness and Substance Abuse Services Division Associate Commissioner's office as according to 580-9-44-.09, and to the Alabama Department of Human Resources in accordance with DMH incident reporting procedures, incorporated herein by reference.

(3) All mandatory notifications relative to neglect and abuse shall be made in accordance with applicable Federal and
Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.05 Grievances, Complaints, And Appeals.

(1) The entity shall document implementation of written policies and procedures by which a person served may make a formal complaint, file a grievance, or appeal a decision made by the organization's staff members or team that, at a minimum:

(a) Specify that actions taken to file a complaint, grievance, or appeal will not result in retaliation or barriers to service.

(b) Identify program personnel with whom the grievance, complaint, or appeal may be initiated.

(c) Ensure easy client accessibility to the grievance/complaint/appeal process, including allowing the process to be initiated verbally or in writing.

(d) Rights information is posted in commonly used public areas of residential facilities where clients live and also where they receive services; such notices shall include the 800 numbers of the DMH Mental Illness and Substance Abuse Advocacy Program, Federal Protection and Advocacy System and local Department of Human Resources.

(e) Describe each step of the grievance/complaint/appeal process, including:

1. Staff and client responsibilities.
2. The role of third parties, including advocates, in dispute resolution.
3. Procedures for review and investigation, including participation by external parties.
4. Time frames that are adequate for prompt consideration and that result in timely decisions for the person served.
5. Procedures to provide both verbal and written notification to the client regarding actions taken to address the grievance/complaint/appeal.

(2) Clients shall be provided a copy of the entity's grievance/complaint/appeal procedures at admission and the procedures shall be posted throughout the facility in which services are provided.

(3) The entity shall document implementation of procedures to explain the grievance/complaint/appeal process in a manner that is understandable to the client.

(4) The entity shall maintain a written log of all grievances, complaints, and appeals filed, including the date initiated and the date resolved.

(5) The governing authority shall annually review, update as appropriate, and approve the entity's grievance, complaint, and appeal process.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.06 Confidentiality And Privacy. The entity shall develop, maintain, and document implementation of written policies and procedures that govern confidentiality and privacy of client information that include, at a minimum, the following specifications:

(1) Policies and procedures shall comply with all state and federal laws and regulations relative to confidentiality and privacy of client information, including but not limited to, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164, and shall address:

(a) Protected information, including, but not limited to:

1. On-site and off-site correspondence.
2. Telephone correspondence.
3. Face-to-face correspondence.
4. Written correspondence.

5. The provision of any other information that would disclose the identity of an individual as an alcohol or drug abuse client.

6. The provision of identifiable health information, including medical record numbers.

(b) Disclosure of client information with the client's consent.

(c) Revocation of authorized information releases.

(d) Authorized information releases.

1. Disclosures with the client's consent shall be authorized in writing, in a manner understood by the client, and shall include, at a minimum:

(i) The name of the client for whom the information will be disclosed.

(ii) The name of the program making the disclosure.

(iii) The purpose of the disclosure.

(iv) The identity of the person or organization that will be the recipient of the disclosed information.

(v) A description of exactly what information will be disclosed.

(vi) A statement that the client may revoke the consent to release information at any time, except to the extent the program has already acted in reliance upon the consent.

(vii) A statement that the revocation may be oral as well as written.

(viii) The date, event, or condition upon which the consent for release of information will expire, not to exceed one (1) year from the date of its execution.

(ix) Notification to the information recipient prohibiting re-disclosure.

(x) The signature of the client or the signature of the person who is legally authorized to sign the release.

(xi) The name and signature of the staff member witnessing the client's signature.

- (xii) The date the consent form is signed.
- (e) Disclosure of protected information without the client's consent.
- (f) Re-disclosure of protected information.
- (g) The entity's response to:
 - 1. Subpoenas.
 - 2. Court orders.
 - 3. Search warrants.
 - 4. Arrest warrants.
 - 5. Deceased client disclosures.
- (h) Electronic health information and records.
- (2) The entity shall:
 - (a) Document implementation of the process in which clients are notified of their rights to confidentiality and privacy. At a minimum, notice must:
 - 1. Be given at first delivery of service.
 - 2. Inform the client of the federal law and regulations that protect alcohol and drug abuse patient records.
 - 3. Describe limited circumstances of disclosure.
 - 4. State that violation of the law and regulations is a crime.
 - 5. State that the client's commission of a crime on the premises or against program personnel is not protected.
 - 6. State that suspected child abuse or neglect may be reported.
 - 7. Provide citations to the applicable federal law and regulations.
 - 8. Be provided in writing and orally in a manner understood by the client.

- (b) Identify program personnel authorized to disclose protected client information.
 - (c) Specify procedures for documenting all disclosures of protected information in the client record.
 - (d) Specify procedures utilized to give clients access to their records and to ensure protection of the information disclosed.
- (3) The entity shall not release confidential information in a client's record that pertains to other clients.
- 4) Adolescent Specific Criteria. When a minor, age fourteen (14) through age eighteen (18), is treated for a substance related disorder, with or without parental consent, the entity shall document compliance with relevant federal, state and local laws, relative to disclosure of adolescent client information.

Author: Substance Abuse Services Division
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.07 Seclusion And Restraint.

- (1) Clients treated in programs certified by the Alabama Department of Mental Health have the right to be free of seclusion and restraint. Seclusion and restraint are safety procedures to be used as a last resort.
- (2) Clients may be placed in seclusion or may be physically restrained only when necessary to prevent the client from physically harming self or others, and after less restrictive alternative interventions have been unsuccessful or are determined not to be feasible, and when authorized by a qualified physician.
- (3) Any program providing substance abuse prevention, early intervention, or treatment services, utilizing client seclusion and/or restraint must establish written policies and procedures specifically defining and governing these practices that are reviewed and approved by the governing authority annually.

Author: Substance Abuse Services Division
Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.08 Child And Adolescent Seclusion And Restraint.

Because of the high risk nature of seclusion and restraint procedures and the potential for harm to clients, the Mental Illness and Substance Abuse Services Division of the DMH Seclusion and Restraint is included here to place the standards within the proper context.

(1) Children/adolescents residing or receiving treatment in a community based setting certified by the DMH have the right to be free of seclusion and restraint. Seclusion and restraint are safety procedures of last resort. Seclusion and restraint are not therapeutic interventions and are not interventions implemented for the purpose of behavior management.

(2) Children/adolescents may be placed in seclusion or physically restrained only in emergency situations when necessary to:

(a) Prevent the child/adolescent from physically harming self or others.

(b) Less restrictive alternative treatment interventions have been unsuccessful or are determined not to be feasible.

(c) When authorized by a qualified individual.

(3) The DMH requires that any organization certified by DMH develop special safety procedures that reflect the policy above. Mechanical restraints are prohibited. Additionally, procedures must be developed which address standards of care as required in this section.

(4) The standards for seclusion and restraint do not apply in the following circumstances with the exception that the standard section that addresses staff competence and training is applicable under these circumstances:

(a) To the use of restraint associated with acute medical or surgical care.

(b) When a staff member(s) physically redirects or holds a child without the child's permission, for fifteen (15) minutes or less in outpatient/nonresidential programs.

(c) To timeout less than fifteen (15) minutes in length for residential programs and under thirty (30) minutes in length for outpatient programs implemented in accordance with the procedures described in this section.

(d) To instances when the client is to remain in his or her unlocked room or other setting as a result of the violation of unit/program rules of regulations consistent with organizational policies and procedures. Organizational policies and procedures shall require that room restriction be for a specified time and be limited to no longer than twelve (12) hours. Should the client decide not to comply and leave the area, seclusion and restraint cannot be instituted unless the criteria are met.

(e) To protective equipment such as helmets.

(f) To adaptive support in response to assessed physical needs of the individual (for example, postural support, orthopedic appliances).

(5) The organization must have written policies and procedures that support the protection of clients and reflect the following:

(a) Emphasize prevention of seclusion and restraint.

(b) Demonstrate seclusion or restraint use is limited to situations in which there is immediate, imminent risk of a child/adolescent harming self or others.

(c) Implemented only when less restrictive alternative treatment interventions have been unsuccessful or are determined not to be feasible and documented in the client record.

(d) Is never used as coercion, discipline, or for staff convenience.

(e) Is limited to situations with adequate, appropriate clinical justification.

(f) Is used only in accordance with an authorization from a seclusion and restraint trained QSAP I or qualified trained registered nurse.

(g) Seclusion and restraint may not be used in lieu of effective communication with clients who are deaf, hard of hearing, or have limited English proficiency. In the case of clients who are deaf and who use sign language to communicate,

restraints must be applied in a way that leaves at least one (1) hand free to sign.

(h) When appropriate, Transitional Hold, rather than prone restraint, will be used as an effective safer technique in behavioral emergency situations in which restraint is needed.

(6) Nonphysical interventions are always considered the most appropriate and preferred intervention. These may include redirecting the child/adolescent focus, verbal de-escalation, or directing the child/adolescent to take a timeout.

(7) Utilization of restraint, seclusion, timeouts, and other techniques associated with the safety of the client or used to help him/her gain emotional control shall be implemented and documented in accordance with all applicable requirements and documentation shall be maintained in the client record. The client's parent/legal guardian will be asked at diagnostic interview examination for the frequency with which they would like such information shared with them and client records shall reflect that notifications conform with requests.

(8) The initial assessment of each client at the time of admission or diagnostic interview examination assists in obtaining all of the following information about the client that could help minimize the use of seclusion and restraint. Such information is documented in the client record. The program informs the family/legal guardian about use and reporting. The following information is obtained/provided:

(a) Techniques, methods, or tools that would help the client control his or her behavior. When appropriate, the client and/or family/legal guardian shall assist in the identification of such techniques.

(b) Preexisting medical conditions or any physical disabilities and limitations that would place the client at greater risk during seclusion or restraint including developmental age and history, psychiatric condition, and trauma history.

(c) Any history of sexual or physical abuse that would place the client at greater psychological risk during seclusion or restraint.

(d) If the client is deaf and uses sign language, provision shall be made to assure access to effective communication and that techniques used will not deprive the client of a method to communicate in sign language.

(e) The client and/or family/legal guardian is informed of the organization's philosophy on the use of seclusion and restraint to the extent that such information is not clinically contraindicated.

(f) The role of the family/legal guardian, including their notification of a seclusion or restraint episode, is discussed with the client and, as appropriate, the client's family/legal guardian. An agreement will be made with the family/legal guardian at diagnostic interview examination regarding notification.

(9) Seclusion/physical restraint may be authorized only by a licensed independent practitioner (LIP), Seclusion and Restraint trained QSAP I, preferably the one who is primarily responsible for the client's care or by a qualified registered nurse. The person authorizing seclusion or restraint meets the requirements and such is verifiable in the personnel records. Chemical restraint may be ordered only by a licensed physician, certified registered nurse practitioner, or licensed physician's assistant. The authorization for each instance is documented in the client record.

(10) In the event that a client who is deaf, hard of hearing, or limited English proficient must be restrained, effective communication shall be established by a staff member fluent in the client's language of choice. If the client's preferred language is sign, the staff member shall hold an Intermediate Plus level or higher on the Sign Language Proficiency Interview or be a qualified interpreter. The manner of communication is documented in the client record. A client who is deaf must have at least one hand free during physical restraint.

(11) Authorizations for the use of seclusion and restraint have the following characteristics:

(a) Are limited to one (1) hour.

(b) Are not written as a standing order or on an as needed basis (that is, PRN).

(c) Specify the behavioral criteria necessary to be released from seclusion and restraint. It is documented that clients are released as soon as the behavioral criteria are met.

(12) Agency written policies and procedures require every effort to be made to terminate seclusion and restraint at the earliest time it is safe to do so. Time limited orders do not

mean that restraint or seclusion must be applied for the entire length of time for which the order is written. Efforts to terminate seclusion and restraint shall be documented in the client's record including when seclusion and restraint is appropriately terminated sooner than the timeframe for the order ends.

(13) When seclusion or restraint is terminated before the time limited order expires, that original order can be used to reapply the seclusion or restraint if the individual is at imminent risk of physically harming self or others and nonphysical interventions are not effective.

(14) At the time the initial authorization for seclusion or restraint expires, the client receives an in person reevaluation conducted by a Licensed Independent Practitioner (LIP), Seclusion and Restraint trained QSAP I preferably the one who is primarily responsible for the client's care or by a Qualified Registered Nurse. Documentation in the client record shall address all of the following requirements of the in person evaluation:

- (a) The client's psychological status.
- (b) The client's physical status as assessed by a RN, MD, DO, CRNP, or PA.
- (c) The client's behavior.
- (d) The appropriateness of the intervention measures.
- (e) Any complications resulting from the intervention.
- (f) The need for continued seclusion and restraint.
- (g) The need for immediate changes to the client's course of care such as the need for timely follow up by the client's primary clinician or the need for medical, psychiatric, or nursing evaluation for needed medication changes.

(15) If the seclusion or restraint is to be continued at the time of the reevaluation, the following procedures must be followed and documented in the client record:

- (a) A new written authorization is given by a Licensed Independent Practitioner or by a Qualified Registered Nurse as defined above, preferably by the one who is responsible for the care of the client.

(b) When next on duty, the S and R trained QSAP I licensed independent practitioner evaluates the efficacy of the individual's treatment plan and works with the client to identify ways to help him or her regain self-control.

(c) If the authorization is continued past the first hour, the case responsible QSAP I licensed independent practitioner will be notified within twenty-four (24) hours of the client's status.

(16) Clients in seclusion or restraint are monitored to ensure the individual's physical safety through continuous in-person observation by an assigned staff member who is competent, fluent in the preferred language of the client (spoken or signed), and trained in accordance with the standard. The items in 580-9-44-.08(22) are checked and documented every fifteen (15) minutes. If the client is in restraint, a second staff person is assigned to observe him/her.

(17) Within twenty-four (24) hours after a seclusion or restraint has ended, the client and staff who were involved in the episode and who are available participate in a face-to-face debriefing about each episode of seclusion or restraint. To the extent possible, the debriefing shall include:

(a) All staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the client.

(b) Other staff and the client's personal representative(s) as specified in the notification agreement may participate in the debriefing.

(c) The facility must conduct such discussion in a language that is understood by the client and the client's personal representative(s).

(d) The debriefing must be documented in the client record. The debriefing is used to:

1. Identify what led to the incident and what could have been handled differently.

2. Ascertain that the client's physical well-being, psychological comfort, and right to privacy and communication were addressed.

3. Facilitate timely clinical follow up with between the client and primary therapist as needed to address trauma.

4. When indicated, modify the individual's treatment plan.

(18) Within twenty-four (24) hours after a seclusion or restraint has ended or the next business day appropriate supervisory staff, administrative staff, and the case responsible QSAP I shall perform an administrative review. To the extent that it is possible, the review should include all staff involved in the intervention, when available. The administrative review is used to:

(a) Identify the procedures, if any, that staff are to implement to prevent any recurrence of the use of seclusion or restraint.

(b) Discuss the outcome of the intervention, including any injuries that may have resulted from the use of seclusion or restraint.

(c) Staff must document in the client's record that the review sessions took place and must include in that documentation the names of staff who were present for the review, names of staff excused from the review, and any changes to the client's treatment plan that result from the review.

(d) The review shall include particular attention to the following:

1. Multiple incidents of seclusion and restraint experienced by a client within a twelve (12) hour timeframe.

2. The number of episodes for the client.

3. Adequacy of communication in instances of seclusion or restraint of clients who are deaf, hard of hearing, or limited English proficient.

4. Instances of seclusion or restraint that extend beyond two (2) consecutive hours.

5. The use of psychoactive medications as an alternative to, or to enable discontinuation of restraint or seclusion.

(19) In order to minimize the use of seclusion and restraint, all direct care staff as well as any other staff involved in the use of seclusion and restraint receive annual training and demonstrate competency in the safe use of restraint before they participate in any use of seclusion or restraint:

(a) The underlying causes of threatening behaviors exhibited by the clients they serve.

(b) That sometimes a client may exhibit an aggressive behavior that is related to a medical condition and not related to his or her emotional condition, for example, threatening behavior that may result from delirium in fevers, hypoglycemia.

(c) That sometimes inability to effectively communicate due to hearing loss or limited English proficiency leads to misunderstanding or increased frustration that may be misinterpreted as aggression.

(d) How their own behaviors can affect the behaviors of the clients they serve.

(e) The use of de-escalation, mediation, self-protection and other techniques, such as timeout.

(f) Recognizing signs of physical distress in clients who are being held, restrained, or secluded.

(g) The viewpoints of clients who have experienced seclusion or restraint are incorporated into staff training and education in order to help staff better understand all aspects of seclusion and restraint use. Whenever possible, clients who have experienced seclusion or restraint contribute to the training and education curricula and/or participate in staff training and education.

(20) Staff who are authorized to physically apply seclusion or restraint receive the training and demonstrate competency described in 580-9-44-.08(22).

(21) Staff who are authorized to physically apply seclusion or restraint receive annual training and demonstrate competency in the safe use of restraint, including physical holding techniques.

(22) Staff who are authorized to perform the fifteen (15) minute monitoring of individuals who are in seclusion or restraint receive the training and demonstrate the competence cited above and also receive ongoing training and demonstrate competence in:

(a) Taking and recording vital signs.

(b) Effective communication.

(c) Offering and providing nutrition/hydration.

(d) Checking for adequate breathing, circulation and range of motion in the extremities.

(e) Providing for hygiene and elimination needs.

(f) Providing physical and psychological comfort.

(g) Assisting clients in meeting behavior criteria for the discontinuation of seclusion or restraint.

(h) Documenting behavior and informing clinical staff of behavior indicating readiness for the discontinuation of seclusion or restraint.

(i) Recognizing when to contact a medically trained licensed independent practitioner or emergency medical services.

(j) Recognizing signs of injury associated with seclusion and restraint.

(k) Recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which an individual reacts to physical contact.

(l) Recognizing the behavior criteria for the discontinuation of seclusion or restraint.

(m) Records of initial and ongoing staff training and competency testing shall be maintained in personnel records and training materials shall be available for review as needed.

(23) All direct care staff are competent to initiate first aid and cardiopulmonary resuscitation. Records of staff training shall be maintained in personnel records.

(24) There is a written plan for provision of emergency medical services. Client records demonstrate that appropriate medical services were provided in an emergency.

(25) Seclusion and restraint shall:

(a) Be implemented in a manner that protects and preserves the rights, dignity, and well-being of the child/adolescent.

(b) Be implemented in the least restrictive manner possible in accordance with safe, appropriate restraining techniques.

(c) Not be used as punishment, coercion, discipline, retaliation, for the convenience of staff, or in a manner that causes undue physical discomfort, harm, or pain.

(26) Client records document that the use of seclusion or restraint is consistent with organization policy, and documentation focuses on the individual. Each episode of use is recorded. Documentation includes:

(a) The circumstances that led to their use.

(b) Consideration or failure of nonphysical interventions.

(c) That clients who are deaf or limited English proficient are provided effective communication in the language that they prefer (signed or spoken) during seclusion and restraint.

(d) The rationale for the type of physical intervention selected.

(e) Notification of the individual's family/legal guardian consistent with organizational policy and the agreement with the family/legal guardian.

(f) Specification of the behavioral criteria for discontinuation of seclusion or restraint, informing the client of the criteria, and assistance provided to the client to help him or her meet the behavioral criteria for discontinuation.

(g) Each verbal order received from a LIP physician, certified registered nurse practitioner, or physician's assistant must be signed within forty-eight (48) hours.

(h) Each evaluation of the client signed by the staff person who provided the evaluation.

(i) Continuous monitoring to include fifteen (15) minute assessments of the client's status.

(j) Debriefing of the individual with staff.

(k) Any injuries that are sustained and treatment received for these injuries.

(l) Circumstances that led to death.

(27) Staffing numbers and assignments are adequate to minimize circumstances leading to seclusion and restraint and to maximize safety when seclusion and restraint are used. Staff qualifications, the physical design of the facility, the diagnoses and acuity level of the residents, age, gender, and developmental level of the residents shall be the basis for the staffing plan.

(28) The provider must report the use of seclusion and restraint to DMH in accordance with published reporting guidelines. Additionally, the organization is required by applicable law and regulations to report injuries and deaths to external agencies.

(29) The provider must demonstrate that procedures are in place to properly investigate and take corrective action where indicated and where seclusion and restraint results in client injury or death.

(30) Timeout shall be implemented as follows:

(a) A client in timeout must never be physically prevented from leaving the timeout area.

(b) Timeout may take place away from the area of activity or from other clients such as in the client's room (exclusionary) or in the area of activity of other clients (inclusionary).

(c) Staff must monitor the client while he or she is in timeout.

(d) Documentation shall support that these procedures were followed and shall include the following:

1. Circumstances that lead to the use of timeout regardless of whether the timeout was client requested, staff suggested, or staff directed.

2. Name and credentials of staff who monitored the client throughout the timeout.

3. Where on the provider's premises either an inclusionary or an exclusionary timeout was implemented.

4. The length of time for which timeout was implemented.

5. Behavioral or other criteria for release from timeout if applicable.

6. The status of the client when timeout ended.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.09 Incident Reporting. The entity shall develop, maintain, and document compliance with written policies and procedures to promptly address the occurrence of any incident and/or critical incident that has the potential to adversely impact the health, safety, and well-being of any client at any location in which the entity provides services.

(1) A formal process shall be established to govern the entity's response to the following events, at a minimum, in the course of service delivery:

(a) Actual or perceived abuse, including but not limited to:

1. Physical abuse.
 2. Sexual abuse.
 3. Neglect.
 4. Exploitation.
 5. Mistreatment.
 6. Verbal abuse.
- (b) Major client injury.
- (c) Confidentiality or privacy breach.
- (d) Death.
- (e) Client elopement.
- (f) Unplanned relocation of clients.
- (g) Legal/criminal activity.
- (h) Media events

- (i) Medication errors.
- (j) Non-consensual sexual contact.
- (k) Suicide attempt.
- (l) Hospitalization.
- (m) Seclusion.
- (n) Restraint.

(o) Any other events that adversely affect, or has the potential to be harmful or hazardous to the health, safety, or well-being of a client, and does not fall into one of the categories listed above.

(2) Policies and procedures governing the entity's response to the occurrence of an incident and/or critical incident shall include, at a minimum:

(a) Staff responsibilities relative to reporting incidents and/or critical incidents.

(b) The process used to document the occurrence of incidents and/or critical incidents.

(c) Timeframes for initial and subsequent response by the entity's executive and clinical leadership staff to the occurrence of incidents and/or critical incidents and to the need, as appropriate, to ensure the safety of the parties involved.

(d) The process used to investigate the circumstances surrounding an incident and/or critical incident and to take appropriate action to bring resolution to the event.

(e) Timely and appropriate review of incident and/or critical incident reports by the organization's governing body, along with, its executive and clinical leadership staff.

(f) Incorporation of incident and/or critical incident report data into the entity's performance improvement processes.

(g) A process to ensure the timely reporting of incidents and/or critical incidents as required by law, to DMH as according to the Mental Illness and Substance Abuse Services Division Incident/Critical Incident Reporting Procedures incorporated herein by reference, and to families or others as according to the circumstances of the incident.

(3) The entity shall comply with the published incident reporting requirements of DMH.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.10 Infection Control. The entity shall develop, maintain, and document compliance with a written plan for exposure control relative to infectious diseases that shall, at a minimum, include the following requirements:

(1) The plan shall be inclusive of the entity's staff, clients, and volunteers.

(2) The plan shall be consistent with protocols and guidelines established for infection control in healthcare settings by the Federal Center for Disease Control, and shall at a minimum include:

(a) Policies and procedures to mitigate the potential for transmission and spread of infectious diseases within the agency.

(b) Risk assessment and screening of clients reporting high risk behavior and symptoms of communicable disease.

(c) Procedures to be followed for clients known to have an infectious disease.

(d) Provisions to offer directly or by referral to all clients who voluntarily accept the offer for HIV/AIDS early intervention services to include, HIV pre-test and post-test counseling and case management and referral services, as needed, for medical care.

(e) The provision of HIV/AIDS, Hepatitis, STD, and TB education for all program admissions.

(f) A formal process for screening all program admissions for TB.

(g) TB testing for all employees prior to initiation of duties after hiring, and annually thereafter.

(h) The entity shall document compliance with all laws and regulations regarding reporting of communicable diseases to the Alabama Department of Public Health.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.11 Performance Improvement. The provider shall provide written documentation of the entity's operation and maintenance of a Performance Improvement System.

(a) The Performance Improvement System shall be designed to:

1. Monitor and assess organizational processes and outcomes.

2. At a minimum, identify and monitor important processes and outcomes for the six (6) components of Performance Improvement, Quality Improvement, Incident Prevention and Management, Utilization Review, Consumer and Family Satisfaction, Review and Treatment Plans, and Seclusion and Restraint (if applicable) consistent with the definitions described in this section.

(i) Correct and follow up on identified organizational problems.

(ii) Improve the quality of services provided.

(iii) Improve client and family satisfaction with services provided.

3. The Performance Improvement System shall provide meaningful opportunities for input, relative to the operation and improvement of services, from key stakeholders including clients, family members, consumer groups, advocates, and advocacy organizations.

4. The Performance Improvement System shall be described in a written plan, which, at a minimum shall:

(i) Identify and encompass all program service areas and functions, including volunteer and subcontracted client services.

(ii) Outline the provider's mission related to Performance Improvement.

(iii) Include the entity's goals and objectives for Performance Improvement.

(iv) Define the organizational structure of Performance Improvement activities, which shall include establishment of a functional Performance Improvement Committee. This committee shall:

(I) Consist of representatives of various professional disciplines within the organization.

(II) Determine the processes and outcomes to be monitored, in addition to those required by these rules.

(III) Determine the frequency in which information will be reviewed.

(IV) Select indicators.

(V) Evaluate gathered information.

(VI) Decide actions to be taken to correct identified problems.

(VII) Recommend corrective actions.

(VIII) Evaluate implementation and effectiveness of corrective actions taken.

(IX) Meet at least quarterly.

(X) Generate written, dated minutes of each meeting prior to the next meeting that shall include, at a minimum:

I. Member attendance.

II. Indicators reviewed at the meeting.

III. Conclusions reached.

IV. Recommendations for corrective action.

V. Indicators to be reviewed at the next meeting.

(XI) Document all performance improvement activities and maintain them on site for review for a minimum of two (2) years.

(XII) Establish specific staff responsibility for coordination of the Performance Improvement System.

(XIII) Specify the manner in which Performance Improvement findings and recommendations are communicated to all levels of the organization and key stakeholders, including, but not limited to:

- I. The governing authority.
- II. Staff.
- III. Clients, families, and advocates.
- IV. DMH.

(XIV) Provide for review and approval by the governing authority on an annual basis and when revisions are made.

5. Performance Improvement Activities. The entity shall develop, maintain, and document implementation of written policies and procedures to:

- (i) Establish quality indicators that are:
 - (I) Relevant to the level of care and services provided.
 - (II) Based upon professionally recognized standards of care.
 - (III) Inclusive of indicators required by DMH.
- (ii) Systematically monitor and evaluate the entity's program utilization data, including, but not limited to:
 - (I) Time from initial client contact with the program to initial appointment.
 - (II) Appointment no show rates.
 - (III) Behavioral Health Screening/Placement Assessment only (i.e. clients who have a Behavioral Health Screening/Placement Assessment and do not follow through with treatment recommendation and those who are not deemed appropriate for any level of care).
 - (IV) The number of active cases.

- (V) Retention rates.
- (VI) Length of stay.
- (VII) The number of admissions.
- (VIII) The number of program discharges.
- (IX) The number terminated due to choosing no further treatment.
- (X) The number of dropouts due to inability to contact.
- (XI) The number of referrals to another agency.
- (XII) The number of transfers to another level of care within the continuum of care.
- (XIII) The number and types of services rendered to clients.
- (XIV) Average number of individuals waiting for admission.
- (XV) Average number of days individuals remain on the waiting list for admission.
- (iii) Monitor service access and retention processes.
- (iv) Conduct periodic and timely review of any deficiencies, requirements, and performance improvement recommendations received from DMH certification site visits, advocacy visits, and/or from any other funding, auditing, regulatory, accrediting, or licensing bodies. This process shall include a specific mechanism for the development, implementation, and evaluation of the effectiveness of action plans designed to correct deficiencies and prevent reoccurrence of deficiencies cited.
- (v) Conduct an administrative and clinical review of a representative sample of active and closed client records. This review shall function to:
 - (I) Assess the appropriateness of the admission relative to published admission criteria.
 - (II) Assess the presence, accuracy and completeness of clinical documentation in relation to these rules and the organization's policies and procedures.

(III) Monitor the timeliness, adequacy, and appropriateness of service planning for each client, which shall address, at a minimum:

I. Timeliness of individualized service plan development.

II. Implementation of service plan reviews and updates as required by program policy and DMH.

III. Appropriateness of the Individualized Service Plan in relation to assessed client needs.

IV. Evidence of active involvement of the client, family, and collateral support systems in the service planning process.

V. Evidence of cultural competency in service planning and delivery.

VI. Documentation of service delivery in relation to the Individualized Service Plan.

(IV) Adequacy of case development and management.

(vi) Assess the satisfaction of clients and families, including:

(I) The client's perception of the outcome of services received.

(II) The client's perception of the quality of the therapeutic alliance.

(III) Other perceptions of clients and families regarding factors that impact care and treatment, including but not limited to:

I. Access to care.

II. Knowledge of program information.

III. Staff helpfulness.

(vii) Monitor treatment outcomes, with proximal formal client feedback in real time (i.e. session rating scales, stage of change, etc.) and post-treatment outcomes including, but not limited to, those specified in 580-9-44-.13(28).

(viii) Monitor appropriate utilization of clinical/treatment services and other resources for the clients served (i.e. clinical peer reviews, clinical reviews, etc.).

(ix) Determine if treatment or care procedures are deficient or flawed.

(x) Monitor incidents and/or critical incidents involving clients to include at a minimum:

(I) Timeliness of identification and reporting of incidents and/or critical incidents.

(II) Identification of trends and actions taken to reduce risk, and to improve the safety of the service environment for clients.

(xi) Monitor staff development activities.

6. The entity shall document development and implementation of a process to produce:

(i) Quarterly reports of performance improvement activities, findings, and recommendations.

(ii) An annual aggregate review of performance improvement findings, assessment of trends and patterns, actions taken relative to findings, and recommendations for needed improvements.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.12 Operational Policies And Procedures Manual. The entity shall develop a written, indexed Policies and Procedures Manual which shall, minimally, contain each of the required written policies, procedures, practices, plans, and processes as specified by these rules.

(1) All policies and procedures contained within the Policies and Procedures Manual shall be:

(a) Approved by the organization's governing body.

(b) Include input by the programs' staff, clients, their families, and client advocates, as appropriate.

(c) Consistent with DMH Mental Illness and Substance Abuse Services Division standards relative to client rights.

2. The Policies and Procedures Manual shall be:

(a) Updated as needed, with modifications clearly specified and approved as according to written procedures established by the governing authority before they are instituted.

(b) Reviewed and approved, at least, on an annual basis by the governing authority with this review process documented in writing.

(c) Easily accessible to all program personnel, with a copy available at each service location.

(d) Accessible for review by DMH upon request.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.13 Program Description.

(1) A program description shall be maintained for each level of care provided by the entity and shall specify the name, address, fax number, email address, phone number, and website of the program wherein the level of care is provided.

(2) Program Philosophy. The entity shall develop and maintain written documentation of a science, theological, or other evidence based philosophy that provides the framework around which the agency's programs and services have been developed.

(a) The framework shall reflect knowledge of and incorporate elements that address, at a minimum:

1. The American Society for Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders.

(b) The entity's program philosophy shall be reviewed and approved annually as dictated by the provider's governing authority.

(3) Goals and Objectives. The entity shall establish annual goals and objectives for each level of care.

(4) Accessibility:

(a) Each entity shall demonstrate accessibility planning that addresses the needs of clients, family members, visitors, personnel, and other stakeholders.

1. The address and directions to the program.
2. The hours of operation.
3. Telephone numbers for information, access to care, and emergencies.
4. The levels of care and services provided directly by the entity and those by affiliated subcontractors.
5. The criteria for admission to the program.
6. Referral services provided.
7. Fees required for services.

(b) Each entity shall provide written documentation and evidence of implementation of policies and procedures that seek to establish a welcoming, accessible, culturally linguistically competent system of care for all.

1. Incorporate a "welcoming policy" into the entity's philosophy and mission statement, and demonstrate implementation of this policy through staff training, business and clinical practice, and performance improvement efforts.

2. Establish policies governing, and the processes utilized to ensure access to care for individuals with co-occurring mental illness and substance use disorders.

3. Describe the procedures utilized to publicize the organization's co-occurring capabilities.

4. Establish policies governing, and the processes utilized to ensure access to care for individuals with disabilities, speech, language, and/or hearing impairments.

5. All certified providers serving women shall develop, maintain, and document implementation of written policies and procedures to:

(i) Ensure priority access to services for pregnant women and IV drug users and make this information known to the public.

(c) Marketing and promotional material distributed by or on behalf of each entity shall accurately portray the scope of services provided.

(5) General Clinical Practice. The program shall have and implement written procedures to assure that consumers who are deaf or who have limited English proficiency are provided culturally sensitive, linguistically appropriate access to services.

(6) Screening. The entity shall develop, maintain, and document implementation of written policies and procedures for a screening process to briefly screen individuals prior to initiation of a behavioral health screening or diagnostic interview examination, or early intervention, treatment, or recovery support service. At a minimum, this process shall:

(a) Identify the presence of risk factors for a substance use or substance use and co-occurring mental disorder.

(b) Specify when and where the screening process may take place.

(c) Specify the instruments utilized to conduct the screening process.

(d) Describe the procedures followed when the screening process:

1. Identifies risk factors for a substance use or co-occurring substance use and mental disorder.

2. Does not identify risk factors for a substance or co-occurring substance use and mental disorder.

3. Identifies the need for crisis intervention.

(e) Specify the procedures for documenting the screening process.

(f) The entity shall document that the results of the screening are clearly explained to the client and to the client's family as appropriate.

(g) The entity shall submit screening data to the DMH management information system, ASAIS, as according to the most recent edition of Data Reporting Guidelines established and published by DMH, incorporated herein by reference.

(7) Placement Assessment.

(a) All entities seeking to have a client admitted to a DMH certified facility for early intervention, treatment, or recovery support services shall develop, maintain, and document implementation of written policies and procedures to:

1. Conduct, or receive from another entity, a written Placement Assessment containing an evaluation of each client's level of functioning in the six (6) ASAM dimensions that shall:

(i) Describe the process for scheduling a Placement Assessment and how this information is publicized.

(ii) Identify the tools utilized to formulate the Placement Assessment which shall include at a minimum the DMH Authorized Placement Assessment.

(iii) Describe the procedures for addressing request by other organizations to conduct a Placement Assessment.

(iv) Identify the staff positions to conduct a Placement Assessment.

2. Develop a level of care recommendation based upon the Placement Assessment, which shall describe:

(i) The process for determining the appropriate level of care.

(ii) The role of the client and significant others in this process.

3. Initiate service delivery including referral, as appropriate, based upon the client's level of care recommendation, which shall identify the procedures followed when the Placement Assessment:

(i) Identifies the need for an available level of care.

(ii) Identifies the need for an unavailable level of care.

(iii) Identifies the need for crisis intervention.

4. The entity shall develop, maintain, and document implementation of policies and procedures to ensure completion of the referral process resulting from the Placement Assessment, regardless of the outcome of the Placement Assessment.

5. The entity shall submit Placement Assessment data to the DMH management information system, ASAIS, as according to the most recent edition of Data Reporting Guidelines established and published by DMH, incorporated herein by reference.

(8) Levels of Care Designation. Each entity shall specifically name and describe in policy each level of care, as listed in 580-9-44-.13(1-4), provided as according to authorization of the governing authority.

(a) Level 0.5: Early Intervention Services, consisting of:

1. Early Intervention Services for Adults.
2. Early Intervention Services for Adolescents.
3. Early Intervention Services for Pregnant Women and Women with Dependent Children.
4. Early Intervention Services for Persons with Co-Occurring Substance Use and Mental Illness Disorders.

(b) Level I: Outpatient Treatment, consisting of:

1. Outpatient Services for Adults.
2. Outpatient Services for Adolescents.
3. Outpatient Services for Pregnant Women and Women with Dependent Children.
4. Outpatient Services for Persons with Co-Occurring Substance Use and Mental Illness Disorders.

5. Ambulatory Detoxification Without Extended on-site Monitoring.

6. Opioid Maintenance Therapy Program.

(c) Level II: Intensive Outpatient Services/Partial Hospital Treatment, consisting of:

1. Intensive Outpatient Services for Adults.

2. Intensive Outpatient Services for Adolescents.
 3. Intensive Outpatient Services for Pregnant Women and Women with Dependent Children.
 4. Intensive Outpatient Services for Persons with Co-Occurring Substance Use and Mental Illness Disorders.
 5. Partial Hospitalization Program for Adults.
 6. Partial Hospitalization Program for Adolescents.
 7. Partial Hospitalization Program for Pregnant Women and Women with Dependent Children.
 8. Partial Hospitalization Program for Persons with Co-Occurring Substance Use and Mental Illness Disorders.
 9. Ambulatory Detoxification With Extended on-site Monitoring.
- (d) Level III: Residential Treatment Services, consisting of:
1. Transitional Residential Services for Adults.
 2. Transitional Residential Services for Adolescents.
 3. Clinically Managed Low Intensity Residential Programs for Adults.
 4. Clinically Managed Low Intensity Residential Programs for Adolescents.
 5. Clinically Managed Low Intensity Residential Programs for Pregnant Women and Women with Dependent Children.
 6. Clinically Managed Low Intensity Residential Programs for Persons with Co-occurring Substance Use and Mental Illness Disorders.
 7. Clinically Managed Medium Intensity Residential Programs for Adults.
 8. Clinically Managed Medium Intensity Residential Programs for Adolescents.
 9. Clinically Managed Medium Intensity Residential Programs for Pregnant Women and Women with Dependent Children.

10. Clinically Managed Medium Intensity Residential Programs for Persons with Co-occurring Substance Use and Mental Illness Disorders.

11. Clinically Managed High Intensity Residential Programs for Adults.

12. Clinically Managed High Intensity Residential Programs for Pregnant Women and Women with Dependent Children.

13. Clinically Managed High Intensity Residential Programs for Persons with Co-occurring Substance Use and Mental Illness Disorders.

14. Medically Monitored Intensive Residential Programs for Adults.

15. Medically Monitored Intensive Residential Programs for Pregnant Women and Women with Dependent Children.

16. Medically Monitored Intensive Residential Programs for Persons with Co-occurring Substance Use and Mental Illness Disorders.

17. Medically Monitored High Intensity Residential Programs for Adolescents.

18. Medically Monitored Residential Detoxification Program.

(9) Admission Criteria. Each entity shall develop, maintain, and document compliance with written criteria that shall govern admission to each respective level of care provided by the organization. The criteria shall, at a minimum:

(a) Specify that no person will be denied admission to the program, beyond the scope of unique service level eligibility criteria, on the basis of sex, race, color, creed, handicap, or age in accordance with Title VI of the Civil Rights Act of 1964, as amended, 42 USC 2000d, Title XI of the Education Amendments of 1972, 20 USC 1681-1686 and s.504 of the Rehabilitation Act of 1973, as amended 29 USC 794, and the American with Disabilities Act of 1990, as amended, 42 USC 12101-12213.

(b) Specify the unique characteristics of the program's target population.

(c) Incorporate the admissions criteria for the respective level of care provided as specified in these rules.

(d) Specify that priority access to admission for treatment will be given to the following groups in order of priority:

1. Individuals who are pregnant and have intravenous substance use disorders.
2. Individuals who are pregnant and have substance use disorders.
3. Individuals who have intravenous substance use disorders.
4. Women with dependent children.
5. Individuals who are HIV positive.
6. All others with substance use disorders.

(e) Describe the process utilized for prioritizing admission requests.

(f) Specify the criteria for readmission.

(g) Describe the process implemented when an individual is found to be ineligible for admission. This process shall include the following procedures, at a minimum:

1. Upon request, a written rationale that objectively states or describes the reasons for service denial shall be provided to clients who have been determined ineligible for admission.
2. The entity shall provide referrals appropriate to the prospective client's needs.
3. Reassessment (Behavioral Health Screening) shall be allowed when an individual presents for services after a previous denial of admission.

(i) Describe the process for clients to appeal an adverse admission decision, which shall include the process in which clients are informed of this right.

(10) Exclusionary Criteria. Each entity shall provide written documentation of criteria used to deny admission or readmission of clients into the program.

(a) The entities policies, procedures and practices shall not support admission denials based exclusively on:

1. Age, with consideration of whether the program is an adult or adolescent program.

2. Gender, with consideration given to whether the program serves one or both sexes.

3. Pregnancy status, with consideration given to programs that only serve males.

4. Educational achievement and literacy.

5. Household composition.

6. Ethnic background.

7. Income level and ability to pay (unless private for profit).

8. Need for or use of medication assisted therapy.

9. Disability.

10. Existence of a co-occurring mental illness and substance use disorder.

11. HIV status.

12. Current maintenance on methadone.

13. Previous admissions to the program.

14. Prior withdrawal from treatment against clinical advice.

15. Referral source.

16. Involvement with the criminal justice system.

17. Relapse.

(11) Continuous Assessment.

(a) Each entity shall develop, maintain and document implementation of written policies and procedures that define a

continuous Assessment Service process that shall, at a minimum, incorporate the following elements:

1. The entity shall establish a process that begins during the Placement Assessment.
2. The entity shall establish a continuous assessment service process that provides for ongoing reassessment throughout the service delivery episode in response to client progress or the lack thereof, newly identified symptoms or other concerns, client requests to address specific issues, evaluation of continued stay needs, etc. At a minimum continuous assessment shall consist of a structured process that incorporates the following components:
 - (i) Continuous client engagement for collaboration in identification of service needs, establishment of goals and objectives for treatment and progress assessment.
 - (ii) Collection and evaluation of current client data and historical information presenting issues relative to the ASAM diagnostic and dimensional criteria and client feedback relative to service needs and desired outcomes. This data and information may include, but shall not be limited to:
 - (I) Review of the findings of the Intake and Assessment.
 - (II) Psychological, intellectual, and other testing.
 - (III) Client and family interviews
 - (iii) Identification of the scope of services needed to address each client's needs in the least restrictive environment.
 - (iv) Determination if the care required by the client can be adequately provided in the level(s) of care offered by the program.
 - (v) Identification of client risk for harm to self or others.
 - (vi) The continuous assessment service process shall ensure the collection and evaluation of sufficient information to establish a basis for service planning.
 - (vii) The continuous assessment service process shall be reflective of each client's presenting needs and desires for treatment outcome, and shall document the client's involvement in the process.

3. Adolescent Specific Criteria. The intake process for adolescents shall include the components specified in 580-9-44-.13(6-7), and shall also include, at a minimum, evaluation of:

- (i) Legal custody status, including clear identification of the legal parent or guardian.
- (ii) All aspects of the adolescent's functioning, including physical, emotional, cognitive, educational, nutritional and social in relation to normative development for chronological age.
- (iii) Play, recreation and daily activity needs.
- (iv) Family history and current living situation.
- (v) Family dynamics and its impact on the youth's and family's current needs.
- (vi) Environmental issues.
- (vii) Physical health, when required, that assesses:
 - (I) Motor development and functioning.
 - (II) Sensorimotor functioning.
 - (III) Speech, hearing and language functioning.
 - (IV) Visual functioning.
 - (V) Immunization status.
 - (VI) Oral health and oral hygiene.

4. Co-occurring Disorders Specific Criteria. The intake process for individuals who have co-occurring disorders shall address criteria, as relevant in 580-9-44-.13(6-7), and specific to level of care, also:

- (i) Include a chronological history of past mental symptoms, diagnosis, treatment, and impairment, particularly listing that period of time before the onset of substance abuse and during extended periods of abstinence.
- (ii) Include a description of current strengths, supports, limitations, skills deficits, and cultural barriers as they affect (impede or enhance) the individual's ability to

follow treatment recommendations due to their illness, disorder, or problem.

(iii) Identify and determine disability, and/or functional impairment.

5. Women and Dependent Children Specific Criteria. The intake process for women who are pregnant and/or have dependent children shall address criteria, as relevant in 580-9-44-.13(6-7), and specific to level of care at a minimum:

(i) Shall be family centered and gender responsive addressing:

(I) Assessment of primary medical care to include prenatal care, primary pediatric care and immunization for their children.

(II) Relationships.

(III) Sexual & physical abuse.

(IV) Parenting skills and practices.

(V) Childcare.

(ii) Include assessment of children participating in treatment with their mothers which shall, at a minimum, evaluate:

(I) Developmental, emotional, and physical health functioning and needs.

(II) Sexual & physical abuse.

(III) Neglect.

(b) Each entity shall specify in writing the procedures to ensure:

1. Pregnant women and/or women with dependent children are given preference in admission.

2. Sufficient case management to include transportation.

3. Publicizing the availability of service to women through:

(i) Street outreach programs.

- (ii) Ongoing public service announcements.
- (iii) Advertisements in print media.
- (iv) Posters and other information placed in targeted areas.
- (v) Frequent notification of availability of such treatment distributed to the network of community based organizations, health care providers and social service agencies.

4. Interim services are available and offered.

(12) Individual Service Planning Process. Each entity shall develop, maintain and document implementation of written policies and procedures defining the client service planning process that shall include, at a minimum, the following components:

(a) An individualized service plan shall be developed for each person admitted to a level of care.

1. The plan shall be developed in partnership with the client and, initially, based upon the client's goals at the time of admission.

2. The client shall be in agreement with the service plan and able to understand and articulate the plan's goals and strategies.

3. There shall be documentation in the clinical record describing the client's participation in development of the service plan and the process utilized to assure the client's understanding and ability to articulate the plan's goals and strategies.

(b) Development of the service plan shall be initiated during the placement assessment to a level of care.

(c) The entity shall specify the processes used to ensure that the client:

1. Will be an active participant in the service planning process.

2. Is provided the opportunity to involve family members or significant others of his/her choice in formulation, review, and update of the service plan.

(d) The service plan shall:

1. Be formalized as a written document that the client receives, understands, and is in agreement.
 2. Include measurable goals and strategies that are clearly reflective of the client's expressed reason for seeking treatment and stated desires for treatment outcomes.
 3. Be representative of the client's strengths, needs, abilities, and preferences.
 4. Specify goals and strategies for goal attainment in words understandable to the client.
 5. Be developed in collaboration with other professional staff, the client, family and others designated by the client.
 6. Begin development within twenty-four (24) hours of the Placement Assessment.
 7. Utilizes interventions and strategies that the client indicates are acceptable to his/her culture, age, ethnicity, development, and disabilities/disorders.
 8. Include a variety of strategies, which are relevant to the clients' needs and desired outcomes for treatment.
 9. Be dated and signed by the client and the entity's employee who has primary responsibility for development of the plan.
 10. Be maintained as a working document throughout the client's treatment and/or care process with modifications to the service plan based on the client's progress, the lack of progress, client preferences, or other documented clinical issues.
 11. Be approved in writing by the program director, clinical director, or medical director, as appropriate to the level of care provided.
 12. Be provided to the client when initially developed and at each update and revision.
- (e) Service Plan Revisions. The entity shall establish and implement written policies and procedures for service plan revisions.

1. Service plan revisions for each client shall be:

(i) Initiated at regular intervals in accordance with the client's severity and level of function, progress or lack of progress, and the intensity of services in the level of care.

(ii) The plan is developed in collaboration with other professional staff, the client, family and others designated by the client.

(iii) Approved in writing by the program director, clinical director, or medical director.

2. A copy of the revised service plan shall be provided to the client.

(13) Case Reviews. The entity shall document implementation of a process to conduct client case reviews at regular periodic intervals, appropriate to the client's current level of care.

(a) A written report of the case reviews shall be developed by the client's primary counselor, discussed with the client and filed in the client's record as required in 580-9-44-.13(21).

(14) Continuing Stay Criteria. The entity shall develop, maintain, and document implementation of written policies and procedures governing continuing stay for each level of care provided. At a minimum, these policies and procedures shall:

(a) Provide for ongoing assessment service of each client's need for continued services at the current level of care.

(b) Include the client and others designated by the client as active participants in the continuing care assessment service and decision making process.

(c) Establish criteria for continued stay that address the following considerations, at a minimum:

1. The client is making progress but has not yet achieved the goal(s) articulated in the individualized service plan. Continued treatment at the current level of care has been assessed as necessary to permit the client to continue to work toward the established goals.

2. The client is not yet making progress but has the capacity to resolve identified problem(s). The client is actively working toward goal(s) articulated in individualized service plan. Continued treatment at this level of care has been assessed as necessary to permit the client to continue to work toward goals.

3. New problems have been identified that are appropriate for service delivery at this level of care. This level is the least intensive at which the client's new problem(s) may be addressed effectively.

4. Client preferences.

(15) Transfer. The entity shall develop, maintain, and document implementation of written policies and procedures governing a process for client transfer from one level of care to another that shall, at a minimum:

(a) Provide for continuous assessment service process of each client's need for transfer from the current level of care.

(b) Include the client and others designated by the client as active participants in the transfer consideration assessment service and decision making process.

(c) Establish procedures to notify the client's referral source of a change of the client's status in accordance with privacy and confidentiality regulations.

(d) Establish criteria for transfer that shall address the following considerations, at a minimum:

1. The client has achieved the goals articulated in the individualized service plan, thus resolving the problem(s) that justified admission to the current level of care, and continuation of services at another level of care is indicated; or

2. The client has been unable to resolve the problem(s) that justified admission to the present level of care, despite modifications of the service plan. Services at another level of care is therefore indicated; or

3. The client has demonstrated a lack of capacity to resolve identified problem(s). Service at another level of care is therefore indicated; or

4. The client has experienced an intensification of problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

5. Client preferences.

(e) Establish a process for transferring clients to another service provider for a different level of care, or for changing a client's level of care within the current provider's service organization.

(f) Provide for development and utilization of a transfer summary.

1. A transfer summary shall be completed for each client transferred to another service provider for a different level of care, or for changing a client's level of care within the current provider's service organization, and shall at a minimum, include:

(i) The transfer summary shall be forwarded to the service to which the client is being transferred no later than two (2) days prior to the actual transfer.

(ii) A copy of the transfer summary shall be provided to the client.

(16) Discharge.

(a) The entity shall develop, maintain, and document implementation of written policies and procedures governing discharge from the program.

1. Provide for development of a written discharge summary that shall be entered into each client's case record within five (5) days after discharge and shall include:

(i) A summary of goals for continuing care after discharge.

(ii) A description of the reasons for discharge.

(iii) The client's status and condition at discharge.

(iv) An evaluation of the client's progress toward goals established in the service plan and participation in the program.

(v) Circumstances under which a return for additional treatment or care may be needed.

2. Discharge summaries shall be completed for all clients regardless of discharge status.

3. The discharge summary shall be signed by the client when possible, the primary counselor, and the clinical supervisor or program director.

4. A copy of the discharge summary shall be provided to the client upon discharge, when possible.

(17) Continuing Care. The entity shall develop, maintain and document implementation of and compliance with written policies and procedures established to support continued service delivery after transfer or discharge from each level of care provided. At a minimum, these policies and procedures shall include establishment of a continuing care plan for each client as part of the service planning process.

(a) A copy of the continuing care plan shall be filed in the client's case record.

(18) Waiting List Maintenance. The entity shall establish a formal process to address requests for services when space is unavailable in the program. This process shall include, at a minimum:

(a) Written procedures for management of the waiting list that shall include, at a minimum, provisions for:

1. Priority admission of pregnant women and IV drug users.

2. Referral for emergency services.

3. Client access to interim services while awaiting program admission.

4. Maintaining contact with a client while awaiting space availability.

5. Adding and removing a client from the waiting list.

6. Data gathering and reporting of the following information:

(i) Demographic description of clients on the waiting list, including age, race, sex, pregnancy status, and IV drug use status.

(ii) Length of stay on the waiting list from initial request for care to admission.

(iii) Service need.

(iv) Number/percentage of clients on waiting list who are never admitted to a level of care.

(v) Number of clients receiving interim services.

(b) The entity shall designate a staff person with responsibility for management of the waiting list.

(c) The entity shall comply with requests from DMH for data reports relative to waiting list maintenance and management i.e., compliance with ASAIS reporting.

(19) Referral Policies/Community Linkage. The entity shall develop, maintain and document compliance with written policies and procedures for referring clients and receiving client referrals from other service providers.

(20) Client Records. The entity shall develop, maintain and document implementation of written policies and procedures governing the care, custody, control and maintenance of records of persons served, that shall, at a minimum, include the following specifications:

(a) A client record shall be established for each client accepted for service delivery by a provider organization.

1. The client record shall communicate information in a manner that is:

(i) Organized into related sections with entries in chronological order.

(ii) Clear and complete.

(iii) Current.

(iv) Legible.

(b) Client records shall contain the following information, at a minimum:

1. Client identifying data including:

(i) Name.

- (ii) Address.
- (iii) Phone number.
- (iv) Social security number.
- (v) Sex.
- (vi) Race/ethnic background.
- (vii) Date of birth.
- (viii) Marital status.
- (ix) Case number.
- (x) Unique client identifier.
- 2. Date of service initiation.
- 3. Source of referral.
- 4. Alcohol/drug testing results.
- 5. Presenting problem(s).
- 6. Informed consents for treatment, drug screens, release of protected information, etc.
- 7. Screening, assessment and service plans.
- 8. Progress notes.
- 9. Case review reports.
- 10. Medication records.
- 11. Copies of service related correspondence.
- 12. Transfer summaries.
- 13. Discharge summaries.
- 14. Continued care plans.
- (c) All entries included in the client record:
 - 1. Shall be dated and signed.

2. Shall be made in ink and be legible, or shall be recorded in an electronic format.

3. Shall have a typed, printed, or stamped name below any non-legible signature.

4. Shall be appropriately authenticated in the electronic system for organizations that maintain electronic records.

(d) When client records are corrected or amendments are completed using the mark through method, amendments or marked through changes must be executed as follows:

1. The information to be amended is struck out with a single line that allows the stricken information to be read.

2. The amended entry is initialed and dated.

(e) At the completion of assessment for treatment, the following information, if available, shall be recorded in the client record: a description of how linguistic support services will be provided to clients who are deaf or have limited English proficiency including a signed waiver of free language assistance if the client who is deaf has limited English proficiency has refused interpreting or translating services. If a family member is used to interpret, such should be documented in the consumer record. No one under the age of eighteen can be used as interpreters.

(f) The provider organization shall establish a formal system to control and manage access to client records that shall include, at a minimum:

1. Procedures for control and management of access to paper and electronic records.

2. A designated staff member responsible for the storage and protection of client records at each location where records are stored.

3. A process in which the location of a record can be tracked and documented at all times.

4. Identification of program personnel with access to client records.

5. A process for providing clients access to their records.

6. A process for storing closed client records and for disposing of outdated records.

(g) Client records shall be retained after termination, discharge or transfer of the client for a minimum of seven (7) years.

(h) Adolescent Specific Criteria: Client records shall be retained after termination, discharge or transfer of the client for a minimum of seven (7) years after age of majority for children/adolescents.

(21) Clinical Documentation. The entity shall develop, maintain and document compliance with written policies and procedures governing clinical documentation for each level of care provided that shall include, at a minimum, the following specifications:

(a) Written documentation shall be maintained in the client record to support each service, activity and session provided, within the scope of the program, for a client or for a collateral source in regard to the client.

(b) Written documentation of service delivery shall be recorded and shall be filed in the client record no later than twenty-four (24) hours from the date of service provision. Documentation shall consist of the following elements, at a minimum:

1. Identification of the service rendered.
2. Identification of the service recipient.
3. Identification of the setting in which the service was rendered.
4. Date the service was rendered.
5. The start and ending time of the service.
6. Relationship of the service to the client's individual service plan.
7. Signature and credentials of the staff person providing the service, as well as signature of the client.

(22) Emergency/Crisis Care. The entity shall develop, maintain and document implementation of policies and procedures governing the provision of routine and emergency health care for clients. At a minimum, the policies and procedures shall:

(a) Be specific to the population served and the level of care provided.

(b) Provide for emergency service availability twenty-four (24) hours a day, seven (7) days each week.

(c) Describe the extent of services provided, including but not limited to:

1. Emergency medical services.
2. Suicide intervention services.
3. Emergency psychiatric services.
4. First Aid and CPR.
5. Emergency transportation.

(d) Specify the process for implementation of emergency services provided on site as well as those provided off site through contract, MOU, or other arrangement.

(e) Specify staff responsibilities for implementation of emergency services.

(23) Medical Services. The entity shall have medical protocols established for each applicable level of care by a licensed physician on staff or under contract with the entity as the medical director. The medical protocols shall be in compliance with standards, ethics and licensure requirements of the medical profession.

(24) Pharmacotherapy & Medication Administration. The entity shall develop, maintain and document implementation of written policies and procedures regarding the use, purchase, control, administration and disposal of medication that include, at a minimum, the following elements:

(a) Compliance With Regulatory Requirements: The organization shall document compliance with all applicable federal and state laws and regulations regarding the use, purchase, control, administration, disposal, and use of medication including, but not limited to Code of Alabama 1975, Section 34-23-94; Code of Alabama 1975, Section 20-2-1 through 20-2-93; Federal Controlled Substance Act of 1970; Indigent Drug Program Manual for Mental Health Centers; and Nurse Delegation Act.

(b) Medication Control: The organization must demonstrate implementation of accurate accounting, tracking and inventory procedures for all medication acquired for use by the entity's clientele, as well as, for any client owned medication that is present in the facility. These procedures shall include the following elements, at a minimum:

1. The entity shall identify all personnel with responsibilities relative to medication control and shall specify the required responsibilities of each and the timeframes in which these duties shall be performed.

2. The following records must be kept on all drugs administered by the agency's staff or self-administered by clients:

(i) A medication log/running inventory in which the following information is recorded:

(I) Date on which drug(s) were placed in inventory.

(II) Brand name/generic name.

(III) Quantity/dosage of drug(s).

(IV) Date drug(s) administered.

(V) Initials/signature of individual administering drug(s).

(ii) All medications assisted with or administered shall be documented on the medication administration record (MAR) or an agency approved observation record for clients who self-medicate (Self-Medication Observation Record-SMOR). Documentation on the MAR/SMOR shall be made in permanent ink and shall be legible. The MAR/SMOR shall include, at a minimum, the following information:

(I) Name of all medications ordered.

(II) Dosage of medication.

(III) Form of medication (tablet, capsule, liquid, cream, etc.).

(IV) Route/method of administration (by mouth, under tongue, in eye, etc.).

(V) Time medication is scheduled for administration.

(VI) Date medication given.

(VII) Initials, signature and credentials/title of person assisting, observing or administering medication.

(VIII) Medication allergies of the client.

(IX) Name of the client.

(X) Sex of the client.

(XI) Client's date of birth.

(XII) Client's diagnosis.

(XIII) Facility/program/agency name.

3. Any organization storing bulk quantities of "controlled substance" or "prescription legend" drugs must document that one of the following Drug Enforcement Administration (DEA) registration procedures has been met:

(i) The supervising or consulting physician for the program has registered the facility as one of his offices with the DEA Registration Branch; or

(ii) The program itself has been registered with the DEA Registration Branch when there is more than one physician involved with the program.

4. Medications shall be kept in the original containers unless properly labeled and stored in medication planners or medication packs by a pharmacist utilizing a valid prescription.

5. All medications must be stored in a locked cabinet or other substantially constructed storage that precludes surreptitious entry.

6. Narcotic medications shall be stored under double lock and key.

7. Medications shall be stored separately from non-medical items.

8. Medications shall be stored under proper conditions of temperature, light, humidity, sanitation, and ventilation.

9. All medication storage units must be locked when not in use.

10. Access to all "controlled substance" and/or "prescription legend" drugs must be restricted to the absolute minimum number of employees needed to handle daily transactions of such drugs.

11. A listing of employees permitted access to the medication storage units will be on file at the organization. This listing should be displayed in the drug storage area.

12. In the event of loss or the theft of controlled substances, the entity shall document implementation of the following procedures:

(i) Notify local law enforcement personnel immediately upon detection of the loss.

(ii) Notify the supervising physician immediately upon the loss if the supervising or consulting physician has registered the program as one of his offices with the DEA Registration Branch.

(iii) Notify the DEA Registration Branch directly if the program itself has been registered with the DEA.

(iv) Notify the DMH Associate Commissioner for Mental Illness and Substance Abuse Services within twenty-four (24) hours of detection of the loss.

(v) Provide subsequent written reports of the events and extent of the loss to the DMH Associate Commissioner for Mental Illness and Substance Abuse Services, as according to DMH published incident reporting procedures.

13. The entity shall document implementation of written procedures to account for all medication acquired by agency by whatever means, and for reconciliation of the drug inventory, which shall include the following processes, at a minimum:

(c) Medication Administration: The entity shall develop, maintain and document implementation of written policies and procedures governing medication administration that shall, at a minimum, incorporate the following requirements:

1. Medication shall only be administered by an authorized licensed medical professional, self-administered by

the client, or provided by a Medication Assistant Certified (MAC) worker with delegated authority to administer client medications.

2. A list of licensed medical personnel and Medication Assistant Certified (MAC) Workers authorized to administer medication shall be posted at each facility in which medications are administered.

3. No prescription or nonprescription medication, including over-the-counter medication, shall be administered to a client without a current written order from a physician, certified registered nurse practitioner, physician's assistant or dentist.

4. A copy of each client's prescription(s) shall be kept in the clinical record at the facility/agency that administers the client's medication.

5. All medications, prescription, nonprescription, routine, and PRN, shall be administered and recorded as according to valid orders and in compliance with the Nurse Practice Act and the Alabama Administrative Code.

6. All clients shall be provided information on the risks and benefits of the medication prescribed for administration during treatment.

7. Medications shall only be used by the person for whom they are prescribed.

8. Each medication shall be identifiable, (i.e. clearly labeled with the name of the person, name of the medication, specific dosage and the expiration date) up to the point of administration.

9. Each person who receives medication shall receive medical supervision by the prescribing or the entity's physician, to include regular evaluation of the person's response to the medication.

(i) Factors/criteria to be taken into account for consideration of changes in medication dose levels shall be identified, assessed and documented in the clinical record.

10. The entity's incident prevention and management plan shall include procedures to follow in the event of a medication related emergency, including adverse reactions, accidental overdose, administration of the wrong medication, dosage, or frequency, etc.

11. All medication errors and adverse reactions to medications shall be recorded in the client's clinical record, reported to the MAS Nurse immediately upon discovery and reported in accordance with the entity's incident prevention and management plan according to the Mental Illness and Substance Abuse Services Division's published incident reporting procedures.

12. Documentation of corrective action taken in regards to medication errors shall be maintained by the agency, and reported to DMH as required by the Mental Illness and Substance Abuse Services Division's incident reporting procedures.

(d) Nurse Delegation: Entities utilizing unlicensed personnel to administer medication to clients shall develop, maintain and document implementation of written policies and procedures to assure compliance with the Alabama Board of Nursing Regulations. The entity's policies and procedures shall incorporate, at a minimum, the following applicable specifications:

1. The entity shall employ a registered nurse or licensed practical nurse as a full-time, part-time, or consultant employee who shall be responsible for delegation of specific limited tasks to designated unlicensed assistive personnel, Medication Assistant Certified (MAC) workers, employed by the entity.

2. The entity shall designate a nurse, who has a current certification as a Medication Assistance Supervising (MAS) Nurse, with responsibility for determining tasks that may be safely performed by each MAC worker employed by the agency, respectively.

3. Prior to the assumption of any medication assistance duties, each MAC worker shall:

(i) Receive a minimum of twelve (12) documented hours of Alabama Board of Nursing approved relevant classroom training.

(ii) Receive twelve (12) documented hours of practical training at the facility in which he/she is employed.

(iii) Pass a written DMH authorized MAC worker knowledge competency test.

(iv) Demonstrate competency in the performance of tasks expected to be delegated at the site of planned service delivery in the presence of a MAS nurse.

4. Specific tasks delegated by the MAS nurse shall not require the exercise of independent nursing judgment or intervention by the MAC worker. Dependent upon the demonstrated competency of the MAC worker, assigned tasks may include but are not limited to the following responsibilities:

(i) Assist in the administration of oral, topical, inhalant and eye or ear medications that are readily identifiable and labeled at the time of delivery.

(ii) Basic first aid, (i.e., dressing simple scratches, bite marks, or other superficial injuries).

(iii) Administer Epinephrine injectors, Epi-pens, routinely carried for persons with allergic reaction.

(iv) Clean and monitor devices such as C-Pap machines, nebulizers and other durable medical goods routinely used in the home environment.

5. Specific tasks requiring the exercise of independent nursing judgment that shall not be delegated by a MAS nurse to a MAC worker shall include, but shall not be limited to:

(i) Administration of injectable medications, with the exception of injectable medications for anaphylaxis such as the EpiPen.

(ii) Catheterization, clean or sterile.

(iii) Administration of rectal or vaginal medications.

(iv) Tracheotomy care, including suctioning.

(v) Gastric tube insertion, replacement or feedings.

(vi) Invasive procedures or techniques.

(vii) Sterile procedures.

(viii) Ventilator care.

(ix) Calculation of medication dosages other than measuring a prescribed amount of liquid medication or breaking a scored tablet.

(x) Receipt of verbal or telephone orders from a licensed prescriber.

(xi) Independent administration of standing order PRN medication.

6. The entity shall maintain current written documentation identifying:

- (i) Each MAC worker employed by the agency.
- (ii) The specific delegated tasks of each MAC worker.
- (iii) Documentation of training and competency to perform duties.

7. The entity's MAC workers shall have access to consultation with a MAS nurse twenty-four (24) hours a day, seven (7) days a week.

8. The MAS nurse shall conduct, at a minimum, every six (6) months quality monitoring reviews of the job performance of each MAC worker, including, but not limited to the following areas:

- (i) Fulfillment of training/continued education requirements.
- (ii) Competency relative to the performance of delegated tasks.
- (iii) Specific skills in regard to:
 - (I) Documentation.
 - (II) Error reporting.
 - (III) Methods of identification of the right client, the right task, the right method, and the right quantity at the right time.

9. The MAS nurse may suspend or withdraw the delegation of specific tasks to a MAC worker(s) at any time.

(e) Self-administration of Medication: Entities permitting clients to self-administer their own medication shall develop, maintain and document implementation of written policies and procedures to govern this process that include, at a minimum, the following requirements:

1. A Medication Assistant Supervising Registered Nurse (MAS RN) or a Medication Assistant Supervising Licensed Practical Nurse (MAS LPN) shall evaluate the client and make a

determination if the client can self-medicate based upon the following criteria, at a minimum:

(i) The client must be able to recognize their medications in order to be sure that he/she is not inadvertently given another client's medicine.

(ii) The client must know the purpose for which he/she is taking the medicine.

(iii) The client must be able to describe important side effects of the medicine.

(iv) Demonstrate self-administration appropriately.

2. The MAS RN/MAS LPN shall provide written documentation in the clinical record specifying:

(i) The date of evaluation for self-administration of medication.

(ii) Identification of all persons involved in the evaluation process and the nature of their involvement.

(iii) The results of the evaluation, to include the following findings, at a minimum:

(I) The client is able to self-medicate.

(II) The client is able to receive medications from a Medications Assistant Certified (MAC) worker.

(III) The client has a complex medication routine that requires medication administration by an RN or LPN.

(IV) Any special instructions relative to the client's medication administration needs.

3. The entity shall establish criteria for the MAS RN/MAS LPN to provide at least annual reassessment of each client's continued capabilities to self-administer medications.

(f) Medication Disposal and Destruction: The entity shall develop, maintain and document implementation of written policies and procedures to govern medication disposal and destruction that shall, at a minimum, include the following specifications:

1. Any discontinued, contaminated or expired medication shall be destroyed by incineration or by other

approved means within seven (7) days of being discontinued, contaminated or expired.

2. Destruction of medication shall include all of the following:

(i) Be accomplished only by a nurse, pharmacist or physician.

(ii) Be witnessed by one staff member.

(iii) The amount and name of medication must be recorded and signed by the two staff individuals.

(iv) The destruction record shall be maintained in the clinical record of the client for whom the medication was prescribed and maintained on a separate medication log for review.

(25) Drug Testing.

(a) The program shall implement written policies and procedures for testing clients for drug use, if drug testing is utilized. Policies and procedures shall specify, at a minimum:

1. The circumstances under which drug testing of clients will occur.

2. The specimens used for testing including breath, blood, urine, hair and saliva.

3. Individualized drug screen procedures, which include:

(i) Frequency of testing based on needs of the client.

(ii) Collection of specimens in a respectful manner.

(iii) Procedures used to ensure that drug test screening results are not used as the sole basis for treatment decisions or termination of treatment unless the client refuses the recommended level of care.

(iv) Procedures to ensure that drug testing is used as a treatment tool and is addressed with the client as a way to intervene with drug use behavior.

(v) Procedures to review for false-negative and false-positive results.

(vi) Procedures to minimize falsification during the drug screening sample collection.

(vii) Medically-oriented specimen handling procedures.

(b) The entity shall document all drug testing results, confirmation results and related follow-up therapeutic interventions in the client record.

(26) Transportation.

(a) When an agency/organization provides transportation the entity shall develop, maintain and document compliance with written policies and procedures that govern client transportation and include, at a minimum, the following specifications:

1. All vehicles used to transport clients shall have properly operating seat belts or child restraint seats and provide for seasonal comfort with proper functioning heat and air.

2. All vehicles used for client transportation shall be in good repair and have documentation of regular maintenance inspections.

3. The number of clients permitted in any vehicle shall not exceed the number of seats, seat belts and age appropriate child restraint seats in the vehicle.

4. Vehicles used to transport clients shall not be identifiable as a vehicle belonging to a substance abuse treatment program.

5. All entities operated by the entity shall carry proof of:

(i) Accident and liability insurance.

(ii) Documentation of the vehicle's ownership.

(iii) A fire extinguisher and first aid kit.

(b) The driver of any vehicle used in client transportation shall be at least eighteen (18) years old and in possession of a valid driver's license.

(c) The driver of any vehicle used in client transportation shall carry, at all times, the name and telephone

number of the program's staff to notify in case of a medical or other emergency.

(d) The driver of any vehicle used in client transportation:

1. Shall be prohibited from the use of tobacco products, cellular phones or other mobile devices, or from eating while driving.

2. Shall be prohibited from leaving a minor unattended in the vehicle at any time.

3. Shall be prohibited from making stops between authorized destinations, altering destinations and taking clients to unauthorized locations.

(e) The entity shall provide an adequate number of staff for supervision of clients during transportation to ensure the safety of all passengers.

(27) Smoking. The entity shall develop, maintain and document compliance with written policies and procedures governing smoking by the program's staff and clientele that include compliance with federal, state and local ordinances, at a minimum, the following specifications:

(a) Tobacco use shall be prohibited by all clients, employees, volunteers, contractors, and visitors in all indoor areas of the facility.

(b) Tobacco use shall be prohibited by minors on the premises of programs that provide services to minors.

(c) Smoking shall not be allowed within fifty (50) feet of any entry to a facility that houses children or adolescents.

(d) Written guidelines for personnel in regard to smoking on the premises shall be established.

(e) The entity shall directly or by referral provide a continuum of services for all clients enrolled in each level of care that addresses tobacco use.

(28) Outcome Measures.

(a) At a minimum, the entity shall collect information at time of assessment and at transfer or discharge to provide measures of outcome as specified in the following domains:

1. Reduced Morbidity:
 - (i) Outcome: Abstinence from Drug/Alcohol Use.
 - (ii) Measure: Reduction/no change in frequency of use at date of last service compared to date of first service.
2. Employment/Education:
 - (i) Outcome: Increased/Retained Employment or Return to/Stay in School.
 - (ii) Measure: Increase in/no change in number of employed or in school at date of last service compared to first service.
3. Crime and Criminal Justice:
 - (i) Outcome: Decreased Criminal Justice Involvement.
 - (ii) Measure: Reduction in/no change in number of arrests in past thirty (30) days from date of first service to date of last service.
4. Stability in Housing:
 - (i) Outcome: Increased Stability in Housing.
 - (ii) Measure: Increase in/no change in number of clients in stable housing situation from date of first service to date of last service.
5. Social Connectedness:
 - (i) Outcome: Increased Social Supports/Social Connectedness.
 - (ii) Measure: Increase in or no change in number of clients in social/recovery support activities from date of first service to date of last service.
 - (b) The entity shall maintain a data collection process to provide measures of outcome as specified in the following domains:
 1. Access/Capacity.
 - (i) Outcome: Increased Access to Services.

- (ii) Measure: Unduplicated count of persons served.
 - 2. Retention.
 - (i) Outcome: Increased Retention in Treatment.
 - (ii) Measures: Length of stay from date of first service to date of last service.
 - 3. Use of Evidence Based Practices.
 - (i) Outcome: Use of Evidence Based Practices.
 - (ii) Measure: Total number of evidence-based programs and strategies utilized in each level of care.
 - (c) The entity shall provide reports of outcomes to DMH in the manner, medium and period specified.
 - (29) Emergency Disaster Plan.
 - (a) Different areas of the state are more apt to experience different types of natural disasters (hurricanes, tornados, ice/snow, etc.), as well as some disasters that are common across the state (fire, flooding, bomb threat, power failure, etc.). The entity shall develop, maintain and document that they have a well defined written disaster plan to address procedures to follow in the event a disaster should occur within their agency/organization.
- Author:** Substance Abuse Services Division
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.14 Level 0.5: Early Intervention.

- (1) Rule Compliance. Each Level 0.5 Early Intervention Program shall comply with the following rules and the rules specified in this chapter.
 - (a) Operational Plan. The entity shall develop, maintain and document implementation of a written operational plan that defines its Level 0.5 Early Intervention Program. The program description shall comply with all of the requirements specified in 580-9-44-.13 and the following additional specifications:

1. Location. The entity shall specifically identify and describe the setting in which Level 0.5 Early Intervention services shall be provided. Services may be provided in any appropriate setting that protects the client's right to privacy, confidentiality, safety and meets the DMH facility certification standards as appropriate to the location. Service locations may include traditional clinical offices and behavioral health sites, residences, schools, shelters, work sites, community centers and other locations as pre-authorized by DMH.

(i) Adolescent Specific Criteria.

(I) Location. Shall not provide services in locations that would require shared services or significant contact with individuals receiving treatment for substance use disorders.

2. Admission Criteria. The entity shall develop, maintain, and document implementation of written criteria for admission to its Level 0.5 Outpatient Program, as according to 580-9-44-.13(9), and the following criteria:

(i) The entity's admission criteria shall specify the target population for Level 0.5 services to include, at a minimum, individuals whose problems and risk factors appear to be related to substance use, but do not meet the diagnostic criteria for a substance-related disorder as defined in the current Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(ii) The entity shall provide written documentation in individual case records that each client admitted to receive Level 0.5 Early Intervention Services meets the most current edition of the ASAM Patient Placement Criteria diagnostic and dimensional criteria for this level of care.

(iii) Adolescent Program Specific Criteria. The entity shall provide written documentation in individual case records that each adolescent admitted to receive Level 0.5 Early Intervention services meets the most recent edition of the ASAM Patient Placement Criteria adolescent diagnostic and dimensional criteria for this level of care.

3. Core Services. Each Level 0.5 Early Intervention Program shall demonstrate the capacity to provide a basic level of skilled services appropriate to the needs of its clientele:

(i) Screening and assessment sufficient to screen for, and rule in or out, substance-related disorders.

(ii) Individual counseling.

- (iii) Group counseling.
- (iv) Family counseling.
- (v) Psychoeducation.
- (iv) Case Management:
 - (I) Case planning.
 - (II) Linkage.
 - (III) Advocacy.
 - (IV) Monitoring.

4. Service Intensity. The entity shall document that the amount and frequency of services is established on the basis of the unique needs of each client served.

5. Documentation: In addition to meeting the requirements of 580-9-44-.13(21), an individualized progress note shall be recorded for each service provided in Level 0.5.

6. Support Systems.

(i) At a minimum, the Early Intervention Program shall develop, maintain and document implementation of written policies and procedures which govern the process used to ensure the availability of and provide referrals as needed for:

- (I) Treatment of substance use disorders.
- (II) Medical, psychological or psychiatric services, including assessment.
- (III) Community social services.

(ii) The entity shall maintain up-to-date, written Memorandums of Understanding, Collaborative Agreements or Referral Agreements as applicable.

7. Program Personnel. Each Level 0.5 Early Intervention Program shall employ an adequate number of qualified individuals to carry out personalized care for its clientele and to meet the program's goals and objectives.

(i) Program Coordinator: There shall be a full time program coordinator that meets the requirements specified in 580-9-44-.02(1)(c).

(ii) Every client in a Level 0.5 Program shall be assigned to a specific Primary Counselor for care management.

8. Training. The entity shall provide written documentation that all Level 0.5 Program personnel satisfy the competency and training requirements as specified in 580-9-44-.02(3).

9. Service Intensity: The entity shall document that the amount and frequency of Level 0.5 Early Intervention Services are established on the basis of the unique needs of each client served.

10. Length of Service: The entity shall provide written documentation that the duration of treatment in each Level 0.5 Program shall vary as determined by:

- (i) The client's ability to comprehend the information provided and use that information to make behavior changes; or
- (ii) The appearance of new problems which require another modality of service.

11. Service Availability: The entity shall provide written documentation describing the process utilized to establish the hours of service availability for its Level 0.5 Early Intervention Program. At a minimum, this process shall:

(i) Include consideration of the needs of the target population, including work, school and parenting responsibilities.

(ii) Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.15 Level I: Outpatient Treatment.

(1) Rule Compliance. Each Level I Outpatient Program shall comply with the following rules and the rules specified in this chapter.

(a) Program Description. The entity shall develop, maintain and document implementation of a written operational plan that defines its Level I Outpatient Program. The program description shall comply with all of the requirements specified in 580-9-44-.13.

1. Location. The entity shall specifically identify and describe the setting in which Level I Outpatient Services shall be provided. Services may be provided in any appropriate setting that protects the client's right to privacy, confidentiality and safety, including but not limited to, traditional clinical offices and behavioral health sites, residences, schools, shelters, work sites, community centers and other locations as pre-authorized by DMH.

2. Admission Criteria: The entity shall develop, maintain and implement written criteria for admission to its Level I Outpatient Program in compliance with the requirements of 580-9-44-.13(9) and the following specifications:

(i) The entity's admission criteria shall specify the target population for the Level I Program, which shall include, at a minimum, individuals whose assessed severity of illness initially warrants this level of care, including but not limited to:

(I) Whose progress in a more intensive level of care warrants a step-down to a less intensive level of care.

(II) Who are in the early stages of change and who are not yet ready to commit to full recovery.

(III) Who are experiencing increased conflict, demonstrating passive compliance or considering leaving treatment.

(ii) The entity shall provide written documentation in individual case records that each client admitted to receive Level I Outpatient Services meets:

(I) The diagnostic criteria for a substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iii) Adolescent Program Specific Criteria: The entity shall provide written documentation in individual case records that each adolescent admitted to receive Level I Outpatient Services meets:

(I) The diagnostic criteria for a substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The adolescent dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iv) Co-occurring Disorders Program Specific Criteria: The entity shall provide written documentation in individual case records that each client admitted to receive Level I Outpatient Services in a Co-occurring Enhanced Treatment Program meets:

(I) The diagnostic criteria for a substance use and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(v) Women and Dependent Children Program Specific Criteria: The entity shall provide written documentation in individual case records that each client admitted to receive Level I Outpatient Services in a Women and Children Program:

(I) Meets the diagnostic criteria for a substance use disorder as defined in the most recent edition Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(III) Is pregnant; or

(IV) Has care and custody of dependent children; or

(V) Has lost custody of dependent children and has the potential for family reunification.

3. Core Services. Each Level I Outpatient Program shall demonstrate the capacity to provide a basic level of skilled treatment services appropriate to the needs of its clientele.

(i) At a minimum, the entity shall directly or by referral provide the following core services:

- (I) Behavioral Health Screening.
- (II) Individual counseling.
- (III) Group counseling.
- (IV) Family counseling.
- (V) Psychoeducation.
- (VI) Mental health consultation.
- (VII) Recovery support services.
- (VIII) Peer counseling services.
- (IX) Medication management.
- (X) Alcohol and/or drug screening/testing.
- (XI) Smoking cessation.
- (XII) Sign language interpreter services.
- (XIII) HIV early intervention services.
- (XIV) Case management:
 - I. Case planning.
 - II. Linkage.
 - III. Advocacy.
 - IV. Monitoring.

(ii) Adolescent Program Specific Criteria: Each Level I Adolescent Outpatient Program shall document the capacity to provide each of the core services and to include activity therapy.

- (I) Activity therapy.

(iii) Co-occurring Disorders Program Specific Criteria: Each level I Co-occurring Disorders Outpatient Program shall document the capacity to provide each of the core services to

include basic living skills, crisis intervention services, and intensive case management.

(iv) Women and Dependent Children Program Specific Criteria: Each Level I Women and Dependent Children Outpatient Program shall document the capacity to provide each of the core services and/or arrange for the following services:

- (I) Transportation.
- (II) Child sitting services.
- (III) Developmental delay and prevention services.
- (IV) Activity therapy.
- (V) Parenting skills development.

4. Therapeutic Component Implementation. The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency and intensity appropriate to the client's assessed needs and expressed desires for care.

(i) Service strategies for each Level I Outpatient Program shall include, at a minimum:

- (I) Implementation of individualized counseling plan strategies.
- (II) Ongoing individualized assessment services.
- (III) Motivational enhancement and engagement strategies.
- (IV) Relapse prevention strategies.
- (V) Interpersonal choice/decision-making skill development.
- (VI) Health education.
- (VII) Random drug screening.
- (VIII) Family education.
- (IX) Gender responsive treatment.

(ii) Adolescent Program Specific Criteria: Each Level I Adolescent Outpatient Program shall document the capacity to

provide the service strategies and the following therapeutic components:

(I) Adolescent specific evidence based therapeutic interventions.

(II) Client education on key adolescent development issues, including but not limited to, adolescent brain development and the impact of substance use, emotional and social influence on behavior, value system development, puberty/physical development, sexuality and self esteem.

(III) Recreation and leisure time skills training.

(IV) Family, community and school reintegration services.

(iii) Co-occurring Disorders Program Specific Criteria: Each Level I Co-occurring Disorders Outpatient Program shall document the capacity to provide the service strategies and the following therapeutic components:

(I) Groups and classes that address the signs and symptoms of mental health and substance use disorders.

(II) Groups, classes, and training to assist clients in becoming aware of cues or triggers that enhance the likelihood of alcohol and drug use or psychiatric decompensation and to aid in development of alternative coping responses to those cues.

(III) Dual recovery groups that provide a forum for discussion of the interactions of and interrelations between substance use and mental health disorders.

(iv) Women and Dependent Children Program Specific Criteria: Each Level I Women and Dependent Children Outpatient Program shall document the capacity to provide the service strategies and the following therapeutic components:

(I) Specific services which address issues of relationships, parenting, abuse, and trauma.

(II) Primary medical care, including prenatal care.

(III) Primary pediatric care for children.

(IV) Therapeutic interventions for children which address their developmental needs and issues of sexual abuse and neglect.

(V) Outreach to inform pregnant women of the services and priorities.

(VI) Interim services while awaiting admission to this level of care.

(VII) Recreation and leisure time skills training.

5. Documentation: An individual progress note shall be recorded for each respective service provided in Level I.

6. Support Systems. Each Level I Outpatient Program shall develop, maintain and document implementation of written policies and procedures which govern the process used to provide client access to support services on site, or through consultation or referral, which shall minimally include:

(i) Medical, psychiatric, psychological, laboratory and toxicology services.

(ii) Medical and psychiatric consultation shall be available within twenty-four (24) hours by telephone or if in person, within a timeframe appropriate to the severity and urgency of the consultation requested.

(iii) Direct affiliation with or coordination through referral to more intensive levels of care and medication management.

(iv) Emergency services shall be available by telephone twenty-four (24) hours a day, seven (7) days a week.

(v) Mutual self help groups that are tailored to the needs of the specific client population.

(vi) Referral for other services as according to the client's assessed needs.

7. Program Personnel. Each level I Outpatient Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

(i) Program Coordinator. Each Level I Outpatient Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years post master's supervised experience in a direct service area treating clients with substance use, mental health, or co-occurring mental illness and substance use disorders.

(ii) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level I Outpatient program as delineated in its operational plan.

(iii) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(iv) Every client in a Level I program shall be assigned to a specific Primary Counselor for care management.

(v) Each primary counselor shall maintain a case load not to exceed forty (40) clients with active cases at any one time.

(vi) Adolescent Program Specific Criteria Adolescent Program Specific Criteria:

(I) Program Coordinator. Each Level I Adolescent Outpatient Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years post master's supervised experience in a direct service area treating adolescents who have substance use, mental health, or co-occurring mental health and substance use disorders.

(II) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level I Adolescent Outpatient program as delineated in its operational plan.

(III) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(IV) Every client in a Level I adolescent program shall be assigned to a specific Primary Counselor for care management.

(V) Each primary counselor shall maintain a case load not to exceed thirty (30) clients with active cases at any one time.

(vii) Co-occurring Disorders Program Specific Criteria:

(I) The Level I Co-occurring Enhanced Outpatient Program shall be coordinated by a full-time member of the staff who has the minimum of a master's degree in a mental health related field and at least two (2) years post master's supervised

experience in a direct service area treating clients with co-occurring disorders.

(II) The Level I Co-occurring Enhanced Outpatient Program shall have access to psychiatric services (led by a qualified psychiatrist or nurse practitioner) that are fully capable of evaluating, diagnosing, and prescribing medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

(III) Treatment staff that provide therapy and ongoing clinical assessment services to individuals diagnosed with co-occurring disorders.

(IV) Every client in a Level I Enhanced Co-occurring Outpatient Program shall be assigned to a specific Primary Counselor for care management.

(V) Each primary counselor shall maintain a case load not to exceed thirty (30) clients with active cases at any one time.

(viii) Women and Dependent Children Program Specific Criteria:

(I) Program Coordinator. Each Level I Women and Dependent Children Outpatient Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating women who have substance use, mental health, or co-occurring mental health and substance use disorders.

(II) Direct Care Personnel. All direct care personnel shall be a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(III) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level I Women and Dependent Children Outpatient Program as delineated in its operational plan.

(IV) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(V) Every client in a Level I Women and Dependent Children Program shall be assigned to a specific primary counselor for care management.

(VI) Each primary counselor shall maintain a case load not to exceed thirty (30) clients with active cases at any one time.

8. Training. The entity shall provide written documentation that all Level I Program personnel satisfy the competency and training requirements as specified in Rule 580-9-44-.02(3).

9. Service Intensity. The entity shall document that the amount and frequency of Level I Outpatient services are established on the basis of the unique needs of each client served, not to exceed eight (8) contact hours weekly.

10. Length of Service. The entity shall provide written documentation that the duration of treatment in each Level I Outpatient Program shall vary as determined by:

(i) The severity of the client's illness.

(ii) The client's ability to comprehend the information provided and use that information to implement treatment strategies and attain treatment goals; or

(iii) The appearance of new problems that require another level of care; or

(iv) The availability of services at an assessed level of need when Level I services have been utilized as interim services.

11. Service Availability: The entity shall provide written documentation describing the process utilized to establish the hours of service availability for its Level I Outpatient Programs. At a minimum, this process shall:

(i) Include consideration of the needs of the target population, including work, school and parenting responsibilities.

(ii) Include consideration of transportation accessibility.

(iii) Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.16 Level I-D: Ambulatory Detoxification Without Extended On-Site Monitoring.

(1) Rule Compliance. Each Level I-D Detoxification Program shall comply with the following rules and the rules specified in this chapter.

(a) Program Description: The entity shall develop, maintain and implement a written program description that defines the Level I-D Ambulatory Detoxification without Extended On-site Monitoring Program it provides to include the following specifications:

1. Location: The entity shall specifically identify and describe the setting in which Level I-D Ambulatory Detoxification without Extended On-Site Monitoring Services shall be provided. Services may be provided in any appropriate setting that protects the client's right to privacy, confidentiality, safety and including but not limited to, a general healthcare facility, a physician's office or an addiction or mental health treatment facility as pre-authorized by DMH.

2. Admission Criteria: The entity shall develop, maintain and document implementation of written criteria for admission to its Level I-D Ambulatory Detoxification without Extended On-Site Monitoring Program and the following specifications:

(i) The entity's admission criteria shall specify the target population for the Level I-D Program, which shall include, at a minimum, individuals:

(I) Experiencing mild withdrawal or at risk of experiencing withdrawal from alcohol and/or other drugs at a level of assessed severity appropriate for outpatient care.

(II) Who have adequate systems in place to support outpatient detoxification process.

(ii) The entity shall provide written documentation in individual case records that each client admitted to receive Level I-D Ambulatory Detoxification without Extended On-Site Monitoring Services meets:

(I) The diagnostic criteria for a Substance Induced Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the ASAM PPC-2R.

3. Core Services: Each Level I-D Detoxification Program shall demonstrate the capacity to provide a basic level of skilled treatment services appropriate to the needs of its clientele.

(i) At a minimum, the Level I-D Ambulatory Detoxification Program shall document the capacity to provide the following core services:

- (I) Placement assessment.
- (II) Individual counseling.
- (III) Psychoeducation.
- (IV) Family counseling.
- (V) Peer support.
- (VI) Medication administration.
- (VII) Medication monitoring.
- (VIII) Alcohol and/or drug screening/testing.
- (IX) Case management:
 - I. Case planning.
 - II. Linkage.
 - III. Advocacy.
 - IV. Monitoring.

4. Therapeutic Component Implementation. The entity shall document implementation of medical and other clinical services organized to enhance the client's understanding of addiction, support completion of the detoxification process and initiate transfer to an appropriate level of care for continued treatment.

(i) Service strategies for each Level I-D Detoxification Program shall include, at a minimum:

(I) Implementation of individualized counseling plan strategies.

(II) Completion of a comprehensive medical history and physical examination of the client at admission.

(III) Protocols and/or standing orders, established by the entity's medical director for management of detoxification from each major drug category of abused drugs that are consistent with guidelines published by nationally recognized organizations, including but not limited to, Substance Abuse and Mental Health Services Administration (SAMHSA), American Society of Addiction Medicine (ASAM), the American Psychiatric Association, and the American Academy of Addiction Psychology.

I. Level I-D Ambulatory Detoxification Programs that utilize Benzodiazepines in the detoxification protocol:

A. Shall have written protocols and procedures to show that all doses or amounts of benzodiazepines are carefully monitored and are slowly reduced as appropriate.

B. Shall have written longer-term detoxification protocols and procedures that adhere to general principles of management including clear indications of benzodiazepine dependence, clear intermediate treatment goals and strategies, regular review and methods to prevent diversion from the plan.

(IV) Individual ongoing assessment services, including, but not limited to:

I. Physical examination by a physician, physician assistant or nurse practitioner.

II. Human services needs assessment by a case manager.

(V) Medication administration and monitoring services including specific procedures for pregnant women.

(VI) Motivational enhancement therapy.

(VII) Direct affiliation with other levels of care.

5. Documentation: In addition to meeting the requirements an individualized progress note shall be recorded for each respective service provided in Level I-D:

- (i) Daily assessment of progress, including response to medication, which also notes any treatment regimen changes.
- (ii) Regular and frequent monitoring of vital signs.
- (iii) The use of detoxification rating scale tables and flow sheets.
- (iv) Physician review of all services.

6. Support Systems. The Level I-D Ambulatory Detoxification Program shall develop, maintain and document implementation of written policies and procedures utilized to provide client access to support services on site or through consultation or referral, which shall minimally include:

- (i) Specialized clinical consultation for biomedical, emotional, behavioral and cognitive problems.
- (ii) Appropriate laboratory and toxicology testing.
- (iii) Psychological and psychiatric services.
- (iv) Twenty-four (24) hour access to emergency services.
- (v) Transportation.

7. Program Personnel. Each Level I-D Detoxification Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

(i) Program Coordinator: Each Level I-D Ambulatory Detoxification Program shall be coordinated by a full-time employee who is an Alabama licensed Registered Nurse, Nurse Practitioner, Physician or Physician's Assistant with two (2) years direct care experience treating persons with substance induced disorders.

(ii) Medical Director: The Level I-D Detoxification Program shall have a medical director who is a physician licensed to practice in the State of Alabama, with a minimum of one (1) year experience treating persons with substance use disorders. The medical director shall be responsible for admission, diagnosis, medication management and client care.

(iii) Nursing Services Director: The Level I-D Program shall have a nursing services director who shall be a Registered

Nurse licensed according to Alabama law with training and work experience in behavioral health.

(iv) Nursing Personnel: The entity shall have an adequate number of Alabama licensed nurses to assure that the administration of medications during Level I-D Services complies with applicable state and federal regulations.

(v) Case Manager Coordinator: The entity shall have a case manager coordinator who shall be available to the Level I-D Program on at least a 50% Full-time Equivalent (FTE) basis and shall, at a minimum:

(I) Have a Bachelor's Degree in a behavioral science, at least two (2) years case management experience relative to substance use disorders, and completed DMH/Mental Illness and Substance Abuse Services Division approved case management training.

(II) Supervise and delegate responsibilities to case managers working in the Level I-D Program.

(III) Ensure the availability of person centered case management services to facilitate Level I-D clients' transition into ongoing treatment and recovery.

(IV) Each client shall be assigned to a case manager for care management.

(V) All direct care personnel shall have the qualifications, as a qualified paraprofessional, to provide the specific services delineated in the entity's program description for this level of care.

8. Training. The entity shall provide written documentation that all Level I-D Program personnel satisfy the competency and training requirements as specified in Rule 580-9-44-.02(3).

9. Service Intensity. The entity shall document in the clinical record that Level I-D Services are provided in regularly scheduled sessions and that the frequency and amount of these services are established on the basis of the unique needs of each client served.

10. Length of Service. The entity shall provide written documentation in the clinical record that the duration of treatment in a Level I-D Program shall vary as determined by the client's assessed needs and that the client continues in treatment until:

(i) Withdrawal signs and symptoms are sufficiently resolved; or

(ii) Withdrawal signs and symptoms have failed to respond to treatment and have intensified warranting a transfer to a more intense level of care; or

(iii) The client is otherwise unable to complete detoxification at this level of care.

11. **Service Availability:** The entity shall provide written documentation describing the process utilized to establish the hours of service availability for its Level I-D Ambulatory Detoxification Programs. At a minimum, this process shall:

(i) Include consideration of the needs of the target population, including work, school and parenting responsibilities.

(ii) Include consideration of transportation accessibility.

(iii) Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.17 Level II.1: Intensive Outpatient Treatment.

(1) **Rule Compliance.** Each Level II.1 Intensive Outpatient Program shall comply with the following rules and the rules specified in this chapter.

(a) **Program Description.** The entity shall develop, maintain and implement a written program description that defines the Level II.1 Intensive Outpatient Program it provides to include the following specifications:

1. **Location.** The entity shall specifically identify and describe the setting in which Level II.1 Intensive Outpatient Services shall be provided. Services may be provided in any appropriate setting that protects the client's right to privacy,

confidentiality, safety and meets the DMH facility certification standards.

2. Admission Criteria. The entity shall develop, maintain and implement written criteria for admission to its Level II.1 Outpatient Program and the following specifications:

(i) The entity's admission criteria shall specify the target population for the Level II.1 Program which shall include, at a minimum, individuals whose assessed severity of illness initially warrants this level of care including but not limited to:

(I) Individuals who have fairly stable to stable mental and/or physical health problems; and

(II) Who have supportive living arrangements.

(ii) The entity shall provide written documentation in individual case records that each client admitted to receive Level II.1 Intensive Outpatient Services meets:

(I) The diagnostic criteria for a substance dependence disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iii) Adolescent Program Specific Criteria: The entity shall provide written documentation in individual case records that each adolescent admitted to receive Level II.1 Intensive Outpatient Services meets:

(I) The diagnostic criteria for a substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The adolescent dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iv) Co-occurring Disorders Program Specific Criteria: The entity shall provide written documentation in individual case records that each client admitted to receive Level II.1 Intensive Outpatient Services in a Co-occurring Enhanced Treatment Program meets:

(I) The diagnostic criteria for a substance dependence and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(v) Women and Dependent Children Program Specific Criteria: The entity shall provide written documentation in individual case records that each client admitted to receive Level II.1 Intensive Outpatient Services in a Women and Children Program:

(I) Meets the diagnostic criteria for a substance dependence disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) Meets the dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(III) Is pregnant; or

(IV) Has care and custody of dependent children; or

(V) Has lost custody of dependent children and has the potential for family reunification.

3. Core Services. Each Level II.1 Intensive Outpatient Program shall demonstrate the capacity to provide a basic level of skilled treatment services appropriate to the needs of its clientele.

(i) At a minimum, the Level II.1 Intensive Outpatient Program shall directly or by referral provide the following core services:

(I) Placement assessment.

(II) Individual counseling.

(III) Group counseling.

(IV) Family counseling.

(V) Psychoeducation.

(VI) Mental health consultation.

- (VII) Recovery support services.
- (VIII) Peer counseling services.
- (IX) Medication management.
- (X) Alcohol and/or drug screening/testing.
- (XI) Smoking cessation.
- (XII) Sign language interpreter services.
- (XIII) HIV early intervention services.
- (XIV) Case management:
 - I. Case planning.
 - II. Linkage.
 - III. Advocacy.
 - IV. Monitoring.

(ii) Adolescent Program Specific Criteria: Each Level II.1 Adolescent Intensive Outpatient Program shall document the capacity to provide each of the core services to include the following services:

- (I) Activity therapy.
- (II) Academic and vocational services.
- (III) Vocational services.

(iii) Co-occurring Disorders Program Specific Criteria: Each level II.1 Co-occurring Disorders Intensive Outpatient Program shall document the capacity to provide each of the core services to include the following services:

- (I) Basic living skills.
- (II) Crisis intervention services.
- (III) Intensive case management.
- (IV) Academic and vocational services.

(iv) Women and Dependent Children Program Specific Criteria: Each Level II.1 Women and Dependent Children Intensive Outpatient Program shall document the capacity to provide each of the core services and/or arrange for the following services:

- (I) Transportation.
- (II) Child sitting services.
- (III) Developmental delay and/or prevention services.
- (IV) Activity therapy.
- (V) Parenting skills development.

4. Therapeutic Component Implementation. The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency and intensity appropriate to the client's assessed needs and expressed desires for care.

(i) Service strategies for each Level II.1 Intensive Outpatient Program shall include, at a minimum:

- (I) Implementation of individualized counseling plan strategies.
- (II) Ongoing individualized assessment.
- (III) Motivational enhancement and engagement strategies.
- (IV) Relapse prevention strategies.
- (V) Interpersonal choice/decision-making skill development.
- (VI) Health education.
- (VII) Random drug screening.
- (VIII) Medication administration and monitoring.
- (IX) Gender responsive treatment.

(ii) Adolescent Program Specific Criteria: Each Level II.1 Adolescent Intensive Outpatient Program shall document the capacity to provide the service strategies and the following therapeutic components:

(I) Adolescent specific evidence based therapeutic interventions.

(II) Client education on key adolescent development issues including, but not limited to, adolescent brain development and the impact of substance use, emotional and social influence on behavior, value system development, puberty/physical development, sexuality and self esteem.

(III) Recreation and leisure time skills training.

(IV) Family, community and school reintegration services.

(V) Academic or vocational services.

(iii) Co-occurring Disorders Program Specific Criteria: Each Level II.1 Co-occurring Disorders Outpatient Program shall document the capacity to provide the service strategies and the following therapeutic components:

(I) Groups and classes that address the signs and symptoms of mental health and substance use disorders.

(II) Groups, classes and training to assist clients in becoming aware of cues or triggers that enhance the likelihood of alcohol and drug use or psychiatric decompensation and to aid in development of alternative coping responses to those cues.

(III) Dual recovery groups that provide a forum for discussion of the interactions of and interrelations between substance use and mental health disorders.

(IV) Intensive Case Management.

(iv) Women and Dependent Children Program Specific Criteria: Each Level II.1 Women and Dependent Children Intensive Outpatient Program shall document the capacity to provide the service strategies and the following therapeutic components:

(I) Specific services which address issues of relationships, parenting, abuse and trauma.

(II) Primary medical care, including prenatal care.

(III) Primary pediatric care for children.

(IV) Therapeutic interventions for children which address their developmental needs and issues of sexual abuse and neglect.

(V) Outreach to inform pregnant women of the services and priorities.

(VI) Interim services while awaiting admission to this level of care.

(VII) Recreation and leisure time skills training.

(VIII) Academic and vocational services.

(IX) Financial resource development and planning.

(X) Family planning services.

5. Documentation: For each day in attendance, an individualized progress note shall be recorded to reflect services provided in Level II.1.

6. Support Systems. Each Level II.1 Intensive Outpatient Program shall develop, maintain and document implementation of written policies and procedures which govern the process used to provide client access to support services on site or through consultation or referral, which shall include:

(i) Medical, psychiatric, psychological, laboratory and toxicology services.

(ii) Medical and psychiatric consultation shall be available within twenty-four (24) hours by telephone or, if in person, within seventy-two (72) hours.

(iii) Direct affiliation with or coordination through referral to more and less intensive levels of care and supportive housing services.

(iv) Emergency services shall be available by telephone twenty-four (24) hours a day, seven (7) days a week.

(v) Mutual self help groups that are tailored to the needs of the specific client population.

(vi) Referral for other services as according to the client's assessed needs.

7. Program Personnel. Each level II.1 Intensive Outpatient Program shall employ an adequate number of qualified

individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

(i) Program Coordinator: Each Level II.1 Intensive Outpatient Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years post master's supervised experience in a direct service area treating clients with substance use, mental health, or co-occurring mental illness and substance use disorders.

(ii) Direct Care Personnel. All direct care personnel shall be qualified as a qualified paraprofessional to provide the specific services delineated in the entity's operational procedures for this level of care.

(iii) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level II.1 Intensive Outpatient Program as delineated in its operational procedures.

(iv) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(v) Every client in a Level II.1 Program shall be assigned to a specific primary counselor for care management.

(vi) Each primary counselor shall maintain a case load not to exceed thirty (30) clients with active cases at any one time.

(vii) Adolescent Program Specific Criteria.

(I) Program Coordinator: Each Level II.1 Adolescent Intensive Outpatient Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years post master's supervised experience in a direct service area treating adolescents who have substance use, mental health or co-occurring mental health and substance use disorders.

(II) Direct Care Personnel. All direct care personnel shall be qualified, as a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(III) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level II.1

Adolescent Intensive Outpatient Program as delineated in its operational plan.

(IV) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(V) Every client in a Level II.1 Adolescent Intensive Outpatient Program shall be assigned to a specific primary counselor for care management.

(VI) Each primary counselor shall maintain a case load not to exceed thirty (30) clients with active cases at any one time.

(viii) Co-occurring Disorders Program Specific Criteria.

(I) The Level II.1 Co-occurring Enhanced Intensive Outpatient Program shall be coordinated by a full-time member of the staff who has the minimum of a master's degree in a mental health related field and at least two (2) years post master's supervised experience in a direct service area treating clients with co-occurring disorders.

(II) The Level II.1 Co-occurring Enhanced Intensive Outpatient Program shall have access to psychiatric services (led by a qualified psychiatrist or nurse practitioner) that are fully capable of evaluating, diagnosing and prescribing medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

(III) Treatment staff that provide therapy and ongoing clinical assessment services to individuals diagnosed with co-occurring disorders shall have, at a minimum:

I. A master's degree in a behavioral health related field with a minimum of two (2) years work experience with individuals who have co-occurring disorders, mental health or substance use disorders.

II. Specialized training to work with individuals who have co-occurring disorders.

(IV) All other direct care personnel in a Level II.1 Co-occurring Enhanced Intensive Outpatient Program shall be qualified as a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(V) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level II.1 Co-occurring Enhanced Outpatient Program as delineated in its operational plan.

(VI) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(VII) Every client in a Level II.1 Co-occurring Intensive Outpatient Program shall be assigned to a specific primary counselor for care management.

(VIII) Each primary counselor shall maintain a case load not to exceed twenty (20) clients with active cases at any one time.

(ix) Women and Dependent Children Program Specific Criteria:

(I) Program Coordinator: Each Level II.1 Women and Dependent Children Intensive Outpatient Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years post master's supervised experience in a direct service area treating women who have substance use, mental health, or co-occurring mental health and substance use disorders.

(II) Direct Care Personnel. All direct care personnel shall be qualified as a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(III) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level II.1 Women and Dependent Children Intensive Outpatient Program as delineated in its operational plan.

(IV) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(V) Every client in a Level II.1 Women and Dependent Children Program shall be assigned to a specific primary counselor for case management.

(VI) Each primary counselor shall maintain a case load not to exceed twenty (20) clients with active cases at any one time.

8. Training. The entity shall provide written documentation that all Level II.1 Program personnel satisfy the competency and training requirements as specified in Rule 580-9-44-.02(3).

9. Service Intensity.

(i) The entity shall document that the amount and frequency of Level II.1 Intensive Outpatient Services are established on the basis of the unique needs of each client served and shall be available a minimum of nine (9) hours but no greater than nineteen (19) hours each week.

(ii) Adolescent Program Specific Criteria. The entity shall document that the amount and frequency of Level II.1 Intensive Outpatient Services for adolescents are established on the basis of the unique needs of each client served and shall be available a minimum of six (6) hours but no greater than nineteen (19) hours each week.

10. Length of Service: The entity shall provide written documentation that the duration of treatment in each Level II.1 Intensive Outpatient Program shall vary as determined by:

(i) The severity of the client's illness.

(ii) The client's ability to comprehend the information provided and use that information to implement treatment strategies and attain treatment goals.

(iii) The appearance of new problems that require another level of care; or

(iv) The availability of services at an assessed level of need, when Level II.1 services have been utilized as interim services.

11. Service Availability: The entity shall provide written documentation describing the process utilized to establish the hours of service availability for its Level II.1 Intensive Outpatient Programs. At a minimum, this process shall:

(i) Include consideration of the needs of the target population, including work, school and parenting responsibilities.

(ii) Include consideration of transportation accessibility.

(iii) Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.18 Level II.5: Partial Hospitalization Treatment Program.

(1) Rule Compliance. Each Level II.5 Partial Hospitalization Program shall comply with the following rules and the rules specified in this chapter: (List applicable rules found throughout the standards)

(a) Program Description. The entity shall develop, maintain and implement a written program description that defines the Level II.5 Partial Hospitalization Program it provides, as according to Rule 580-9-44-.13 and the following specifications:

1. Location. The entity shall specifically identify and describe the setting in which Level II.5 Partial Hospitalization Services shall be provided. Services may be provided in any appropriate setting that protects the client's right to privacy, confidentiality, safety and meets DMH facility certification criteria.

2. Admission Criteria. The entity shall develop, maintain and implement written criteria for admission to its Level II.5 Partial Hospitalization Program, in compliance with the requirements of Rule 580-9-44-.13(9), and the following specifications:

(i) The entity's admission criteria shall specify the target population for the Level II.5 Program, which shall include at a minimum, individuals whose assessed severity of illness initially warrants this level of care including but not limited to:

(I) Individuals who have fairly unstable mental and/or physical health problems.

(II) Who have unstable or dysfunctional, but adequate living arrangements.

(ii) The entity shall provide written documentation in individual case records that each client admitted to receive Level II.5 Partial Hospitalization Services meets:

(I) The diagnostic criteria for a substance dependence disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iii) Adolescent Program Specific Criteria: The entity shall provide written documentation in individual case records that each adolescent admitted to receive Level II.5 Partial Hospitalization Services meets:

(I) The diagnostic criteria for a substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The adolescent dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iv) Co-occurring Disorders Program Specific Criteria: The entity shall provide written documentation in individual case records that each individual admitted to receive Level II.5 Partial Hospitalization Services in a Co-occurring Enhanced Treatment Program meets:

(I) The diagnostic criteria for a substance dependence and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(v) Women and Dependent Children Program Specific Criteria: The entity shall provide written documentation in individual case records that each client admitted to receive Level II.5 Partial Hospitalization Services in a Women and Dependent Children Program meets:

(I) The diagnostic criteria for a substance dependence disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(III) Is pregnant; or

(IV) Has care and custody of dependent children; or

(V) Has lost custody of dependent children and has the potential for family reunification.

3. Core Services. Each Level II.5 Partial Hospitalization Program shall demonstrate the capacity to provide a basic level of skilled treatment services appropriate to the needs of its clientele.

(i) At a minimum, the Level II.5 Partial Hospitalization Program shall provide the following core services:

(I) Placement assessment.

(II) Individual counseling.

(III) Group counseling.

(IV) Family counseling.

(V) Psychoeducation.

(VI) Mental health consultation.

(VII) Recovery support services.

(VIII) Peer counseling services.

(IX) Medication management.

(X) Alcohol and/or drug screening/testing.

(XI) Smoking cessation.

(XII) Sign language interpreter services.

(XIII) HIV early intervention services.

(XIV) Case management:

I. Case planning.

- II. Linkage.
- III. Advocacy.
- IV. Monitoring.

(ii) Adolescent Program Specific Criteria: Each Level II.5 Partial Hospitalization Program shall document the capacity to provide each of the core services to include the following services:

- (I) Activity therapy.
- (II) Academic or vocational services.

(iii) Co-occurring Disorders Program Specific Criteria: Each Level II.5 Partial Hospitalization Program shall document the capacity to provide each of the core services to include the following services:

- (I) Basic living skills.
- (II) Crisis intervention services.
- (III) Activity therapy.
- (IV) Intensive case management.

(iv) Women and Dependent Children Program Specific Criteria: Each Level II.5 Women and Dependent Children Partial Hospitalization Program shall document the capacity to provide each of the core services and/or arrange for the following services:

- (I) Transportation.
- (II) Child sitting services.
- (III) Developmental delay and prevention services.
- (IV) Activity therapy.
- (V) Parenting skills development.

4. Therapeutic Component Implementation. The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency and intensity appropriate to the client's assessed needs and expressed desires for care.

(i) Service strategies for each Level II.5 Partial Hospitalization Program shall include, at a minimum:

(I) Implementation of individualized counseling plan strategies.

(II) Ongoing individualized assessment services.

(III) Motivational enhancement and engagement strategies.

(IV) Relapse prevention strategies.

(V) Interpersonal choice/decision-making skill development.

(VI) Health education.

(VII) Random drug screening.

(VIII) Medication administration and monitoring.

(VII) Family education.

(X) Gender responsive treatment.

(ii) Adolescent Program Specific Criteria: Each Level II.5 Adolescent Partial Hospitalization Program shall document the capacity to provide the service strategies to include the following therapeutic components:

(I) Adolescent specific evidence based therapeutic interventions.

(II) Client education on key adolescent development issues including, but not limited to, adolescent brain development and the impact of substance use, emotional and social influence on behavior, value system development, puberty/physical development, sexuality and self esteem.

(III) Recreation and leisure time skills training.

(IV) Family, community and school reintegration services.

(V) Academic or vocational services

(iii) Co-occurring Disorders Program Specific Criteria: Each Level II.5 Co-occurring Enhanced Partial Hospitalization

Program shall document the capacity to provide the service strategies to include the following therapeutic components:

(I) Groups and classes that address the signs and symptoms of mental health and substance use disorders.

(II) Groups, classes and training to assist clients in becoming aware of cues or triggers that enhance the likelihood of alcohol and drug use or psychiatric decompensation and to aid in development of alternative coping responses to those cues.

(III) Dual recovery groups that provide a forum for discussion of the interactions of and interrelations between substance use and mental health disorders.

(IV) Intensive case management.

(iv) Women and Dependent Children Program Specific Criteria: Each Level II.5 Women and Dependent Children Partial Hospitalization Program shall document the capacity to provide the service strategies and/or arrange for the following therapeutic components:

(I) Specific services which address issues of relationships, parenting abuse and trauma.

(II) Primary medical care, including prenatal care.

(III) Primary pediatric care for children.

(IV) Therapeutic interventions for children which address their developmental needs and issues of sexual abuse and neglect.

(V) Outreach to inform pregnant women of the services and priorities.

(VI) Interim services while awaiting admission to this level of care.

(VII) Recreation and leisure time skills training.

(VIII) Academic and vocational services.

(IX) Financial resources and planning.

(X) Family planning services.

5. Documentation: For each day in attendance an individual progress note shall be recorded to reflect services provided in Level II.5 Partial Hospitalization.

6. Support Systems. Each Level II.5 Partial Hospitalization Program shall develop, maintain and document implementation of written policies and procedures that govern the process used to provide client access to support services on site, or through consultation or referral, which shall minimally include:

(i) Medical, psychiatric, psychological, laboratory and toxicology services.

(ii) Medical and psychiatric consultation shall be available within twenty-four (24) hours by telephone or, if in person, within forty-eight (48) hours.

(iii) Direct affiliation with, or coordination through referral to more and less intensive levels of care and supportive housing services.

(iv) Emergency services shall be available by telephone twenty-four (24) hours a day, seven (7) days a week.

(v) Mutual self help groups that are tailored to the needs of the specific client population.

(vi) Referral for other services as according to the client's assessed needs.

7. Program Personnel. Each Level II.5 Partial Hospitalization Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

(i) Program Coordinator: Each Level II.5 Partial Hospitalization Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years post master's supervised experience in a direct service area treating clients with substance use, mental health, or co-occurring mental health and substance use disorders.

(ii) Direct Care Personnel. All direct care personnel shall be qualified as a qualified paraprofessional to provide the specific services delineated in the entity's operational procedures for this level of care.

(iii) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level II.5 Partial Hospitalization Program as delineated in its operational procedures.

(iv) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(v) Every client in a Level II.5 Partial Hospitalization Program shall be assigned to a specific Primary Counselor for care management.

(vi) Each primary counselor shall maintain a case load not to exceed thirty (30) clients with active cases at any one time.

(vii) Adolescent Program Specific Criteria.

(I) Program Coordinator: Each Level II.5 Adolescent Partial Hospitalization Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years post master's supervised experience in a direct service area treating adolescents who have substance use, mental health, or co-occurring mental health and substance use disorders.

(II) Direct Care Personnel. All direct care personnel shall be qualified as a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(III) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level II.5 Partial Hospitalization Program as delineated in its operational plan.

(IV) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(V) Every client in a Level II.5 Adolescent Partial Hospitalization Program shall be assigned to a specific primary counselor for care management.

(VI) Each primary counselor shall maintain a case load not to exceed thirty (30) clients with active cases at any one time.

(viii) Co-occurring Disorders Program Specific Criteria.

(I) The Level II.5 Partial Hospitalization Program shall be coordinated by a full-time member of the staff who has the minimum of a master's degree in a mental health related field and at least two (2) years post master's supervised experience in a direct service area treating clients with co-occurring disorders.

(II) The Level II.5 Co-occurring Enhanced Partial Hospitalization Program shall have access to psychiatric services (led by a qualified psychiatrist or nurse practitioner) that are fully capable of evaluating, diagnosing and prescribing medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

(III) The treatment organization/agency shall have access to an Alabama licensed physician, full time, part time, or on contract, who shall be available to the program for client care and shall assume liability for the medical aspects of the program.

(IV) Treatment staff that provide therapy and ongoing clinical assessment services to individuals diagnosed with co-occurring disorders, shall have, at a minimum:

I. A master's degree in a behavioral health related field with a minimum of two (2) years work experience with individuals who have co-occurring disorders, mental health or substance use disorders.

II. Specialized training to work with individuals who have co-occurring disorders.

(V) All other direct care personnel in a Level II.5 Co-occurring Enhanced Partial Hospitalization Program shall be qualified, as a qualified paraprofessional to provide the specific services delineated in the entity's operational procedures for this level of care.

(VI) The entity shall maintain an adequate number of clinical personnel to sustain the Level II.5 Co-occurring Enhanced Partial Hospitalization Program as delineated in its operational procedures.

(VII) The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(VIII) Every client in a Level II.5 Co-occurring Enhanced Partial Hospitalization Program shall be assigned to a specific primary counselor for care management.

(IX) Each primary counselor shall maintain a case load not to exceed twenty (20) clients with active cases at any one time.

(ix) Women and Dependent Children Program Specific Criteria:

(I) Program Coordinator: Each Level II.5 Partial Hospitalization Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years post master's supervised experience in a direct service area treating women who have substance use, mental health, or co-occurring mental health and substance use disorders.

(II) Direct Care Personnel. All direct care personnel shall be qualified, as a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(III) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level II.5 Women and Dependent Children Partial Hospitalization Program as delineated in its operational plan.

(IV) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(V) Every client in a Level II.5 Women and Dependent Children program shall be assigned to a specific primary counselor for care management.

(VI) Each primary counselor shall maintain a case load not to exceed twenty (20) clients with active cases at any one time.

8. Training. The entity shall provide written documentation that all Level II.5 program personnel satisfy the competency and training requirements as specified in Rule 580-9-44-.02(3).

9. Service Intensity: The entity shall document that the amount and frequency of Level II.5 Partial Hospitalization Services are established on the basis of the unique needs of each

client served and shall be available a minimum of twenty (20) hours each week.

10. Length of Service: The entity shall provide written documentation that the duration of treatment in each Level II.5 Partial Hospitalization Program shall vary as determined by:

(i) The severity of the client's illness.

(ii) The client's ability to comprehend the information provided and use that information to implement treatment strategies and attain treatment goals.

(iii) The appearance of new problems that require another level of care; or

(iv) The availability of services at an assessed level of need when Level II.5 services have been utilized as interim services.

11. Service Availability: The entity shall provide written documentation describing the process utilized to establish the hours of service availability for its Level II.5 Partial Hospitalization Program. At a minimum, this process shall:

(i) Include consideration of the needs of the target population, including work, school and parenting responsibilities.

(ii) Include consideration of transportation accessibility.

(iii) Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.19 Level II-D: Ambulatory Detoxification With Extended On-site Monitoring.

(1) Rule Compliance. Each Level II-D Ambulatory Detoxification Program shall comply with the following rules and the rules specified in this chapter.

(a) Program Description. The entity shall develop, maintain and implement a written program description that defines the Level II-D Ambulatory Detoxification Program it provides, as according to Rule 580-9-44-.13 and the following specifications:

1. Location. The entity shall specifically identify and describe the setting in which Level II-D Ambulatory Detoxification with Extended On-Site Monitoring services shall be provided. Services may be provided in any appropriate setting that protects the client's right to privacy, confidentiality, safety and meets the DMH facility certification standards.

2. Admission Criteria: The entity shall develop, maintain and document implementation of written criteria for admission to its Level II-D Ambulatory Detoxification With Extended On-Site Monitoring Program, in compliance with the requirements of Rule 580-9-44-.13(9) and the following specifications:

(i) The entity's admission criteria shall specify the target population for the Level II-D program, which shall include, at a minimum, individuals who:

(I) Have been assessed as being at moderate risk of severe withdrawal syndrome outside of the program setting.

(II) Are free of severe, unstabilized physical and psychiatric complications.

(III) Who do not have adequate family or other service systems in place to support an outpatient detoxification process.

(ii) The entity shall provide written documentation in individual case records that each client admitted to receive Level II-D Ambulatory Detoxification with Extended On-Site Monitoring Services meets:

(I) The diagnostic criteria for Substance Induced Disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the ASAM PPC-2R.

3. Core Services: Each Level II-D Ambulatory Detoxification Program shall demonstrate the capacity to provide a basic level of skilled treatment services appropriate to the needs of its clientele.

(i) At a minimum, the Level II-D Ambulatory Detoxification Program shall document the capacity to provide the following core services:

- (I) Placement assessment.
- (II) Individual counseling.
- (III) Group counseling.
- (IV) Psychoeducation.
- (V) Family counseling.
- (VI) Medical and somatic services.
- (VII) Medication administration.
- (VIII) Medication monitoring.
- (IX) Alcohol and/or drug screening/testing.
- (X) Case management:
 - I. Case planning.
 - II. Linkage.
 - III. Advocacy.
 - IV. Monitoring.

4. Therapeutic Component Implementation: The entity shall document implementation of medical and other clinical services organized to enhance the client's understanding of addiction, support completion of the detoxification process and initiate transfer to an appropriate level of care for continued treatment. The entity's Level II-D program shall, at a minimum, consist of the following components:

(i) Completion of a comprehensive medical history and physical examination of the client at admission.

(ii) Protocols and/or standing orders, established by the entity's medical director, for management of detoxification from each major drug category of abused drugs that are consistent with guidelines published by nationally recognized organizations (e.g., SAMHSA, ASAM, American Academy of Addiction Psychology).

(I) Level II-D Ambulatory Detoxification Programs that utilize benzodiazepines in the detoxification protocol:

I. Shall have written protocols and procedures to show that all doses or amounts of benzodiazepines are carefully monitored and are slowly reduced as appropriate.

II. Shall have written longer-term detoxification protocols and procedures that adhere to general principles of management including clear indications of benzodiazepine dependence, clear intermediate treatment goals and strategies, regular review and methods to prevent diversion from the plan.

(iii) On-site physician and/or nurse monitoring, assessment and management of signs and symptoms of intoxication and withdrawal.

(iv) Medication administration and monitoring services including specific procedures for pregnant women.

(v) Ongoing Intake Interview Examination.

(vi) Direct affiliation with other levels of care.

5. Documentation: Level II-D Ambulatory Detoxification Programs shall provide the following:

(i) Documentation of each clinical/therapeutic intervention provided.

(ii) Daily assessment of progress including response to medication, which also notes any treatment changes.

(iii) Monitoring of vital signs each day the client is on site.

(iv) The use of detoxification rating scale tables and flow sheets.

(v) Physician review of all services.

6. Support Systems. The Level II-D Ambulatory Detoxification Program shall develop, maintain and document implementation of written policies and procedures utilized to provide client access to support services on site, or through consultation or referral, which shall minimally include:

(i) Specialized clinical consultation for biomedical, emotional, behavioral and cognitive problems.

- (ii) Appropriate laboratory and toxicology testing.
- (iii) Psychological and psychiatric services.
- (iv) Transportation.
- (v) Twenty-four (24) hour access to emergency medical services.

7. Program Personnel: Each Level II-D Ambulatory Detoxification Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

(i) Program Coordinator: Each Level II-D Ambulatory Detoxification Program shall be coordinated by a full-time employee who is an Alabama licensed Registered Nurse, Nurse Practitioner, Physician, or Physician's Assistant, with two (2) years direct care experience treating persons with substance induced disorders.

(ii) Medical Director: The Level II-D Detoxification Program shall have a medical director who is a physician licensed to practice in the state of Alabama, with a minimum of one (1) year experience treating persons with substance induced disorders. The medical director shall be responsible for admission, diagnosis, medication management and client care.

(iii) Nursing Services Director: The Level II-D Program shall have a nursing services director who shall be a Registered Nurse licensed according to Alabama law, with training and work experience in behavioral health.

(iv) Nursing Personnel: The entity shall have an adequate number of Alabama licensed nurses to assure that the administration of medications during Level I-D services complies with applicable state and federal regulations.

(I) There shall be a Registered Nurse or Licensed Practical Nurse on site during all hours of the Level II-D Program's operation.

(v) Clinical staff providing services shall have access to a full-time clinical director.

(vi) All direct care personnel shall have the qualifications as a qualified paraprofessional, to provide the specific services delineated in the entity's program description for this level of care.

(vii) The entity shall maintain an adequate number of physicians, nurses, counselors and case managers to sustain the Level II-D Ambulatory Detoxification Outpatient Program as delineated in its program operational procedures.

(viii) The entity shall maintain an adequate number of administrative support personnel to sustain the program's administrative functions.

8. Training. The entity shall provide written documentation that all Level II-D Program personnel satisfy the competency and training requirements as specified in Rule 580-9-44-.02(3).

9. Service Intensity. The entity shall document in the clinical record that Level II-D Services are provided in regularly scheduled sessions and that:

(i) The entity has the demonstrated capacity to provide a structured program of clinical services for a minimum of nine (9) hours per week.

(ii) The frequency and amount of Level II-D Services are established on the basis of the unique needs of each client served.

10. Length of Service. The entity shall provide written documentation in the clinical record that the duration of treatment in a Level II-D Program varies as determined by the client's assessed needs and that the client continues in treatment until:

(i) Withdrawal signs and symptoms are sufficiently resolved; or

(ii) Withdrawal signs and symptoms have failed to respond to treatment and have intensified warranting a transfer to a more intense level of care; or

(iii) The client is, otherwise, unable to complete detoxification at this level of care.

11. Service Availability: The entity shall provide written documentation describing the process utilized to establish the hours of service availability for its Level II-D Program. At a minimum, this process shall:

(i) Include consideration of the needs of the target population including work, school and parenting responsibilities.

(ii) Include consideration of transportation.

(iii) Not be based solely on standard eight(8) to five(5), Monday through Friday office hours.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.20 Level III.01: Transitional Residential Program.

(1) Rule Compliance. Each Level III.01 Transitional Residential Program shall comply with the following rules and the rules specified in this chapter.

(a) Program Description. The entity shall develop, maintain, and implement a written program description that defines the Level III.01 Transitional Residential Program it provides, as according to Rule 580-9-44-.13 and the following specifications:

1. Location. The entity shall specifically identify and describe the setting in which the Level III.01 Transitional Residential Program shall be provided. Services shall be provided in any facility that meets all applicable federal, state and local certification, licensure, building, life-safety, fire, health and zoning regulations including the DMH facility certification standards.

2. Admission Criteria: The entity shall develop, maintain and document implementation of written criteria for admission to its Level III.01 Transitional Residential Program, in compliance with the requirements of Rule 580-9-44-.13(9) and the following specifications:

(i) The entity's admission criteria shall specify the target population for its Level III.01 Services, which shall include, at a minimum:

(I) Individuals whose assessed severity of illness warrants this level of care.

(II) Individuals who have a need for support in a twenty-four (24) hour drug-free environment in order to reintegrate into the community after treatment in a more intense level of care.

(ii) The entity shall provide written documentation in individual case records that each client admitted to a Level III.01 Program meets the following diagnostic and modified ASAM PPC2R dimensional criteria for this level of care:

(I) The client shall meet the criteria for a substance use disorder, as according to the specific diagnostic criteria given in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(II) Acute Intoxication and/or Withdrawal:

I. The client shall not report experiencing or display any signs or symptoms of alcohol or other drug withdrawal.

(III) Biomedical Conditions and Complications:

I. The client's biomedical problems, if any, shall be stable, and shall not require medical or nurse monitoring by the transitional program.

II. The client shall be capable of self-administering any prescribed or required over the counter medication.

(IV) Emotional, Behavioral, or Cognitive Conditions and Complications:

I. The client shall not report or display symptoms of a co-occurring psychiatric, emotional, behavioral, or behavioral condition; or

II. The client's co-occurring psychiatric, emotional, behavioral, or cognitive disorder shall be:

A. Stable.

B. Self-manageable.

C. Addressed concurrently through appropriate psychiatric services.

III. The client shall be assessed as not posing a risk of harm to self or others.

(V) Readiness to Change:

I. The client shall acknowledge the existence of a substance use disorder, or a co-occurring substance use and

psychiatric, emotional, behavioral, or cognitive disorder and expresses and demonstrates a desire to make needed changes to support recovery.

(VI) Relapse, Continued Use, or Continued Problem Potential:

I. The client's history indicates a high risk of relapse in a less structured level of care; or

II. The client needs regimented support to maintain engagement in a recovery focused process on community reintegration.

(VII) Recovery Environment:

I. The client has insufficient resources and skills to maintain a recovery oriented lifestyle outside of a twenty-four (24) hour supportive environment.

3. Core Services: Each Level III.01 Transitional Residential Program shall demonstrate the capacity to provide a basic level of treatment services appropriate to the needs of its clientele.

(i) At a minimum, the entity shall demonstrate and document its capacity to provide a twenty-four (24) hour structured residential treatment environment with the following core services:

(I) Placement assessment.

(II) Psychoeducation.

(III) Peer support.

(IV) Daily living skills.

(V) Alcohol and/or drug screening/testing.

(VI) Transportation.

(VII) Case Management:

I. Case planning.

II. Linkage.

III. Advocacy.

IV. Monitoring.

4. Therapeutic Component Implementation. The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency and intensity appropriate to the client's assessed needs and expressed desires for care.

(i) Service strategies for each Level III.01 Transitional Residential Program shall include, at a minimum:

(I) Maintenance of an alcohol and illicit drug free environment.

(II) Implementation of individualized service plan strategies.

(III) On duty, awake staff shall provide supervision of client's health, welfare and safety twenty-four (24) hours a day.

(IV) All clients enrolled in Level III.01 Programs shall have access to clinical services twenty-four (24) hours a day, seven (7) days a week.

(V) The entity shall document the provision of planned recovery support services and activities that shall, at a minimum, include:

I. Motivational strategies.

II. Relapse prevention counseling.

III. Interpersonal choices/decision making skills development.

IV. Development of a social network supportive of recovery.

V. Daily living and recovery skills development.

VI. Random drug screening.

VII. Health education.

5. Documentation. Individualized progress notes shall be recorded each day for each respective service provided in Level III.01 Services.

6. Support Systems. Each level III.01 Transitional Residential Program shall develop, maintain and document

implementation of written policies and procedures that govern the process used to provide client access to support services at the Level III.01 Program site, or through consultation or referral, which shall minimally include:

(i) Telephone or in person consultation with emergency services twenty four (24) hours a day, seven (7) days a week.

(ii) Telephone or in person consultation with a Registered Nurse twenty-four (24) hours a day, seven (7) days a week.

(iii) Direct affiliation with or coordination through referral to more and less intensive levels of care.

(iv) Direct affiliation with or coordination through referral to supportive services, including vocational rehabilitation, literacy training and adult education.

(v) Mutual self help groups which are tailored to the needs of the specific client population.

7. Program Personnel. Each Level III.01 Transitional Residential Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

(i) Program Coordinator: Level III.01 Transitional Program shall have a full-time program coordinator or manager who shall have a minimum of three years (3) work experience in a direct service area treating clients with substance use or co-occurring mental health and substance use disorders, plus other qualifications and credentials as designated in writing by the governing authority.

(ii) Direct Care Personnel: All direct care personnel shall have the qualifications as a qualified paraprofessional to provide the specific services delineated in the entity's program description for this level of care.

(iii) Administrative Support Personnel: The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(iv) Every client in a Level III.01 Transitional Residential Program shall be assigned to a specific primary counselor for care management.

8. Training. The entity shall provide written documentation that all Level III.01 Program personnel satisfy the

competency and training requirements as specified in Rule 580-9-44-.02(3).

9. Service Intensity. The entity shall document that the amount and frequency of Level III.01 Services are established on the basis of the unique needs of each client served.

10. Length of Service. The entity shall provide written documentation that the duration of treatment in its Level III.01 Program is variable as determined by:

- (i) The severity of the client's illness.
- (ii) The client's ability to comprehend the information provided and use that information to meet treatment goals and strategies; or
- (iii) The appearance of new problems that require another level of care; or
- (iv) The availability of services at an assessed level of need, when a Level III.01 Transitional Residential Program has been utilized as an interim level of care.

11. Service Availability: The entity shall provide written documentation describing the process utilized to establish hours of availability for screening, assessment and intake services, admission and counseling services at its Level III.01 Transitional Residential Program. At a minimum, this process shall:

- (i) Include consideration of the needs of the target population, including work, school and parenting responsibilities.
- (ii) Include consideration of transportation accessibility.
- (iii) Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.21 Level III.1: Clinically Managed Low Intensity Residential Treatment Program.

(1) Rule Compliance. In addition to compliance with the rules as specified in this chapter, each Level III.1 Clinically Managed Low Intensity Residential Treatment Program shall comply with the rules as specified in the following chapters.

(a) Program Description. The entity shall develop, maintain and implement a written program description that defines the Level III.1 Clinically Managed Low Intensity Residential Treatment Program it provides, as according to Rule 580-9-44-.13 and the following specifications:

1. Location. The entity shall specifically identify and describe the setting in which the Level III.1 Program shall be provided. Services shall be provided in any facility that meets all applicable federal, state and local certification, licensure, building, life-safety, fire, health and zoning regulations including the DMH facility certification standards.

2. Admission Criteria: The entity shall develop, maintain and document implementation of written criteria for admission to its Level III.1 Program, in compliance with the requirements of Rule 580-9-44-.13(9) and the following specifications:

(i) The entity's admission criteria shall specify the target population for its Level III.1 Services, which shall include, at a minimum, individuals:

(I) Whose assessed severity of illness warrants this level of care including, but not limited to:

I. Individuals who have a need for structure and support in a twenty-four (24) hour drug-free environment in order to:

A. Engage in treatment.

B. Sustain participation in regular productive, daily activities or current treatment for physical or mental disorders.

C. Develop, integrate and practice recovery and coping skills.

D. Continue treatment for a substance use disorder as a step-down from a more intense level of care.

(ii) The entity shall provide written documentation in individual case records that each client admitted to a Level III.1 Program meets:

(I) The diagnostic criteria for a substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iii) Adolescent Program Specific Criteria: The entity shall provide written documentation in individual case records that each adolescent admitted to a Level III.1 Program meets:

(I) The diagnostic criteria for a substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The adolescent dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iv) Co-occurring Disorders Program Specific Criteria: The entity shall provide written documentation in individual case records that each individual admitted to a Level III.1 Co-occurring Enhanced Treatment Program meets:

(I) The diagnostic criteria for a substance dependence and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(v) Women and Dependent Children Program Specific Criteria: The entity shall provide written documentation in individual case records that each client admitted to a Level III.1 Program for Women and Dependent Children:

(I) Meets the diagnostic criteria for a substance dependence disorder as defined in the most recent edition Diagnostic and Statistical Manual for Mental Disorders; and

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

- (III) Is pregnant; or
- (IV) Has care and custody of dependent children; or
- (V) Has lost custody of dependent children and has the potential for family reunification.

3. Core Services: Each Level III.1 Low Intensity Residential Program shall demonstrate the capacity to provide a basic level of treatment services appropriate to the needs of its clientele.

(i) At a minimum, the entity shall demonstrate and document its capacity to provide a twenty-four (24) hour structured residential treatment environment with the following core services:

- (I) Placement assessment.
- (II) Individual counseling.
- (III) Group counseling.
- (IV) Family counseling.
- (V) Psychoeducation.
- (VI) Peer support.
- (VII) Daily living skills.
- (VIII) Medication management.
- (IX) Alcohol and/or drug screening/testing.
- (X) Transportation.
- (XI) Case management:
 - I. Case planning.
 - II. Linkage.
 - III. Advocacy.
 - IV. Monitoring.

(ii) Medical Services. Medical services, including a physical examination, shall be provided as specified by the

entity's medical protocols established as required by Rule 580-9-44-.13(24).

(iii) Adolescent Program Specific Criteria: Each Level III.1 Adolescent Low Intensity Residential Treatment Program shall document the capacity to provide each of the core services and the following services:

- (I) Activity therapy.
- (II) Academic or vocational services.

(iv) Co-occurring Disorders Program Specific Criteria: Each Level III.1 Co-occurring Disorders Low Intensity Residential Treatment Program shall document the capacity to provide each of the core services and the following services:

- (I) Basic living skills.
- (II) Crisis intervention services.
- (III) Activity therapy.
- (IV) Intensive case management.

(v) Women and Dependent Children Program Specific Criteria: Each Level III.1 Women and Dependent Children Low Intensity Residential Treatment Program shall document the capacity to provide each of the core services and the following services:

- (I) Transportation.
- (II) Child sitting services.
- (III) Developmental delay and prevention services.
- (IV) Activity therapy.
- (V) Parenting skills development.

4. Therapeutic Component Implementation. The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency and intensity appropriate to the client's assessed needs and expressed desires for care.

(i) Service strategies for each Level III.1 Residential Program shall include, at a minimum:

(I) Maintenance of an alcohol and illicit drug-free residential environment.

(II) Implementation of individualized counseling plan strategies.

(III) On duty, awake staff shall provide supervision of client's health, welfare and safety twenty-four (24) hours a day.

(IV) All clients enrolled in Level III.1 Programs shall have access to clinical services twenty-four (24) hours a day, seven (7) days a week.

(V) The entity shall document the provision of planned counseling and recovery support services and activities that shall, at a minimum, include:

I. Motivational and engagement strategies.

II. Relapse prevention.

III. Interpersonal choice/decision making skill development.

IV. Development of a social network supportive of recovery.

V. Daily living and recovery skills development.

VI. Random drug screening.

VII. Health education.

VIII. Medication management and administration.

(ii) Adolescent Program Specific Criteria: Each Level III.1 Adolescent Low Intensity Residential Treatment Program shall document the capacity to provide the service strategies and the following therapeutic components:

(I) Client education on key adolescent development issues, including but not limited to, adolescent brain development and the impact of substance use, emotional and social influence on behavior, value system development, puberty/physical development, sexuality and self esteem.

(II) Recreation and leisure time skills training.

(III) Gender specific treatment.

(IV) Family, community and school reintegration services.

(V) Academic or vocational services.

(iii) Co-occurring Disorders Program Specific Criteria: Each Level III.1 Co-occurring Disorders Low Intensity Residential Program shall document the capacity to provide the service strategies and the following therapeutic components:

(I) Groups and classes that address the signs and symptoms of mental health and substance use disorders.

(II) Groups, classes and training to assist clients in becoming aware of cues or triggers that enhance the likelihood of alcohol and drug use or psychiatric decompensation and to aid in development of alternative coping responses to those cues.

(III) Dual recovery groups that provide a forum for discussion of the interactions of and interrelations between substance use and mental health disorders.

(IV) Intensive case management.

(iv) Women and Dependent Children Program Specific Criteria: Each Level III.1 Low Intensity Residential Treatment Women and Dependent Children Program shall document the capacity to provide the service strategies and the following therapeutic components:

(I) Gender specific services which address issues of relationships, parenting, abuse and trauma.

(II) Primary medical care including prenatal care.

(III) Primary pediatric care for children.

(IV) Therapeutic interventions for children which address their developmental needs and issues of sexual abuse and neglect.

(V) Outreach to inform pregnant women of the services and priorities.

(VI) Interim services while awaiting admission to this level of care.

(VII) Recreation and leisure time skills training.

(VIII) Academic or vocational services.

(IX) Financial resource development and planning.

(X) Family planning services.

5. Documentation: Each Level III.1 Intensive Outpatient Program shall provide the following documentation in each client record:

(i) Individualized progress notes shall be recorded each day for each respective service provided in Level III.1 Services.

6. Support Systems. Each Level III.1 Program shall develop, maintain and document implementation of written policies and procedures which govern the process used to provide client access to support services on site, or through consultation or referral, which shall minimally include:

(i) Telephone or in person consultation with a physician available twenty-four (24) hours a day, seven (7) days a week.

(ii) Telephone or in person consultation with emergency services twenty-four (24) hours a day, seven (7) days a week.

(iii) Direct affiliation with, or coordination through referral to more and less intensive levels of care.

(iv) Direct affiliation with, or coordination through referral to supportive services, including vocational rehabilitation, literacy training and adult education.

(v) Mutual self help groups which are tailored to the needs of the specific client population.

7. Program Personnel. Each level III.1 Low Intensity Residential Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

(i) Program Coordinator. Each Level III.1 Low Intensity Residential Treatment Program shall have a full-time program coordinator or manager who shall have a minimum of three (3) years work experience in a direct service area treating clients with substance use or co-occurring mental health and substance use disorders, plus other qualifications and credentials as designated in writing by the governing authority.

(ii) Direct Care Personnel. All direct care personnel shall have the qualifications as specified to provide the specific services delineated in the entity's program description for this level of care.

(iii) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.1 Program as delineated in its operational procedures.

(iv) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(v) Every client in a Level III.1 program shall be assigned to a specific primary counselor for care management.

(vi) Each primary counselor shall maintain a case load not to exceed fifteen (15) clients with active cases at any one time.

(vii) Adolescent Program Specific Criteria.

(I) Each Level III.1 Low Intensity Residential Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years post master's supervised experience in a direct service area treating adolescents who have substance use, mental health, or co-occurring mental health and substance use disorders.

(II) Direct Care Personnel. All direct care personnel shall be qualified as a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(III) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.1 Low Intensity Residential Program as delineated in its operational plan.

(IV) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(V) Every client in a Level III.1 Adolescent Low Intensity Residential Treatment Program shall be assigned to a specific primary counselor for care management.

(VI) Each primary counselor shall maintain a case load not to exceed fifteen (15) clients with active cases at any one time.

(viii) Co-occurring Disorders Program Specific Criteria.

(I) Each Level III.1 Co-occurring Enhanced Low Intensity Residential Program shall be coordinated by a full-time member of the staff who has the minimum of a master's degree in a mental health related field and at least two (2) years post master's supervised experience in a direct service area treating clients with co-occurring disorders.

(II) Each Level III.1 Co-occurring Enhanced Low Intensity Residential Program shall have access to psychiatric services (led by a qualified psychiatrist or nurse practitioner) that are fully capable of evaluating, diagnosing and prescribing medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

(III) The treatment organization/agency shall have access to an Alabama licensed physician, full time, part time, or on contract, who shall be available to the program for client care and shall assume liability for the medical aspects of the program.

(IV) Treatment staff that provide therapy and ongoing clinical assessment services to individuals diagnosed with co-occurring disorders shall have, at a minimum:

I. A master's degree in a behavioral health related field with a minimum of two (2) years work experience with individuals who have co-occurring disorders, mental health, or substance use disorders.

II. Specialized training to work with individuals who have co-occurring disorders.

(V) All other direct care personnel in a Level III.1 Co-occurring Enhanced Low Intensity Residential Program shall be qualified as a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(VI) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.1 Co-occurring Enhanced Residential Program as delineated in its operational plan.

(VII) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(VIII) Every client in a Level III.1 Residential Program shall be assigned to a specific primary counselor for care management.

(IX) Each primary counselor shall maintain a case load not to exceed sixteen (16) clients with active cases at any one time.

(ix) Women and Dependent Children Program Specific Criteria:

(I) Program Coordinator. Each Level III.1 Low Intensity Women and Dependent Children Residential Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years post master's supervised experience in a direct service area treating women who have substance use, mental health, or co-occurring mental health and substance use disorders.

(II) Direct Care Personnel. All direct care personnel shall be qualified as a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(III) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.1 Low Intensity Women and Dependent Children Residential Program as delineated in its operational plan.

(IV) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(V) Every client in a Level III.1 Women and Dependent Children Program shall be assigned to a specific primary counselor for care management.

(VI) Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

8. Training. The entity shall provide written documentation that all Level III.1 Program personnel satisfy the competency and training requirements as specified in Rule 580-9-44-.02(3).

9. Service Intensity: The entity shall document that the amount and frequency of Level III.1 Low Intensity Residential Treatment Services are established on the basis of the unique needs of each client served. To assist in addressing these needs the entity shall ensure the availability of no less than five (5) hours of structured services each week.

10. Length of Service: The entity shall provide written documentation that the duration of treatment in each Level III.1 Low Intensity Residential Program shall vary as determined by:

- (i) The severity of the client's illness.
- (ii) The client's ability to comprehend the information provided and use that information to implement treatment strategies and attain treatment goals.
- (iii) The appearance of new problems that require another level of care; or
- (iv) The availability of services at an assessed level of need when a Level III.1 Residential Program has been utilized to provide interim services.

11. Service Availability: The entity shall provide written documentation describing the process utilized to establish hours of availability for screening, assessment and intake service, and counseling services at its Level III.1 Low Intensity Residential Program. At a minimum, this process shall:

- (i) Include consideration of the needs of the target population, including work, school and parenting responsibilities.
- (ii) Include consideration of transportation accessibility.
- (iii) Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.22 Level III.2-D: Clinically Managed Residential Detoxification.

(1) Rule Compliance. In addition to compliance with the rules as specified in this chapter, each Level III.2-D Clinically Managed Residential Detoxification Program shall comply with the rules as specified in the following chapters.

(a) Program Description. The entity shall develop, maintain and implement a written program description that defines its Level III.2-D Program, as according to Rule 580-9-44-.13 and the following specifications:

1. Location. The entity shall specifically identify and describe the setting in which the Level III.2-D Program is provided. Services may be provided in any facility that meets all applicable federal, state and local certification, licensure, building, life-safety, fire, health and zoning regulations including the DMH facility certification standards.

2. Admission Criteria: The entity shall develop, maintain and document implementation of written criteria for admission to its Level III.2-D Program, in compliance with the requirements of Rule 580-9-44-.13(9) and the following specifications:

(i) The entity's admission criteria shall specify the target population for the Level III.2-D Program, which shall include, at a minimum, individuals who:

(I) Are experiencing signs and symptoms of withdrawal, or there is evidence based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition and/or emotional behavioral or cognitive condition that withdrawal syndrome is imminent.

(II) Assessed as not being at risk of severe withdrawal syndrome and moderate withdrawal is safely manageable at this level.

(III) Have a history of insufficient skills and supports to complete detoxification at a less intense level of care.

(ii) The entity shall provide written documentation in individual case records that each client admitted to receive Level III.2-D services meets:

(I) The diagnostic criteria for Substance Induced Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(II) The dimensional criteria for admission to this level of care as defined in the ASAM PPC-2R.

3. Core Services: At a minimum, the Level III.2-D Program shall document the capacity to provide the following core services:

- (i) Placement assessment.
- (ii) Individual counseling.
- (iii) Group counseling.
- (iv) Psychoeducation.
- (v) Family counseling.
- (vi) Peer support.
- (vii) Medical and somatic services.
- (viii) Medication administration.
- (ix) Medication monitoring.
- (x) Alcohol and/or drug screening/testing.
- (xi) Case management:
 - (I) Case planning.
 - (II) Linkage.
 - (III) Advocacy.
 - (IV) Monitoring.

4. Therapeutic Component Implementation: The entity shall document implementation of medical and other clinical services organized to enhance the client's understanding of addiction, support completion of the detoxification process and initiate transfer to an appropriate level of care for continued treatment. The entity's Level III.2-D Program shall, at a minimum, consist of the following components:

(i) Completion of a comprehensive medical history and physical examination of the client at admission.

(ii) Protocols and/or standing orders, established by the entity's medical director, for management of detoxification

from each major drug category of abused drugs that are consistent with guidelines published by nationally recognized organizations (e.g., SAMHSA, ASAM, American Academy of Addiction Psychology).

(I) Level III.2-D Programs that utilize benzodiazepines in the detoxification protocol:

I. Shall have written protocols and procedures to show that all doses or amounts of benzodiazepines are carefully monitored and are slowly reduced as appropriate.

II. Shall have written longer-term detoxification protocols and procedures that adhere to general principles of management, including clear indications of benzodiazepine dependence, clear intermediate treatment goals and strategies, regular review and methods to prevent diversion from the plan.

(iii) On duty awake staff shall provide supervision for each client's health, welfare and safety twenty-four (24) hours a day, seven (7) days a week.

(iv) On-site physician care and phone availability twenty-four (24) hours a day, seven (7) days a week.

(v) Credentialed personnel who are trained and competent to implement physician approved protocols for client observation and supervision, determination of appropriate level of care and facilitation of the client's transitioning to continuing care.

(vi) Services designed explicitly to safely detoxify clients without the need for ready on-site access to medical and nursing personnel.

(vii) Medical evaluation and consultation available twenty-four (24) hours a day in accordance with practice guidelines.

(viii) Clinicians who assess and treat clients are able to obtain and interpret information regarding the needs of the client to include the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as, the appropriate treatment and monitoring of these conditions.

(ix) Medication administration and monitoring services, including specific procedures for pregnant women.

(x) Continuous assessment.

(xi) Planned counseling and other therapeutic interventions.

(xii) Motivational enhancement therapy.

(xiii) Direct affiliation with other levels of care.

5. Documentation: Level III.2-D Programs shall provide the following clinical record documentation:

(i) Documentation of each clinical/therapeutic intervention provided.

(ii) Daily assessment of progress, through detoxification, including response to medication, which also notes any treatment changes.

(iii) Monitoring of vital signs, at a minimum, every eight (8) hours until discharge.

(iv) The use of detoxification rating scale tables and flow sheets.

6. Support Systems: The Level III.2-D Program shall develop, maintain and document implementation of written policies and procedures utilized to provide client access to support services on site, or through consultation or referral, which shall minimally include availability to:

(i) Specialized clinical consultation for biomedical, emotional, behavioral and cognitive problems.

(ii) Appropriate laboratory and toxicology testing.

(iii) Psychological and psychiatric services.

(iv) Transportation.

(v) Twenty four (24) hour emergency medical services.

7. Staff Requirements.

(i) Program Coordinator. The Level III.2-D Program shall be coordinated by a full-time employee who is an Alabama licensed Registered Nurse, Nurse Practitioner, Physician, or Physician's Assistant, with two (2) years direct care experience treating persons with substance induced disorders.

(ii) Medical Director. The Level III.2-D Program shall have a medical director who is a physician licensed to practice

in the State of Alabama, with a minimum of one (1) year experience treating persons with substance induced disorders. The medical director shall be responsible for admission, diagnosis, medication management and client care.

(iii) Nursing Services Director. The Level III.2-D Program shall have a nursing services director who shall be a Registered Nurse licensed according to Alabama law, with training and work experience in behavioral health.

(iv) There shall be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) on site during all hours of the Level III.2-D Program's operation.

(v) Direct Care Personnel. All direct care personnel shall have the qualifications as a qualified paraprofessional to provide the specific services delineated in the entity's program description for this level of care.

(vi) The entity shall maintain an adequate number of personnel, including physicians, nurses, counselors and case managers to sustain the Level III.2-D Program as delineated in its operational plan.

(vii) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

8. Training: The entity shall provide written documentation that:

(i) All Level III.2-D Program personnel satisfy the requirements of the core training curriculum, as specified in Rule 580-9-44-.02(3).

(ii) All clinical and medical services staff in a Level III.2-D Program shall receive training during the initial twelve (12) months employment and develop basic competencies in the following areas:

(I) Biopsychosocial dimensions of alcohol and other drug dependence, including:

I. The signs and symptoms of alcohol and other drug intoxication and withdrawal.

II. Evidence-based treatment and monitoring strategies for alcohol and other drug intoxication and withdrawal.

III. Continuing care motivational and engagement strategies.

(II) Pharmacotherapy.

(III) ASAM Patient Placement Criteria.

(IV) Assessment of and service planning to address biopsychosocial needs.

9. Service Intensity: The entity shall document in the clinical record that the intensity of Level III.2-D Services is established on the basis of the unique needs of each client served.

10. Length of Service: The entity shall provide written documentation in the clinical record that the duration of treatment in a Level III.2-D Program varies as determined by the client's assessed needs, and that the client continues in treatment until:

(i) Withdrawal signs and symptoms are sufficiently resolved; or

(ii) Withdrawal signs and symptoms have failed to respond to treatment and have intensified warranting a transfer to a more intense level of care; or

(iii) The client is, otherwise, unable to complete detoxification at this level of care.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.23 Level III.3: Clinically Managed Medium Intensity Residential Treatment Program For Adults.

(1) Rule Compliance. In addition to compliance with the rules as specified in this chapter, each Level III.3 Clinically Managed Medium Intensity Residential Treatment Program shall comply with the rules as specified in the following chapters.

(a) Program Description. The entity shall develop, maintain and implement a written program description that defines the Level III.3 Clinically Managed Medium Intensity Residential

Treatment Program it provides, as according to Rule 580-9-44-.13 and the following specifications:

1. Location. The entity shall specifically identify and describe the setting in which the Level III.3 Program shall be provided. Services shall be provided in any facility that meets all applicable federal, state and local certification, licensure, building, life-safety, fire, health and zoning regulations including the DMH facility certification standards.

2. Admission Criteria: The entity shall develop, maintain and document implementation of written criteria for admission to its Level III.3 Program, in compliance with the requirements of Rule 580-9-44-.13(9) and the following specifications:

(i) The entity's admission criteria shall specify the target population for its Level III.3 Services which shall include, at a minimum, individuals:

(I) Who are at least nineteen (19) years old.

(II) Whose assessed severity of illness warrants this level of care including, but not limited to:

I. Individuals who have a substance dependence disorder and concomitant cognitive impairments, developmental delays, emotional, and/or behavioral problems; and/or

II. Significant functional deficits in regard to management of activities of daily living.

(ii) The entity shall provide written documentation in individual case records that each client admitted to a Level III.3 Program meets:

(I) The diagnostic criteria for a substance dependence disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iii) Co-occurring Disorders Program Specific Criteria. The entity shall provide written documentation in individual case records that each individual admitted to a Level III.3 Co-occurring Enhanced Treatment Program meets:

(I) The diagnostic criteria for a substance dependence and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iv) Women and Dependent Children Program Specific Criteria: The entity shall provide written documentation in individual case records that each client admitted to a Level III.3 Program for Women and Dependent Children:

(I) Meets the diagnostic criteria for a substance dependence disorder as defined in the most recent edition Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(III) Is pregnant; or

(IV) Has care and custody of dependent children; or

(V) Has lost custody of dependent children and has the potential for family reunification.

3. Core Services: Each Level III.3 Medium Intensity Residential Program shall demonstrate the capacity to provide a basic level of treatment services appropriate to the needs of its clientele.

(i) At a minimum, the entity shall demonstrate and document its capacity to provide a twenty-four (24) hour structured residential treatment environment with the following core services:

(I) Placement assessment.

(II) Individual counseling.

(III) Group counseling.

(IV) Family counseling.

(V) Psychoeducation.

(VI) Peer support.

- (VII) Medical and somatic services.
- (VIII) Daily living skills.
- (IX) Medication management.
- (X) Alcohol and/or drug screening/testing.
- (XI) Transportation.
- (XII) Case management:
 - I. Case planning.
 - II. Linkage.
 - III. Advocacy.
 - IV. Monitoring.

(ii) Medical Services. Medical Services shall be provided as specified by the entity's medical protocols established as required by Rule 580-9-44-.13(24).

(I) Clients who have not had a physical examination within the last twelve (12) months shall be scheduled a physical examination within two weeks of admission.

(II) Pregnant clients who are not receiving routine prenatal care shall be seen by physician within two (2) weeks of admission.

(iii) Family Support. The entity shall initiate and document in the client record continuous efforts to involve the client's family and other natural supports in the treatment process.

(iv) Co-occurring Disorders Program Specific Criteria: Each Level III.3 Co-occurring Disorders Low Intensity Residential Treatment Program shall document the capacity to provide each of the core services and the following services:

- (I) Mental health consultation.
- (II) Crisis intervention services.
- (III) Activity therapy.
- (IV) Intensive case management.

(v) Women and Dependent Children Program Specific Criteria: Each Level III.3 Women and Dependent Children Medium Intensity Residential Treatment Program shall document the capacity to provide each of the core services and the following services:

- (I) Child sitting services.
- (II) Developmental delay and prevention services.
- (III) Activity therapy.
- (IV) Parenting skills development.
- (V) Academic and vocational services.
- (VI) Financial resource development and planning.
- (VII) Family planning services.

4. Therapeutic Component Implementation. The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency and intensity appropriate to the client's assessed needs and expressed desires for care.

(i) Service strategies for each Level III.3 Residential Program shall include, at a minimum:

(I) On duty, awake staff shall provide supervision of client's health, welfare and safety twenty-four (24) hours a day.

(II) Client shall have access to clinical services personnel twenty-four (24) hours a day, seven (7) days a week.

(III) Daily clinical services to improve the client's ability to structure and reorganize the tasks of daily living and recovery.

(IV) The provision of daily scheduled treatment and recovery support services and activities that shall, at a minimum, include those that address:

I. Implementation of individualized service plan strategies.

II. Relapse prevention.

III. Interpersonal choice/decision making skill development.

IV. Development of a social network supportive of recovery.

V. Daily living and recovery skills development.

VI. Random drug screening.

VII. Health education.

VIII. Medication administration and monitoring.

5. Documentation: Each Level III.3 Medium Intensity Residential Program shall provide the following documentation in each client record:

(i) Individualized progress notes shall be recorded each day for each respective service provided in Level III.3 Services.

6. Support Systems. Each Level III.3 Program shall develop, maintain and document implementation of written policies and procedures which govern the process used to provide client access to support services on site, or through consultation or referral, which shall minimally include:

(i) Telephone or in person consultation with a physician available twenty-four (24) hours a day, seven (7) days a week.

(ii) Telephone or in person consultation with emergency services twenty-four (24) hours a day, seven (7) days a week.

(iii) Telephone or in person consultation with a registered nurse twenty-four (24) hours a day, seven (7) days a week.

(iv) Direct affiliation with or coordination through referral to more and less intensive levels of care.

(v) Direct affiliation with or coordination through referral to supportive services including vocational rehabilitation, literacy training and sheltered workshops.

(vi) Mutual self help groups which are tailored to the needs of the specific client population.

(vii) Appropriate laboratory and toxicology testing.

(viii) Psychological and psychiatric services.

(ix) Direct affiliation with or coordination through referral to more and less intensive levels of care.

7. Program Personnel. Each level III.3 Medium Intensity Residential Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

(i) Program Coordinator. Each Level III.3 Medium Intensity Residential Treatment Program shall have a full-time program coordinator or manager who shall have a minimum of three (3) years work experience in a direct service area treating clients with substance use or co-occurring mental health and substance use disorders, plus other qualifications and credentials as designated in writing by the governing authority.

(ii) Direct Care Personnel. All direct care personnel shall have the qualifications to provide the specific services delineated in the entity's program description for this level of care.

(iii) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.3 Program as delineated in its operational procedures.

(iv) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(v) Every client in a Level III.3 Program shall be assigned to a specific primary counselor for care management.

(vi) Each primary counselor shall maintain a case load not to exceed twenty (20) clients with active cases at any one time.

(vii) Co-occurring Disorders Program Specific Criteria.

(I) Each Level III.3 Co-occurring Enhanced Medium Intensity Residential Program shall be coordinated by a full-time member of the staff who has the minimum of a master's degree in a mental health related field and at least two (2) years post master's supervised experience in a direct service area treating clients with co-occurring disorders.

(II) Each Level III.3 Co-occurring Enhanced Medium Intensity Residential Program shall have access to psychiatric services led by a qualified psychiatrist or nurse practitioner that are fully capable of evaluating, diagnosing and prescribing

medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

(III) The treatment organization/agency shall have access to an Alabama licensed physician, full time, part time or on contract who shall be available to the program for client care and shall assume liability for the medical aspects of the program.

(IV) Treatment staff that provide therapy and ongoing clinical assessment services to individuals diagnosed with co-occurring disorders shall have, at a minimum;

I. A master's degree in a behavioral health related field with a minimum of two (2) years work experience with individuals who have co-occurring disorders, mental health or substance use disorders.

II. Specialized training to work with individuals who have co-occurring disorders.

(V) All other direct care personnel in a Level III.3 Co-occurring Enhanced Medium Intensity Residential Program shall be qualified, as a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(VI) Every client in a Level III.3 Residential Program shall be assigned to a specific primary counselor for care management.

(VII) Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

(viii) Women and Dependent Children Program Specific Criteria.

(I) Program Coordinator. Each Level III.3 Medium Intensity Women and Dependent Children Residential Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years post master's supervised experience in a direct service area treating women who have substance use, mental health or co-occurring mental health and substance use disorders.

(II) Direct Care Personnel. All direct care personnel shall be qualified as a qualified paraprofessional to provide the

specific services delineated in the entity's operational plan for this level of care.

(III) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.3 Medium Intensity Women and Dependent Children Residential Program as delineated in its operational plan.

(IV) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(V) Every client in a Level III.3 Women and Dependent Children Program shall be assigned to a specific primary counselor for care management.

(VI) Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

8. Training. The entity shall provide written documentation that all Level III.3 Program personnel satisfy the competency and training requirements as specified in Rule 580-9-44-.02(3).

9. Service Intensity:

(i) The entity shall document that the amount and frequency of Level III.3 Medium Intensity Residential Treatment Services are established on the basis of the unique needs of each client served. To assist in addressing these needs, the entity shall ensure the availability of no less than fifteen (15) hours of structured services each week.

10. Length of Service: The entity shall provide written documentation that the duration of treatment in each Level III.3 Medium Intensity Residential Program shall vary as determined by:

(i) The severity of the client's illness.

(ii) The client's ability to comprehend the information provided and use that information to implement treatment strategies and attain treatment goals.

(iii) The appearance of new problems that require another level of care; or

(iv) The availability of services at an assessed level of need when a Level III.3 Residential Program has been utilized to provide interim services.

11. Service Availability: The entity shall provide written documentation describing the process utilized to establish hours of availability for screening, assessment and intake service and counseling services at its Level III.3 Medium Intensity Residential Program. At a minimum this process shall:

(i) Include consideration of the needs of the target population including work, school and parenting responsibilities.

(ii) Include consideration of transportation accessibility.

(iii) Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.24 Level III.5: Clinically Managed Medium Intensity Residential Treatment Program For Adolescents.

(1) Rule Compliance. In addition to compliance with the rules as specified in this chapter, each Level III.5 Clinically Managed Medium Intensity Residential Treatment Program for Adolescents shall comply with the rules as specified in the following chapters.

(a) Program Description. The entity shall develop, maintain and implement a written program description that defines its Level III.5 Adolescent Clinically Managed Medium Intensity Residential Treatment Program, as according to Rule 580-9-44-.13 and the following specifications:

1. Location. The entity shall specifically identify and describe the setting in which the Level III.5 Adolescent Program shall be provided. Services may be provided in any facility that meets all applicable federal, state and local certification, licensure, building, life-safety, fire, health and zoning regulations, including the DMH facility certification standards.

2. Admission Criteria: The entity shall develop, maintain and document implementation of written criteria for admission to its Level III.5 Adolescent Program in compliance

with the requirements of Rule 580-9-44-.13(9) and the following specifications:

(i) The entity's admission criteria shall specify the target population for its Level III.5 Adolescent Services which shall include, at a minimum, individuals:

(I) Who are less than nineteen (19) years old.

(II) Whose assessed severity of illness warrants this level of care including but not limited to individuals who have impaired functioning across a broad range of psychosocial domains that may be expressed as:

I. Disruptive behaviors.

II. Delinquency and juvenile justice involvement.

III. Educational difficulties.

IV. Family conflicts and chaotic home situations.

V. Developmental immaturity and/or

VI. Psychological problems.

(III) Who do not require significant medical, psychiatric, or nurse monitoring or interventions.

(IV) For whom treatment for identified problems has been rendered ineffective at less intensive levels of care.

(ii) The entity shall provide written documentation in individual case records that each client admitted to a Level III.5 Adolescent Program meets:

(I) The diagnostic criteria for a substance related disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders; and

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iii) Co-occurring Disorders Program Specific Criteria. The entity shall provide written documentation in individual case records that each individual admitted to a Level III.5 Adolescent Co-occurring Enhanced Treatment Program meets:

(I) The diagnostic criteria for a substance related and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iv) Women and Dependent Children Program Specific Criteria: The entity shall provide written documentation in individual case records that each client admitted to a Level III.5 Adolescent Program for Women and Dependent Children:

(I) Meets the diagnostic criteria for a substance related disorder as defined in the most recent edition Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(III) Is pregnant; or

(IV) Has care and custody of dependent children; or

(V) Has lost custody of dependent children and has the potential for family reunification.

3. Core Services: Each Level III.5 Adolescent Medium Intensity Residential Program shall demonstrate the capacity to provide a basic regimen of treatment services appropriate to the adolescent's developmental and cognitive levels and other assessed needs.

(i) At a minimum, the entity shall demonstrate and document its capacity to provide a twenty-four (24) hour structured residential treatment environment with accessibility to the following core services:

(I) Placement assessment.

(II) Individual counseling.

(III) Group counseling.

(IV) Family counseling.

(V) Psychoeducation.

(VI) Peer support.

- (VII) Medical and somatic services.
- (VIII) Daily living skills.
- (IX) Medication management.
- (X) Medication administration.
- (XI) Alcohol and/or drug screening/testing.
- (XII) Transportation.
- (XIII) Activity therapy.
- (XIX) Case management:
 - I. Case planning.
 - II. Linkage.
 - III. Advocacy.
 - IV. Monitoring.

(ii) Medical Services. The entity shall implement procedures for the provision of medical services as according to protocols established in compliance with Rule 580-9-44-.13(24).

(I) Clients who have not had a physical examination within the last twelve (12) months shall be scheduled a physical examination within two (2) weeks of admission.

(II) Pregnant clients who are not receiving routine prenatal care shall be seen by physician within two (2) weeks of admission.

(iii) Mental Health Services. The entity shall develop, maintain and document implementation of written policies and procedures to ensure that each client's mental health needs are identified through the assessment process and access to appropriate care for these needs is provided concurrently with treatment for assessed substance related disorders.

(iv) Family Support. The entity shall initiate and document in the client record continuous efforts to involve the client's family and other natural supports in the treatment process.

(v) Co-occurring Disorders Program Specific Criteria: Each Level III.5 Adolescent Co-occurring Disorders Medium Intensity Residential Treatment Program shall document the capacity to provide each of the core services and the following services:

(I) Mental health consultation.

(II) Crisis intervention services.

(vi) Women and Dependent Children Program Specific Criteria: Each Level III.5 Adolescent Women and Dependent Children Medium Intensity Residential Treatment Program shall document the capacity to provide each of the core services and the following services:

(I) Child sitting services.

(II) Developmental delay and prevention services.

(III) Parenting skills development.

4. Therapeutic Component Implementation. The entity shall document the implementation of a planned regimen of twenty-four (24) hour professionally directed program activities for adolescents and their families. Evaluation, treatment and care shall be provided in an amount, frequency and intensity appropriate to the client's assessed needs and expressed desires for care.

(i) Service strategies for each Level III.5 Adolescent Residential Program shall include, at a minimum:

(I) On duty, awake staff shall provide supervision of client's health, welfare and safety twenty-four (24) hours a day.

(II) Clients shall have access to clinical services personnel twenty-four (24) hours a day, seven (7) days a week.

(III) Daily clinical services to improve the client's ability to structure and reorganize the tasks of daily living and recovery.

(IV) The provision of daily scheduled treatment, recovery support services and other activities that shall, at a minimum, include those that address:

I. Implementation of individualized service plan strategies.

- II. Development and application of recovery skills including relapse prevention.
- III. Interpersonal choice/decision making skill development.
- IV. Enhancement of the understanding of addiction.
- V. Development of a social network supportive of recovery.
- VI. Random drug screening.
- VII. Health education.
- VIII. Medication administration and monitoring.
- IX. Promotion of successful involvement in regular productive daily activity such as school or work.
- X. Enhancement of personal responsibility, developmental maturity and prosocial values.
- XI. Educational services in accordance with state and local regulations.
- XII. Opportunities to remedy educational deficits created by involvement with alcohol and other drugs.
 - (ii) The entity shall actively promote and provide referrals and/or access to community support services.
 - (iii) All services shall be shall be organized and provided according to evidence-based and best practice standards and guidelines.
 - (iv) Co-occurring Disorders Program Specific Criteria: Each Level III.5 Adolescent Co-occurring Enhanced Program shall document the capacity to provide the service strategies and the following therapeutic components:
 - (I) Groups and classes that address the signs and symptoms of mental health and substance use disorders.
 - (II) Groups, classes and training to assist clients in becoming aware of cues or triggers that enhance the likelihood of alcohol and drug use or psychiatric decompensation and to aid in development of alternative coping responses to those cues.

(III) Dual recovery groups that provide a forum for discussion of the interactions of and interrelations between substance use and mental health disorders.

(IV) Intensive case management.

(v) Women and Dependent Children Program Specific Criteria: Each Level III.5. Adolescent Women and Dependent Children Program shall document the capacity to provide the service strategies and the following therapeutic components:

(I) Gender specific services which address issues of relationships, parenting, abuse and trauma.

(II) Primary medical care including prenatal care.

(III) Primary pediatric care for children.

(IV) Therapeutic interventions for children which address their developmental needs and issues of sexual abuse and neglect.

(V) Outreach to inform pregnant women of the services and priorities.

(VI) Interim services while awaiting admission to this level of care.

(VII) Recreation and leisure time skills training.

(VIII) Academic and vocational services.

(IX) Family planning services.

5. Documentation: Each Level III.5 Adolescent Medium Intensity Residential Program shall provide the following documentation in each client record:

(i) Individualized progress notes shall be recorded each day for each respective service provided.

6. Support Systems. Each Level III.5 Adolescent Program shall develop, maintain and document implementation of written policies and procedures which govern the process used to provide client access to support services on site, or through consultation or referral, which shall minimally include:

(i) Emergency consultation with a physician available twenty-four (24) hours a day, seven (7) days a week.

(ii) Telephone or in person consultation with emergency services twenty-four (24) hours a day, seven (7) days a week.

(iii) Telephone or in person consultation with a MAS nurse twenty-four (24) hours a day, seven (7) days a week.

(iv) Indicated laboratory and toxicology testing.

(v) Indicated medical procedures.

(vi) Medical treatment.

(vii) Psychological and psychiatric treatment.

(viii) Direct affiliation with or coordination through referral to more and less intensive levels of care, including detoxification services.

7. Program Personnel. Each Level III.5 Adolescent Medium Intensity Residential Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

(i) Program Coordinator. Each Level III.5 Medium Intensity Residential Treatment Program shall have a full-time program coordinator or manager who shall have a minimum two (2) years work experience in a direct service area treating adolescents who have substance use or co-occurring mental health and substance use disorders.

(ii) Direct Care Personnel. All direct care personnel shall have the qualifications, as a qualified paraprofessional to provide the specific services delineated in the entity's program description for this level of care.

(iii) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.5 Program as delineated in its operational procedures.

(iv) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(v) Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

(vi) Co-occurring Disorders Program Specific Criteria.

(I) Each Level III.5 Adolescent Co-occurring Enhanced Medium Intensity Residential Program shall be coordinated by a

full-time member of the staff who has the minimum of a master's degree in a mental health related field and at least two (2) years supervised experience in a direct service area treating adolescent clients with substance related mental health or co-occurring disorders.

(II) Each Level III.5 Adolescent Co-occurring Enhanced Medium Intensity Residential Program shall have access to psychiatric services led by a qualified psychiatrist or nurse practitioner that are fully capable of evaluating, diagnosing and prescribing medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

(III) The treatment organization/agency shall have access to an Alabama licensed physician, full time, part time or on contract who shall be available to the program for client care and shall assume responsibility for the medical aspects of the program.

(IV) All other direct care personnel in a Level III.5 Adolescent Co-occurring Enhanced Medium Intensity Residential Program shall be qualified, as a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(V) Every client in a Level III.5 Adolescent Residential Program shall be assigned to a specific primary counselor for care management.

(VI) Each primary counselor shall maintain a case load not to exceed sixteen (16) clients with active cases at any one time.

(vii) Women and Dependent Children Program Specific Criteria.

(I) Each Level III.5 Adolescent Medium Intensity Women and Dependent Children Residential Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years supervised experience in a direct service area treating women who have substance use, mental health or co-occurring mental health and substance related disorders.

(II) Direct Care Personnel. All direct care personnel shall be qualified, as a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(III) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.5 Adolescent Medium Intensity Women and Dependent Children Residential Program as delineated in its operational plan.

(IV) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(V) Every client in a Level III.5 Adolescent Women and Dependent Children program shall be assigned to a specific Primary Counselor for care management.

(VI) Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

8. Training. The entity shall provide written documentation that all Level III.5 Adolescent Program personnel satisfy the competency and training requirements as specified in Rule 580-9-44-.02(3).

9. Service Intensity:

(i) The entity shall document that the amount and frequency of Level III.5 Adolescent Medium Intensity Residential Treatment Services are established on the basis of the unique needs of each client served. To assist in addressing these needs, the entity shall ensure the availability of no less than fifteen (15) hours of structured services each week.

(ii) The entity shall provide written documentation describing the procedures utilized to ensure the provision of services appropriate to the client's developmental stage and level of comprehension, including any necessary adaptations.

10. Length of Service: The entity shall provide written documentation that the duration of treatment in each Level III.5 Adolescent Medium Intensity Residential Program shall vary as determined by:

(i) The severity of the client's illness.

(ii) The client's ability to comprehend the information provided and use that information to implement treatment strategies and attain treatment goals.

(iii) The appearance of new problems that require another level of care; or

(iv) The availability of services at an assessed level of need, when a Level III.5 Adolescent Residential Program has been utilized to provide interim services.

11. Service Availability: The entity shall provide written documentation describing the process utilized to establish hours of availability for screening assessment and intake services at its Level III.5 Medium Intensity Adolescent Residential Program. At a minimum, this process shall:

(i) Include consideration of the needs of the target population, including work, school and parenting responsibilities.

(ii) Include consideration of transportation accessibility.

(iii) Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.25 Level III.5: Clinically Managed High Intensity Residential Treatment Program For Adults.

(1) Rule Compliance. In addition to compliance with the rules as specified in this chapter, each Level III.5 Clinically Managed High Intensity Residential Treatment Program shall comply with the rules as specified in the following chapters.

(a) Program Description. The entity shall develop, maintain and implement a written program description that defines the Level III.5 Clinically Managed High Intensity Residential Treatment Program it provides, as according to Rule 580-9-44-.13 and the following specifications:

1. Location. The entity shall specifically identify and describe the setting in which the Level III.5 Program shall be provided. Services shall be provided in any facility that meets all applicable federal, state and local certification, licensure, building, life-safety, fire, health and zoning regulations, including the DMH facility certification standards.

2. Admission Criteria: The entity shall develop, maintain and document implementation of written criteria for admission to its Level III.5 Program, in compliance with the requirements of Rule 580-9-44-.13(9) and the following specifications:

(i) The entity's admission criteria shall specify the target population for its Level III.5 Services, which shall include, at a minimum, individuals who have been assessed to have multiple, significant social and psychological functional deficits that cannot be adequately addressed on an outpatient basis.

(ii) The entity shall provide written documentation in individual case records that each client admitted to a Level III.5 Program meets:

(I) The diagnostic criteria for a substance dependence disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iii) Co-occurring Disorders Program Specific Criteria. The entity shall provide written documentation in individual case records that each individual admitted to a Level III.5 Co-occurring Enhanced Treatment Program meets:

(I) The diagnostic criteria for a substance dependence and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iv) Women and Dependent Children Program Specific Criteria: The entity shall provide written documentation in individual case records that each client admitted to a Level III.5 Program for Women and Dependent Children:

(I) Meets the diagnostic criteria for a substance dependence disorder as defined in the most recent edition Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

- (III) Is pregnant; or
- (IV) Has care and custody of dependent children; or
- (V) Has lost custody of dependent children and has the potential for family reunification.

3. Core Services: Each Level III.5 High Intensity Residential Program shall demonstrate the capacity to provide a basic level of treatment services appropriate to the needs of its clientele.

(i) At a minimum, the entity shall demonstrate and document its capacity to provide a twenty-four (24) hour structured residential treatment environment with the following core services:

- (I) Placement assessment.
- (II) Individual counseling.
- (III) Group counseling.
- (IV) Family counseling.
- (V) Psychoeducation.
- (VI) Peer support.
- (VII) Medical and somatic services.
- (VIII) Daily living skills.
- (IX) Medication management.
- (X) Alcohol and/or drug screening/testing.
- (XI) Transportation.
- (XII) Case Management:
 - I. Case planning.
 - II. Linkage.
 - III. Advocacy.
 - IV. Monitoring.

(ii) Medical Services. Medical Services shall be provided as specified by the entity's medical protocols established as required by Rule 580-9-44-.13(24).

(I) Clients who have not had a physical examination within the last twelve (12) months shall be provided a physical examination within two (2) weeks of admission.

(II) Pregnant clients who are not receiving routine prenatal care, shall be seen by physician within two (2) weeks of admission.

(iii) Mental Health Services. The entity shall develop, maintain and document implementation of written policies and procedures to ensure that each client's mental health needs are identified through the assessment service process and access to appropriate care for these needs is provided concurrently with treatment for assessed substance related disorders.

(iv) Family Support. The entity shall initiate and document in the client record continuous efforts to involve the client's family and other natural supports in the treatment process.

(v) Co-occurring Disorders Program Specific Criteria: Each Level III.5 Co-occurring Disorders Low Intensity Residential Treatment Program shall document the capacity to provide each of the core services and the following services:

(I) Mental health consultation.

(II) Crisis intervention services.

(III) Activity therapy.

(IV) Intensive case management.

(vi) Women and Dependent Children Program Specific Criteria: Each Level III.5 Women and Dependent Children Medium Intensity Residential Treatment Program shall document the capacity to provide each of the core services and the following services:

(I) Child sitting services.

(II) Developmental delay and prevention services.

(III) Activity therapy.

(IV) Parenting skills development.

- (V) Academic and vocational services.
- (VI) Financial resource development and planning.
- (VII) Family planning services.

4. Therapeutic Component Implementation. The entity shall document implementation of regularly scheduled treatment sessions that are provided in an amount, frequency and intensity appropriate to each client's assessed needs and expressed desires for care.

(i) Service strategies for each Level III.5 Residential Program shall include, at a minimum:

(I) On duty awake staff shall provide supervision of client's health, welfare and safety twenty-four (24) hours a day.

(II) Client shall have access to clinical services personnel twenty-four (24) hours a day, seven (7) days a week.

(III) Daily clinical services to improve the client's ability to structure and reorganize the tasks of daily living and recovery.

(IV) The provision of daily scheduled treatment and recovery support services and activities that shall, at a minimum, include those that address:

I. Implementation of individualized service plan strategies.

II. Relapse prevention.

III. Interpersonal choice/decision making skill development.

IV. Development of a social network supportive of recovery.

V. Daily living and recovery skills development.

VI. Random drug screening.

VII. Health education.

VIII. Medication administration and monitoring.

(ii) The entity shall actively promote and provide referrals and/or access to community support services.

(iii) All services shall be organized and provided according to evidence-based and best practice standards and guidelines.

(iv) Co-occurring Disorders Program Specific Criteria: Each Level III.5 Co-occurring Enhanced Program shall document the capacity to provide the service strategies and the following therapeutic components:

(I) Groups and classes that address the signs and symptoms of mental health and substance use disorders.

(II) Groups, classes and training to assist clients in becoming aware of cues or triggers that enhance the likelihood of alcohol and drug use or psychiatric decompensation and to aid in development of alternative coping responses to those cues.

(III) Dual recovery groups that provide a forum for discussion of the interactions of and interrelations between substance use and mental health disorders.

5. Documentation: Each Level III.5 High Intensity Residential Program shall provide the following documentation in each client record:

(i) Individualized progress notes shall be recorded each day for each respective service provided in Level III.5 Services.

6. Support Systems. Each Level III.5 Program shall develop, maintain and document implementation of written policies and procedures which govern the process used to provide client access to support services on site or through consultation or referral, which shall minimally include:

(i) Telephone or in person consultation with a physician available twenty-four (24) hours a day, seven (7) days a week.

(ii) Telephone or in person consultation with emergency services twenty-four (24) hours a day, seven (7) days a week.

(iii) Telephone or in person consultation with a registered nurse twenty-four (24) hours a day, seven (7) days a week.

- (iv) Direct affiliation with, or coordination through referral to more and less intensive levels of care.
- (v) Direct affiliation with, or coordination through referral to supportive services, including vocational rehabilitation, literacy training and adult education.
- (vi) Mutual self help groups which are tailored to the needs of the specific client population.
- (vii) Appropriate laboratory and toxicology testing.
- (viii) Psychological and psychiatric services.
- (ix) Direct affiliation with or coordination through referral to more and less intensive levels of care.
- (x) Co-occurring Disorders Program Specific Criteria: In addition to compliance with the criteria, each Level III.5 Co-occurring Enhanced High Intensity Residential Program shall provide client access to intensive case management services.
- (xi) Women and Dependent Children's Program Specific Criteria: In addition to compliance with the criteria, the each Level III.5 High Intensity Residential Treatment Program for Women and Dependent Children shall provide client access to the following support services:
 - (I) Academic and vocational services.
 - (II) Financial resource development and planning.
 - (III) Family planning services.

7. Program Personnel. Each level III.5 High Intensity Residential Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

- (i) Program Coordinator. Each Level III.5 High Intensity Residential Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two years post master's supervised experience in a direct service area treating clients with substance use, mental health, or co-occurring mental illness and substance use disorders.
- (ii) Direct Care Personnel. All direct care personnel shall be qualified as a qualified paraprofessional to provide the

specific services delineated in the entity's operational procedures for this level of care.

(iii) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.5 High Intensity Residential Program as delineated in its operational procedures.

(iv) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(v) Every client in a Level III.5 Program shall be assigned to a specific primary counselor for care management.

(vi) Each primary counselor shall maintain a case load not to exceed sixteen (16) clients with active cases at any one time.

(vii) Co-occurring Disorders Program Specific Criteria.

(I) The Level III.5 Co-occurring Enhanced High Intensity Residential Program shall be coordinated by a full-time member of the staff who has the minimum of a master's degree in a mental health related field and at least two (2) years post master's supervised experience in a direct service area treating clients with co-occurring disorders.

(II) The Level III.5 Co-occurring Enhanced Program shall have access to psychiatric services led by a qualified psychiatrist or nurse practitioner that are fully capable of evaluating, diagnosing and prescribing medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

(III) The treatment organization/agency shall have access to an Alabama licensed physician, full time, part time, or on contract who shall be available to the program for client care and shall assume liability for the medical aspects of the program.

(IV) Treatment staff that provide therapy and ongoing clinical assessment services to individuals diagnosed with co-occurring disorders, shall have at a minimum,

I. A master's degree in a behavioral health related field with a minimum of two (2) years work experience with individuals who have co-occurring disorders, mental health or substance use disorders.

II. Specialized training to work with individuals who have co-occurring disorders.

(V) All other direct care personnel in a Level III.5 Co-occurring Enhanced Program shall be qualified to provide the specific services delineated in the entity's operational plan for this level of care.

(VI) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.5 Enhanced High Intensity Residential Program as delineated in its operational plan.

(VII) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(VIII) Every client in a Level III.5 Co-occurring Program shall be assigned to a specific primary counselor for care management.

(IX) Each primary counselor shall maintain a case load not to exceed sixteen (16) clients with active cases at any one time.

(viii) Women and Dependent Children Program Specific Criteria:

(I) Each Level III.5 Women and Dependent Children High Intensity Residential Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years post master's supervised experience in a direct service area treating women who have substance use, mental health or co-occurring mental health and substance use disorders.

(II) Direct Care Personnel. All direct care personnel shall be qualified as a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(III) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.5 Women and Dependent Children Program as delineated in its operational plan.

(IV) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(V) Every client in a Level III.5 Women and Dependent Children Program shall be assigned to a specific primary counselor for care management.

(VI) Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

8. Training. The entity shall provide written documentation that all Level III.5 Program personnel satisfy the competency and training requirements as specified in Rule 580-9-44-.02(3).

9. Service Intensity: The entity shall develop, maintain and document implementation of policies and procedures in regard to service intensity for its Level III.5 Residential Program, which shall at a minimum specify:

(i) The amount and frequency of Level III.5 Services are established on the basis of the unique needs of each client served.

(ii) The program has the capacity to provide a minimum of twenty-five (25) contact hours of clinical services weekly for each client.

10. Length of Service: The entity shall provide written documentation that the duration of treatment in its Level III.5 Program is variable as determined by:

(i) The severity of the client's illness.

(ii) The client's ability to comprehend the information provided and use that information to meet treatment goals and strategies; or

(iii) The appearance of new problems that require another level of care; or

(iv) The availability of services at an assessed level of need, when a Level III.5 High Intensity Residential Program has been utilized as an interim level of care.

11. Service Availability: The entity shall provide written documentation describing the process utilized to establish hours of availability for screening, assessment and intake service, admission and counseling services at its Level III.5 High Intensity Residential Program. At a minimum, this process shall:

(i) Include consideration of the needs of the target population, including work, school and parenting responsibilities.

(ii) Include consideration of transportation accessibility.

(iii) Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.26 Level III.7: Medically Monitored Intensive Residential Treatment Program for Adults.

(1) Rule Compliance. In addition to compliance with the rules as specified in this chapter, each Level III.7 Medically Monitored Intensive Treatment Program for Adults shall comply with the rules as specified in the following chapters.

(a) Program Description. The entity shall develop, maintain and implement a written program description that defines its Level III.7 Medically Monitored Intensive Residential Treatment Program, as according to Rule 580-9-44-.13 and the following specifications:

1. Location. The entity shall specifically identify and describe the setting in which the Level III.7 Program shall be provided. Services may be provided in any facility that meets all applicable federal, state and local certification, licensure, building, life-safety, fire, health and zoning regulations including the DMH facility certification standards.

2. Admission Criteria: The entity shall develop, maintain and document implementation of written criteria for admission to its Level III.7 Program, in compliance with the requirements of Rule 580-9-44-.13(9) and the following specifications:

(i) The entity's admission criteria shall specify the target population for its Level III.7 Program which shall include, at a minimum, individuals:

(I) Whose assessed severity of illness warrants this level of care, including but not limited to, adults whose

subacute biomedical and emotional, behavioral, or cognitive problems are so severe that they require medically monitored treatment, but do not need the full resources of an acute care general hospital.

(II) For whom treatment for identified problems has been rendered ineffective at less intensive levels of care.

(ii) The entity shall provide written documentation in individual case records that each client admitted to a Level III.7 Adult Program meets:

(I) The diagnostic criteria for a substance dependence disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iii) Co-occurring Disorders Program Specific Criteria. The entity shall provide written documentation in individual case records that each individual admitted to a Level III.7 Co-occurring Enhanced Treatment Program meets:

(I) The diagnostic criteria for a substance dependence and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iv) Women and Dependent Children Program Specific Criteria: The entity shall provide written documentation in individual case records that each client admitted to a Level III.7 Program for Women and Dependent Children:

(I) Meets the diagnostic criteria for a substance dependence disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(III) Is pregnant; or

(IV) Has care and custody of dependent children; or

(V) Has lost custody of dependent children and has the potential for family reunification.

3. Core Services: Each Level III.7 Medically Monitored Intensive Residential Program shall demonstrate the capacity to provide a basic regimen of treatment services appropriate to the client's developmental and cognitive levels and other assessed needs.

(i) At a minimum, the entity shall demonstrate and document its capacity to provide a twenty-four (24) hour structured residential treatment environment with accessibility to the following core services:

- (I) Placement assessment.
- (II) Individual counseling.
- (III) Group counseling.
- (IV) Family counseling.
- (V) Psychoeducation.
- (VI) Peer support.
- (VII) Medical and somatic services.
- (VIII) Daily living skills.
- (IX) Medication management.
- (X) Medication administration.
- (XI) Alcohol and/or drug screening/testing.
- (XII) Transportation.
- (XIII) Activity therapy.
- (XIX) Case management:
 - I. Case planning.
 - II. Linkage.
 - III. Advocacy.
 - IV. Monitoring.

(ii) Medical Services. The entity shall implement procedures for the provision of medical services, as according to protocols established in compliance with Rule 580-9-44-.13(24).

(I) Pregnant clients who are not receiving routine prenatal care shall be seen by physician within two (2) weeks of admission.

(iii) Mental Health Services. The entity shall develop, maintain and document implementation of written policies and procedures to ensure that each client's mental health needs are identified through the assessment service process and access to appropriate care for these needs is provided concurrently with treatment for assessed substance related disorders.

(iv) Family Support. The entity shall initiate and document in the client record continuous efforts to involve the client's family and other natural supports in the treatment process.

(v) Co-occurring Disorders Program Specific Criteria: Each Level III.7 Co-occurring Disorders Medically Monitored Intensive Residential Treatment Program shall document the capacity to provide each of the core services and the following services:

(I) Mental health consultation.

(II) Crisis intervention services.

(III) Intensive case management.

(vi) Women and Dependent Children Program Specific Criteria: Each Level III.7 Women and Dependent Children Medically Monitored Intensive Residential Treatment Program shall document the capacity to provide each of the core services and the following services:

(I) Child sitting services.

(II) Developmental delay and prevention services.

(III) Parenting skills development.

(IV) Academic and vocational services.

(V) Financial resource development and planning.

(VI) Family planning services.

4. Therapeutic Component Implementation. The entity shall document the implementation of a planned regimen of professionally directed program activities for clients and their families. Evaluation, treatment and care shall be provided in an amount, frequency and intensity appropriate to each client's assessed needs and expressed desires for care.

(i) Service strategies for each Level III.7 Residential Program shall include, at a minimum:

(I) On duty awake staff shall provide supervision of client's health, welfare and safety twenty-four (24) hours a day.

(II) Clients shall have access to clinical services personnel twenty-four (24) hours a day, seven (7) days a week.

(III) Daily clinical services to improve the client's ability to structure and reorganize the tasks of daily living and recovery.

(IV) The provision of daily scheduled treatment and recovery support services and activities that shall, at a minimum, include those that address:

I. Implementation of individualized service plan strategies.

II. Development and application of recovery skills including relapse prevention.

III. Interpersonal choice/decision making skill development.

IV. Enhancement of the understanding of addiction.

V. Development of a social network supportive of recovery.

VI. Random drug screening.

VII. Health education.

VIII. Medication administration and monitoring.

IX. Promotion of successful involvement in regular productive daily activity, such as school or work.

X. Skill development to support productive daily activity and successful reintegration into the family and community.

XI. Supervised therapeutic recreational activities.

(ii) The entity shall actively promote and provide referrals and/or access to community support services.

(iii) All services shall be organized and provided according to evidence-based and best practice standards and guidelines.

5. Documentation: Each Level III.7 Medically Monitored Intensive Residential Program shall provide the following documentation in each client record:

(i) Individualized progress notes shall be recorded each day for each respective service provided.

6. Support Systems. Each Level III.7 Program shall develop, maintain and document implementation of written policies and procedures, which govern the process used to provide client access to support services on site or through consultation or referral, which shall minimally include:

(i) The availability of a physician or physician extender to assess each client in person within twenty-four (24) hours of admission and thereafter as medically necessary.

(ii) Emergency consultation with a physician available twenty-four (24) hours a day, seven (7) days a week.

(iii) Telephone or in person consultation with emergency services twenty-four (24) hours a day, seven (7) days a week.

(iv) The availability of a MAS Registered Nurse to conduct a nursing assessment at the time of admission, monitor the client's progress during treatment and manage medication administration.

(v) Telephone or in person consultation with a MAS Nurse twenty-four (24) hours a day, seven (7) days a week.

(vi) Indicated laboratory and toxicology testing.

(vii) Indicated medical procedures.

(viii) Medical treatment.

(ix) Psychiatric services shall be available within eight (8) hours by telephone or twenty four (24) hours in person.

(x) Community based services assessed as needed but not provided by the entity.

(xi) Direct affiliation with or coordination through referral to more and less intensive levels of care including detoxification services.

7. Program Personnel. Each Level III.7 Intensive Residential Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

(i) Program Coordinator. Each Level III.7 Intensive Residential Treatment Program shall have a full-time program coordinator or manager who shall have a minimum two (2) years work experience in a direct service area treating individuals who have substance related or co-occurring mental health and substance related disorders.

(ii) Nursing Personnel. MAS Registered Nurses or Licensed Practical Nurses shall be available for primary nursing care and observation twenty-four (24) hours a day.

(iii) Direct Care Personnel. All direct care personnel shall have the qualifications as a qualified paraprofessional to provide the specific services delineated in the entity's program description for this level of care.

(iv) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.7 Adult Program as delineated in its operational procedures.

(v) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(vi) Every client in a Level III.7 Program shall be assigned to a specific primary counselor.

(vii) Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

(viii) Co-occurring Disorders Program Specific Criteria.

(I) Each Level III.7 Co-occurring Enhanced Medically Monitored Intensity Residential Program shall be coordinated by a full-time member of the staff who has the minimum of a master's

degree in a mental health related field and at least two (2) years supervised experience in a direct service area treating individuals who have co-occurring disorders.

(II) Each Level III.7 Co-occurring Enhanced Intensive Residential Program shall have access to psychiatric services led by a qualified psychiatrist or nurse practitioner that are fully capable of evaluating, diagnosing and prescribing medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

(III) The treatment organization/agency shall have access to an Alabama licensed physician, full time, part time, or on contract who shall be available to the program for client care and shall assume responsibility for the medical aspects of the program.

(IV) Treatment staff that provide therapy and ongoing clinical assessment services to individuals diagnosed with co-occurring disorders shall have, at a minimum,

I. A master's degree in a behavioral health related field with a minimum of two (2) years work experience with individuals who have co-occurring disorders, mental health, or substance use disorders.

II. Specialized training to work with individuals who have co-occurring disorders.

(V) Direct Care Personnel. All other direct care personnel in a Level III.7 Co-occurring Enhanced Intensive Residential Program shall be qualified as a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(VI) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.7 Co-occurring Enhanced Residential Program as delineated in its operational plan.

(VII) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(VIII) Every client in a Level III.7 Residential Program shall be assigned to a primary counselor.

(IX) Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

(ix) Women and Dependent Children Program Specific Criteria.

(I) Program Coordinator. Each Level III.7 Intensive Women and Dependent Children Residential Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years supervised experience in a direct service area treating women or adolescents who have substance use, mental health or co-occurring mental health and substance use disorders.

(II) Direct Care Personnel. All direct care personnel shall be qualified as a qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(III) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.7 Intensive Women and Dependent Children Residential Program as delineated in its operational plan.

(IV) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(V) Every client in a Level III.7 Women and Dependent Children Program shall be assigned to a primary counselor.

(VI) Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

8. Training. The entity shall provide written documentation that all Level III.7 Program personnel satisfy the competency and training requirements as specified in Rule 580-9-44-.02(3).

9. Service Intensity:

(i) The entity shall document that the amount and frequency of Level III.7 Intensive Residential Treatment Services are established on the basis of the unique needs of each client served. To assist in addressing these needs the entity shall ensure the availability of no less than twenty (20) hours of structured services each week.

10. Length of Service: The entity shall provide written documentation that the duration of treatment in each Level III.7 Intensive Residential Program shall vary as determined by:

- (i) The severity of the client's illness.
- (ii) The client's ability to comprehend the information provided and use that information to implement treatment strategies and attain treatment goals.
- (iii) The appearance of new problems that require another level of care; or
- (iv) The availability of services at an assessed level of need, when a Level III.7 Residential Program has been utilized to provide interim services.

11. Service Availability: The entity shall provide written documentation describing the process utilized to establish hours of assessment and intake services at its Level III.7 Medically Monitored Intensive Residential Program. At a minimum, this process shall:

- (i) Include consideration of the needs of the target population, including work, school and parenting responsibilities.
- (ii) Include consideration of transportation accessibility.
- (iii) Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.27 Level III.7: Medically Monitored High Intensity Residential Treatment Program For Adolescents.

(1) Rule Compliance. In addition to compliance with the rules as specified in this chapter, each Level III.7 Medically Monitored High Intensity Residential Treatment Program for Adolescents shall comply with the rules as specified in the following chapters.

(a) Program Description. The entity shall develop, maintain and implement a written program description that defines its Level III.7 Adolescent Medically Monitored High Intensity

Residential Treatment Program, as according to Rule 580-9-44-.13 and the following specifications:

1. Location. The entity shall specifically identify and describe the setting in which the Level III.7 Adolescent Program shall be provided. Services may be provided in any facility that meets all applicable federal, state and local certification, licensure, building, life-safety, fire, health and zoning regulations including the DMH facility certification standards.

2. Admission Criteria: The entity shall develop, maintain, and document implementation of written criteria for admission to its Level III.7 Adolescent Program, in compliance with the requirements of Rule 580-9-44-.13(9) and the following specifications:

(i) The entity's admission criteria shall specify the target population for its Level III.7 Adolescent Services, which shall include, at a minimum, individuals:

(I) Who are less than nineteen (19) years old and:

(II) Whose assessed severity of illness warrants this level of care, including but not limited to adolescents whose sub-acute biomedical and emotional, behavioral, or cognitive problems are so severe that they require medically monitored treatment but do not need the full resources of an acute care general hospital.

(III) For whom treatment for identified problems has been rendered ineffective at less intensive levels of care.

(ii) The entity shall provide written documentation in individual case records that each client admitted to a Level III.7 Adolescent Program meets:

(I) The diagnostic criteria for a substance related disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iii) Co-occurring Disorders Program Specific Criteria. The entity shall provide written documentation in individual case records that each individual admitted to a Level III.7 Adolescent Co-occurring Enhanced Treatment Program meets:

(I) The diagnostic criteria for a substance related and mental illness disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iv) Women and Dependent Children Program Specific Criteria: The entity shall provide written documentation in individual case records that each client admitted to a Level III.7 Adolescent Program for Women and Dependent Children:

(I) Meets the diagnostic criteria for a substance related disorder as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

(II) The dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(III) Is pregnant; or

(IV) Has care and custody of dependent children; or

(V) Has lost custody of dependent children and has the potential for family reunification.

3. Core Services: Each Level III.7 Adolescent High Intensity Residential Program shall demonstrate the capacity to provide a basic regimen of treatment services appropriate to the adolescent's developmental and cognitive levels and other assessed needs.

(i) At a minimum, the entity shall demonstrate and document its capacity to provide a twenty-four (24) hour structured residential treatment environment with the following core services:

(I) Placement assessment.

(II) Individual counseling.

(III) Group counseling.

(IV) Family counseling.

(V) Psychoeducation.

- (VI) Peer support.
- (VII) Medical and somatic services.
- (VIII) Daily living skills.
- (IX) Medication management.
- (X) Medication administration.
- (XI) Alcohol and/or drug screening/testing.
- (XII) Transportation.
- (XIII) Activity therapy.
- (XIX) Case management:
 - I. Case planning.
 - II. Linkage.
 - III. Advocacy.
 - IV. Monitoring.

(ii) Medical Services. The entity shall implement procedures for the provision of medical services as according to protocols established in compliance with Rule 580-9-44-.13(24).

(I) Pregnant clients who are not receiving routine prenatal care shall be seen by physician within two (2) weeks of admission.

(iii) Mental Health Services. The entity shall develop, maintain and document implementation of written policies and procedures to ensure that each client's mental health needs are identified through the assessment service process and access to appropriate care for these needs is provided concurrently with treatment for assessed substance related disorders.

(iv) Family Support. The entity shall initiate and document in the client record continuous efforts to involve the client's family and other natural supports in the treatment process.

(v) Co-occurring Disorders Program Specific Criteria: Each Level III.7 Adolescent Co-occurring Disorders High Intensity Residential Treatment Program shall document the capacity to provide each of the core services and the following services:

(I) Mental health consultation.

(II) Crisis intervention services.

(III) Intensive case management.

(vi) Women and Dependent Children Program Specific Criteria: Each Level III.7 Adolescent Women and Dependent Children High Intensity Residential Treatment Program shall document the capacity to provide each of the core services and the following services:

(I) Child sitting services.

(II) Developmental delay and prevention services.

(III) Parenting skills development.

(IV) Academic and vocational services.

(V) Financial resource development and planning.

(VI) Family planning services.

4. Therapeutic Component Implementation. The entity shall document the implementation of a planned regimen of professionally directed program activities for adolescents and their families. Evaluation, treatment and care shall be provided in an amount, frequency and intensity appropriate to the client's assessed needs and expressed desires for care.

(i) Service strategies for each Level III.7 Adolescent Residential Program shall include, at a minimum:

(I) On duty awake staff shall provide supervision of client's health, welfare and safety twenty-four (24) hours a day.

(II) Clients shall have access to clinical services personnel twenty-four (24) hours a day seven (7) days a week.

(III) Daily clinical services to improve the client's ability to structure and reorganize the tasks of daily living and recovery.

(IV) The provision of daily scheduled treatment and recovery support services and activities that shall, at a minimum, include those that address:

- I. Implementation of individualized service plan strategies.
 - II. Development and application of recovery skills including relapse prevention.
 - III. Interpersonal choice/decision making skill development.
 - IV. Enhancement of the understanding of addiction.
 - V. Development of a social network supportive of recovery.
 - VI. Random drug screening.
 - VII. Health education.
 - VIII. Medication administration and monitoring.
 - IX. Promotion of successful involvement in regular productive daily activity, such as school or work.
 - X. Enhancement of personal responsibility, developmental maturity and prosocial values.
 - XI. Educational services in accordance with state and local regulations.
 - XII. Opportunities to remedy educational deficits created by involvement with alcohol and other drugs.
 - XIII. Supervised therapeutic recreational activities.
 - (ii) The entity shall actively promote and provide referrals and/or access to community support services.
 - (iii) All services shall be shall be organized and provided according to evidence-based and best practice standards and guidelines.
5. Documentation: Each Level III.7 Adolescent High Intensity Residential Program shall provide the following documentation in each client record:
- (i) Individualized progress notes shall be recorded each day for each respective service provided.
6. Support Systems. Each Level III.7 Adolescent Program shall develop, maintain and document implementation of

written policies and procedures which govern the process used to provide client access to support services on site or through consultation or referral, which shall minimally include:

(i) The availability of a physician or physician extender to assess each adolescent in person within twenty-four (24) hours of admission and thereafter as medically necessary.

(ii) Emergency consultation with a physician available twenty-four (24) hours a day seven (7) days a week.

(iii) Telephone or in person consultation with emergency services twenty-four (24) hours a day seven (7) days a week.

(iv) The availability of a MAS Registered Nurse to conduct a nursing assessment at the time of admission, monitor the client's progress during treatment and manage medication administration.

(v) Telephone or in person consultation with a MAS Nurse twenty-four (24) hours a day, seven (7) days a week.

(vi) Indicated laboratory and toxicology testing.

(vii) Indicated medical procedures.

(viii) Medical treatment.

(ix) Psychological and psychiatric treatment.

(x) Community based services assessed as needed but not provided by the entity.

(xix) Direct affiliation with or coordination through referral to more and less intensive levels of care including detoxification services.

7. Program Personnel. Each Level III.7 Adolescent High Intensity Residential Program shall employ an adequate number of qualified individuals to provide personalized care for its clientele and to meet the program's goals and objectives.

(i) Program Coordinator. Each Level III.7 Adolescent High Intensity Residential Treatment Program shall have a full-time program coordinator or manager who shall have a minimum two (2) years work experience in a direct service area treating adolescents who have substance related or co-occurring mental health and substance related disorders.

(ii) Nursing Personnel. MAS Registered Nurses or Licensed Practical Nurses shall be available for primary nursing care and observation twenty-four (24) hours a day.

(iii) Direct Care Personnel. All direct care personnel shall have the qualifications as a qualified paraprofessional to provide the specific services delineated in the entity's program description for this level of care.

(iv) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.7 Program as delineated in its operational procedures.

(v) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(vi) Every client in a Level III.7 Adolescent Program shall be assigned to a specific primary counselor for care management whose principal responsibilities shall include, but not limited to:

(I) Development and implementation of the individualized service plan.

(II) Ensuring service delivery and coordination of service delivery as delineated in the plan.

(III) Evaluation of the client's overall progress in treatment and preparation of staffing reports.

(IV) Discharge and continuing care planning and implementation.

(vii) Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

(viii) Co-occurring Disorders Program Specific Criteria.

(I) Each Level III.7 Adolescent Co-occurring Enhanced High Intensity Residential Program shall be coordinated by a full-time member of the staff who has the minimum of a master's degree in a mental health related field and at least two (2) years supervised experience in a direct service area treating adolescent clients with co-occurring disorders.

(II) Each Level III.7 Adolescent Co-occurring Enhanced High Intensity Residential Program shall have access to psychiatric services led by a qualified psychiatrist or nurse practitioner that are fully capable of evaluating, diagnosing and

prescribing medications to clients with co-occurring disorders. On-call psychiatric services shall be available twenty-four (24) hours a day, seven (7) days a week.

(III) The treatment organization/agency shall have access to an Alabama licensed physician, full time, part time, or on contract, who shall be available to the program for client care and shall assume responsibility for the medical aspects of the program.

(IV) Treatment staff that provide therapy and ongoing clinical assessment services to individuals diagnosed with co-occurring disorders, shall have at a minimum,

I. A master's degree in a behavioral health related field with a minimum of two (2) years work experience with individuals who have co-occurring disorders, mental health or substance use disorders.

II. Specialized training to work with individuals who have co-occurring disorders.

(V) All other direct care personnel in a Level III.7 Adolescent Co-occurring Enhanced High Intensity Residential Program shall be qualified to provide the specific services delineated in the entity's operational plan for this level of care.

(VI) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.7 Adolescent Co-occurring Enhanced Residential Program as delineated in its operational plan.

(VII) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(VIII) Every client in a Level III.7 Adolescent Residential Program shall be assigned to a specific primary counselor for care management as a qualified paraprofessional.

(ix) Women and Dependent Children Program Specific Criteria.

(I) Program Coordinator. Each Level III.7 Adolescent High Intensity Women and Dependent Children Residential Program shall be coordinated by a full-time member of the staff who has a minimum of a master's degree in a behavioral health related field and at least two (2) years supervised experience in a direct service area treating women or adolescents who have substance

use, mental health, or co-occurring mental health and substance use disorders.

(II) Direct Care Personnel. All direct care personnel shall be qualified as qualified paraprofessional to provide the specific services delineated in the entity's operational plan for this level of care.

(III) Clinical Personnel. The entity shall maintain an adequate number of clinical personnel to sustain the Level III.7 Adolescent High Intensity Women and Dependent Children Residential Program as delineated in its operational plan.

(IV) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the program's administrative functions.

(V) Every client in a Level III.7 Adolescent Women and Dependent Children Program shall be assigned to a specific primary counselor for care management.

(VI) Each primary counselor shall maintain a case load not to exceed ten (10) clients with active cases at any one time.

8. Training. The entity shall provide written documentation that all Level III.7 Adolescent Program personnel satisfy the competency and training requirements as specified in Rule 580-9-44-.02(3).

9. Service Intensity:

(i) The entity shall document that the amount and frequency of Level III.7 Adolescent High Intensity Residential Treatment Services are established on the basis of the unique needs of each client served. To assist in addressing these needs, the entity shall ensure the availability of no less than twenty (20) hours of structured services each week.

(ii) The entity shall provide written documentation describing the procedures utilized to ensure the provision of services appropriate to the client's developmental stage and level of comprehension including any necessary adaptations.

10. Length of Service: The entity shall provide written documentation that the duration of treatment in each Level III.7 Adolescent High Intensity Residential Program shall vary as determined by:

(i) The severity of the client's illness.

(ii) The client's ability to comprehend the information provided and use that information to implement treatment strategies and attain treatment goals.

(iii) The appearance of new problems that require another level of care; or

(iv) The availability of services at an assessed level of need, when a Level III.7 Adolescent Residential Program has been utilized to provide interim services.

11. **Service Availability:** The entity shall provide written documentation describing the process utilized to establish hours of availability for Behavioral Health Screening and Diagnostic Interview Examination Services at its Level III.7 High Intensity Residential Program. At a minimum, this process shall:

(i) Include consideration of the needs of the target population, including work, school and parenting responsibilities.

(ii) Include consideration of transportation accessibility.

(iii) Not be based solely on standard eight (8) to five (5), Monday through Friday office hours.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012.

580-9-44-.28 Level 3.7-D: Medically Monitored Residential Detoxification Program And Level 3.7-D NTP: Medically Monitored Residential Detoxification Narcotic Treatment Program.

(1) **Scope.** This Chapter establishes rules for the operation of Medically Monitored Residential Detoxification Programs (Level 3.7-D) and Medically Monitored Residential Detoxification Programs designated as Narcotic Treatment Programs (Level 3.7-D NTP).

(2) **Definitions.** The following definitions apply to this Chapter:

(a) **Accreditation elements:** The standards that are developed and adopted by an accreditation body and approved by

the Substance Abuse and Mental Health Services Administration (SAMHSA).

(b) **Detoxification:** The dispensing of medication, approved for such purposes, in decreasing doses to an individual to alleviate adverse physical or psychological effects incident to withdrawal from the continuous or sustained use of alcohol and/or other relevant addictive drugs. Detoxification functions, also, as a method of bringing the individual to a drug-free state within such period.

(c) **Federal opioid treatment standards:** 42 CFR 8.12.

(d) **Level 3.7-D Medically Monitored Residential Detoxification Program:** An organized regimen of services provided by nursing and medical professionals, which provides for 24-hour medically supervised alcohol or other drug withdrawal management with medication approved for such use.

(e) **Level 3.7-D NTP Medically Monitored Residential Detoxification Program:** An organized regimen of services provided by nursing and medical professionals, which provides for 24-hour medically supervised opioid withdrawal management utilizing buprenorphine or a buprenorphine combination product approved for treatment of opioid use disorders by the Food and Drug Administration (FDA). A Level 3.7-D NTP may not dispense Methadone unless the entity is certified by the Alabama Department of Mental Health to operate an Opioid Treatment Program in compliance with Chapter 580-9-44-.29 of these rules and holds a valid Certificate of Need for the operation of a Methadone Treatment Program issued by the Alabama State Health Planning and Development Agency.

(f) **Long-term detoxification:** Detoxification treatment services provided for a period more than 30 days, but not in excess of 180 days.

(g) **Medical director:** A physician, licensed to practice medicine in Alabama, who assumes responsibility for administering all medical services performed by the program, either by performing them directly or by delegating specific responsibility to authorized program physicians and healthcare professionals functioning under the medical director's direct supervision.

(h) **Program sponsor:** The individual, named in the entity's application for certification by SAMHSA as according to 42 CFR 8.11, who is responsible for the operation of the Level 3.7-D NTP. The sponsor assumes responsibility for all of the entity's employees, including any practitioners, agents, or other

persons providing medical, rehabilitative, or counseling services.

(i) Short-term detoxification: Detoxification treatment for a period not in excess of 30 days.

(3) Rule Compliance.

(a) In addition to compliance with the rules as specified in this chapter, each Level 3.7-D and 3.7-D NTP shall comply with the rules as specified in the following chapters: 580-9-44-.02 Personnel, 580-9-44-.03 Client Rights, 580-9-44-.04 Abuse and Neglect, 580-9-44-.05 Grievances, Complaints and Appeals, 580-9-44-.06 Confidentiality and Privacy, 580-9-44-.07 Seclusion and Restraint, 580-9-44-.08 Child and Adolescent Seclusion and Restraint, 580-9-44-.09 Incident Reporting, 580-9-44-.10 Infection Control, 580-9-44-.11 Performance Improvement, 580-9-44-.12 Operational Policies and Procedures Manual, and 580-9-44-.13 Program Description.

(b) Each Level 3.7-D NTP shall comply with all regulations enforced by the DEA under 21 CFR Chapter II, and must be registered by the DEA before administering or dispensing opioid agonist treatment medications.

(c) Each Level 3.7-D NTP must operate in accordance with Federal opioid treatment standards and approved accreditation elements.

(4) Program Description. The entity shall develop, maintain and implement a written program description that defines its Level 3.7-D program or Level 3.7-D NTP, as according to Rule 580-9-44-.13 and the following specifications:

(a) Location. The entity shall specifically identify and describe the setting in which the Level 3.7-D Program or Level 3.7-D NTP is provided. Services may be provided in any facility that meets all applicable federal, state and local certification, licensure, building, life-safety, fire, health and zoning regulations including the DMH facility certification standards.

(b) Admission Criteria:

1. Level 3.7-D. The entity's admission criteria shall specify the target population for the Level 3.7-D Program, which shall include, at a minimum, individuals who are experiencing signs and symptoms of withdrawal, or for whom there is evidence that a withdrawal syndrome is imminent, and who have a history of

insufficient skills and supports to complete detoxification at a less intense level of care.

(i) The entity shall provide written documentation in individual case records that each patient admitted to receive Level 3.7-D services meets the diagnostic criteria for a Substance Related Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(ii) The entity shall provide written documentation in individual case records that each patient admitted to receive Level 3.7-D services meets the dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM Criteria.

2. Level 3.7-D NTP. The entity's admission criteria shall specify the target population for the Level 3.7-D NTP Program, which shall include, at a minimum, individuals who are experiencing signs and symptoms of opioid withdrawal, or for whom there is evidence that a withdrawal syndrome is imminent; and who have a history of insufficient skills and supports to complete detoxification at a less intense level of care.

(i) The entity shall provide written documentation in individual case records that each patient admitted to receive Level 3.7-D NTP services meets the diagnostic criteria for an Opioid Related Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(ii) The entity shall provide written documentation in individual case records that each patient admitted to receive Level 3.7-D NTP services meets the dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM Criteria.

(iii) The entity shall not admit a patient for more than two detoxification treatment episodes in one year. Patients with two or more unsuccessful detoxification episodes within a 12-month period must be assessed by the program's Medical Director or other authorized medical professional for other forms of treatment.

(c) Core Services: At a minimum, each Level 3.7-D Program and 3.7D NTP shall document the capacity to provide the following core services:

1. Placement assessment.

2. Individual counseling.
3. Group counseling.
4. Psychoeducation.
5. Family counseling.
6. Peer support.
7. Medical and somatic services.
8. Medication administration.
9. Medication monitoring.
10. Alcohol and/or drug screening/testing.
11. Case management, including:
 - (i) Case planning.
 - (ii) Linkage.
 - (iii) Advocacy.
12. Patient Progress Monitoring.

(d) Therapeutic Component Implementation: The entity shall document implementation of medical and other clinical services organized to enhance the patient's understanding of addiction, support completion of the detoxification process and initiate transfer to an appropriate level of care for continued treatment. At a minimum, this shall include the following therapeutic components:

1. For each Level 3.7-D program:
 - (i) Completion of a comprehensive medical history and physical examination of the patient at admission.
 - (ii) Protocols established by the entity's medical director, for management of detoxification from each major drug category of abused drugs that are consistent with guidelines published by nationally recognized organizations (e.g., SAMHSA, ASAM, American Academy of Addiction Psychology) and with product labeling of medications utilized.
 - (iii) Level 3.7-D Programs that utilize benzodiazepines in the detoxification protocol shall have:

(I) Written protocols and procedures to show that all doses or amounts of benzodiazepines are carefully monitored and are slowly reduced as appropriate.

(II) Written longer-term detoxification protocols and procedures that adhere to general principles of management, including clear indications of benzodiazepine dependence, clear intermediate treatment goals and strategies, regular review and methods to prevent diversion from the plan.

2. For each Level 3.7-D NTP:

(i) The Level 3.7-D NTP shall maintain current procedures that are designed to ensure that patients are admitted to short- or long-term detoxification treatment by a program physician, who determines that such treatment is appropriate for the specific patient by applying established diagnostic criteria.

(ii) Each patient must undergo a complete, fully documented physical evaluation by a program physician or a primary care physician, or an authorized healthcare professional under the supervision of a program physician, before admission to the Level 3.7-D NTP. The full medical examination, including the results of serology and other tests, must be completed within 14 days following admission.

(iii) The program must maintain current policies and procedures that reflect the special needs of patients who are pregnant. Prenatal care and other gender specific services for pregnant patients must be provided either by the Level 3.7-D NTP or by referral to appropriate healthcare providers.

(iv) The entity shall maintain current procedures adequate to ensure that each buprenorphine and/or buprenorphine combination product used by the program is administered and dispensed in accordance with its approved product labeling. Dosing and administering decisions shall be made by a program physician familiar with the most up-to-date product labeling.

(v) Medication orders and changes in dosage shall be written on an acceptable order sheet and signed by a program physician or through utilization of a comparable electronic signatory process.

(vi) Policies and procedures for medication administration, dispensing, and use shall ensure that buprenorphine and buprenorphine combination products are administered or dispensed only by a physician, pharmacist, registered nurse, or licensed practical nurse.

(vii) At least one (1) initial drug test should be conducted for patients in short-term detoxification treatment for analysis of illicit drug use or prescription drug misuse.

(viii) Buprenorphine and/or buprenorphine combination products shall only be dispensed or administered to patients who are admitted to the Level 3.7-D NTP. The entity shall not prescribe or dispense buprenorphine and/or buprenorphine combination products for unsupervised and/or take home use or for use in another level of treatment.

3. Each Level 3.7-D Program and Level 3.7-D NTP shall provide:

(i) On duty awake staff shall provide supervision each patient's health, welfare and safety twenty-four (24) hours a day, seven (7) days a week.

(ii) On-site physician care and phone availability twenty-four (24) hours a day, seven (7) days a week.

(iii) Nurse monitoring, assessment and management of signs and symptoms of intoxication and withdrawal twenty-four (24) hours a day, seven (7) days a week.

(iv) A pregnancy test for females of childbearing age prior to administration of medication.

(v) Medication administration and monitoring services, including specific procedures for pregnant women.

(vi) Continuous assessment.

(vii) Planned counseling and other therapeutic interventions.

(viii) Motivational enhancement therapy.

(ix) Peer support services.

(x) Relapse prevention counseling.

(xi) Overdose prevention education.

(xii) Direct affiliation with other levels of care.

(e) Documentation:

1. Each Level 3.7-D Programs and Level 3.7-D NTP shall provide the following clinical record documentation:

- (i) Documentation of each clinical/therapeutic intervention provided.
- (ii) Daily assessment of progress, including response to medication, which also notes any treatment changes.
- (iii) Monitoring of vital signs, at a minimum, every eight (8) hours until discharge.
- (iv) The use of detoxification rating scale tables and flow sheets.

2. Each Level 3.7-D NTP.

(i) The entity shall establish and maintain a recordkeeping system that is adequate to document and monitor patient care that complies with all Federal and State reporting requirements relevant to opioid drugs approved for use in treatment of opioid addiction. All records are required to be kept confidential in accordance with all applicable Federal and State requirements.

(ii) The Level 3.7 NTP shall include, as an essential part of the recordkeeping system, documentation in each patient's record that the entity made a good faith effort to review whether or not the patient is enrolled in an Opioid Treatment Program (OTP) or taking other opioids that would contraindicate buprenorphine treatment.

(f) Support Systems: Each Level 3.7-D Program and 3.7-D NTP shall develop, maintain, and document implementation of written policies and procedures utilized to provide patient access to support services on site, or through consultation or referral, which shall minimally include:

- 1. Specialized clinical consultation for biomedical, emotional, behavioral and cognitive problems.
- 2. Appropriate laboratory and toxicology testing.
- 3. Psychological and psychiatric services.
- 4. Transportation.
- 5. Twenty four (24) hour access to emergency medical services.

(g) Staff Requirements.

1. Each Level 3.7-D and 3.7-D NTP shall, at a minimum, maintain the following positions as part of its staff:

(i) Medical Director. The medical director shall be a physician licensed to practice in the State of Alabama, who has a minimum of one (1) year experience treating substance related disorders. The medical director shall be responsible for admission, diagnosis, medication management, patient care, and for ensuring that the program is in compliance with all Federal, State, and local laws and regulations.

(ii) Each Program shall be coordinated by a full-time employee who is an Alabama licensed Registered Nurse, Nurse Practitioner, Physician, or Physician's Assistant, with two (2) years direct care experience treating substance related disorders.

(iii) Nursing Services Director. Program shall have a nursing services director who shall be a Registered Nurse licensed according to Alabama law, with training and work experience in behavioral health.

(iv) There shall be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) on site during all hours of the Program's operation.

(v) Direct Care Personnel. All direct care personnel must have sufficient education, training, and experience, or a combination thereof, to enable that person to perform the assigned job responsibilities. All physicians, nurses, and other licensed professional care providers, including certified addiction counselors, must comply with the credentialing requirements of their respective professions.

(vi) The entity shall maintain an adequate number of personnel, including physicians, nurses, counselors and case managers to sustain the Program as delineated in its operational plan.

(vii) Administrative Support Personnel. The entity shall maintain an adequate number of support personnel to sustain the Program's administrative functions.

(h) Training: Each Level 3.7-D and 3.7-D NTP shall provide written documentation that:

1. All program personnel satisfy the requirements of the core training curriculum, as specified in Rule 580-9-44-.02(3).

2. All clinical and medical services staff receive training during the initial twelve (12) months employment and develop basic competencies in the following areas:

(i) Biopsychosocial dimensions of substance related disorders.

(ii) The signs and symptoms of alcohol and other drug intoxication and withdrawal.

(iii) Evidence-based treatment and monitoring strategies for alcohol and other drug intoxication and withdrawal.

(iv) Continuing care motivational and engagement strategies.

(v) Pharmacotherapy.

(vi) ASAM Criteria.

(vii) Assessment of and service planning to address biopsychosocial needs.

(i) Service Intensity: The entity shall document in the clinical record that the intensity of Level 3-D Services and Level 3.7-D NTP is established on the basis of the unique needs of each served.

(j) Length of Service: The entity shall provide written documentation in the clinical record that the duration of treatment in each Level 3.-D Program and 3.7-D NTP varies as determined by the patient's assessed needs, and that the patient continues in treatment until:

1. Withdrawal signs and symptoms are sufficiently resolved; or

2. Withdrawal signs and symptoms have failed to respond to treatment and have intensified warranting a transfer to a more intense level of care; or

3. The patient is, otherwise, unable to complete detoxification at this level of care.

K. Diversion Control Plan. Each Level 3.7-D NTP shall maintain a current Diversion Control Plan (DCP) as part of its quality assurance program that, at a minimum:

1. Contains specific measures to reduce the possibility of diversion of controlled substances from legitimate use, and

2. Assigns specific responsibility to the medical and administrative staff of the Level 3.7-D NTP for carrying out the diversion control measures and functions described in the DCP.

(1) Emergency Administration of Medication. Each Level 3.7-D program and Level 3.7-D NTP shall maintain policies and procedures for administration of patient medication in the event of an emergency leading to the temporary closure of the program.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed January 26, 2012; effective March 1, 2012. **Amended:** Filed December 8, 2016; effective January 22, 2017.

580-9-44-.29 Level I-O: Opioid Maintenance Therapy.

(1) Rule Compliance. Each Level I-O Opioid Maintenance Therapy Program shall comply with all applicable rules and the rules specified in this chapter:

(a) Program Description. The entity shall develop, maintain and implement a written program description that defines its Level I-O Opioid Maintenance Therapy Program.

1. Location. The entity shall specifically identify and describe the setting in which the Level I-O Program is provided. Services may be provided in any facility that meets all applicable federal, state and local certification, licensure, building, life-safety, fire, health and zoning regulations, including the DMH facility certification standards.

2. Admission Criteria. The entity shall develop, maintain and document implementation of written criteria for admission to its Level I-O Program, in compliance with the requirements of Rule 580-9-44-.13(9) and the following specifications:

(i) The entity's admission criteria shall specify the target population for its Level I-O Program, which shall include, at a minimum:

(I) Individuals who are currently physiologically dependent upon an opiate drug and who became physiologically dependent at least one (1) year prior to seeking admission to Opioid Maintenance Therapy.

(II) Other individuals, as authorized by the entity's medical director, who have a history of Opioid use and are susceptible to relapse to Opioid addiction leading to high risk behaviors with potentially life-threatening consequences, but who do not present with a one (1) year history of addiction, including:

I. Pregnant women.

II. Individuals who have been released from a penal institution within six (6) months of the current admission request, if the client was eligible for admission prior to incarceration.

III. Individuals who have had a previous admission to Opioid maintenance therapy of at least six (6) months duration that occurred within two (2) years of the current admission request.

IV. Individuals who are HIV positive.

(ii) The entity shall provide written documentation in each individual clinical record that each client admitted to a Level I-O Program for Opioid Maintenance or Withdrawal Therapy meets the criteria for Opioid Dependence Disorder, as according to the specific diagnostic criteria given in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(iii) The entity shall provide written documentation in each individual case record that each client admitted to a Level I-O Program meets the dimensional criteria for admission to this level of care as defined in the most recent edition of the ASAM PPC-2R.

(iv) Medical necessity of each admission to a Level I-O Program shall be established by the program's medical director or a physician authorized by the program's medical director and documented in the clinical record.

(v) Adolescent Specific Criteria. An entity shall not admit an individual under age eighteen (18) to a Level I-O Program for Opioid Maintenance Therapy unless the entity can document that:

(I) The client has had two (2) unsuccessful attempts at drug-free treatment within a twelve (12) month period of time; or

(II) The client has had two (2) unsuccessful attempts at short-term detoxification.

(III) The entity has obtained written authorization of the admission from the State Opioid Treatment Authority (SOTA).

I. The entity shall develop, maintain and document implementation of written policies and procedures which govern the process utilized to request and obtain written authorization from the SOTA prior to admission of an individual under age eighteen 18 to a Level I-O Program.

3. Core Services. Each Level I-O Program shall demonstrate the capacity to provide a basic regimen of treatment services appropriate to the client's developmental and cognitive levels and other assessed needs.

(i) At a minimum, the entity shall demonstrate and document its capacity to provide the following core services:

(I) Placement assessment.

(II) Medication management.

(III) Medication administration.

(IV) Alcohol and/or drug screening/testing.

(V) Individual counseling.

(VI) Group counseling.

(VII) Family counseling.

(VIII) Psychoeducation.

(IX) Case management:

I. Case planning.

II. Linkage.

III. Advocacy.

IV. Monitoring.

(ii) Medical Services. The entity shall have medical protocols established for I-O Level of Care by a licensed physician or staff or under contract with the entity as the medical director. The medical protocol shall be in compliance with the program standards, ethics and licensure requirements of the medical profession.

(iii) Mental Health Services. The entity shall develop, maintain and document implementation of policies and procedures to ensure that clients with mental health needs are identified through assessment services and have access to appropriate care concurrently with Opioid Maintenance or Withdrawal Therapy.

(iv) Family Support. The entity shall initiate and document in the client record:

(I) Continuous efforts to involve the client's family and other natural supports in the treatment process.

(II) Family and other natural supports' participation in the client's treatment process.

4. Therapeutic Component Implementation.

(i) Each Level I-O Program shall provide written documentation of compliance with all applicable local, state and federal regulations, including Federal Regulation 42 CFR Part 8, DEA, Certificate of Need, etc. in addition to all applicable sections of the rules set forth, herein.

(ii) Each Level I-O Program shall establish a written schedule of operating hours and services that shall:

(I) Provide for dosing and counseling services seven (7) days each week.

(II) Establish hours of operation that are flexible to accommodate the majority of client school, work and family responsibility schedules.

(III) Provide access to clinical services personnel twenty-four (24) hours a day, seven (7) days a week.

I. The physical plant is of adequate size to accommodate the proposed number of clients, required program

activities, and provide a safe, therapeutic environment that supports enhancement of each client's well-being and affords protection of privacy and confidentiality.

(iii) **Counseling Services:** The entity shall document the provision of scheduled counseling and recovery support services and activities that shall, at a minimum, include:

(I) Interventions that address:

I. Emotional and psychological needs.

II. Health education.

III. Medication administration and monitoring.

5. **Assessment:** The entity shall comply with all standards set forth in Rule 580-9-44-.13(7) of these rules and in addition, shall comply with the requirements of this section:

(i) Before an entity admits an individual to a Level I-O Program, the program's medical director, or a physician or physician extender properly authorized by the medical director, shall conduct and document the findings of a medical evaluation.

(ii) A pregnancy test shall be completed, and the results documented, for each female of childbearing potential prior to the initiation of Opioid Maintenance Therapy, or any medically assisted withdrawal or detoxification procedures.

(iii) A comprehensive medical examination that includes the following components, at a minimum, shall be completed and documented in the clinical record, within fourteen (14) days of each admission:

(I) A complete medical history.

(II) A tuberculosis (TB) skin test or chest x-ray if the skin was ever previously positive.

(III) Screening tests for STDs.

(IV) Other laboratory tests as clinically indicated by the client's history and physical examination.

(iv) An annual medical examination shall be conducted and documented in the clinical record by the program's medical director, or a physician or physician extender authorized by the program's medical director.

6. Client Orientation:

(i) All clients shall be oriented to the Opioid Therapy process prior to administration of any medication.

(ii) The entity shall provide written documentation that each client, upon admission and throughout the treatment process, receives oral and written information that explains in a manner understood by the client:

(I) Signs and symptoms of overdose and when to seek emergency assistance.

(II) A description of the medications to be administered by the program, including potential:

I. Benefits.

II. Risks.

III. Side effects.

IV. Drug interactions.

(III) Common myths about Opiate Maintenance Therapy and medications used in the treatment and withdrawal process.

(IV) The nature of addictive disorders.

(V) The goals and benefits of medication assisted treatment and the process of recovery.

(VI) Noncompliance and discharge procedures, including administrative withdrawal from medication.

(VII) Toxicology testing procedures.

(VIII) Medication dispensing procedures.

7. Drug Testing: The entity shall develop, describe in writing and document implementation of an organized process to monitor drug use by program participants, which shall, at a minimum, comply with the standards provided in Rule 580-9-44-.13(25), and include the following specifications:

(i) The results of a drug test shall be utilized as a guide to review and modify treatment approaches and not as the sole criterion to discharge a client from treatment.

(ii) Baseline toxicology tests shall be completed on the day of Diagnostic Interview Examination that shall, at a minimum, screen for:

- (I) Opiates.
- (II) Methadone.
- (III) Benzodiazepines.
- (IV) Barbiturates.
- (V) Cocaine.
- (VI) Amphetamines.
- (VII) Tetrahydrocannabinol.
- (VIII) Alcohol.

(IX) Any other drug known to be frequently abused in the locality of the Opiate Maintenance Therapy Program.

(iii) Random drug tests shall be conducted at least once per month throughout the duration of each client's participation in Opioid Maintenance Therapy. A minimum of twelve (12) drug tests shall be conducted per year.

(iv) The entity shall document the provision of a minimum of two (2) drug tests per month for each client during the first ninety (90) days in Opioid Maintenance Therapy and for those, otherwise, in Phase 1 of the program.

(v) The entity shall document the utilization of drug testing cutoff concentrations as follows:

- (I) Marijuana: 100 ng/ml
- (II) Cocaine: 300 ng/ml
- (III) Opiate: 300 ng/ml
- (IV) Amphetamine/methamphetamine: 1000 ng/ml
- (V) Benzodiazepine: 200 ng/ml
- (VI) Methadone: 300 ng/ml
- (VII) Barbiturates: 200 ng/ml

(VIII) Alcohol: .03 gm/dl

(IX) In cases where Opiate Maintenance drugs other than methadone are being used, the clinic should contact the State Opioid Treatment Authority to determine the acceptable immunoassay cut-off concentrations.

(vi) The entity shall provide documentation that all drug tests are conducted by a laboratory certified by an independent, federally approved accreditation entity.

(vii) The results of all drug tests shall be filed in the clinical record.

8. Procedure for Addressing Positive Toxicology Reports. The entity shall develop, maintain and document implementation of written policies and procedures that establish protocols for addressing positive toxicology results for illicit drugs and negative results for drugs administered by the Opioid Maintenance Therapy Program that shall, at a minimum, include the following specifications:

(i) Baseline drug testing results shall be discussed with the client and documentation of this discussion recorded as a progress note in the clinical record.

(ii) At his/her next scheduled clinic visit after receiving a positive alcohol/drug screen, clients shall be informed of drug testing results that are positive for substances of abuse, or negative for Opioid Maintenance Therapy medication. Following client notification, the entity shall implement the following procedures, as appropriate:

(I) New Clients. During the first ninety (90) days of treatment, the first drug testing report that is positive for substances of abuse or negative for treatment medication, after baseline testing, shall result in a meeting between the client and the client's primary counselor to review the treatment plan, and to modify or intensify treatment services as appropriate to the client's current needs.

(II) Clients with take-home privileges.

I. A positive toxicology report for illicit drugs or a negative toxicology result for treatment medication shall require that the client with take-home privileges, at a minimum:

A. Be placed on probation for ninety (90) days.

B. Receive a minimum of two (2) random drug screens per month during the probationary period.

C. Collaborate with his/her primary counselor for discussion of the toxicology results and for service plan modification as according to the client's needs.

II. A second toxicology result that is positive for substances of abuse or negative for treatment medication during a probationary period shall require that the client with take-home privileges, at a minimum:

A. Transfer to a lower dosing phase.

B. Receive a minimum of two (2) random drug screens per month.

C. Participate in a clinical staffing.

D. Collaborate with the treatment team to develop and implement a plan for remedial action.

(III) Subsequent Drug Tests for All Clients. For subsequent drug testing results that are positive for substances of abuse or negative for treatment medication the entity shall take steps to provide assistance for each client, as according to assessed needs, that shall include but shall not be limited to:

I. Treatment team staffings in collaboration with the client.

II. Continued assessment services of the client's biopsychosocial needs and levels of functioning.

III. Re-evaluation of the client's medication dosage, plasma levels, metabolic responses and adjustment of the dosage for adequacy and client comfort.

IV. Assessment for co-occurring disorders, prescribing therapy and psycho-pharmacotherapy as needed.

V. Intensify counseling or add of other types of services.

VI. Treatment of medical or other associated problems.

VII. Consideration of alternative opiate addiction treatment medications.

VIII. Detoxification from substances of abuse while maintaining the client on Opioid pharmacotherapy.

IX. Initiating a change of counselors when indicated.

X. Providing family intervention.

(IV) If any client has six (6) or more consecutive toxicology results that are positive for substances of abuse or negative for treatment medication, the entity shall inform the client that administrative withdrawal procedures will begin immediately and a referral will be made to an appropriate level of care unless the entity's medical director:

I. Provides objective clinical contraindications of the need for this action.

II. Develops a written intervention plan in consultation with the client and the client's treatment team that shall at a minimum, include provisions for:

A. Detoxification from substances other than the maintenance therapy drug; and/or

B. Intensified counseling and other services.

III. Documents all actions taken, in this regard, as appropriate.

IV. The entity shall maintain a data base of drug testing results which shall at a minimum:

V. List each client by unique client identifier, date of birth, gender, date of each drug test, identify each drug for which tests are completed and the results of each test.

VI. Allow for development of aggregate reports of each variable as well sorting of data by each variable.

9. Take Home Medication: The entity shall develop, maintain and document implementation of written policies and procedures that govern the processes utilized to provide clients with unsupervised use of program dispensed Opioid treatment medication. At a minimum, these policies and procedures shall include the following specifications:

(i) The entity's medical director, in consultation with the client's treatment team, shall make all decisions relative to dispensing Opioid treatment medication to clients for

unsupervised use, in consideration of the following minimum criteria:

(I) Absence of recent abuse of drugs (narcotic or non-narcotic), including alcohol.

(II) Regularity of clinic attendance.

(III) No observed, reported, or otherwise known serious behavioral problems.

(IV) Absence of known recent criminal activity, e.g., drug dealing.

(V) Stability of the client's home environment and social relationships.

(VI) Length of time in treatment.

(VII) Assurance that take-home medication can be safely stored within the client's home.

(VIII) Whether the rehabilitative benefit to the client derived from decreasing the frequency of clinic attendance outweighs the potential risks of diversion.

(ii) Decisions to approve unsupervised use of Opioid medications, including the rationale for the approval, shall be documented in the clinical record.

(iii) Patients must have in their possession a secure locking storage device in order to receive take-home medication. There are no exceptions.

(iv) The amount of take-home medication shall be based on the clinical judgment of the physician in consultation with the multidisciplinary treatment team. If it is determined that a client meets the criteria for unsupervised dosing the supply shall be limited to the following schedule:

(I) Phase 1 Treatment. Clients who are not eligible for any take home medication shall be designated by the program as in Phase 1 of Opioid Maintenance Therapy.

I. During the first ninety (90) days of treatment, clients shall not be eligible for any take home medication.

II. Twice-a-month drug tests shall document that each client in Phase I is free of all substances of abuse including

alcohol and positive for the prescribed maintenance drug for at least ninety (90) consecutive days in order to be eligible for consideration for unsupervised dosing.

(II) Phase 2 Treatment. Clients in treatment between ninety-one (91) and one hundred eighty (180) days, who satisfy the criteria specified in Rule 580-9-44-.29 8(i)(II) shall be eligible for a take-home supply that shall not exceed two (2) doses per week.

I. Clients who are eligible for a two (2) day take home medication supply shall be designated by the program as in "Phase 2" of Opioid Maintenance Therapy.

II. A minimum of one (1) random drug test per month must be conducted while the patient is in Phase 2.

III. It shall be documented that the client is free of all substances of abuse including alcohol and positive for the prescribed maintenance drug for at least ninety (90) consecutive days in order to be considered for Phase 2 unsupervised dosing.

(III) Phase 3 Treatment. Clients in treatment between one hundred eighty-one (181) and two-hundred seventy (270) days, who satisfy the criteria specified in Rule 580-9-44-.29 8(i)(II) shall be eligible for a take-home supply that shall not exceed three (3) doses per week.

I. Clients who are eligible for a three (3) day take home medication supply shall be designated by the program as in Phase 3 of Opioid Maintenance Therapy.

II. A minimum of one (1) random drug test per month must be conducted while the patient is in Phase 3.

III. It shall be documented that the client is free of all substances of abuse including alcohol and positive for the prescribed maintenance drug for at least one hundred eighty (180) consecutive days in order to be considered for Phase 3 unsupervised dosing.

(IV) Phase 4 Treatment. Clients in treatment between two hundred seventy-one (271) and three hundred sixty-five (365) days, who satisfy the criteria specified in Rule 580-9-44-.29 8(i)(II) shall be eligible for a take-home supply that shall not exceed six (6) doses per week

I. Clients who are eligible for a six (6) day take home medication supply shall be designated by the program as in Phase 4 of Opioid Maintenance Therapy.

II. A minimum of one (1) random drug test per month must be conducted while the patient is in Phase 4.

III. It shall be documented that the client is free of all substances of abuse including alcohol and positive for the prescribed maintenance drug two hundred seventy (270) consecutive days in order to be considered for Phase 4 unsupervised dosing.

(V) Phase 5 Treatment. After two (2) years of continuous treatment with uninterrupted clean drug screens, client shall be eligible for up to a thirteen (13) day take home medication supply.

I. Clients who are eligible for a thirteen (13) day take home medication supply shall be designated by the program as in Phase 5 of Opioid Maintenance Therapy.

II. A minimum of one (1) random drug test per month must be conducted while the patient is in Phase 5.

(iv) Temporary Special Take-Home Medication for Non-Emergency: The entity shall develop, maintain and document implementation of written policies and procedures that govern the process utilized to provide temporary take home medication for exceptional circumstances, which shall at a minimum include the following specifications:

(I) The need for temporary special unsupervised take-home medication shall be clearly delineated with verifiable documentation in the clinical record.

(II) A client seeking approval for temporary special unsupervised take-home medication shall, at a minimum, meet the criteria to determine eligibility for take home medication specified in Rule 580-9-44-.29 9.

(III) Requests for temporary special take-home medication shall be approved in writing by the entity's medical director, the State Opioid Treatment Authority and SAMHSA.

(IV) The provision and supply of temporary special unsupervised take-home medication shall be at the direction of the State Opioid Treatment Authority.

(v) Temporary Special Take-Home Medication for Emergency: The entity shall develop, maintain and document implementation of written policies and procedures that govern the process utilized to provide emergency take-home medication for exceptional circumstances, which at a minimum include:

(I) The need for emergency unsupervised take-home medication shall be clearly delineated with verifiable documentation in the client's clinical record.

(II) Requests for emergency take-home medication shall be approved in writing by the entity's Medical Director and shall not exceed a three (3) day medication supply at any one time.

I. Situations that might warrant emergency take-home medication include:

- A. Death in the family.
- B. Illness.
- C. Inclement weather.
- D. Other uniquely identified situations.

(vi) Hardship Waiver. The entity shall develop, implement and document implementation of written policies and procedures to address requests for hardship exceptions to the rules for early phase advancement:

(I) Specify the conditions under which a client may request a hardship waiver and the conditions required for its consideration.

(II) Describe the process utilized to ensure continuity of care when a client is unable, due to a verifiable hardship, to report to the program for routine ingestion of medication.

(III) Describe the program's use of Chain-of Custody Record procedures and identify the specific persons/positions responsible in each step of the process, along with the specifications of their duties.

(IV) Include provisions for hardship exception requests to be authorized by the entity's medical director and submitted to the State Opioid Treatment Authority and to SAMHSA for review and approval.

(V) Provide for all considerations given, recommendations for and conditions of hardship waivers, as well as, denials of such to be documented in the clinical record.

(vii) Denial or Rescinding of Take Home Privileges. The entity shall develop, maintain and document implementation of

policies and procedures which govern the process utilized to deny or rescind approval of take-home privileges.

10. Diversions Control: The entity shall develop, maintain and document implementation of a written plan to reduce the possibility of diversion of controlled substances from legitimate treatment to illicit use. The diversion control plan shall, at a minimum, include the following elements:

(i) A process for routine surveillance and monitoring of the internal and external treatment environment to identify diversion problems.

(ii) A process for continuous examination of dosing and take-home dispensing practices to identify weaknesses in the dispensing of medication that could lead to diversion problems.

(iii) Procedures for clients who are dispensed three (3) or more take home doses to receive a minimum of two (2) call-backs annually.

(iv) A process to address identified diversion problems through corrective and preventive efforts.

(v) Specific assignment to the entity's medical and administrative staff for implementation of the diversion control measures and functions identified in the diversion control plan.

11. Dosing: The entity shall develop, maintain and document implementation of written policies and procedures to govern the process of drug dispensing and administration that shall, at a minimum, include the following specifications:

(i) A standardized process that includes the use of identification by photograph shall be utilized to properly establish the identity of each individual before any Opioid Therapy Medication is administered.

(ii) The entity shall maintain current procedures adequate to ensure that each Opioid dependency treatment medication used by the program is administered and dispensed in accordance with approved product labeling.

(iii) Dosing and administration decisions, including prescribing, reassessment and regulation shall only be made by an authorized program physician who is familiar with the most up-to-date product labeling.

(iv) Any deviations from the approved labeling, including deviations with regard to dose, frequency, or the

conditions of use described in the approved labeling shall be specifically documented in the case record.

(v) An authorized program physician shall employ clinical judgment to determine the individual dose of Opioid therapy medication, with consideration of the following stipulations, at a minimum:

(I) The initial dose of methadone administered on the first visit shall not exceed 25 mg.

(II) Subsequent doses of medication shall be:

I. Individually determined based upon the physician's evaluation of the history and present condition of the client.

II. Reviewed and updated as according to the client's treatment plan and in consideration of the following criteria:

A. Cessation of withdrawal symptoms.

B. Cessation of illicit Opioid use as measured by:

(A) Negative drug tests.

(B) Reduction of drug-seeking behavior.

C. Establishment of a blockade dose of an agonist.

D. Absence of problematic craving as measured by:

(A) Subjective report.

(B) Clinical observations.

E. Absence of signs and symptoms of too large an agonist dose after an interval adequate for the client to develop complete tolerance to the blocking dose.

(vi) A process shall be established wherein the dosage to be dispensed shall be verified with the current dosage ordered and ingestion observed and documented by the person who administers the Opioid dependency treatment medication.

(vii) Methadone shall be dispensed in oral form in one liquid dose per container.

(viii) Buprenorphine shall be dispensed in sub-lingual tablets.

(ix) A process shall be established to address the entity's response, in regard to dosing, to individuals who are objectively intoxicated or who are experiencing other problems that would render the administration of methadone unsafe.

12. Split Dosing: The organization shall have a written split dosage policy that shall:

(i) Include input from the program physician in consultation with the multidisciplinary treatment team and the SOTA.

(ii) Accurately reflect that split dosing is guided by outcome criteria that shall include:

(I) The client complains that the dosage level is not holding.

(II) The client exhibits signs and symptoms of withdrawal.

(III) The physician employs peak and trough criteria for split dosing, if appropriate.

(IV) The physician is unable to obtain a peak and trough ration for 2.0 or lower, increasing intervals of dosing may be appropriate.

(V) Addressing the failure of all avenues of stabilization.

(VI) Addressing stabilization failures with the client involving the physician and multidisciplinary team.

(iii) Include provisions for education of the client on the rationale for split dosing and take home medication.

13. Guest Dosing: The entity shall develop, maintain and document implementation of dosing policies and procedures for the provision of medication to a guest client in a program in which the client is not enrolled that shall, at a minimum specify:

(i) The sending program's responsibilities to, at a minimum:

(I) Develop a document to utilize in transmitting all relevant client and dosing information to the receiving agency to request guest dosing privileges.

- (II) Forward this document to the receiving program.
- (III) Provide the client with a copy of the document that was sent to the receiving agency.
- (IV) Verify receipt of the information sent to the receiving program.
- (V) Verify that the client understands all stipulations of the guest dosing process including, but not limited to, fees, receiving program contacts, dosing times and procedures.
- (VI) Accept the client upon return from guest dosing unless other arrangements have been made.
- (VII) Document all procedures implemented in the guest dosing process in each client's case record.
 - (ii) The receiving program's responsibilities to, at a minimum:
 - (I) Verify receipt of the sending program's request for guest dosing privileges and acceptance or rejection of the client for guest medication within forty-eight (48) hours of the request.
 - (II) Communicate any requirements of the receiving program that have not been specified on the document submitted by the sending program.
 - (III) Establish a process for medical personnel to verify dose prior to dosing.
 - (IV) Document all procedures implemented in the guest dosing process in each client's case record.
 - (iii) If guest dosing exceeds fourteen (14) days, a drug screen shall be obtained.
 - (iv) Guest dosing shall not exceed twenty-eight (28) days.

14. Multiple Client Enrollments: The entity shall develop, maintain and document implementation of written policies and procedures established to insure that it does not admit or provide medication for an individual who is enrolled in another Opioid Treatment Program. The policies and procedures shall include the following components, at a minimum:

(i) The State Opioid Treatment Authority shall establish written guidelines, incorporated herein by reference, for participation in a central registry process to aid in the prevention of multiple enrollment of a client in more than one Opioid Maintenance Therapy Program at the same time. Each OMT Program shall provide written documentation of adherence to the State Opioid Treatment Authority guidelines that shall, at a minimum, include the following specifications:

(I) The entity shall make a disclosure to the central registry at each of the following occurrences:

I. A client is admitted for Opioid Maintenance Therapy.

II. A client is transferred to another provider for Opioid Maintenance Therapy.

III. A client is discharged from Opioid Maintenance Therapy.

(II) The entity shall make disclosures in the format and within timeframes established by the State Methadone Authority.

(III) The entity shall limit disclosures to client identifying information and the dates of admission, transfer and discharge.

(IV) The entity shall obtain the client's written consent, in accordance with 42 CFR Part 2, prior to making any disclosures to the central registry.

(V) The entity shall inform each client of the required written consent for participation in the central registry before services are initiated.

(VI) The entity shall deny admission to individuals who refuse to provide written consent for disclosures to the central registry and shall document these denials in the case record.

(ii) The entity shall obtain the client's written consent, in accordance with 42 CFR Part 2, to photograph the applicant at the time of admission. The photograph shall be maintained in the client's case record.

(iii) The entity shall require that all clients show proof of identification in the form of an official state driver's license or a non-driver's license issued by the state's

Department of Public Safety. A copy of current identification will be maintained in the clinical record.

15. Medically Supervised Withdrawal: The entity shall develop, maintain and document implementation of written policies and procedures that govern the processes utilized to withdraw clients from Opioid maintenance medication. At a minimum, the policies and procedures shall include the following specifications:

(i) A process for voluntary medically supervised withdrawal shall be established that shall:

(I) Acknowledge that participation in Opioid Maintenance Therapy is voluntary and that a client is free to leave treatment at any time.

(II) Identify the steps to be taken by the entity when a client and program personnel agree on a need to initiate withdrawal procedures.

(III) Identify the steps to be taken by the entity when the client requests withdrawal against the medical advice of the program's personnel.

(IV) Ensure the availability of a variety of supportive options to improve the chances of a successful episode of medically supervised withdrawal.

(V) Establish the protocol wherein the Opioid Maintenance Therapy Program resumes medication assisted treatment if the client experiences impending or actual relapse.

(ii) A process for involuntary medically supervised withdrawal shall be established that shall:

(I) Identify the circumstance under which involuntary administrative withdrawal procedures will be implemented.

(II) Identify the steps to be taken and delineate the responsibilities of program personnel in implementation of involuntary administrative withdrawal procedures.

(III) Ensure the availability of a variety of supportive options to improve the chances of a successful episode of medically supervised withdrawal.

(IV) Provide for referral or transfer of the client to an appropriate treatment program upon completion of the withdrawal process.

(iii) The entity's medical director shall approve all requests for voluntary and involuntary withdrawal from Opioid Therapy medication.

(iv) Clients who have been determined by the program's medical director or other authorized program physician to be currently physiologically dependent on Opioids may participate in medically supervised withdrawal, regardless of age.

(v) The entity's medical director shall establish each individual's withdrawal schedule in accordance with sound medical treatment and ethical considerations.

(vi) No set dosage reduction schedules shall be established for any patient whether voluntarily or involuntarily participating in medically supervised withdrawal. Dosage reduction schedules shall be based upon objective assessment of each client's unique needs.

(vii) A medically supervised withdrawal schedule for administrative withdrawal shall be for a time period of not less than thirty (30) days, unless otherwise clinically contraindicated. In cases of clinical contraindication, supporting documentation shall be entered in the client's case record by the medical director or a program physician operating under the supervision and authority of the medical director.

(viii) Take-home medications shall not be allowed during medically supervised withdrawal.

(ix) A history of one (1) year physiologic dependence shall not be required for admission to an Opioid Maintenance Therapy Program for supervised withdrawal.

(x) Clients who have two (2) or more unsuccessful detoxification episodes within a twelve (12) month period shall be assessed by the entity's medical director for other forms of treatment.

(xi) An entity shall not admit a client for more than two (2) detoxification episodes in one (1) year.

(xii) Drug screens during detoxification shall be performed as follows:

(I) An initial drug screen shall be performed at the beginning of the detoxification process.

(II) At least one (1) random screen shall be performed monthly during the detoxification process.

16. Women and Pregnancy Services: The entity shall develop, maintain and document implementation of written policies and procedures to address the needs of women which shall, at a minimum, include the following requirements:

(i) The entity shall acknowledge by policy and practice that pregnant women are the number one treatment priority and cannot be denied treatment access solely because of pregnancy.

(I) When an organization is unable to provide services for a pregnant woman, the State Opioid Treatment Authority shall be contacted immediately for assistance with placement.

(ii) The entity shall have a written description of the procedures utilized to:

(I) Inform each female client of the possible risks and benefits of the use of Opioid Maintenance Therapy during pregnancy.

(II) Document in the case record that this information has been provided to the client.

(iii) The entity shall describe in writing and document implementation of the process used to provide pregnant clients with access or referral to:

(I) Prenatal care.

(II) Pregnancy/parenting education.

(III) Postpartum follow-up.

(iv) The nature of services provided in relation to a client's pregnancy shall be documented in the case record and signed or countersigned by the entity's medical director.

(v) When the woman consents to a referral for pregnancy related care, or if the woman is already under the care of a physician for her pregnancy, the entity shall obtain the woman's informed consent to ensure reciprocity in the exchange of pertinent clinical information between the woman's perinatal specialist or obstetrician and the OMT Program.

(vi) When the woman refuses an appropriate referral for prenatal services, the entity shall:

(I) Utilize informed consent procedures to have the client formally acknowledge, in writing, that the Opioid Maintenance Therapy Program offered a referral to prenatal services, but the client refused the offer.

(II) Provide the client with basic prenatal instruction on maternal, physical, and dietary care as part of the Opioid Maintenance Therapy Program counseling services and document service delivery in the clinical record.

(vii) The entity shall provide written documentation of implementation of the following procedures in regard to care for pregnant women:

(I) Clients who become pregnant during treatment shall be maintained on the pre-pregnancy dosage, if effective as determined by the entity's medical director and the client and shall apply the same dosing principles as used with any other non-pregnant person served.

(II) The initial methadone dose and the subsequent induction and maintenance dosing strategy for a person who is newly admitted and pregnant shall reflect the same effective dosing protocols used for all other persons served.

(III) The methadone dose shall be monitored carefully, especially during the third trimester and adjustments made as needed.

(viii) The entity shall describe in writing and document in the clinical record the process utilized if a pregnant woman elects to withdraw from methadone which shall, at a minimum, include the following requirements:

(I) A physician experienced in addiction medicine shall supervise the withdrawal process.

(II) Regular fetal assessments, as appropriate for gestational age, shall be part of the withdrawal process.

(III) Education shall be provided on medically supervised withdrawal and the impact of medically supervised withdrawal services on the health and welfare of unborn children.

(IV) Withdrawal procedures shall adhere to accepted medical standards of care for women who are pregnant.

(V) Withdrawal procedures shall adhere to accepted medical standards regarding adequate dosing strategies.

(VI) When providing medically supervised withdrawal services to pregnant women whose withdrawal symptoms cannot be eliminated, referrals to inpatient medical programs shall be made.

(ix) The entity shall describe in writing and document implementation of policies and procedures, including informed consent, to ensure appropriate post-pregnancy follow-up and primary care for the new mother and well-baby care for the infant.

17. Medication Management: The entity shall comply with all standards set forth in Rule 580-9-44-.13(23-24) of these rules, and, in addition, shall comply with the requirements of this section:

(i) The entity's clinical records and client outcomes shall indicate that medications used in the Opioid Maintenance Therapy Program are sufficient to:

(I) Produce the desired response.

(II) Provide freedom from adverse abstinence symptoms for the desired length of time.

(III) Block the effects of other Opiates without producing euphoria or other undesirable effects.

(ii) The program shall provide written documentation, which indicates all medications used in the Opioid Maintenance Therapy Program are:

(I) Approved by the Food and Drug Administration for the treatment of Opioid addiction.

(II) Dispensed according to product labeling.

(III) Managed using written procedures that ensure secure storage, accurate dosage and safe handling,

(IV) Controlled using a method to ensure that an accurate inventory of all medication in stock is available.

(iii) The entity shall develop, maintain and document implementation of written policies and procedures for dispensing medication used in Opioid Maintenance and Withdrawal Therapy, which shall, at a minimum:

(I) Ensure that the program's medical director or other program physician authorized by the medical director:

I. Initiates all medication orders and/or any dosage change.

II. Documents all medication orders and/or any dosage change in the clinical record.

(II) Ensures that each dose is recorded in the clinical record of the person served.

(III) Ensures that take-home medications are properly labeled, which shall include, at a minimum:

I. Name of Opioid Maintenance Therapy prescribing clinic.

II. Address of Opioid Maintenance Therapy prescribing clinic.

III. Telephone number of Opioid Maintenance Therapy prescribing clinic.

IV. Client's name.

V. Medication name.

VI. Dose.

VII. Physician's name.

VIII. Date filled.

IX. Directions for single use.

X. Warning: Caution; Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed.

(iv) Ensure that that take-home medication is packaged in child-proof containers designed to reduce the risk of accidental ingestion.

18. Client Transfers: The Level I-O Program shall develop, maintain and document implementation of written policies and procedures to effect orderly transfer of clients between substance abuse programs, which shall, at a minimum, address the following specifications:

(i) The entity shall meet the standards set forth in these rules for client transfers.

(ii) A client's request for transfer to another Level I-O Program shall be honored without restriction, even if the client has an outstanding financial balance.

(iii) Records to the receiving substance abuse program shall be provided promptly and shall include, at a minimum:

(I) Original date of admission for the current treatment episode.

(II) Current treatment phase and date entering phase.

(III) Urinalysis results for the past twelve (12) months.

(IV) Dose level, to be confirmed by nursing staff at transferring clinic and documented in the clinical record.

(V) Most recent TB test results and date of test.

(VI) Reason for transfer.

(VII) Other information as requested by the receiving program and specified in an appropriate client authorization for release of information.

(iv) All client records shall be complete and up to date at the time of transfer.

(v) Reports to the DMH Central Registry shall be completed at the time of transfer.

19. Documentation: The entity shall comply with all standards set forth in Rule 580-9-44-.13(21) of these rules, and, in addition, shall comply with the requirements of this section:

(i) Clinical records of clients receiving Opioid Maintenance or Withdrawal Therapy shall include the following documentation:

(I) That clients have been questioned about being pregnant and informed about pregnancy and physiological implications with Opiate maintenance drugs.

(II) Support services were recommended and utilized when needed.

(III) An individualized clinical note for each occurring clinical or medical encounter.

(IV) Each dose of medication administered, with a copy of the physician's order for medication.

(V) Ongoing communication with physicians prescribing psychoactive and/or control medication to clients receiving Opioid Maintenance Therapy services.

(VI) Ongoing communication with Obstetrics and Gynecology physicians providing medical care to pregnant women receiving Opioid Maintenance Therapy services.

20. Support Systems: The entity shall develop, maintain and document implementation of written policies and procedures that define the process utilized to provide client access to support services.

(i) Support services shall include, at a minimum:

(I) Linkage with or access to psychological, medical and psychiatric consultation.

(II) Linkage with or access to emergency medical and psychiatric care.

(III) Linkage with or access to evaluation and ongoing primary medical care.

(IV) Ability to conduct or arrange for appropriate laboratory and toxicology tests.

(V) Direct affiliation with or coordination through referral to more and less intensive levels of care.

(ii) The entity shall maintain up-to-date, written Memoranda of Understanding, collaborative agreements or referral agreements with support systems.

21. Staffing:

(i) Program Sponsor: The Level I-O Program shall have a program sponsor who shall be an Alabama Licensed Practitioner of the Healing Arts with at least two (2) years supervised work experience in a substance related disorders treatment program.

(I) The entity shall provide written documentation of the program sponsor's responsibilities and the processes through which they are implemented, which shall, at a minimum, include:

I. Ensure compliance with all Federal, State and local laws and regulations regarding the use of Opioid agonist treatment medications in the treatment of Opioid addiction.

II. Assume responsibility for all Level I-O Program employees, including all practitioners, agents, or other persons providing medical, rehabilitative, or counseling services at the program.

III. Assign duties of the program coordinator.

IV. Meet the qualifications of a staff member and be included in the listing of personnel authorized access to the medication unit where he/she has access to the medication unit.

(ii) Program Coordinator: The Level I-O Program shall have a full-time program coordinator.

(I) The Opioid Maintenance Therapy Program coordinator shall be:

I. An Alabama licensed Registered Nurse, Nurse Practitioner, Physician, or Physician's Assistant, who has two (2) years direct care substance related disorders treatment experience, or

II. An individual with a master's degree in a behavioral health related field and at least two (2) years direct care substance use disorders treatment experience.

(II) The entity shall provide written documentation of the program coordinator's responsibilities and the processes through which they are implemented, which shall include, at a minimum:

I. Manage the day to day operation of the program as according to duties delegated by the program sponsor.

II. Maintain regular office hours, which coordinate with the operation of the program.

III. Be readily accessible to the State Opioid Treatment Authority.

(iii) Medical Director: The Level I-O Program shall have a medical director who shall be a physician who is licensed to practice in the State of Alabama and who has a minimum of one (1) year experience in the treatment of Opioid dependency.

(I) The entity shall provide written documentation of the medical director's responsibilities and the processes through which they are implemented, which shall, at a minimum, include:

I. Administration of all Level 1-0 medical services performed by the program.

II. Ensure that the Level I-O Program complies with all applicable federal, state and local laws and regulations relative to medical care.

III. Attend weekly staffings with counselors, or document in the client record alternative and equivalent supervisory contact on a weekly basis.

A. When the medical director is unable to attend a weekly staffings, the entity must date the occurrence and provide written documentation of how equivalent supervisory contact was accomplished, e.g. by phone, electronic correspondence, etc.

IV. Maintain ongoing communication with clients' physicians regarding the prescription of psychoactive and/or control medication during Opioid Maintenance Therapy, and to coordinate client care in regard to other medical needs.

V. Maintain ongoing communication with Obstetrics and Gynecology physicians when providing Opioid Maintenance Therapy services to pregnant women.

VI. Perform client physical examinations prior to dosing and provide thorough documentation of each client's Opioid dependency at the time of admission.

VII. Perform annual client physical examinations.

VIII. Authorize:

A. All initial dose orders.

B. All dose and phase changes.

C. All take-home medications.

D. All changes in frequency of take-home medications.

E. Opioid withdrawal protocols.

IX. Delegate responsibility for medical care and procedures to other Opioid Maintenance Therapy Program physicians and physician extenders.

(II) The entity shall provide written documentation that the Level I-O Program's medical director, or a staff physician supervised and assigned by the medical director, is physically present in the clinic a minimum of two (2) hours per week for each fifty (50) clients enrolled in the program.

(iv) Pharmacist: The level I-O Program shall have an Alabama licensed pharmacist on its staff.

(I) The entity shall provide written documentation of the pharmacist's responsibilities and the processes through which they are implemented, which shall, at a minimum, include:

I. Prepare all take-home medication.

II. Conduct, at a minimum, an annual physical drug inventory.

III. Assist in the development of program policies and procedures governing medication administration, dispensing, use and security.

(v) Nursing Personnel: The entity shall have an adequate number of Alabama licensed nurses to assure that all medications utilized during Opioid Maintenance and Withdrawal Therapy are administered in compliance with Alabama Board of Nursing regulations.

(i) Supervise and delegate responsibilities to the Licensed Practical Nurses (LPNs) on staff.

(ii) There shall be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) on site during all hours of the Level 1-0 Program's operation.

(vi) Clinical Supervision: The entity shall have a clinical director who shall provide routine clinical supervision of each Level I-O Program employee who provides treatment and recovery support services.

(vii) All direct care personnel shall have the qualifications as a qualified paraprofessional to provide the specific services delineated in the entity's program description for this level of care.

(viii) The entity shall document the daily availability of an adequate number of personnel to sustain the Level I-O Program as delineated in its operational plan and the rules specified, herein.

(ix) All clients will be assigned to the caseload of a primary counselor. The caseload of each primary counselor shall not exceed forty (40) individuals.

(x) The entity shall document the daily availability of the medical director, or a physician under the supervision and authority of the medical director, during medication dispensing and clinic operating hours, either in person or by telephone.

(xi) The entity shall establish a written protocol for notifying the State Opioid Treatment Authority, within forty-eight (48) hours, of any replacement or other change in the status of the program sponsor or medical director.

22. Training. The entity shall provide written documentation that:

(i) All Level I-O Program personnel complete the core training curriculum, as specified in Rule 580-9-44-.02(3).

(ii) The entity shall provide written documentation that all clinical and medical services staff in a Level I-O Program receive training during the initial twelve (12) months employment and develop basic competencies in the following areas:

(I) Opioid addiction treatment methodologies.

(II) Regulatory requirements for Opioid addiction treatment.

(III) Biopsychosocial dimensions of alcohol and drug use disorders.

(IV) Motivational and engagement strategies.

(V) Pharmacotherapy for Opioid dependency.

(VI) ASAM Patient Placement Criteria.

(VII) Assessment of and service planning to address biopsychosocial needs of individuals with Opioid dependency and related disorders.

(iii) Physicians who dispense methadone and other Opiate replacement drugs must receive a minimum of eight (8) hours of training each year relevant to Opioid Maintenance Therapy approved by SAMHSA and the State Opioid Treatment Authority.

23. Service Intensity: The entity shall develop, maintain and document implementation of written policies and procedures relative to Level I-O service intensity, which shall, at a minimum, include the following specifications:

(i) The dose and intensity of Level I-O Treatment Services shall be established on the basis of the unique assessed needs of each client served.

(ii) The program shall demonstrate appropriate staffing to provide core counseling services.

(I) Issues identified through the assessment and ongoing reassessment process must be addressed directly in a therapeutic setting or referred to an appropriate, qualified entity.

(II) If no clinical services are indicated for a client, appropriate identification shall be documented in the clinical record.

(III) In no case shall counseling services be scheduled less frequent than one session (individualized or group) per month.

24. Length of Service: The entity shall provide written documentation that the duration of treatment in each Level I-O Program shall vary as determined by:

(i) The severity of the client's illness.

(ii) The client's ability to comprehend the information provided and use that information to implement treatment strategies and attain treatment goals.

(iii) The appearance of new problems that require another level of care.

(iv) The client's desire to continue treatment.

Author: Substance Abuse Services Division

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