DEPARTMENT OF MENTAL HEALTH
MENTAL ILLNESS COMMUNITY PROGRAMS
ADMINISTRATIVE CODE

CHAPTER 580-2-9
PROGRAM OPERATION

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580-2-9-.01 Type Of Certificate.

(1) A provider that meets the respective requirements will be issued one of two types of certificates depending upon the number and type of services delivered by the provider. The criteria listed below will be applied at the time an initial Application for Certification is submitted and during the initial and subsequent site visits after the effective date of this edition of the standards.

(a) Mental Health Services Provider. A provider may be certified as a Mental Health Services provider if it provides one or more (but not all) of the services as listed in 580-2-9-.09 thru 580-2-9-.25 in compliance with the standards. The services for which a provider seeks certification should be listed on the Application for Certification and will be specifically reviewed during the on-site visit. The services that a mental health service provider are certified to provide will be listed in the cover letter mailed with the certificate.

(b) Community Mental Health Center. A provider will be certified as a Community Mental Health Center (CMHC) if the requirements listed below are met. The requirements are designed to assure that any provider certified as a CMHC provides the array of services defined below either directly or through specific arrangement with another agency/individual to a broad array of recipients in an identified service area without regard to age, race, language of preference, sex, and degree of psychiatric disability. The services must be coordinated in a manner that assures access to inpatient and residential care and to community supports for adults with serious mental illness and children and adolescents with severe emotional disturbance.

1. The provider must provide the following services as defined in Paragraph 2. below directly through its employees:

(i) Emergency Services,

(ii) Outpatient Services,

(iii) Consultation and Education Services, and

(iv) Partial Hospitalization/Intensive Day Treatment/ Rehabilitative Day Program, and

(v) Must provide residential services either directly through its employees or through agreement with other certified providers.

2. In addition to the specific criteria listed below, the provider must also comply with the applicable sections of the program standards for each program element. For each required program element under the CMHC certificate, the criteria that must be met at the time of initial application and at the time of the first on-site visit and subsequent site visits are specified below. Providers who do not meet all criteria below for each service required to be a Community Mental Health Center (CMHC) at the time of the initial Application for Certification are not eligible to be surveyed as a CMHC. If all the criteria for a CMHC are not met during a site visit, the provider is not eligible for certification as a CMHC. A provider may request certification as a Mental Health Services Provider for those services which do meet the applicable standards.

(i) Emergency Services.

(I) At the time of application:

I. The program description for Emergency Services describes how it will be available 24 hours a day, 7 days a week both by telephone and face-to-face and how consumers are informed about emergency services.

A. Policies/job descriptions include requirements for Emergency Service staff to be on call 24 hours a day, 7 days a week.

B. The Emergency Service program description includes the following crisis intervention services for consumers with serious mental illness or severe emotional disturbance.

(A) Demonstrated capacity to gain access to inpatient psychiatric services.

(B) Capability to assure that consumers who are in jail can be evaluated and medications, if any, continued unless not permitted by the jail.

(C) Capacity to ensure that consumers who are deaf/hard of hearing can gain access to linguistically appropriate emergency care.

(II) At the time of the initial and subsequent site visit(s):

I. There is evidence in consumer records and/or other documents that services described in (i) above were provided.

II. In the sole discretion of the DMH, the number of consumers served demonstrates that there is a creditable effort to provide emergency services.

(ii) Outpatient Services.

(I) At the time of application:

I. Outpatient services are listed on the provider's organizational chart.

II. The Outpatient program description has admission criteria inclusive of all ages, persons with serious mental illness/severe emotional disturbance, and persons discharged from inpatient psychiatric treatment.

III. Specialty services for children and elderly are described.

IV. Policies/job descriptions require staff treating children and elderly to have the required credentials.

V. Specialty services for persons discharged from an inpatient psychiatric setting and for persons with a serious mental illness/severe emotional disturbance must include the following:

A. Evaluation and medication monitoring by a psychiatrist.

B. Outreach capability to provide services to consumers in their usual living situation.

C. Provision of case management services in accordance with the program standards either directly or through an arrangement approved by the Alabama Department of Mental Health.

D. Screening for admission to state psychiatric hospitals as evidenced by a written agreement with the local 310 Board (if not a 310 Board), relative to coordination of screening petitions for involuntary inpatient commitment for consumers of the CMHC.

E. Follow-up on all missed appointments for all high risk consumers including those who:

(A) Have been discharged from psychiatric inpatient care within the past 12 months.

(B) Were decompensating at the last visit.

(C) Are considered potentially harmful to self or others.

(II) At the time of the initial and subsequent site visit(s):

I. A review of a sample of consumer records demonstrates that the services described in the application are provided to consumers.

II. In the sole discretion of the DMH, the number and type of consumers served demonstrates that there is a creditable effort to provide Outpatient specialty services as described in I. through V. above.

III. The staff employed in the Outpatient program meet the credential requirements for both general and specialty services.

(iii) Consultation and Education Services

(I) At the time of application:

I. Application materials describe planned consultation and education activities to include both program and consumer consultation and public education.

(II) At the time of the initial and subsequent site visit(s):

I. Consultation and education activities have been provided and documented as described in the application materials.

(iv) Partial Hospitalization/Day Treatment Services.

(I) At the time of application:

I. There is a program description for either Partial Hospitalization, Intensive Day Treatment, or Rehabilitative Day Program that complies with the respective program standards.

II. The proposed staffing pattern conforms to the applicable standards in the Mental Illness Program Staff section and the respective program standards.

III. The organizational chart includes at least one type of day treatment service.

(II) At the time of the initial and subsequent site visit(s):

I. The schedule of activities and the consumer records document that the program description has been implemented in accordance with the respective certification standards for the service.

II. Staff meet the credential requirements.

III. In the sole discretion of the DMH, the number of consumers served demonstrates that there is a creditable effort to provide Partial Hospitalization/Day Treatment Services.

(v) Residential Services

(I) At the time of application:

I. There must be available either a written program description if residential services are offered directly by the provider or a written agreement with another residential treatment services provider certified under 580-2-9-.18 relative to delivery of residential services.

II. If the provider is applying to deliver residential services directly, the program description and proposed staff must conform to the Residential Services standards.

III. If the provider proposes to offer this service through arrangement with another provider, there must be a written agreement that identifies the services to be provided and the manner in which admission to and follow-up after discharge will be coordinated by the provider.

(II) At the time of the initial and subsequent site visit(s):

I. The consumer records and program documentation validate that the program is operating in accordance with the program description and the Residential Services Standards.

II. There is documentation of the number of the provider's consumers that have received residential services through the written agreement with another certified residential service provider. The consumer records and any other relevant documents clearly demonstrate coordination of admission and follow-up after discharge from the provider.

III. In the sole discretion of the DMH, the number of consumers served demonstrates that there is a creditable effort to provide residential services.

3. Because Community Mental Health Centers are expected to offer a broad array of services to a demographically and psychiatrically diverse population, the following additional requirements regarding the overall operation of the agency must be met:

(i) At the time of the first site visit, the agency should have:

(I) Staff capable of providing specialty outpatient services to children, adolescents, adults, and older adults.

(II) Should be able to demonstrate community outreach efforts designed to promote access from all age groups with particular emphasis on those who are seriously mentally ill or severely emotionally disturbed.

(III) The number of recipients both total and by service type and the services provided are acceptable for the time period that the agency has been operational and are roughly proportionate to the number of consumers and types of services provided by agencies similarly certified.

80-2-9-.02 Governing Authority.

(1) The provider must submit written documentation to DMH of its source of authority through its Articles of Incorporation (or Charter) and Bylaws.

(2) The Bylaws or Articles specify that the Board of Directors is responsible for the overall operation of the program. The minutes of the meetings of the Board of Directors document that the Board is carrying out the designated responsibilities.

(3) The Board shall assure compliance with 580-3-26, Human Rights Committee in Certified Community Programs.

(4) The Board shall assure compliance with the Nurse Delegation Program.

(5) The Board shall assure compliance with applicable federal, state, and local laws. Reviews by the Alabama Department of Mental Health only certify compliance with standards issued by it.

Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: March 5, 2010; effective July 19, 2010.

580-2-9-.03 Mental Illness Program Staff.

~~(1) The executive director of a provider shall be a full-time employee and shall have at least a master's degree in an administrative or mental health related field and at least five years of post master's progressive managerial experience in a mental health treatment setting. The job description for the executive director includes overall responsibility for the operation of the agency.~~

(2) There shall be a psychiatrist, as a full-time or part-time employee or a consultant to the provider who is responsible for medical aspects of consumer psychiatric care as delineated in the job description or employment contract. Access to on-call psychiatric services must be available 24 hours a day, 7 days a week and must be documented.

~~(3) There shall be a fulltime Clinical Director (in addition to the Executive Director) who has full-time responsibility for the quality of clinical care and the appropriateness of clinical programs as delineated in the job description. The Clinical Director shall have as a minimum either a master's degree in psychology, social work, counseling, or psychiatric nursing and have a minimum of 3 years post master's relevant clinical experience or shall be a physician who has completed an approved residency in psychiatry.~~ Notwithstanding any other provision of this regulation, the DMH/MR Commissioner may waive any provision set forth herein when, in his or her sole discretion, it is reasonable to do so based on circumstances at the time.

(4) There is an organizational chart that depicts functional areas of responsibility and lines of supervision for all programs operated by the agency.

(5) Each direct treatment service functional area of responsibility on the organizational chart shall be coordinated by a member of the staff who has a master's degree in a mental health related field and at least 2 years post master's supervised experience in a direct service area, except program coordinators of Adult Rehabilitative Day Programs and Residential Care Homes shall have, at a minimum, at least a bachelor’s degree or RN plus 2 years supervised post degree mental health related experience.

(6) For residential services, there shall be a registered nurse or licensed practical nurse as a full-time or part-time employee or a consultant to the provider who is responsible for supervision of delegation of medication assistance to the unlicensed personnel. Access to an on-call nurse must be available 24 hours a day, 7 days a week. Provider will implement policies and procedures approved by their Board of Directors requiring full compliance with the Alabama Board of Nursing regulation 610X7.06 Alabama Department of Mental Health Residential Community Programs.

(7) All treatment staff who provide therapy and clinical assessments for mental illness consumers must have a master's degree in a mental health related field.

(8) Treatment staff who meet (7) but do not have 2 years post master's supervised clinical experience must receive supervision from a therapist who has a Masters Degree in a mental health related field and at least 2 years post master's experience in a direct service functional area. The supervision must include 2 face-to-face supervisory sessions per month (minimum 1 hour per session) in addition to case staffing and other Performance Improvement functions for 2 years post master's supervision.

(9) The credentials of staff shall be appropriate for the levels and types of services they are providing.

(10) Staff who provide services primarily to specific subgroups (such as people who are elderly or deaf/hard of hearing) shall have either 2 years supervised experience with the specific subgroup or 2 specialized graduate courses related specifically to the subgroup or 12 continuing education credits of training in the specialty area to work with such subgroups or shall receive supervision by a staff member with the required training/experience.

(11) Staff who provide treatment and clinical services primarily to children and adolescents shall have 2 years supervised experience serving children/adolescents or shall receive supervision in this area 1 hour a week by a staff member with 2 years experience working with children and adolescents and shall receive 20 hours of specialized training per year for 2 years from the date they begin providing such services.

(12) Teachers who provide educational service to children must be certified for the type of class they are teaching.

(13) Case Managers must complete a case management training program approved by DMH.

(14) All staff who transport consumers shall have a driver's license valid in Alabama.

(15) Documentation of all required supervision must include the following information for each supervisory session:

(a) Name and signature of supervisor.

(b) Name and signature of employee.

(c) Date of supervision.

(d) Amount of time in supervisory session.

(e) Brief description of topics covered in session.

(16) The Board shall establish a policy describing the manner in which background checks will be conducted prior to employment/engagement on all employees, volunteers, and agents. All employees/volunteers/agents of the provider will have a background check prior to employment.

(17) Students who are completing a graduate degree in psychology, counseling, social work, or psychiatric nursing may be used for direct services under the following conditions:

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

(b) The student receives a minimum of one hour per week direct clinical supervision (face-to-face) from a licensed/certified mental health professional having at least 2 years post master's experience in a direct service functional area.

(c) The student's clinical notes are cosigned by the student's supervisor described in (b) above.

(18) All staff having direct service contact with consumers must be trained in professionally accepted management of aggressive/assaultive behavior and crisis intervention techniques. The training must have been within the past 2 years, and the training must have been conducted prior to the employee working alone with consumers.

(19) All staff who have direct service contact with consumers shall be trained in infection control. Staff shall be trained prior to working with consumers and annually thereafter.

(20) All staff who have direct service contact with consumers shall receive initial training on the following topics:

(a) Diagnostic categories.

(b) Classes of psychotropic medications.

(c) Recovery orientation.

(d) Interaction with consumers and families.

(21) Each program provides training for all staff on abuse and neglect and all state laws pertaining to abuse and neglect including reporting required by the Department of Human Resources. Training is required for all new employees prior to working alone with consumers and for everyone on an annual basis.

(22) There shall be evidence that each employee who has direct service contact with consumers has an annual tuberculosis skin test or clearance letter from a licensed physician.

(23) Vacancies in the Executive Director and Clinical Director positions shall be reported to the Department of Mental Health immediately.
Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
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Filed: August 15, 2018.

580-2-9-.04 Consumer Protection. REPEALED

(1) There must be written policies and procedures that protect the consumer's welfare, the manner in which the consumer is informed of these protections, and the means by which these protections will be enforced. The legal guardian of a minor, except where the minor is above the age of 14 and chooses not to involve parents consistent with state law, will be given a copy of the consumer's rights and a copy of the grievance policies. Documentation must exist, unless waived by a minor at or above the age of 14 that demonstrates that family members of a minor receive a copy of the consumer's rights written information and grievance policies. The written policies and procedures shall, at a minimum, address the following rights:

(a) The right to privacy.

(b) The right to confidentiality and access to consumer records.

(c) The right to access upon requests all information in the consumer's mental health, medical, and financial records consistent with applicable laws and regulations.

(d) The right to manage personal funds.

(e) The right to access funds when the provider is payee.

(f) The right to complaint and grievance procedures.

(g) The right to be informed of the financial aspects of treatment.

(h) The right to be informed of the need for parental or guardian consent for treatment, if applicable.

(i) The right to a written statement of services to be provided.

(j) The right to give informed consent prior to being involved in research projects.

(k) The right to be protected from harm including any form of abuse, neglect, or mistreatment.

(l) The right to have access to and privacy of mail, telephone communications, and visitors for consumers in residential or inpatient settings.

(m) The right to have access to courts and attorneys.

(n) The right to enforce rights through courts or appropriate administrative proceedings.

(o) The right to be informed of commitment status, if any.

(p) If committed, the right to be included in the community with appropriate and adequate supports on completion of or in conjunction with the terms of commitment.

(q) The right to be accorded human respect and dignity on an individual basis in a consistently humane fashion.

(r) The right to refuse mental health services without reprisal except as permitted by law.

(s) The right to be informed of the means for accessing advocates, an ombudsman, or rights protection services.

(t) The right to be free from seclusion, restraint, drugs, or other interventions administered for purposes of punishment, discipline, or staff convenience.

(u) The right to a well-balanced diet if in inpatient or residential.

(v) The right to assistance in accessing medical and dental care if in residential and inpatient.

(2) Each program affords every consumer the right to privacy relative to their treatment and care, unless contraindicated by clinical determination made by professional staff for therapeutic or security purposes.

(a) Emergency determinations limiting privacy shall be reviewed and documented frequently.

(b) Each program respects consumers' privacy during toileting, bathing, and personal hygiene activities.

(c) Each program allows consumers to converse privately with others and to have private access to telephone and visitors at reasonable hours.

(d) Searches of a consumer or his/her living area and personal possessions are only conducted when it is documented that the program director deems such to be necessary for the safety and security of the consumer, others, and/or the physical environment. The consumer and a witness must be present during a search unless there is documentation why the consumer could not be present.

(e) Each program has procedures established for conducting searches, which observe and adhere to the consumer's right to be accorded human respect and dignity on an individual basis in a consistently humane manner.

(f) In residential programs, written policies and procedures require that staff alert consumers prior to entering consumer living areas.

(g) Written and informed consent must be signed by the personal representative of a consumer less than 14 years of age before photographs are taken and the photograph is to be returned to the personal representative upon request when the consumer is discharged.

(3) Each program ensures that all information in a consumer's record(s) is kept confidential, including any

financial information, in accordance with state and federal laws and regulations.

(a) Each program ensures that access to clinical records is restricted to individuals, entities, and instances permitted by applicable state and federal law and regulation.

(b) No consumer's record(s) is released to other individuals or agencies without the written, informed consent of the consumer except for requests in accordance with state and federal laws and regulations (e.g. emergencies) and so documented.

(c) Each program is responsible for the safekeeping of each consumer's records and for securing it against loss, destruction, or use by unauthorized persons.

(4) Each program has established procedures regarding the content of a consumer's records and procedures for release or disclosure of parts thereof.

(a) Upon request by a consumer/personal representative for access to the contents of his/her records, the program makes a clinical assessment to determine whether such access would or would not be detrimental to the consumer's health or present a threat of physical harm to a third party. Additional requests may be made at any time.

(b) Each program has established an appeals procedure regarding denial of the disclosure of the content of a consumer's records.

(5) Consumers shall manage their personal fund unless there is a payee, guardian, or similar appointee who manages the account for them.

(a) Any limitations placed by the provider on a consumer's right to manage his or her personal funds shall be time limited and can only be made

1. after a specific assessment of the consumer's ability to manage funds,

2. after the consumer has been fully informed of the limitation, and

3. in consideration of the consumer's individual treatment plan as it relates to personal finances.

(b) The provider must establish a written, Board approved policy addressing:

1. The procedures for consumers to gain access to their personal funds when the provider is the representative payee or otherwise the custodian of the consumers' personal funds.

2. Any limitations on the manner and frequency in which funds can be accessed.

3. Any limitations on the amount of funds that can be kept in the consumer's personal possession in a residential program.

4. Requirements for the provider on the management, at least quarterly accounting of all expenditures, and reporting of consumer personal funds when the provider is the representative payee or custodian of personal funds.

5. Requirements for obtaining the consent of the consumer or personal representative for the provider to manage consumer personal funds when the provider is not the representative payee.

6. Any expenditure must be exclusively for the consumer's use or benefit.

(c) Funds in excess of what is needed to maintain the consumer's personal fund account will be placed in an interest bearing account accrued to the consumer's account.

(6) Prior to or promptly upon admission, each program provides every consumer/personal representative a concise written statement of rights and responsibilities along with procedures to be followed to initiate, review, and resolve allegations of rights violations.

(a) Each program obtains from the consumer a written verification of receipt of statement of rights and grievance procedure information.

(b) Promptly upon admission, or as soon as the consumer's condition permits, each program provides the

consumer/personal representative a verbal orientation regarding rights, complaint procedures, and responsibilities as consumers in language and terms appropriate for the consumer to understand.

(c) At a minimum, the complaint/grievance procedures include:

1. The name and telephone number of a designated local contact within the program. The designated person shall be able to inform consumers of the means of filing grievances and of accessing advocates, ombudsmen, or right protection services within or outside the program.

2. Rights information is posted in commonly used public areas of residential facilities where consumers live and also where they receive services.

3. Such notices shall include the 800 numbers of the DMH Advocacy Program, federal protection and advocacy system, and local Department of Human Resources.

4. Programs assure that consumer access to advocates and the grievance/complaint process occurs without reprisal.

(7) Upon admission, or as soon as clinically appropriate, the facility provides every consumer a written statement of services that will be provided to the consumer and related charges, including limitations placed on the duration of services and/or charges related to such services.

(a) Consumers/personal representatives who are responsible for charges for services are informed of any changes in services or limitations placed on duration of services as they occur during treatment.

(b) Consumers who are primarily responsible for payment of charges for services are informed in writing of their eligibility for reimbursement by third party payers for service rendered and assisted as needed with application.

(8) Consumers are informed of the need for parental or guardian consent for treatment, if appropriate.

(9) Consumers are informed on an individual basis, when needed, concerning services provided, with information

presented in a setting and in the language the consumer prefers and in terms appropriate to the consumer's condition and ability to understand.

(a) Upon admission, the program provides every consumer/personal representative a written statement of the services to be provided. The program shall provide the consumer with written notification when any changes or limitations in services or charges occur.

(10) Each program will provide any consumer/personal representative who is asked to participate in a research or experimental project full information regarding procedures to be followed before consent is sought. The information presented shall follow the General Requirements for Informed Consent as cited in the Code of Federal Regulations 45 CFR 46.116, Department of Health and Human Services, National Institute of Health, Office for Protection from Research Risks: "Protection of Human Subjects".

(a) Each program seeks the written, informed consent of the consumer/personal representative for participation in research or experimental procedures.

(b) The consumer/personal representative may withdraw or withhold consent at any time.

(c) The consumer's/personal representative's withdrawal of consent to participate in an experimental or research project will not be used in a coercive or retaliatory manner against the consumer.

(11) Without regard to competency or legal restrictions, each program affords every consumer the same dignity and respect as other individuals of society.

(12) Consumers shall receive treatment and care in an environment which is safe, humane, and free from physical, verbal, or sexual abuse, neglect, exploitation, or mistreatment.

(a) Each program actively investigates and maintains investigation documentation for any suspected abuse and/or neglect of consumers.

(b) Acts or alleged acts which are applicable under state and local laws are reported for investigation and/or disciplinary action.

(c) Each program provides each staff upon employment or promptly thereafter a written policy statement regarding abuse and neglect. The statement is prominently displayed and available in the program or facility.

(d) Each day and residential program employs sufficient numbers of qualified staff in accordance with approved program descriptions to protect consumers from abuse and neglect.

(e) Each program will inform the personal representative of a consumer less than 14 years of age of all special incidents verbally and in writing as documented in the consumers file with the time and number called and the letter is sent the next business day after the incident.

(13) Unless contraindicated for individualized therapeutic or security reasons, each program has in place procedures affording consumers privacy in receiving visitors, receiving or sending communications by sealed mail, direct contact and telephone communications with persons both inside and outside the facility or program.

(a) Every consumer is allowed visitation and opportunity for private conversation with members of his/her family, friends, and significant others.

(b) Consumers who are deaf shall have ready access to adaptive telecommunication devices in order to make and receive telephone calls.

(c) Consumers are allowed to send and receive mail without hindrance.

(d) Consumers are provided adequate opportunities for interaction with members of the opposite sex. Specific interactions may be prohibited by the rules of the program and/or state and local laws.

(e) No restrictions are imposed by the program which would prohibit the consumer from communicating with advocacy officials, the court which ordered confinement, or

the consumer's legal counsel, family or significant others, or personal physician, unless legally restricted.

(14) Attorneys and/or court representatives are allowed to visit privately and communicate with consumers at reasonable times.

(a) Unless a legal determination of incompetence has been made, every consumer is free to access courts, attorneys, and administrative procedures or to participate in those activities generally requiring legal representation, without fear or reprisal, interference, or coercion.

(15) Promptly upon admission, each program or facility provides each legally committed consumer a concise written statement describing his/her commitment status, the requirements of the commitment, and the length of the commitment.

(a) Information regarding consumer rights complaint and appeal procedures relative to legal commitment is made available to consumers in the language they prefer and in terms appropriate for them to understand.

(16) Consumers legally committed to mental health services do not lose any rights to be included in the community with appropriate and adequate supports on completion of or in conjunction with the terms of commitment except as provided in the commitment order.

(a) Prior to termination of the commitment order, the program develops, with the active participation of the consumer, a transition plan which includes referral to community support services necessary and available to ensure the consumer's successful transition.

(17) Consumers are, without fear of reprisal, able to refuse mental health treatment, except when refusals are not permitted under applicable law. Such refusal of mental health treatment shall be documented in the consumer's record.

(18) Without fear of restraint, coercion, interference, discrimination, reprisal, or threat of discharge, consumers and others acting on their behalf are free to access available protection and advocacy services.

(19) Consumers are advised whenever special equipment, such as two-way mirrors or cameras, is used. A written, informed consent must be signed by the consumer when used in non-emergency situations.

(20) Each consumer's personal liberty must be respected to the fullest extent possible with services provided in the least restrictive environment necessary and available. Liberty and/or rights must not be abridged unless the qualified staff documents a specific, clinical need to do so, consistent with treatment needs, applicable requirements of law, applicable judicial orders, and the rights of others.

(21) Consumers of mental health services have the same general rights as other citizens of Alabama. A provider of mental health services should assure that such rights are not abridged by the provider's policies, procedure, or practices. These rights include but are not limited to the following:

(a) The right to exercise rights as a citizen of the United States and the State of Alabama.

(b) The right to be served through general services available to all citizens.

(c) The right to choose to live, work, be educated, and recreate with persons who do not have disabilities.

(d) The right to be presumed competent until a court of competent jurisdiction, abiding by statutory and constitutional provisions, determines otherwise.

(e) The right to vote and otherwise participate in the political process.

(f) The right to free exercise of religion.

(g) The right to own and possess real and personal property. Nothing in this section shall affect existing laws pertaining to conveyance of personal property.

(h) The right to make contracts.

(i) The right to obtain a drivers license on the same basis as other citizens.

(j) The right to social interaction with members of either sex.

(k) The right to marry and divorce.

(l) The right to be paid the value of work performed.

(m) The right to exercise rights without reprisal.

(22) For consumers in residential or inpatient programs, to be assisted in obtaining access to dental and medical care, including vision and hearing services.

(23) Consumers in residential programs have the right to a well-balanced diet that meets his/her daily nutritional and special dietary needs.

(24) Each program provides consumers in residential programs with safe and humane physical and psychological environment(s) in accordance with applicable federal and state laws and DMH standards of certification and licensure. Each program provides safety precautions to promote the individual welfare of all consumers. The environment shall at a minimum provide:

(a) comfortable living and sleeping areas

(b) clean and private bathroom facilities

(c) attractive and adequately furnished visiting and living rooms

(d) clean and comfortable dining facilities

(e) facilities and equipment for laundering services

(f) safe and sturdy furnishings in good repair

(g) adequate provisions for smoking and/or non-smoking preference

(h) adequate and decorative room décor

(i) space and materials for leisure time and recreational activities.

(j) Each program ensures regular housekeeping and maintenance to assure safe and clean conditions throughout the facility or program.

(k) Unless contra-indicated for therapeutic or security purposes, consumers are allowed regular access to the outdoors.

(25) The consumer's personal health and hygiene needs are recognized and addressed in a safe and humane manner.

(26) In addition to treatment for mental disorders, every consumer is provided prompt assistance in accessing medical and dental treatment.

(a) Consumers are referred to other health and/or dental services as deemed necessary by qualified staff.

(b) No program prohibits a consumer from accessing dental or medical services of his/her choice. Such should not be construed to be an obligation for the program to provide/pay for such services.

Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
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580-2-9-.05 Reserved
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580-2-9-.06 Consumer Records.

(1) The provider shall implement written policies and procedures approved by the Board that prohibit creation after the fact, alteration, or falsification of original administrative or clinical documentation in order to make it appear that the documentation is original, factual, or occurred at some time other than it actually did to give the appearance of on-going compliance with these standards or other applicable regulations.

(2) A single case file must be established for each consumer which includes any clinical and case management documentation. The case file may be maintained in physical or electronic format. All requirements in this section apply regardless of format.

(3) If the consumer is involved in more than one program, ready access to consumer information necessary for the safety of the consumer, obtaining emergency medical attention and coordination of services across programs shall be assured.

(4) The provider must describe in writing and maintain a system that provides for the control/location of all case files.

(5) The provider must establish a system to secure consumer records from unauthorized access.

(6) The job descriptions document that a specific staff member is responsible for the storage and protection of consumer records in each location where records are stored.

(7) All entries and forms completed by the service provider in the consumer record shall be dated and signed with name and credentials/position. The entries shall be made in ink and be legible or be done electronically.

(8) Corrections are made in a manner that clearly identifies what is being corrected, by whom, and the date of correction. White-out is not permitted.

(9) Following the completion of Intake and assignment for treatment, the following information, if available, shall be recorded in the consumer record:

(a) Consumer identifying data including:

1. Case number.

2. Consumer name.

3. Date of birth.

4. Sex.

5. Race/ethnic background.

6. Hearing status.

7. Language of preference.

8. Home address.

9. Home telephone number.

10. Next of kin or person to be contacted in case of emergency.

11. Marital status.

12. Social Security number.

13. Referral source.

14. Reason for referral.

15. Date of admission to the program.

16. Admission type (new, readmission).

17. Special supports for consumers who have mobility challenges, hearing or vision loss, and/or limited English Proficiency.

(b) Documentation of the Intake must include information, as appropriate, from among the following:

1. Family history.

2. Educational history.

3. Relevant medical background.

4. Employment/vocational history.

5. Psychological/psychiatric treatment history.

6. Military history.

7. Legal history.

8. Alcohol/drug abuse history.

9. Mental status examination.

10. History of trauma.

11. Thoughts and behavior related to suicide.

12. Thoughts and behavior related to aggression.

(c) Assignment of a diagnosis (latest DSM version) substantiated by an adequate diagnostic database and, when indicated, a report of a medical examination. The diagnosis must be signed by a licensed physician, a licensed

psychologist, a licensed professional counselor, a certified registered nurse practitioner, or licensed physician's assistant. A consumer unknown to the provider must be seen face-to-face by a licensed physician, certified registered nurse practitioner, or licensed physician's assistant prior to writing a prescription for psychotropic medication, except in the case of a documented emergency.

(d) A description/summarization of the significant problem(s) that the consumer is experiencing, including those that are to be treated and those that impact upon treatment.

(e) A description of how linguistic support services will be provided to consumers who are deaf or have limited English proficiency including a signed waiver of free language assistance if the consumer who is deaf or who 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 18 can be used as interpreters.

(f) A written treatment plan that includes elements defined in (g) below completed by the fifth (5^{th}) face-to-face outpatient service ,within ten (10) working days after admission in all day programs and residential programs, or within other time limits that may be specified under program specific requirements.

(g) A treatment plan that:

1. Represents a person-centered, recovery-oriented treatment planning process through which consumers are assisted to articulate their vision and hope for how their lives will be changed for the better within three to five years (long term recovery view), to identify short-term outcomes that will assist in achieving the recovery goal (treatment goals), and to specify objectives and related services and supports necessary to overcome barriers to achieving the outcomes (necessary services and supports).

2. Identifies needed safety interventions based on history of harm to self or others.

3. Uses a strength-based approach to treatment planning by identifying consumer and environmental positive attributes that can be used to support achievement of goals and objectives.

4. Identifies psychiatric, psychological, environmental, and skills deficits that are barriers to achieving specific measurable outcomes.

5. Identifies treatment and supports that are needed to address barriers to achieving desired therapeutic goals, including supports for consumers who have mobility challenges, hearing or vision loss, and/or limited English proficiency.

6. Is approved in writing by a licensed physician, certified nurse practitioner, licensed physician's assistant, licensed psychologist, licensed certified social worker, a licensed marriage and family therapist, a registered nurse with a master's degree in psychiatric nursing, or a licensed professional counselor.

(h) Each consumer and significant other (with the consumer's consent) are invited to actively participate in the formulation and modification of the individual treatment plan. The treatment planning process includes the consumer's signature/mark on the treatment plan to document the consumer's participation in developing or revising the plan, unless clinically contra-indicated. If the consumer agrees to involve significant others in the treatment planning process, a HIPAA compliant authorization for release of information for that party(ies) is (are) signed by the consumer.

(i) Written assessments of the consumer's progress in relation to the treatment plan must be documented at the intervals described below:

1. For each outpatient contact.

2. For residential and Rehabilitative Day Program consumers every two weeks.

3. For partial hospitalization, each service delivered should be documented every day.

4. For Intensive Day Treatment and Child and Adolescent Day Treatment on a weekly basis written or co-signed by the program coordinator/primary therapist. A daily attendance record listing the activities scheduled and attended for each consumer will be maintained in each consumer's record.

5. For Rehabilitative Day Programs every 2 weeks written by a program staff member and co-signed by the program coordinator/case responsible staff member with equivalent credentials. A daily attendance record listing the activities scheduled and attended for each consumer will be maintained in each consumer's record.

6. Progress notes must include the following:

(i) Date.

(ii) Amount of time.

(iii) Setting/location.

(iv) Signature.

(v) Description of services/interventions provided.

(vi) Consumer's response to services/interventions.

(vii) Number of consumers present for group therapy/counseling.

7. In all programs and settings whenever Individual, Family, or Group Therapy/Counseling are provided, such services shall be provided and documented consistent with all requirements for such services described in 580-2-9-.09 (4)(c),(d), and(e). Group Therapy/Counseling progress notes must support that a process-oriented service involving group dynamics was provided. Group Therapy/Counseling for adults may not exceed 15 consumers present or 10 for children and adolescents.

(j) Residential and all day program treatment plans that are reviewed and updated at 3 month intervals or earlier if needed.

(k) Outpatient consumer treatment plans that are reviewed and updated every twelve 12 months.

(l) A medication chart containing a profile of all medication reported by the consumer at intake and an ongoing account of all medications. The chart must contain all of the following information:

1. Both psychotropic and non-psychotropic medications.

2. Both medications prescribed by the providers and by other practitioners.

3. Non-prescription medications.

4. For each category (provider-prescribed, other-prescribed, non-prescription) either a listing of medication or the notation of “none”.

5. Periodic updates at the frequency defined by the provider’s written policy.

(m) For medications prescribed by the provider: The name, strength and dosage of the drugs, the date prescribed, the date refilled, number of refills permitted, and the prescribing physician's name.

(n) The provider will have a system for tracking due dates for injections administered by the provider and scheduling consumers accordingly.

(o) At discharge or 180 days after receipt of last service, documentation completed within 15 days specifying the status of the case.

(p) A written authorization for disclosure covering each instance in which information concerning the identity of, diagnosis, prognosis, treatment, or case management of the consumer is disclosed. Each authorization for disclosure must contain all of the following information:

1. The name of the program that is to make the disclosure.

2. The name or title of the person to whom, or organization to which, disclosure is to be made.

3. The full name of the consumer.

4. The specific purpose or need for the disclosure.

5. The extent and/or nature of information to be disclosed.

6. A statement that the authorization is subject to revocation by the consumer or his agent at any time except to the extent that action has been taken in reliance thereon. In the case of those individuals whose release from confinement, probation or parole is conditioned upon his/her participation in a treatment program, the authorization may not be revoked.

7. A specification of the date (no more than 2 years away as long as the original purpose/need still exists), event, or condition upon which the authorization will expire without express revocation.

8. The date on which the authorization is signed.

9. The signature of the consumer (or agent if applicable). There should be 2 witnesses to the consumer's signature if the consumer signs with a mark (e.g. signs with an "X") or if authorization if given by telephone. When authorization is given by telephone, the consumer's actual signature is obtained at the earliest opportunity.

10. Documentation that authorization was obtained through interpretation or translation when the consumer is deaf or limited English proficient.

(q) A consent for follow-up form which authorizes contact for up to one year after case closure.

Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: **New Rule:** March 5, 2010; effective July 19, 2010.

580-2-9-.07 Performance Improvement. REPEALED

(1) The provider shall operate and maintain a Performance Improvement (PI) System that is designed to identify and assess important processes and outcomes, to correct and follow-up on problems, to improve the quality of services provided, and to improve consumer and family satisfaction with services provided. The PI System shall provide meaningful opportunities for input concerning the operation and improvement of services from consumers, family members, consumer groups, advocacy organizations, and advocates.

(2) The PI System shall be described in writing and shall include, at a minimum, the following characteristics:

(a) Identifies and covers all program service areas and functions including subcontracted consumer services.

(b) Is reviewed and approved by the Board of Directors/Governing Body at least every 2 years and when revisions are made.

(c) Outlines the provider’s mission related to Performance Improvement.

(d) Contains the provider’s goals and objectives related to Performance Improvement.

(e) Defines the organization of PI activities and the person(s) responsible for coordinating the PI System.

(f) Defines the methodology for the assessment, evaluation, and implementation of improvement strategies for important processes and outcomes.

(g) Specifies the manner in which communication of Performance Improvement findings and recommendations for all 6 PI components is done at the governing body, clinical and administrative supervisory levels, staff levels and the manner in which it is documented.

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

(i) Specifies that the agency will participate in all required performance indicators and Quality Improvement Reporting requirements as specified by the DMH Mental Illness Performance Improvement Committee.

(j) Requires that the person(s) responsible for coordinating the agency's PI System attend training on procedures for reporting Special Incidents.

(k) Specifies the manner of cross-departmental and cross-discipline staff input from all levels of the agency regarding the selection of QI indicators to be monitored and improvement activities to be implemented.

(l) Specifies the manner of consumer and family member input regarding the selection of QI indicators to be monitored and improvement activities to be implemented.

(m) Where applicable, ensures that the manner of data collection assures consumer/family member confidentiality.

(n) The plan is implemented as written.

(3) The Performance Improvement component of the PI System shall, at a minimum, include the following:

(a) A description of a process for periodic and timely review of any deficiencies, requirements, and Quality Improvement suggestions related to critical standards from DMH Certification site visits, Advocacy visits, and/or from other pertinent regulatory, accrediting, or licensing bodies. This shall include a specific mechanism for the development,

implementation, and evaluation of the effectiveness of Action Plans designed to correct deficiencies and to prevent reoccurrence of deficiencies cited.

(b) A description of a process for conducting an administrative review of consumer records at 6 months after opening and at closure to determine that all documentation required by these standards and agency policy/procedure is present, complete, and accurate.

(c) A review of aggregate findings from the administrative and clinical review of consumer records at least annually with recommendations and actions taken for improvement as indicated by the data.

(d) There is evidence that the Performance Improvement plan is implemented as written.

(4) The Quality Improvement component of the PI System shall, at a minimum, include indicators to be monitored including any MI System level performance measures as specified by the DMH MI Performance Improvement Committee.

(a) The Plan shall specify frequency of monitoring for each indicator and the period of time that monitoring will continue after goal attainment is achieved.

(b) The Plan shall specify that the agency shall participate in System Level activities (including the use of DMH sanctioned External Monitoring) to assess and to identify actions for improvement.

(c) The Plan shall be implemented as written.

(5) The Incident Prevention and Management System component of the PI System shall include, at a minimum, the following:

(a) Identification and reporting of special incidents.

1. Includes policies and procedures that identify special incidents involving consumers and that outline reporting requirements and procedures including provisions for training all staff on incident reporting. All programs operated by the provider are responsible for knowing and following incident reporting procedures.

2. Includes written policies and procedures that require that all special incidents involving consumers that occur in the provider's 24 hour care, in subcontracted care certified by DMH, on the provider's premises (any location with a DMH Certificate), and/or while involved in an event supervised by the Provider shall be reported in accordance with written procedures published by the DMH.

3. All abuse/neglect allegations involving staff members of the provider are reportable regardless of where the abuse/neglect was alleged to have occurred.

4. Allegations or suspected incidents of physical, verbal, or sexual abuse, neglect, exploitation, or mistreatment of consumers, regardless of age, being served in the program must be reported in the following manner:

(i) Where the alleged perpetrator is an employee or other person working in the program to the Department of Human Resources in accordance with applicable statutory requirements; to law enforcement if criminal behavior is involved; and to the Mental illness Division Performance Improvement Office in accordance with published reporting procedures.

(ii) Where both the perpetrator and the victim are consumers, reports shall be made to the parties listed above as appropriate if it is the judgment of the Executive Director or designee that the incident may have been the result of neglect.

5. Serious Special Incidents, as defined by DMH published procedures, are reported to the DMH within 24 hours of occurrence.

6. Incidents that are judged by the Executive Director or designee to be severe in nature, scope, or consequences to the consumer or the agency in addition to those defined above should be reported to the Director, Office of Community Programs, as soon as possible, but no later than 24 hours of occurrence utilizing the DMH published reporting procedures.

(i) Investigation/review of special incidents.

(I) Includes policies and procedures for investigating and correcting special incidents involving consumers. The agency shall conduct, or cause to be conducted, timely and adequate investigations of and responses to Special Incidents involving consumers.

(II) Investigations must occur immediately after their reported occurrence and such investigations shall be completed within 30 days of their initiation.

(III) Investigations shall follow minimum protocols as specified in DMH published procedures.

(IV) Agency staff members responsible for conducting/supervising investigations shall attend a DMH Special Incident Investigation Training Workshop

(ii) PI review of special incident data.

(I) Includes and describes a process for the timely and appropriate review of special incident data at least quarterly via the PI System. Such reviews shall focus on the identification of trends and actions taken to reduce risks and to improve the safety of the environment of care for consumers, families, and staff members.

(II) Findings and recommendations from the quarterly Special Incident reviews shall be reported at least quarterly to the executive and clinical leaders including the Board of Director/Governing Body.

(III) Pertinent data regarding improvement strategies shall be communicated to staff level employees.

(iii) There is evidence that the plan is implemented as written.

(6) The Consumer and Family Satisfaction component of the PI System shall include tools to assess the satisfaction of consumers and families with services provided and to obtain input from consumers and their families regarding factors which impact the care and treatment of consumers. This component shall include at a minimum the following characteristics:

(a) A description of the mechanism for obtaining consumer input regarding satisfaction with service delivery and outcomes.

(b) A description of the mechanisms for obtaining family member input regarding satisfaction with service delivery and outcomes for consumers.

(c) A description of the mechanism for obtaining input from consumers and family members when either are deaf, limited English proficient, or illiterate.

(d) A description of the mechanism for assessing consumer quality of life.

(e) A periodic review (at least annually) of data collected via the tools as described above.

(f) A periodic review (at least annually) of complaints/grievances filed according to the process required in 580-2-9-.02(3).

(g) Identifies agency specific performance indicators for consumer and family satisfaction.

(7) The Utilization Review (UR) component of the PI system shall include the following:

(a) The agency shall perform at least quarterly reviews of the findings from the UR monitor for all residential programs. At a minimum, this review will assess the agency's compliance with LOS expectations and will determine and implement actions to improve performance when variations in LOS expectations occur.

(b) The agency shall review at least annually a representative sample in each certified program to assess the appropriateness of admission to that program relative to published admission criteria.

(c) There is evidence that the plan is implemented.

(8) The Review of Treatment Plan component of the PI system includes a process for an ongoing review of the treatment planning process to include the implementation of treatment services to ensure adequacy and appropriateness of the process and of the treatment received by each individual.

The treatment plan review component shall include, at a minimum, the following characteristics:

(a) A description of the process for conducting a clinical review of a sample of all direct service staff records every 12 months to determine that the case has been properly managed. The review shall include an assessment of the following:

1. Treatment plan timely.

2. Treatment plan appropriate.

3. Documentation of services is related to the treatment plan and addresses progress toward treatment objectives.

4. Collaterals involved as needed, including linguistic support services for people who are deaf or limited English proficient.

5. Treatment plan modified (if needed).

(b) An aggregate review of the clinical review findings described above at least annually to assess trends and patterns and to determine actions for improvement based on findings.

(9) The organization collects restraint and seclusion data in order to ascertain that restraint and seclusion are used only as emergency interventions, to identify opportunities for incrementally improving the rate and safety of restraint and seclusion use, and to identify any need to redesign care process.

(10) Using a consumer identified, data on all restraint and seclusion episodes are collected from and classified for all settings/units/locations at the frequency determined by the agency on by:

(a) shift
(b) staff who initiated the process

(c) the length of each episode

(d) date and time each episode was initiated

(e) day of the week each episode was initiated

(f) the type of restraint used

(g) whether injuries were sustained by the individual or staff

(h) age of the individual

(i) gender of the individual

(j) multiple instances of restraint or seclusion experienced by an individual within a 12 hour timeframe

(k) the number of episodes per individual

(l) instances of restraint or seclusion that extend beyond 2 consecutive hours

(m) use of psychoactive medications as an alternative to, or to enable discontinuation of, restraint and seclusion.

Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: March 5, 2010; effective July 19, 2010.
Filed: August 15, 2018.

580-2-9-.08 General Clinical Practice.

(1) Each consumer admitted for treatment must be assigned to an appropriately qualified staff member or clinical treatment team who has the primary responsibility for coordination/implementation of the treatment plan.

(2) 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 to include but not limited to the following:

(a) Free language assistance will be offered to consumers with limited English proficiency or who are deaf. All interpreters must be qualified to work in the assigned setting with preference given to Qualified Mental Health Interpreters as defined by 580-3-24.

(b) While face-to-face interpreter services are preferable, procedures will specify how services will be secured when face-to-face interpreters are not available. For consumers needing spoken language assistance, telephonic interpreter services may be used. Video remote interpreters may be used for deaf consumers using sign language.

(c) If qualified interpreters are offered and refused, a signed waiver must be placed in the consumer's file. If family members are used to interpret, this will be noted on the waiver. Family members under the age of 18 cannot be used as interpreters.

(d) In the event that interpreters cannot be secured for an assignment, there must be documentation that reasonable efforts were made to secure interpreters.

(e) For consumers who are deaf, hard of hearing, or otherwise physically disabled, appropriate environmental accommodations shall be provided on an individually assessed basis.

(3) Services must be individualized, well-planned, based on a comprehensive mental health evaluation and assessment of needed treatment and support, and should include treatment designed to enhance the consumer's abilities to recover and function in society as normally as possible.

(a) Upon admission, a comprehensive mental status evaluation and assessment of each consumer.

(b) Each program shall provide individualized mental health care and treatment that is designed to promote Recovery and Resiliency and that represents person-centered treatment planning process.

(c) Treatment for consumers who are deaf or who have limited English proficiency will be offered by staff fluent in language of the consumer's choice or by using qualified interpreters.

(d) Treatment will be modified to effectively serve consumers who are deaf as determined by a communication assessment conducted by the Office of Deaf Services or staff approved by the Office.

(4) The program shall follow up within a reasonable time for missed appointments and other clinical indicators for all high risk consumers such as:

(a) Consumers who were discharged from psychiatric inpatient services (local or state) in the past year.

(b) Consumers who were decompensating on the last visit.

(c) Consumers who are considered potentially harmful to self or others.

(5) All consumers receiving medication prescribed by a physician/certified registered nurse practitioner/physician's assistant employed by the provider shall:

(a) Be seen and evaluated by a licensed physician, certified nurse practitioner, or physician's assistant at intervals not to exceed a 6 month period.

(b) Receive information relative to risks and benefits of the medication in their preferred language in terms they can readily understand.

(c) Give consent if receiving anti-psychotic medication prescribed through the provider. In the case of a child under the age of 14, the parent/guardian must give consent. In the case of an adolescent age 14 and older receiving any medication prescribed through the provider, the parents/guardian must also be informed unless the adolescent refuses to consent to the release of information.

(6) The Provider will have a system for tracking due dates for injections administered by the agency and will schedule appointments accordingly.

(7) Prescriptions shall be limited to 5 refills or a 6 month supply, unless the physician sets more stringent directions.

(8) Phone orders from the physician/certified nurse practitioner/physician's assistant regarding medication in crisis situations must be documented immediately and co-signed by the person issuing the order within 7 days.

(9) The provider must provide or arrange for emergency service for enrolled consumers through compliance with 580-2-9-.12 Emergency Services or through contracts and cooperative agreements that spell out procedures for 24 hour emergency telephone coverage and evaluation services through a local hospital or other appropriate resource including how the provider will handle calls from people who are deaf, hard of hearing, or who have limited English proficiency.

(10) The Board must approve written operational policies. The following minimum procedures must be established:

(a) The provider must have written policies that protect the consumer against discrimination in the provision of services regardless of the consumer's age, race, creed, handicap, national origin, language of preference, sex, social

status, diagnostic category, or length of residence in the service area except that specialized services may be developed for specific target populations (for example, child and adolescent day treatment, Assertive Community Treatment for adults, etc.)

(b) A description of each service functional area of responsibility as contained in the organizational chart and for which certification is requested that includes:

1. Admission criteria.

2. Nature and scope of the program.

3. Discharge/transfer criteria and procedures.

4. Service area for the program.

5. Number and credentials of staff assigned to the program as required by specific program standards

(c) A description of the appeal policies and procedures for:

1. Persons denied admission.

2. Persons involuntarily dismissed from a program.

(11) There must be a written policy addressing circumstances under which drug screening of consumers by urinalysis may be utilized. If it is utilized at any point, the program must:

(a) Establish procedures that protect against the falsification and/or contamination of any urine specimen.

(b) Demonstrate that the individual's privacy is protected each time a urine specimen is collected.

(c) Require that an observer will supervise urine collection.

Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: **New Rule:** March 5, 2010; effective July 19, 2010.

580-2-9-.09 General Outpatient.

(1) The program description is approved by the board as specified in 580-2-9-.08(10)(b)and is consistent with the provisions of this section. The program description must include all of the following components.

(a) A description of the nature and scope of the program that outlines General Outpatient Services provided including any of the services as specified in 580-2-9-.09(4) and as indicated by individual consumer needs and preferences.

(b) Discharge/transfer criteria and procedures.

(c) A description of the geographic service area for the program.

(d) Admission criteria.

(2) As evidenced by personnel records, staff are qualified to provide the services that they render.

(3) Each consumer admitted for treatment must be assigned to an appropriately qualified staff member or clinical treatment team who has the primary responsibility for coordination/implementation of the treatment plan. Consumers receiving medication only may have a registered nurse with the primary case responsibility. Consumer records document that there is a qualified case responsible staff member/team and that this person/team implements/coordinates provision of services included in the treatment plan.

(4) Outpatient services shall include a variety of treatment modalities and techniques. Services (a)-(g) must be provided to be certified for Outpatient Services. The remaining services described below are optional.

(a) Intake - Key service functions include at least:

1. A clinical interview with the consumer and/or family members, legal guardian, significant other.

2. Screening for needed medical, psychiatric, or neurological assessment as well as other specialized evaluations.

3. A brief mental status examination.

4. Review of the consumer's presenting problem, symptoms, functional deficits, and history.

5. Initial diagnostic formulation.

6. Development of an initial plan for subsequent treatment and/or evaluation.

7. Referral to other medical, professional, or community services as indicated.

(b) Individual Therapy/Counseling- Key service functions include at least:

1. Face-to-face interaction where interventions are tailored toward achieving specific measurable goals and/or objectives of the consumer's treatment plan.

2. On-going assessment of the consumer's preexisting condition and progress being made in treatment.

3. Symptom management education and education about mental illness and medication effects.

4. Psychological support, problem solving, and assistance in adapting to illness.

(c) Family Therapy/Counseling- Key service functions include at least:

1. Face-to-face interaction with the consumer, family, and/or significant others where interventions are tailored toward achieving specific measurable goals and/or objectives of the consumer's treatment plan.

2. On-going assessment of the consumer's presenting condition and progress being made in treatment.

(d) Physician Assessment and Treatment - Key service functions include at least:

1. Specialized medical/psychiatric assessment of physiological phenomena.

2. Psychiatric diagnostic evaluation.

3. Medical/psychiatric therapeutic services.

4. Assessment of the appropriateness of initiating or continuing the use of psychotropic medication.

5. Assessment of the need for inpatient hospitalization.

6. May be rendered via teleconference with a direct service or consultation recipient.

(e) Medication Monitoring - Face-to-face contact between a consumer and a mental health professional, registered nurse, or licensed practical nurse. Key service functions include:

1. Review of the overt physiological effects of medication.

2. Monitoring compliance with dosage instructions.

3. Instructing the consumer and/or caregivers of expected effects.

4. Assessing the consumer's need to see the physician.

5. Recommending changes in the medication regime.

(f) Treatment Plan Review – Review and/or revision of a consumer's individualized treatment plan by a licensed physician, certified nurse practitioner, licensed physician's assistant, licensed psychologist, licensed certified social worker, a licensed marriage and family therapist, a registered nurse with a master's degree in psychiatric nursing, or a licensed professional counselor who is not the primary therapist for the consumer. This review will evaluate the consumer's progress toward treatment objectives, the appropriateness of services being provided, and the need for a consumer's continued participation in treatment.

(g) Crisis Intervention – Immediate emergency intervention with a consumer, family member, legal guardian, and/or significant others to ameliorate a consumer's maladaptive emotional/behavioral reaction. Service is designed to resolve the crisis and develop symptomatic relief, increase knowledge of where to turn for help at a time of further

difficulty, and facilitate return to pre-crisis routine functioning.

(h) Diagnostic Testing - Key service functions include the administration and interpretation of standardized objective and/or projective tests of an intellectual, personality, or related nature. Testing of consumers who are deaf or have limited English proficiency must be done by staff or by using a Qualified Mental Health Interpreter as defined by 380-3-24. If the consumer is deaf, the staff member will have at least an Advanced level on the Sign Language Proficiency Interview.

(i) Group Therapy/Counseling- Key service functions include at least:

1. Face to face interaction with a group of consumers (not to exceed 15 for adults except in 16 bed residential programs and 10 for children and adolescents) where interventions utilize the interactions of consumers and group dynamics to achieve specific goals and/or objectives of the consumer's treatment plan.

2. On-going assessment of the consumer's presenting condition and progress being made in treatment.

(j) Pre-hospitalization screening/court screening (RN is also qualified provider) - Key service functions include at least:

1. A clinical assessment of the consumer's need for local or state psychiatric hospitalization.

2. An assessment of whether the consumer meets involuntary commitment criteria, if applicable.

3. Preparation of reports for the judicial system and/or testimony presented during the course of a commitment hearing.

4. An assessment of whether other less restrictive treatment alternatives are appropriate and available.

5. Referral to other appropriate and available treatment alternatives.

6. Coordination with state hospital staff, probate judge, and public mental health center (if provider is not one) as specified in a written agreement.

(k) Medication Administration - Key functions include the administration of injectable or oral psychotropic medications as directed by a physician (RN or LPN are the only qualified providers).

(l) Basic living skills - Psychosocial services provided by a staff member supervised by another staff member who has at least a master's degree and 2 years of post-master's clinical experience on an individual or group basis to enable a consumer(s) to maintain community tenure and to improve their capacity for independent living. Key services functions include the following services as appropriate to individual consumer needs:

1. Training and assistance in developing/maintaining skills such as personal hygiene, housekeeping, meal preparation, shopping laundry, money management, using public transportation, medication management, healthy lifestyle, and stress management.

2. Consumer education about the nature of the illness, symptoms, and the consumer's role in management of the illness.

(m) Family Support - Services provided by a staff member under the supervision of another staff member who has a master's degree and 2 years of post-master's clinical experience to families (caregivers, significant others) of mentally ill consumers to assist them in understanding the nature of the illness of their family member and how to help the consumer be maintained in the community. Key service functions include at least education about:

1. The nature of the illness.

2. Expected symptoms.

3. Medication management.

4. Ways in which the family member can support the consumer.

5. Ways in which the family member can cope with the illness.

(n) Mental Health Consultation – Assisting other external service providers/independent practitioners in providing appropriate services to an identified consumer by providing clinical consultation. Key service functions include written or verbal interaction in a clinical capacity in order to assist another provider to meet the specific treatment needs of an individual consumer and to assure continuity of care to another setting.

Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: March 5, 2010; effective July 19, 2010.

580-2-9-.10 Child and Adolescent In-Home Intervention

(1) The Program description is approved by the board as specified in 580-2-9-.08(10)(b) and is consistent with the provisions of this section. The program description must include all of the following components:

(a) A description of the nature and scope of the program that includes at a minimum the provision of services as specified in this section and as indicated by individual consumer need.

(b) A description of the geographic service area for the program.

(c) Admission criteria that include at least the following:

1. Presence of a serious emotional disturbance and/or serious mental illness.

2. Age range from 5-17 years (exception of Transitional Age specialized teams which are age range of 17-25).

3. IQ of 70 or above (exception of MI/ID specialized teams).

4. Clearly documented need to defuse an immediate crisis situation, stabilize the family unit and prevent out of home placement for the consumer.

5. Admission is approved by a Licensed Independent Practitioner as specified in 580-2-9-.06(9)(g)6.

(d) Discharge/transfer criteria and procedures shall be developed for discharge from the program under any one or combination of the following criteria:

1. The intensive in-home service time limit has been reached (maximum of 16 weeks for IHI and 20 weeks for MI/ID specialty teams.

2. The treatment plan goals have been met to the extent that the intensive in-home therapy services are no longer needed.

3. The child consumer/family has not responded to repeated, documented follow-up by the IHI team during a 14 day period.

4. The IHI team is unable to meet obvious, suspected or expressed needs of the child consumer and/or his/her family system.

5. The child becomes otherwise unavailable for services during a 14 day period.

6. Transfer or referral to a different program outside of IHI will occur when it is determined that the transfer will better meet the needs of the child consumer and his/her family. Transfer shall be considered under the following conditions:

(i) The child or adolescent consumer and their family are in need of more intensive services than the IHI team can provide.

(ii) The child or adolescent consumer is determined to be in need of less intensive services than those dictated by the IHI model and therefore child consumer is not at immediate risk for out-of-home placement.

(iii) The child or adolescent consumer and his/her family are receiving duplicate services from another child-serving agency that either cannot be terminated or are preferred by the family in lieu of IHI services.

(iv) Reflects the following characteristics and philosophy of In-Home Intervention.

(I) Time-limited (12-16 weeks) and home based provided by a 2-person treatment team.

(II) The team is the primary provider of services and is responsible for helping consumers in all aspects of community living.

(III) The majority of services occur in the community in places where consumers spend their time.

(IV) Services are highly individualized both among individual consumers and across time for each consumer.

(V) Persistent, creative adaptation of services to be acceptable to consumers provided in a manner of unconditional support.

(2) The following services must be delivered within the program:

(a) A systematic determination of the specific human service needs of each child consumer and their family as well as a clinical assessment that demonstrates the need for this level of service. The needs determination must be based upon the approved DMH assessment tool.

(b) The development of a written treatment plan that is completed by the 30th day of enrollment.

(c) Individual Therapy.

(d) Family Therapy.

(e) Family Support and Education.

(f) Basic Living Skills.

(g) Crisis Intervention and Management (24 hour availability) including assistance with medication management.

(h) Medication Monitoring.

(i) Mental Health Consultation.

(j) Case Management Services.

(k) Treatment Plan Review.

(3) There must be an assigned team that is Identifiable by job title, job description, and job function. IHI shall be provided by a 2 member treatment team that is composed of 1 professional with a Master's Degree in a mental health-related field with 1 year of post master's experience in child and adolescent or family therapy and 1 professional with a Bachelor's Degree in a human services field, both of whom must have completed a DMH approved Case Management training program and an In-Home Intervention Training program as documented in personnel records.

(4) The team must function in the following manner:

(a) The majority of the IHI services are to be delivered with the team together at a frequency of 2-3 direct face-to-face contacts per week during the Assessment Phase; 2-5 direct face-to face contacts per week in the Treatment Phase; and 1-2 direct face-to-face contacts per week during the Generalization Phase.

(b) The hours of delivering the IHI services shall be flexible to accommodate the scheduling demands and unique issues of the target population (before 8:00 a.m. and after 5:00 pm as needed).

(c) Documentation reflects that services are provided primarily by both team members in attendance. In-Home Intervention services are discontinued and enrollees are referred to other services when the team is no longer a 2 person team. Examples would include the loss of 1 of the team members, extended illness, maternity leave, etc. exceeding a 2 week period.

(d) The active caseload for a team shall not exceed 6 consumers and their families.

(e) The intensive nature of this service should be reflected in the average hours of direct service provided per family per week and documented in the consumer record.

(5) IHI services are supervised by a staff member who has a Master's Degree and 2 years of post-Master's clinical experience and who has completed a DMH approved case

management training program and a DMH approved intensive in home training program. The record shall document a minimum of 1 hour of face to face staffing consultation with the supervisor weekly as documented in clinical chart and shall include any recommendations made to the team.

(6) Consumers who are deaf, hard of hearing, or limited English proficient shall have effective communication access to these services provided by:

(a) Staff fluent in the consumer's preferred language,or

(b) A qualified interpreter.

(c) Staff working with consumers who are deaf shall have at least an Intermediate Plus level on the Sign Language Proficiency Interview.

(7) IHI shall reflect the following characteristics and philosophy of Child and Adolescent In-Home Intervention:

(a) IHI services and activities shall be provided on an outreach basis. IHI services, while by definition and practice are usually provided in the child or adolescent consumer's home, infrequently may be provided in other locations such as schools, juvenile court, a local park, or clinic, etc.

(b) The IHI team's priorities shall include:

1. Intervening in a crisis situation.

2. Stabilizing the family's ability to effectively manage the child consumer's mental health symptoms.

3. Facilitating the reunification of a child consumer back into their family upon return from a more restrictive treatment placement/facility.

4. Actively empowering families to identify, locate and utilize mental health and related community resources

(c) During Assessment Phase (week 1-4), IHI team shall:

1. Complete assessment/re-assessment by the 30th day of enrollment.

2. Collect appropriate information from prior and concurrent treatment sources as appropriate.

3. Assess the consumers need to be evaluated by the physician.

4. Establish a diagnosis(es).

5. Document assessments and services. If 1 team member is absent, this shall be reflected in the assessment/progress notes.

(d) During the Treatment Plan Formulation Phase (week 4), IHI team shall develop the treatment plan.

(e) During the Treatment Phase (weeks 5-10), IHI team shall address treatment plan objectives via a variety of therapeutic approaches, therapeutic modalities, and other interventions.

(f) During the Generalization Phase (weeks 10-12), IHI team shall:

1. Continue to follow the IHI model and be adjusted to ensure the provision of crisis intervention when indicated.

2. Refer the consumer and family to case management services and introduce the consumer and family to a follow-up case manager.

3. Link the consumer and family to the outpatient services and conduct transfer session to review progress and any future treatment needs/issues for the consumer and their family as appropriate.

(g) The IHI team has the option of extending services for an additional 4 weeks if treatment needs are clearly indicated, with prior approval of the direct supervisor. A Treatment Plan Review / Extension Form shall be competed documenting the clinical reasons for the extension, signed by eligible staff as indicated in 580-2-9-.06(9)(g)6., and filed in consumer record.

Author: Division of Mental Illness, DMH

Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: March 5, 2010; effective July 19, 2010.

580-2-9-.11 Adult In-Home Intervention

(1) The Program description is approved by the board as specified in 580-2-9-.08(10)(b) and is consistent with the provisions of this section. The program description must include all of the following components:

(a) A description of the nature and scope of the program that includes at a minimum the provision of services as specified in this section and as indicated by individual consumer need.

(b) A description of the geographic service area for the program.

(c) Admission criteria that includes at least the following:

1. Must meet criteria for Serious Mental Illness.

2. Must be 18 years of age or older and not otherwise meet the criteria for Transitional Age services.

3. Clearly documented need for more intensive outpatient support due to:

(i) An increase in symptoms,

(ii) or to transition from a more intensive level of service.

(iii) To defuse an immediate crisis situation.

(iv) To stabilize the living arrangement,

(v) and/or to prevent out of home placement,

(vi) or a history of failure to engage in other outpatient services.

(d) Discharge/transfer criteria and procedures shall be developed for discharge from the program under any one or combination of the following criteria:

1. The maximum benefits of the intensive in-home service have been reached.

2. The treatment plan goals have been met to the extent that the intensive in-home therapy services are no longer needed.

3. The consumer/family has not responded to repeated, documented follow-up by the IHI team during a 14-day period.

4. The IHI team is unable to meet obvious, suspected or expressed needs of the child consumer and/or their family system.

5. The consumer becomes otherwise unavailable for services during a 14-day period.

(e) Transfer or referral to a different program outside of IHI will occur when it is determined that the transfer will better meet the needs of the consumer. Transfer shall be considered under the following conditions:

1. The consumer is in need of more intensive services than the IHI team can provide.

2. The consumer is determined to be in need of less intensive services than those provided by the IHI team.

(f) Reflects the following characteristics and philosophy of Adult In-Home Intervention.

1. Home-based treatment is provided by a 2-person treatment team. Duration of treatment is determined on an individual basis as indicated on the treatment plan.

2. The team is the primary provider of services and is responsible for helping consumers in all aspects of community living.

3. The majority of services occur in the community and/or in places where consumers spend their time.

4. Services are highly individualized both among individual consumers and across time for each consumer.

5. Persistent, creative adaptation of services to be acceptable to consumers provided in a manner of unconditional support.

(2) There must be an assigned team that is identifiable by job title, job description, and job function. IHI shall be provided by a 2-member treatment team that is composed of one of the following options:

(a) Rehabilitation Professional Option- One professional with a Master's Degree in a mental health related and one professional with a Bachelor's Degree in a human services field.

(b) Registered Nurse Option- One registered nurse under Alabama Law; and one professional with a Bachelor's Degree in a human services field.

(c) In each staffing composition, both team members must complete case management training.

(3) The following key services must be delivered within the program when the team is composed of a master's level clinician and a case manager:

(a) Individual and Family Therapy.

(b) Crises Intervention.

(c) Mental Health Consultation.

(d) Basic Living Skills.

(e) Family Support.

(f) Case Management.

(g) Medication Monitoring.

(4) The following key services must be delivered within the program when the team is composed of a registered nurse and a case manager:

(a) Crisis Intervention.

(b) Mental Health Consultation.

(c) Basic Living Skills.

(d) Family Support.

(e) Case Management.

(f) Medication Monitoring.

(g) Medication Administration.

(5) The team must function in the following manner:

(a) Services should be provided primarily as a team with the team members working individually as dictated by consumer need.

(b) The hours of delivering the IHI services shall be flexible to accommodate the scheduling demands and unique issues of the target population (before 8:00 a.m. and after 5:00 p.m. as needed).

(c) Documentation should reflect that IHI cases are staffed by the team on a regular basis and that joint decisions are made regarding the frequency of consumer contact for team and individual staff services.

(d) The intensive nature of this service should be reflected in the average hours of direct service provided per person per week.

(e) The active caseload for a team shall not exceed 20 consumers.

(6) Consumers who are deaf or limited English proficient shall have effective communication access to these services provided by:

(a) Staff fluent in the consumer's preferred language, or

(b) A qualified interpreter.

(c) Staff working with consumers who are deaf shall have at least an Intermediate Plus level on the Sign Language Proficiency Interview.

Author: Division of Mental Illness, DMH

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

History: New Rule: March 5, 2010; effective July 19, 2010.

580-2-9-.12 Emergency Services.

(1) The program description is approved by the board as specified in 580-2-9-.08(10)(b) and is consistent with the provisions of this section. The program description must include all of the following components:

(a) A description of the nature and scope of the program that includes at a minimum the provision of services as specified below and as indicated by individual consumer need.

(b) A description of the service area for the program.

(2) There is a 24 hour per day 7 day per week capability to respond to an emergency need for mental health services for enrolled consumers. Such capability shall include:

(a) Telephone response by a credentialed staff member (a direct service provider with at least a BA or RN) or

(b) Face-to-face response by a credentialed staff member (a direct service provider with at least a BA or RN).

(c) Adequate provision for handling special and difficult cases, e.g. violent/suicidal, deaf, or limited English proficient.

(3) When an answering service is used, instructions must be provided in the proper handling of emergency calls.

(4) Staff involved in face-to-face emergency services shall be trained in crisis intervention techniques.

(5) A master's level clinical staff member with at least 2 years of post-master's clinical experience shall be available as a backup to those persons providing emergency telephone service.

(6) There shall be a log of all after-hours incoming calls, including time, nature of problem, telephone

number of caller (if possible), and the disposition of the case.

(7) There is documentation of each face-to-face contact including disposition after the initial emergency interview.

(8) All emergency contacts should document any referral to any other agency or non-agency services.

(9) There is documentation of follow-up on disposition recommendations in all high-risk crisis situations, including at a minimum, those situations involving consumers as specified in 580-2-9-.08(4)(a)-(c).
Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: March 5, 2010; effective July 19, 2010.

580-2-9-.13 Partial Hospitalization Program.

(1) The program description is approved by the board as specified in 580-2-9-.08(10)(b). It is consistent with the provisions of this section and defines the Partial Hospitalization Program (PHP) as an identifiable and distinct organizational unit that provides intensive, structured, active, clinical treatment with the goal of acute symptom remission, hospital avoidance, and/or reduction of inpatient length of stay. The program description must include all of the following components:

(a) A description of the nature and scope of the program that includes at a minimum the provision of services as specified in 580-2-13-.13(2).

(b) Discharge/transfer criteria and procedures consistent with 580-2-9-.13 (1)(h).

(c) A description of the geographic service area for the program.

(d) Admission criteria shall include the following inclusionary criteria:

1. Presence of a psychiatric diagnosis.

2. Acute psychiatric symptoms resulting in marked or severe impairment in multiple areas of daily life sufficient to make hospitalization very likely without admission to Partial Hospitalization Program.

3. Admission is an alternative to continued hospitalization.

4. Severe persistent symptoms without acute exacerbation where significant clinical progress has not been made in a less intensive treatment setting and where PHP services are reasonably expected to improve the consumer's symptoms, condition, or functional level.

(e) Exclusionary criteria shall address the following:

1. The consumer requires a more intensive level of care.

2. The consumer is experiencing mild to moderate symptoms without an acute exacerbation.

3. Less intensive levels of treatment can reasonably be expected to improve the consumer's symptoms, condition, and functional level.

(f) The program description clearly identifies the PHP as a time-limited program with the expected length of stay (LOS) not to exceed 3 months, unless clinically justified, but not more than 6 months per admission.

(g) The program description shall state the procedure for extending a consumer past the expected LOS and must require at least one of the following criteria for continued stay and the psychiatrist, certified nurse practitioner, or physician assistant certifies the need to extend the length of stay for a specified period of time not to exceed 3 one-month extensions to achieve clearly articulated clinical objectives:

1. Goals and objectives specified on the treatment plan have not been substantially attained or new problems have emerged and further treatment can be reasonably expected to result in progress toward goals and objectives and/or continued stability.

2. Continued treatment cannot be provided in less intensive levels of care due to a reasonable risk of relapse and/or hospitalization based on documented clinical judgment or failed attempts to transition the consumer to a less intensive level of care.

(h) Discharge/transfer criteria shall include the following:

1. Treatment plan goals and objectives have been substantially attained and continued treatment can be provided in less intensive levels of care.

2. Consumer's degree of impairment, severity of symptoms, and level of functioning have improved enough to resume normal activities (school, work, home) or to receive less intensive services (e.g. intensive day treatment, rehabilitative day program, standard out patient services, case management, etc.).

3. Consumer's degree of impairment, severity of symptoms, and/or level of functioning necessitates admission to a more intensive level of care.

4. Consumer is unwilling or unable to participate in/benefit from the program due to severity of symptoms, functional impairment, behavioral problems, personal choice, or cognitive limitations despite repeated documented efforts to engage the patient.

5. Consumer primarily needs support, activities, socialization, custodial, respite, or recreational care that could be provided in other less intensive settings (e.g. drop-in center, senior center, peer support group.)

(2) The Partial Hospitalization Program shall constitute active, intensive treatment that specifically addresses the presenting problems that necessitate admission. An initial screening to evaluate the appropriateness of the consumer's participation in the program and to develop an individualized treatment plan must be conducted. The following services must be available and provided as indicated by the initial screening:

(a) Medication evaluation and medication management.

(b) Individual, group, and family therapy.

(c) Coping skills training closely related to presenting problems e.g. stress management, symptom management, assertiveness training, and problem solving as opposed to basic living skills such as money management, cooking, etc.

(d) Activity therapy closely related to the presenting problems that necessitated admission (e.g. aerobics, maintaining a recovery diary, creative expression (art, poetry, drama) pertaining to the recovery process).

(e) Medication administration.

(f) Medication monitoring.

(g) Family education closely related to the presenting problems such as diagnosis, symptoms, medication, coping skills, etc.

(h) Consumer education closely related to presenting problems such as diagnosis, symptoms, medication, etc. rather than academic training.

(i) Documentation of daily services attended must be in each consumer's record.

(3) Partial Hospitalization Programs shall have a multi-disciplinary treatment team under the direction of a psychiatrist, certified registered nurse practitioner, or physician's assistant. The team may include social workers, counselors, psychologists, nurses, occupational therapists, recreational therapists, activity therapists, chemical dependency counselors, and other staff trained to work with psychiatric patients. At a minimum, the treatment team will include a psychiatrist (or certified nurse practitioner or physician's assistant), a doctoral or master's level clinician, a licensed practical nurse, and at least one other trained professional and/or para-professional. The clinician, nurse, and other staff member will each be present during the hours of program operation except for excused absences. A qualified interpreter will be present at all team meetings when a consumer who is deaf or who has limited English proficiency is present. There shall be a sufficient number of staff for the daily census of the program with a minimum staff to consumer ratio of 1:10.

(4) The program coordinator must have a master's degree in a mental health related field and at least 2 years of post-master's direct mental illness service experience or be a registered nurse with a minimum of 2 years of psychiatric experience.

(5) A psychiatrist, certified nurse practitioner, or physician's assistant shall be responsible for providing and documenting the following services:

(a) Order for admission.

(b) Initial psychiatric evaluation.

(c) Initial approval and monthly review of the treatment plan.

(d) Medication evaluation and management services.

(e) Evaluation of readiness for discharge and discharge order.

(f) At least monthly face-to-face assessment of the consumer and as medically/psychiatrically indicated.

(g) Face-to-face evaluation and certification of need for continued stay on at least a monthly basis.

(6) Each patient in a Partial Hospitalization Program shall have a counselor/therapist who meets the requirements at 580-2-9-.03(7).

(7) Consumers admitted to the PHP meet the admission criteria as specified above and do not meet the exclusionary criteria as specified above.

(8) The Partial Hospitalization Program shall be scheduled at least 4 hours per day, 5 days per week for day programs and a minimum of 16 hours over at least 4 days per week for evening programs.

(9) Consumers who are deaf will have communication access provided by staff fluent in the preferred language of the consumer or by a qualified interpreter. Staff serving consumers who are deaf will hold certification at Intermediate Plus level or higher on the Sign Language Proficiency

Interview or be a Qualified Interpreter. Programming will be modified to provide effective participation for all consumers who are deaf.

(10) Consumer records document that the consumer received at a minimum 1 hour of individual or group therapy weekly unless clinically contraindicated and documented.

(11) Group size (all types of groups with the exception of activity therapy) shall not exceed 15 except in 16 bed residential programs providing PHP services.

(12) Consumers in a PHP shall be scheduled at least 4 hours per day, 3-5 days per week based on individual clinical needs, preferences, and circumstances. When clinically indicated, less frequent attendance may be utilized during a brief period of transition to less intensive levels of care.

(13) The PHP is a time-limited program with the length of stay (LOS) not to exceed 3 months, unless clinically justified, but not more than 6 months per admission.

(14) Extensions of Length of Stay clearly document reasons consistent with the continued stay criteria, specify a period of time not to exceed one month, specify clinical objectives to be achieved during the extension, are certified by a psychiatrist, a certified nurse practitioner, or licensed physician's assistant, and do not exceed 3 extensions.

(15) Records of discharged consumers indicate that the discharge criteria were met. Consumers attending the program do not meet the discharge criteria.

(16) Each consumer shall have training in infection control at program admission.

Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: **New Rule:** March 5, 2010; effective July 19, 2010.

580-2-9-.14 Adult Intensive Day Treatment.

(1) The program description is approved by the board as specified in 580-2-9-.08(10)(b). It is consistent with the provisions of this section and defines Intensive Day Treatment (AIDT) as an identifiable and distinct program that

provides highly structured services designed to bridge acute treatment and less intensive services such as rehabilitative and outpatient with the goals of community living skills acquisition/enhancement, increased level of functioning, and enhanced community integration. The program description must include all of the following components:

(a) A description of the nature and scope of the program that includes at a minimum the provision of services as specified in 580-2-9-.14(2).

(b) Discharge/transfer criteria and procedures consistent with 580-2-9-.14 (1)(h).

(c) A description of the geographic service area for the program.

(d) Admission shall be approved by a staff member who meets the requirements set forth in section 580-2-9-.06(9)(g)6 and shall include the following criteria:

1. Presence of a psychiatric diagnosis.

2. Moderately disabling persistent, chronic, and/or refractory symptoms with no significant clinical progress made or expected in a less intensive level of care.

3. Symptoms that do not meet admission criteria for more intensive levels of care but do require the daily structure and supervision of a treatment oriented therapeutic milieu.

4. AIDT can be reasonably expected to improve the consumer’s symptoms, condition, or functional level sufficient to permit transition to a less intensive level of care.

(e) Exclusionary criteria shall address the following:

1. The consumer’s degree of impairment, severity of symptoms, and level of functioning require a more intensive level of care.

2. The consumer is experiencing mild persistent, chronic symptoms without acute exacerbation and less intensive levels of care can reasonably be expected to improve the consumer’s symptoms, condition, and functional level.

(f) The program description defines the expected length of stay (LOS) as intermediate term, not to exceed 6 months unless clinically justified.

(g) The program description shall state the procedure for extending a consumer past the expected LOS and must require at least one of the following continued stay criteria and be approved by a staff member who meets the requirements set forth in 580-2-9-.06(9)(g)6:

1. Goals and objectives specified on the treatment plan have not been substantially attained or new problems have emerged and further treatment can be reasonably expected to result in progress toward goals and objectives and/or continued stability, or

2. Continued treatment cannot be provided in less intensive levels of care (e.g., rehabilitative day program, case management, standard outpatient services) due to a reasonable risk of relapse and/or hospitalization based on documented clinical judgment or failed attempts to transition the consumer to a less intensive level of care.

(h) Discharge/transfer criteria shall include the following:

1. Treatment plan goals and objectives have been substantially attained and continued treatment can be provided in less intensive levels of care.

2. Consumer’s degree of impairment, severity of symptoms, and level of functioning have improved enough to resume normal activities or to receive less intensive services (e.g., rehabilitative day program, case management, standard outpatient services).

3. Consumer’s degree of impairment, severity of symptoms, and/or level of functioning necessitates admission to a more intensive level of care.

4. Consumer is unwilling or unable to participate in/benefit from the program due to severity of symptoms, functional impairment, behavioral problems, personal choice, or cognitive limitations despite repeated documented efforts to engage the consumer.

(2) Intensive Day Treatment shall constitute active, intermediate level treatment that specifically addresses the consumer's impairments, deficits, and clinical needs. An initial screening to evaluate the appropriateness of the consumer's participation in the program and to develop an individualized treatment plan must be conducted. The following services must be available and provided as indicated by the initial screening:

(a) Medication evaluation and management.

(b) Individual, group, and family therapy.

(c) Activity/recreational therapy (e.g. sports, leisure activities, hobbies, crafts, music, socialization, field trips).

(d) Social skills training (e.g. conversation and interpersonal skills).

(e) Coping skills training (e.g. stress management, symptom management, problem solving).

(f) Utilization of community resources.

(g) Family education closely related to the presenting problems such as diagnosis, symptoms, medication, coping skills, etc.

(h) Basic living skills (e.g. Adult Basic Education, GED, shopping, cooking, housekeeping, grooming).

(i) Medication administration.

(j) Medication monitoring.

(k) Consumer education closely related to presenting problems such as diagnosis, symptoms, medication, etc. rather than academic training.

(l) A weekly schedule of services attended must be in each consumer's record.

(3) The program coordinator must have a master's degree in a mental health related field and 2 years of post-master's direct mental illness experience. In physically isolated settings, there must be 1 other staff member in

addition to the coordinator present during the hours of operation. The overall staff to consumer ratio cannot exceed 1:15. If a program has a capacity of 15 or less, an additional staff person should be present during the hours of operation to permit individualized treatment.

(4) Consumers admitted to the program meet the admission criteria as specified above and do not meet the exclusionary criteria as specified above.

(5) The program is operated a minimum of 4 hours per day and at least 4 days per week.

(6) Consumer records document that the consumer received a minimum of 1 hour of individual or group therapy weekly.

(7) There is documentation in the consumer record that group therapy size does not exceed 15 in each group.

(8) The AIDT program's length of stay (LOS) is an intermediate term, not to exceed 6 months unless clinically justified.

(9) Extensions of LOS clearly document reasons consistent with the continued stay criteria, specify a period not to exceed 3 months, specify clinical objectives to be achieved during the extension, and are approved by a staff member who meets the requirements set forth in section 580-2-9-.06(9)(g)6.

(10) Each consumer in an Intensive Day Treatment program shall have a counselor/therapist who meets the requirements at 580-2-9-.03(7).

(11) Program statistics document that consumers are scheduled to attend 3 to 5 days per week and at least 4 hours per day. If a consumer is scheduled less frequently, it is clearly documented that the consumer is in a brief transition period.

(12) Consumers who are deaf will have communication access provided by staff fluent in the consumer's preferred language or by a qualified interpreter. Staff serving consumers who are deaf will hold certification at the Intermediate Plus level or higher on the Sign Language

Proficiency Interview. Programming will be modified to provide effective participation for all consumers who are deaf.

(13) Records of discharged consumers indicate that the discharge criteria were met. Consumers attending the program do not meet the discharge criteria listed above.

(14) Each consumer shall have training in infection control at program admission and annually thereafter.
Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: **New Rule:** March 5, 2010; effective July 19, 2010.

580-2-9-.15 Adult Rehabilitation Day Program.

(1) The program description is approved by the board as specified in 580-2-9-.08(10)(b). It is consistent with the provisions of this section and defines Rehabilitative Day Program (RDP) as an identifiable and distinct program that provides long-term recovery services with the goals of improving functioning, facilitating recovery, achieving personal life goals, regaining self-worth, optimizing illness management, and helping consumers to become productive participants in family and community life. The program description must include all of the following components:

(a) A description of the nature and scope of the program that includes at a minimum the provision of services as specified in 580-2-9-.15(2) and as indicated by individual consumer needs and preferences.

(b) Discharge/transfer criteria and procedures consistent with 580-2-9-.15(1)(f).

(c) A description of the geographic service area for the program.

(d) Admission criteria shall address inclusionary criteria as follows and be approved by a staff member who meets the requirements set forth in section 580-2-9-.06(9)(g)6:

1. Presence of a psychiatric diagnosis.

2. Mild to moderate persistent, chronic, and/or refractory symptoms and impairments in one or more areas of

living (e.g. difficulty attaining & sustaining life goals and/or community integration).

3. Does not meet admission or continued stay criteria for more intensive levels of care such as PHP or AIDT, but requires the daily structure and services of a recovery oriented rehabilitative milieu to improve or maintain level of functioning, achieve personal life goals, and sustain a positive quality of life.

4. RDP services are reasonably expected to improve the individual's functional level, increase quality of life, and facilitate attainment of personal life goals.

(e) Exclusionary criteria must include the following:

1. The person's level of functioning requires a more intensive level of care.

2. The individual is not experiencing mild or moderate persistent, chronic symptoms, impairments in one or more areas of daily life, difficulty attaining and sustaining life goals and/or problems with community integration.

(f) Discharge/transfer criteria shall include the following:

1. Rehabilitative goals have been met and the individual no longer needs this type of service.

2. Less intensive levels of care can reasonably be expected to improve or maintain the individual's level of symptom remission, condition, functional level, quality of life, attainment of life goals, and recovery; or the degree of impairment, severity of symptoms, and/or level of functioning necessitates admission to a more intensive level of care.

3. The individual primarily needs support, activities, socialization, or custodial care that could be provided in other less intensive Settings (e.g. peer support group, drop in center, or senior citizen's center).

4. The individual chooses not to participate.

(2) The RDP constitutes active structured, rehabilitative interventions that specifically address the

individual's life goals, builds on personal strengths and assets, improves functioning, increases skills, promotes a positive quality of life, and develops support networks. The RDP should include an initial screening and an individualized treatment plan. Based on the specific focus of the program and the needs and preferences of consumers, one or more of the following rehabilitative services must be provided:

(a) Pre-vocational skills training and, when indicated, linkage to Vocational Rehabilitation Services (VRS) and other appropriate local work programs or settings.

(b) Assistance with the recovery of skills and general education, which might permit the consumer to succeed in Adult Basic Education, GED, computer skills, or other educational activities.

(c) A wide spectrum of activities and services which would permit sustained volunteer activity and/or employment.

(d) Assistance in recovering skills necessary to independently maintain consistent linkage to medical and psychiatric services, access to prescribed medication, and self-monitoring of target symptoms, triggers, etc.

(e) Goal oriented groups (e.g. groups designed to help consumers identify, discuss, achieve and/or maintain personal life goals such as living in preferred housing, having a job, returning to school, having friends, being a contributing member of the community, fulfilling a productive role in a family etc.)

(f) One-to-one goal oriented sessions (e.g. one to one services designed to help a consumer identify, discuss, achieve and/or maintain personal life goals such as living in preferred housing, having a job, returning to school, having friends, being a contributing member of the community, fulfilling a productive role in a family etc.)

(g) Skill building and skill recovery (e.g. skills training sessions focused on learning, recovering, improving and maintaining daily living skills such as grocery shopping, use of public transportation, social skills, budgeting, laundry, and housekeeping to help consumers develop and maintain the skills they need to achieve and/or sustain personal life goals).

(h) Utilization of community resources.

(i) A weekly schedule of services attended must be in each consumer's record.

(3) The program coordinator must have at a minimum a Bachelor's degree in a mental health related field and at least 2 years of direct service experience in a mental health setting or be a registered nurse with at least 2 years of mental health center experience. The overall staff to consumer ratio cannot exceed 1:20. If a program has a capacity of 20 or less, an additional staff person should be present during the hours of operation to permit individualized treatment.

(4) Records document that consumers admitted to the RDP meet the admission criteria as specified above.

(5) Records document that the consumers admitted to the RDP do not meet the exclusionary criteria as specified above.

(6) Rehabilitative Day Programs shall be scheduled at least 4 hours per day 1 day per week.

(7) Consumers who are deaf or who have limited English proficiency will have communication access provided by staff fluent in the consumers' preferred language or by a qualified interpreter.

(a) If the consumer is deaf, the staff member providing service shall have at least an Intermediate Plus level in the Sign Language Proficiency Interview.

(b) Programming will be modified to provide effective participation for all consumers who are deaf.

(8) Consumers are scheduled to attend RDP at least once a week based on individual goals, preferences, needs and circumstances.

(9) The record documents that the treatment plan for rehabilitative day services is evaluated at least every 3 months to assure that continued participation in RDP is clinically indicated.

(10) Consumers discharged from the program meet the discharge criteria as specified above.

(11) Each consumer shall have training in infection control at program admission and annually thereafter.
Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: March 5, 2010; effective July 19, 2010.

580-2-9-.16 Child and Adolescent Day Treatment.

(1) The program description is approved by the board as specified in 580-2-9-.08(10)(b). It is consistent with the provisions of this section. The program description must include all of the following components:

(a) A description of the nature and scope of the program that includes at a minimum the provision of services as specified in section 580-2-9-.16(2) and as indicated by individual consumer need.

(b) A description of the geographic service area for the program.

(c) Admission criteria shall be comprehensive enough to justify a consumer's treatment in Child and Adolescent Day Treatment and shall include the following:

1. Presence of a psychiatric diagnosis, as well as a serious emotional disturbance. Serious emotional disturbance is defined by the child's mental health treatment history, mental health treatment needs, and current functioning in the areas of autonomy/basic living skill, family, school and community.

2. Presence of a combination of at least 5 of the following inclusionary criteria, whose severity would prevent treatment in a less intensive environment or for a temporary, clinically justified period of more intensive services to prevent regression:

(i) Poor self-control.

(ii) Cruelty to animals.

(iii) Inappropriate aggressive behavior.

(iv) Angry/hostile temper tantrums.

(v) Hyperactivity.

(vi) Withdrawn.

(vii) Running away.

(viii) Destructiveness.

(ix) Poor school performance.

(x) Truancy.

(xi) Defiance of authority.

(xii) Manipulative behavior.

(xiii) Sexual maladjustment.

(xiv) Assaultive behavior.

(xv) Child abuse victim.

(xvi) Depression.

(xvii) Anxiety.

(xviii) Homicidal/suicidal ideation.

(xix) Drug experimentation.

(xx) Sexual abuse.

(xxi) Irrational fears.

(xxii) Attention seeking behavior.

(xxiii) Encopretic/enuretic.

(xxiv) Low frustration tolerance.

(xxv) Inadequate social skills.

(xxvi) Dysfunctional family relationships.

(d) Admission is approved by Licensed Independent Practitioners as specified in section 580-2-9-.06(9)(g)6.

(e) Consumer shall have documented moderately disabling persistent, chronic, and/or refractory symptoms with no significant clinical progress made or expected in a less intensive level of care.

(f) The program can be reasonably expected to improve the consumer's symptoms, condition or functional level sufficient to permit transition to a less intensive level of care.

(g) The program description shall state the expected length of stay (LOS) which should not exceed one academic year.

(h) The program description shall state the procedure for extending a consumer past the expected LOS and must include the following continued stay criteria:

1. Goals and objectives specified on the treatment plan have not been substantially attained or new problems have emerged.

2. Further treatment can be reasonably expected to result in progress toward goals and objectives and/or continued stability.

3. Documented clinical judgment indicates that continued treatment cannot be provided in less intensive levels of care due to reasonable risk of relapse and/or hospitalization.

4. Documented clinical judgment indicates that an attempt to transition the consumer to a less intensive level of care is reasonably expected to result in the re-emergence of symptoms sufficient to meet admission criteria.

5. A staff member who meets the requirements at 580-2-9.06 (9)(g) 6 approves extending the length of stay of a specified period of time not to exceed 4 months per extension to achieve clearly articulated clinical objective.

(i) The program description documents the provision of services as specified in 580-2-9-.16(7).

(j) Exclusionary criteria shall address the following:

1. The consumer’s degree of impairment, severity of symptoms, and level of functioning require a more intensive level of care.

2. The consumer is experiencing mild persistent, chronic symptoms without acute exacerbation and less intensive levels of care can reasonably be expected to improve the consumer’s symptoms, condition and functional level.

(k) Discharge/transfer criteria shall include the following:

1. Treatment plan goals and objectives have been substantially attained and continued treatment can be provided in less intensive levels of care.

2. Consumer’s degree of impairment, severity of symptoms, and level of functioning have improved enough or resume normal activities or to receive less intensive services.

3. Consumer’s degree of impairment, severity of symptoms, and/or level of functioning necessitate admission to a more intensive level of care.

4. Consumer is unwilling or unable to participate in/benefit from the program due to severity of symptoms, functional impairment, behavioral problems, personal choice, or cognitive limitation despite repeated documented efforts to engage the consumer.

(l) The program description shall describe how services for consumers who are deaf, hard of hearing, or limited English proficient are provided.

(2) The Child and Adolescent Day Treatment shall constitute active, intensive treatment that specifically addresses the presenting problems that necessitate admission. The daily schedule of services attended must be in each consumer’s record, and consumer/staff interviews confirm that the required services are provided. Consumer records document an initial screening, an individualized treatment plan to include documentation of the consumer’s participation in the program and the development of the treatment plan, and verify

an active, intensive treatment program. Key service functions include, at a minimum, the following services:

(a) Individual, group, and family therapy.

(b) Education for the consumer's parents/guardian regarding age-related emotional and cognitive development and needs.

(c) Services that enhance personal care skills.

(d) Services that enhance family, social, and community living skills.

(e) Services that enhance the use of leisure and playtime.

(f) Medical services including the prescription of psychotropic medication and medication management.

(g) Education services for children who are attending Day Treatment instead of a local school.

(h) Recreational activities.

(i) Therapeutic field trips.

(3) The program coordinator must have a master's degree in a mental health related field and 2 years of direct mental illness service experience, 1 of which must be in services for children and adolescents. In physically isolated settings, there must be at least 1 other staff member present during hours of operation. The overall staff to consumer ratio cannot exceed 1 to 10. In a program that has only 10 consumers, there must be at least one other staff member present during hours of operation.

(4) Consumer records document that consumers admitted to the program meet the admission criteria as specified above.

(5) Programs with an educational component must be in operation 5 days per week with a minimum of 3 hours non-educational service per day. Programs that do not have an educational component must be in operation a minimum of 3 days per week and have a minimum of 4 hours of service each day

with the exception of pre-school and after-school programs which must operate a minimum of 3 hours per day.

(6) Consumers who are deaf or have limited English proficiency will have communication access provided by staff fluent in the consumer's preferred language or by a qualified interpreter. If the consumer is deaf, the staff member providing services shall have at least an Intermediate Plus level in the Sign Language Proficiency Interview. Programming will be modified to provide effective participation for all consumers who are deaf.

(7) Consumers records document that the consumer received at a minimum 1 hour of group therapy per week and 1 hour of individual or family therapy at least every 2 weeks. The minimum services may be met in more than 1 session of less than 1 hour each. The time requirements for pre-school day treatment are 1 half hour of group therapy per week and 1 half hour individual or family therapy every 2 weeks.

(8) There is documentation that group therapy size does not exceed 10 in each session.

(9) Consumer records document that group and individual therapy address clinical issues identified in the consumer's treatment plans.

(10) The length of stay of consumers in the program is consistent with the expected length of stay as specified above.

(11) Extensions of length of stay clearly document:

(a) Reasons consistent with the above criteria.

(b) Specify a period of time not to exceed 4 months.

(c) Specify clinical objectives to be achieved during the extension and are approved by a staff member as required.

(d) Consumer records indicate that extensions of length of stay are consistent with procedures for extending length of stay as stated in the program description.

(12) Child and Adolescent Day Treatment programs that children attend instead of a Local Educational Agency (LEA) must be registered with the State Department of Education. If the program is receiving special education funds, the program must agree to meet the minimum assurance statements set forth by the State Department of Education.

(13) All Child and Adolescent Day Treatment Programs that serve school-age children during school terms must provide an educational curriculum or document coordination with the Local Education Agency.

(14) Each consumer shall have training in infection control at program admission and annually thereafter.
Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: **New Rule:** March 5, 2010; effective July 19, 2010.

580-2-9-.17 Case Management.

(1) The program description is approved by the board as specified in 580-2-9-.08(10)(b) and is consistent with the provisions of this section. The program description must include the following components:

(a) A description of the nature and scope of the program that includes at a minimum the provision of services specified in 580-2-9-.17(2).

(b) Discharge/transfer criteria/procedures.

(c) A description of the geographic services area for the program.

(d) Admission criteria.

(e) Specifies that the program is staffed by qualified individuals whose primary job function is case management.

(2) The following services must be delivered within the program:

(a) A systematic determination of the specific human service needs of each consumer.

(b) The development of a systematic consumer coordinated written plan that is developed within 30 days of first face-to-face case management service unless services terminate earlier and that lists the actions necessary to meet the needs of each consumer.

(c) Assisting the consumer through crisis situations and/or arranging for the provision of such assistance by other professional/personal caregivers.

(d) The direct delivery, or the arrangement for, transportation to needed services if the consumer is unable to transport him or herself.

(e) Establishing links between the consumer and service providers or other community resources.

(f) Advocating for and developing access to needed services on the consumer's behalf when the consumer himself is unable to do so alone.

(g) Monitoring of the consumer's access to, linkage with, and usage of necessary community supports as specified in the case plan.

(h) Systematic reevaluation (at 6 months after the original case plan was developed and intervals of 12 months thereafter) of the consumer's human service needs and the consumer's progress toward planned goals so that the established plans can be continued or revised.

(3) Case Management Services must be provided by a staff member with a Bachelor's Degree and who has completed a DMH approved Case Manager Training Program and infection control training. Case managers who work with consumers who are deaf must complete training focusing on deafness and mental illness by DMH Office of Deaf Services.

(4) Case Management Services for consumers who are deaf or who have limited English proficiency must be provided in a linguistically appropriate manner by staff fluent in the consumer's preferred language, or through the use of a qualified interpreter who achieves at least an Intermediate Plus level on the Sign Language Proficiency Interview.

(5) Adult Case Management Services are supervised by either a staff member who has a Master's degree and 2 years

of post-master's clinical experience and has successfully completed a DMH approved case management supervisor training program, or a staff member who has a master's degree which included a clinical practicum, has 2 years of experience as a case manager regardless of whether the experience occurred pre-or-post master's degree, and has successfully completed a DMH approved case management training program. Child and Adolescent Case Management Services are supervised by a staff member with a Master's Degree and two years of post-Master's clinical experience and who has successfully completed an approved child and adolescent case management training program.

(6) Case Managers must possess a current driver's license valid in Alabama.

(7) Most Case Management Services and activities will occur on an outreach basis.

(8) The following documentation and/or forms are required and must be readily identifiable in the consumer's record:

(a) Needs Assessment Completed:

1. Within 30 days of first face-to-face case management service with a consumer.

2. After 6 months of service,

3. and every 12 months thereafter as long as the consumer receives case management.

4. If a provider is under contract with DMH, the needs assessment must be documented on a DMH approved form.

(b) Case Plan - Goals, methods of accomplishment, and approval of same by the Case Manager supervisor which are completed:

1. Within 30 days of first face-to-face case management service.

2. After 6 months of Case Management Services,

3. and annually thereafter as long as the consumer receives case management.

(c) Service Notes - Notation by Case Manager of date, service duration, nature of service, and Case Manager's signature for each contact with the consumer or collateral.

(d) Documentation that communication access has been provided for consumers who are deaf or who have limited English proficiency.

1. If qualified interpreters are offered and refused.

2. A signed waiver must be placed in the consumer's file.

3. If family members are used to interpret, this will be noted on the waiver. Family members under the age of 18 cannot be used as interpreters.

(e) Authorization and consent forms as necessary to carry out case plans.

Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: **New Rule:** March 5, 2010; effective July 19, 2010.

580-2-9-.18 Residential Services. Sections 580-2-9-.18(1) through 580-2-9-.18(27) apply to any residential setting that provides congregate living and dining to consumers. Sections 580-2-9-.18(28) through 580-2-9-.18(38) apply to specific types of residential care.

(1) All residential programs certified under this section shall have program descriptions approved by the board as specified in 580-2-9-.08(10)(b). The program descriptions shall address the following:

(a) Staffing pattern of the home consistent with staffing requirements as set forth in sections 580-2-9-.18(28) through 580-2-9-.18(38).

(b) Type of the program to include:

1. The number of beds.

2. Services to be provided.

3. Population served.

4. Expected length of stay.

5. Expected outcomes.

(c) Staff qualifications consistent with requirements set forth in sections 580-2-9-.18(28) through 580-2-9-.18(38) for each type of residential program certified.

(d) Discharge/transfer criteria and procedures.

(e) Service area for the program.

(f) Admission criteria shall include the following inclusionary criteria:

1. Require the consumer's willingness to participate in daily structured activities.

2. Require a principal psychiatric diagnosis.

3. Require a setting that has staff on the premises 24 hours/day when consumers are present and a combination of the following criteria, whose severity would preclude treatment in a less restrictive environment:

(i) Impaired contact with reality manifested by hallucinations, delusions, or ideas of reference.

(ii) Withdrawal, regression, or confusion not warranting inpatient hospitalization.

(iii) Moderate to severe disabling depression.

(iv) Moderate to severe disabling anxiety.

(v) Disabling somatic symptoms.

(vi) Poor medication compliance.

(vii) Inpatient care is not warranted.

(viii) Poor socialization skills.

(ix) Inappropriate attention-seeking behaviors.

(x) Poor interpersonal skills.

(xi) Inadequate problem solving skills.

(g) Exclusionary criteria must include the following:

1. Principal diagnosis of alcoholism or drug dependence.

2. Primary physical disorder (serious illness requiring hospital care, nursing care, home health care, or impaired mobility that prohibits participation in program services).

3. Primary organic disorder (brain damage).

4. Principal diagnosis of mental retardation.

(h) The program description should indicate that the following services, at a minimum should be either provided in-house or arranged for by the residential staff, depending upon the needs of the individual consumer:

1. Assistance in applying for benefits.

2. Assistance in improving social and communication skills.

3. Assistance with medication management.

4. Assistance in the development of basic living skills (money management, laundering, meal preparation, shopping, transportation, house cleaning, personal hygiene, nutrition, and health and safety).

5. Vocational services.

6. Community orientation.

7. Recreation and activities.

8. Assistance in locating long term community placement in least restrictive setting.

9. Transportation to and from necessary community services and supports.

10. Education about psychiatric illness.

11. Family support and education.

12. The program description for adult therapeutic group home must include at a minimum the provision of Intensive Day Treatment services within the home.

13. The program description for a crisis residential program must include the provision of Partial Hospitalization Program services within the facility.

14. The program description for a child/adolescent residential program must include a description of how the child/adolescent shall continue to receive appropriate education while in the program.

(i) The program description addresses a procedure for referral to the appropriate resource (DHR, Probate Court, etc.) for those consumers who may need a legal guardian while residing in the program.

(2) Residential facilities, with the exception of apartments, shall demonstrate on-site staff coverage 24 hours a day, 7 days per week as indicated by staff duty rosters.

(3) The personnel records of all residential staff have current certification for First Aid and CPR from an authorized certifying agency. Staff are trained prior to working alone with consumers.

(4) There is documentation that all residential staff have received training in infection control and prevention prior to working with consumers and annually thereafter. There is documentation that consumers have received infection control training at the time of admission and annually thereafter.

(5) There is documentation that all residential staff who transport consumers have a current driver’s license valid in Alabama. The license shall be appropriate for the type of vehicle operated by the driver.

(6) Consumers admitted to each type of residential program meet the admission criteria as specified above, and consumer records verify that admission criteria were met.

(7) The majority of residential staff of a home serving primarily consumers who are deaf shall hold at least Intermediate Plus level fluency in Sign Language as measured by the Sign Language Proficiency Interview (SLPI) with at least one fluent person per shift. Staff providing clinical services shall have an Advanced proficiency. Non-signing staff will engage in on the job training to learn American Sign Language.

(8) Consumers admitted to each type of residential program do not meet exclusionary criteria as specified above.

(9) Residential programs shall provide or arrange access to a wide range of services. The following services, at a minimum, should be either provided in-house or arranged for by the residential staff, depending upon the needs of the individual consumer:

(a) Assistance in applying for benefits.

(b) Assistance in improving social and communication skills.

(c) Assistance with medication management.

(d) Assistance in the development of basic living skills (money management, laundering, meal preparation, shopping, transportation, house cleaning, personal hygiene, nutrition, and health and safety).

(e) Vocational services.

(f) Community orientation.

(g) Recreation and activities.

(h) Assistance in locating long term community placement in least restrictive setting.

(i) Transportation to and from necessary community services and supports.

(j) Education about psychiatric illness.

(k) Family support and education.

(l) Monthly/weekly schedule of activities and consumer/staff member interview confirm that the appropriate services are being access or provided to consumers of residential services.

(m) The consumers' records indicate that the required services are being provided.

(n) The consumers' records indicate that the provision of communication access for people who are deaf is consistent with programming offered by the home.

(10) The residential program will provide each consumer a variety of 3 nutritious meals plus snacks per day 7 days per week as evidenced by weekly menus approved by a nurse, nutritionist, or dietician. (Exception: Consumers served a meal at another location).

(11) There are policies and procedures designed to assure that meals are nutritious, offer a variety of foods, and reflect consumer preferences to the extent possible. There are policies and procedures to assure that consumers who are involved in activities outside of the home during meal times get a meal.

(12) There is a policy that requires provision of special diets as prescribed by a physician.

(13) There is a policy stating that staff shall not serve as the legal guardian for consumers of the residential facility.

(14) All filled prescriptions controlled by staff of residential facilities must be stored in a locked cabinet or other substantially constructed storage area that precludes unauthorized entry. There must be a written policy that medication cabinets be locked when not in use.

(15) There shall be a written policy regarding disposition of unused medication in residential programs in accordance with Alabama Board of Pharmacy and federal Environmental Protection Agency guidelines.

(16) There must be written procedures for handling the disruptive behavior of consumers. Staff shall be trained in these procedures. Such procedures shall include:

(a) Access to agency backup staff and appropriate community personnel.

(b) If incarceration is necessary, the following procedures are required, or documentation why, in an individual case, they could not be implemented:

1. Face-to-face contact by a mental health professional either prior to or within 2 hours of incarceration.

2. A staff member inform the jail/detention center of the consumer's medication and offer to bring medication to the jail/detention center.

3. Regular visits by a staff member during incarceration unless it is considered to be non-therapeutic or is not permitted by the jail/detention center and is so documented in the consumer's record.

4. If the consumer is on temporary visit status, the state hospital will be notified within 24 hours.

5. The emergency contact will be notified within 24 hours.

(17) There is a policy that consumers will not be discharged solely on the basis of one positive urine analysis showing the presence of alcohol, illegal drugs, or medication not prescribed.

(18) At the time of admission, the provider will secure a written agreement with the consumer, family member, placing agency, or significant other indicating who will be responsible for medical and dental expenses.

(19) All residential programs must demonstrate their consumer's accessibility to a local licensed hospital for the purpose of providing emergency hospital care.

(20) Residential programs will assist consumers in obtaining necessary medical care.

(21) First aid supplies in the type and quantity approved by a registered nurse or a pharmacist shall be kept in a readily accessible location for all shifts and will be restocked upon use.

(22) There shall be adequate room for private visits with relatives and friends, for small group activities, and for social events and recreational activities. In homes occupied by consumers who are deaf, an adaptive telecommunication device must be present in order to allow the consumer to make and receive telephone calls.

(23) Radios, television, books, current magazines and newspapers, games, etc. shall be available for consumers. In homes occupied by deaf consumers, televisions will have working closed-caption decoders and such decoders will be turned on.

(24) In the case of an unexpected or unexplained death, the provider will:

(a) Report the death to the Department of Mental Health as soon as possible but at least within 24 hours.

(b) Request the local police or sheriff to conduct an investigation.

(c) Report the death to the County Medical Examiner or assure that the death is reported to the County Medical Examiner.

(25) If the provider uses residential beds for respite services (also known as crisis respite), the following criteria must be met:

(a) There are written admission, expected length of stay, and continued stay criteria.

(b) There is a written screening/referral protocol.

(c) Services provided and documented must be appropriate to meet the identified needs of each person admitted for crisis respite services.

(d) The beds must be in a program certified under section 580-2-9-.18. Programs where all beds are used for crisis residential services must meet the requirements as set

forth in 580-2-9-.18(1) through 580-2-9-.18(28) and 580-2-9-.18(35).

(26) The capacity of each type of residential program shall not exceed 10 except in cases where a waiver is recommended by the Associate Commissioner for Mental Illness and approved by the Commissioner based upon the presence of a compensating advantage to the residents in increased privacy and personal space. Programs in excess of a capacity of 10 and/or that have more than 2 residents per bedroom that have been previously certified are eligible to continue to be certified at the existing capacity and bedroom occupancy at the existing location so long as compliance with all their applicable standards is maintained. If a previously certified program with a capacity greater than 10 and/or with more than two residents per bedroom changes location, the new location cannot exceed a capacity of 10 and cannot have more than 2 residents per bedroom unless a waiver of this regulation, applied for in writing, is granted by the Commissioner of DMH.

(27) There shall be written program rules developed in accordance with the following principles.

(a) Program rules shall be developed with documented active participation of consumers and staff.

(b) Program rules shall promote individual responsibility and prohibit rules for staff convenience and rules based on one person’s behavior.

(c) Program rules shall be based on the Rights Protection and Advocacy guidelines for consumer rights and responsibilities.

(d) Program rules shall address the following areas, at a minimum.

1. Visitation hours.

2. Sign in/out requirements.

3. Curfew.

4. Sexual contact on provider/facility property which respect consumer’s dignity, privacy, and need for social interaction with others.

5. Supervised access to the kitchen for health and safety reasons.

6. Possession and consumption of legal and illegal substances.

7. Possession of weapons.

(e) Program rules shall provide for resolution of disputes on an individual basis. When necessary, adjustments should be made to the treatment plan.

(f) Program rules shall make clear the consequences when rules are not followed.

(g) Program rules shall limit chores to those necessary to maintain personal and treatment areas and prohibit using consumers for other duties, unless the consumer chooses to perform those duties and is compensated fairly.

(h) Application of the rules and consequences will be fair, consistent, and recognize extenuating circumstances.

(28) An adult small capacity (3-bed) residential home must meet the following criteria:

(a) The program coordinator shall have a bachelor's degree in a mental health service related field and shall have 2 years experience in a direct service area. Alternatively, the coordinator shall have 3 years experience in a mental illness residential setting, demonstrate the ability to communicate clearly orally and in writing, and demonstrate the ability to maintain clinical records in accordance with standards.

(b) All staff have received initial and at least annual training related to the special needs of the population served.

(c) The program has the following staffing pattern:

1. Day Shift – 1 Program Coordinator (5 days per week) and 1 Mental Health Worker (2 days per week).

2. Evening Shift – 1 Mental Health Worker (7 days per week).

3. Night Shift – 1 Mental Health Worker (7 days per week, awake).

(d) The program shall provide specialized services that are based on the admission criteria contained in the program description.

(29) An adult residential care home must meet the following criteria:

(a) The program coordinator shall have a bachelor's degree in a mental health related field and 2 years experience in a direct service functional area.

(b) All staff have received initial and at least annual training related to the special needs of the population served.

(c) The program has the following staffing pattern:

1. Day Shift – 1 BA (5 days per week), .25 secretary/aide (5 days per week), and 1 Mental Health Worker (2 days per week).

2. Evening Shift – 1 Mental Health Worker (7 days per week).

3. Night Shift – 1 Mental Health Worker (7 days per week, night shift can sleep).

(d) The program shall provide specialized services that are based on the admission criteria contained in the program description.

(30) An adult residential care home with specialized basic services must meet the following criteria:

(a) The program coordinator shall have a bachelor's degree in a mental health related field and 2 years experience in a direct service functional area.

(b) All staff shall receive initial and at least annual training related to the special needs of the population served.

(c) The program shall provide specialized services that are based on the admission criteria contained in the program description.

(d) The program has the following staffing pattern for a 10 bed home:

1. Day shift – 1 BA (5 days per week), .25 secretary/aide (5 days per week), and 1 Mental Health Worker (2 days per week).

2. Evening shift – 1 Mental Health Worker (7 days per week).

3. Night shift – 1 Mental Health Worker (7 days per week, awake).

(e) The program has the following staffing pattern for a 16 bed home:

1. Day Shift – 1 BA (5 days/week), .25 secretary/aide (5 days/week), and 1 Mental Health Worker (7 days/week).

2. Evening Shift – 1 Mental Health Worker (7 days/week).

3. Night Shift – 1 Mental Health Worker (7 days/week, awake).

(31) An adult residential care home with specialized medical services must meet the following criteria:

(a) The program coordinator shall be a registered nurse.

(b) All staff shall receive initial and at least annual training related to the special needs of the population served.

(c) The program shall provide specialized services that are based on the admission criteria contained in the program description.

(d) The program has the following staffing pattern for a 10 bed home:

1. Day shift – 1 registered nurse (7 days per week), .25 secretary/aide (5 days per week), and 1 Mental Health Worker (7 days per week).

2. Evening shift – 1 licensed practical nurse and 1 Mental Health Worker (7 days per week).

3. Night shift – 1 licensed practical nurse and 1 Mental Health Worker (both 7 days per week, both awake).

(e) The program has the following staffing pattern for a 16 bed home:

1. Day Shift – 2 Registered Nurses (7 days/week), .25 secretary/aid (5 days/week), 1 Mental Health Worker (7days/week).

2. Evening Shift – 1 Licensed Practical Nurse and 2 Mental Health Workers (7days/week).

3. Night Shift – 1 Licensed Practical Nurse and 1 Mental Health Worker (7 days/week, both awake).

(32) An adult residential care home with specialized behavioral services must meet the following criteria:

(a) The program coordinator shall have a bachelor's degree in a mental health related field and 2 years experience in a direct service functional area.

(b) All staff shall receive initial and at least annual training related to the special needs of the population served.

(c) The program shall provide specialized services that are based on the admission criteria contained in the program description.

(d) The program has the following staffing pattern for a 10 bed home:

1. Day shift – 1 BA (5 days per week), .25 secretary/aide (5 days per week), and 2 Mental Health Worker (2 days per week).

2. Evening shift – 2 Mental Health Workers (7 days per week).

3. Night shift – 2 Mental Health Workers (7 days per week, both awake).

(e) The program has the following staffing pattern for a 16 bed home:

1. Day Shift – 1 BA (5day/week), .25 secretary/aide (5days/week), 1 Mental Health Worker 5 days/ week, and 2 Mental Health Workers (2 days/week).

2. Evening Shift – 2 Mental Health Workers (7days/week).

3. Night Shift – 2 Mental Health Workers (7days/week, both awake).

(33) An adult therapeutic group home must meet the following criteria.

(a) The program coordinator shall have a master's degree in a mental health related field and at least 2 years post master's experience in a direct service position.

(b) The program shall provide specialized services that are based on the admission criteria contained in the program description and must include at a minimum the provision of intensive day treatment services within the home.

(c) All staff shall receive initial and at least annual training related to the special needs of the population served.

(d) The program has the following staffing pattern for a 10 bed home:

1. Day shift – 1 MA (5 days per week), 2 BA (7 days per week), .5 secretary/aide (5 days per week).

2. Evening shift – 1 Mental Health Worker (7 days per week).

3. Night shift – 1 Mental Health Worker (7 days per week, awake).

(e) The program has the following staffing pattern for a 16 bed home:

1. Day Shift - 1 MA (5 days per week), 2 BA (7 days per week), .5 secretary/aide (5 days per week).

2. Evening shift – 1 Mental Health Worker (7 days per week).

3. Night shift – 1 Mental Health Worker (7 days per week, awake); Assigned as need – 1 Mental Health Worker (7days/week) assigned as deemed appropriate by the program based on residents' needs.

(34) An Intermediate Care Program must meet the following criteria:

(a) The program coordinator shall have a master's degree in a mental health related field and at least 2 years experience post-master's in a direct service position or be a registered nurse with at least 2 years of psychiatric inpatient experience.

(b) The program shall provide specialized services that are based on the admission criteria contained in the program description and must include at a minimum the provision of partial hospitalization services within the home.

(c) All staff shall receive initial and at least annual training related to the special needs of the population served.

(d) Admissions will be drawn primarily from persons referred from state psychiatric hospitals.

(e) The expected length of stay is 3 months unless an extension is clinically justified, but no more than 6 months.

(f) A psychiatrist shall make daily rounds Monday through Friday and shall be on call 7 days per week.

(g) The program has the following staffing pattern for 16 beds:

1. Day Shift - .5 Psychiatrist (includes on-call time), 1 MA (5 days/week), 1 Registered Nurse (5 days/week), 1 BA (5 days/week), 1 secretary/aide (5 days/week), 1 LPN (7 days/week), and 2 Mental Health Workers (7 days/week) where

either the MA position or the Registered Nurse may be the program coordinator.

2. Evening Shift – 1 Licensed Practical Nurse and 2 Mental Health Workers(7 days/week); Night Shift – 1 Licensed Practical Nurse and 2 Mental Health Workers (7days/week, all awake).

(35) A crisis residential program must meet the following criteria for 10 or less beds:

(a) The program coordinator shall have a master's degree in a mental health related field and 2 years post master's experience in a direct service functional area or be a registered nurse with 2 years of psychiatric inpatient experience.

(b) The program shall provide specialized services that are based on the admission criteria contained in the program description and must include partial hospitalization services provided within the facility.

(c) A psychiatrist shall make daily rounds 5 days per week and shall be on call 7 days per week.

(d) All staff shall receive initial and at least annual training related to the special needs of the population served.

(e) The program has the following staffing pattern:

1. Day shift – .25 psychiatrist, 1 MA (7 days per week), 1 BA (5 days per week), 1 RN (5 days per week), and 1 secretary/aide (5 days per week).

2. Evening shift – 1 MA (5 days per week), 1 LPN, and 1 Mental Health Worker (both 7 days per week).

3. Night shift – 1 LPN and 1 Mental Health Worker (both 7 days per week, both awake).

(f) The expected length of stay is 2 weeks or less.

(g) The crisis residential program must also meet the standards for Designated Mental Health Facilities.

(36) A Psychiatric Assessment Center must meet the following criteria:

(a) The program shall provide specialized services that are based on the admission criteria in the program description.

(b) The program coordinator shall have a Master's degree in a mental health related field and 2 years post-Master's experience in a direct service functional area or be a Registered Nurse with 2 years of psychiatric inpatient experience.

(c) The program has the following staffing pattern for a maximum of 10 beds:

1. Day shift - .25 psychiatrist, 1 MA or RN Coordinator (5 days per week), 1 RN or LPN (7 days per week), 1 Clerical/Aide (5 days per week), 1 Mental Health Worker (7 days per week).

2. Evening Shift – 1 RN or LPN (7 days per week), 1 Mental Health Worker (7 days per week).

3. Night Shift – 1 RN or LPN (7 days per week), 1 Mental Health Worker (7 days per week).

(d) A psychiatrist shall make daily rounds 5 days per week and shall be on call 7 days per week.

(e) Adequate Intensive Case Management will be available within the organization to facilitate discharge planning and diversion from hospitalization in a state hospital.

(f) All staff shall receive initial and at least annual training related to the needs of the population served.

(g) The expected length of stay shall be no more than 4 days.

(37) A child/adolescent program must meet the following criteria:

(a) The program coordinator shall have a master's degree in a mental health related field and shall have at least 2 years post master's experience in a direct service

functional area. One of the two years post master's experience must be with children/adolescents.

(b) Children/adolescents shall continue to receive an appropriate education while in the residential program. Children and adolescents shall receive 6 hours of education each day unless modified by an Individual Education Program. If the educational program is provided by the residential program, it must be registered with the State Department of Education. If the program is receiving special education funds, the program must agree to meet the minimum assurance statements set forth by the State Department of Education.

(c) All staff shall receive initial (before working alone with consumers) and 20 hours of annual training related to the target population with 2 of those 20 hours involving the perspective of families and consumers with regard to residential treatment.

(d) The frequency and intensity of treatment interventions must be specified in the individual treatment plans. Individual service elements must meet the applicable criteria in the Outpatient Service standards.

(e) The treatment plans are consistent with the admission criteria.

(f) The child/adolescent will be assessed for special education services. Once assessed, if the child/adolescent is determined to qualify for Special Education services, an Individualized Education Plan (IEP) is developed and a copy is placed in the clinical record.

(g) If a child/adolescent has an IEP, it shall be followed while in residential care including any updates. The legal guardian shall be informed of any meeting regarding an update or alteration in the child/adolescent's IEP.

(h) Children/adolescents shall receive at least 1 hour of individual therapy and 1 hour of group therapy each week. There is documentation that there are no more than 10 consumers in each group therapy session.

(i) The clinical backgrounds of the children and adolescents should be considered when room assignments are made.

(j) Thirty days prior to discharge the residential facility will begin coordinating recommended transitional services.

(k) Upon discharge, with the permission of the personal representative/legal guardian, the facility will set up appointments for the child/adolescent for all recommended follow-up services.

(l) Upon discharge, the personal representative/legal guardian will be given a list of all medications given during the residential stay and an explanation for why they were prescribed and the reason for discontinuation, if applicable.

(38) The Transitional Age Residential Care Program (age 17-25) must meet the following criteria:

(a) The Program Coordinator shall have either a Bachelor's degree in a mental health related field or be a Registered Nurse and have at least 2 years post-degree experience in a direct service functional area. One of the two years post-degree experience must be with adolescents/youth.

(b) Consumers shall continue to receive educational services while in the residential program, if deemed appropriate based upon an assessment of educational needs and age. School-age consumers shall receive 6 hours of education each day unless modified by an Individual Education Program (IEP). If the educational program is provided by the residential program, it must be registered with the State Department of Education. If the program is receiving special education funds, the program must agree to meet the minimum assurance statements set forth by the State Department of Education.

(c) The consumer's IEP shall be followed and updated as needed while in residential care, including providing access to special needs services. The consumer and/or personal representative shall be informed of any meeting regarding an update or alteration in the consumer's IEP.

(d) All staff shall receive initial training (before working alone with consumers) and 20 hours of annual training related to the target population with 2 of those

hours involving the perspective of families and consumers with regard to residential treatment.

(e) The program shall provide specialized services that are based on the essential service components and the admission criteria contained in the program description. Custody must be verified through the admission process, if applicable.

(f) The frequency and intensity of treatment interventions must be specified in the individual treatment plans. Individual service elements must meet the applicable criteria in the Outpatient Service standards.

(g) The treatment plans are consistent with the admission criteria.

(h) The consumers shall receive at least 1 hour of individual therapy and 1 hour of group therapy each week. There is documentation that there are no more than 10 consumers in each group therapy session.

(i) The clinical backgrounds of the consumers should be considered when room assignments are made.

(j) Thirty days prior to discharge the residential facility will begin coordinating recommended transitional services.

(k) Upon discharge with the permission of the consumer and/or personal representative/legal guardian, the program shall set up appointments for the consumer for all recommended follow-up services.

(l) Upon discharge, the consumer and/or personal Representative/legal guardian will be given a list of all medications given during the residential stay and an explanation for why they were prescribed and the reason for discontinuation, if applicable.

(m) The program has the following staffing pattern for 10 beds:

1. Day Shift – 1 BA/RN Program Coordinator (5 days per week), .25 clerical/aide (5 days per week), 1 BA Case Manager (7 days per week), and 1 Mental Health Worker (7 days per week.

2. Evening Shift – 2 Mental Health Workers (7 days per week); Night Shift – 2 Mental Health Workers (7 days per week with at least 1 awake)

(n) Admissions will be drawn primarily from persons referred from state psychiatric hospitals.

(39) A Medication/Observation/Meals Program is exempt from the following general residential standards in this section (1)(f)1., (9)(l)and (m), (10), (11), (12), (22), (23), (26), and (27) and must meet the following criteria:

(a) The program coordinator shall have a bachelor's degree in a mental health related field and 2 years experience in a direct service functional area.

(b) All staff shall receive initial and at least annual training related to the special needs of the population served.

(c) The program shall provide specialized services that are based on the admission criteria contained in the program description. The program description shall specifically address provisions for the following core services: meals, observation, and medication.

(d) Residents shall be provided choice to what degree, if any, they wish to participate in on-site activities.

(e) Outpatient Services such as psychiatry, nursing, and therapy services shall be delivered on-site.

(f) The program has the following staffing pattern for a 20 bed dwelling:

1. Day shift – 1 BA Coordinator (5 days per week), .1 full-time equivalent psychiatrist, .1 full-time equivalent MA therapist, and .1 full-time equivalent registered nurse, and 1 Mental Health Worker (7 days per week).

2. Evening shift – 1 Mental Health Worker (7 days per week).

3. Night Shift – 1 Mental Health Worker (7 days per week, awake).

(g) Living units shall be exclusively for the target population and shall be communally located with 24/7 on-site awake staff.

(h) The number of living units located at one site shall not exceed 30 unless approved by the Department of Mental Health.

Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: **New Rule:** March 5, 2010; effective July 19, 2010.

580-2-9-.19 Designated Mental Health Facility.

(1) To be a Designated Mental Health Facility (DMHF) for outpatient commitment purposes, an agency must meet the requirements to be certified as a Community Mental Health Center, apply for designation, and be approved by the Department of Mental Health.

(2) For a hospital to be a Designated Mental Health Facility for purposes of inpatient commitment and/or detaining a person in accordance with the Community Mental Health Officer Act, it must operate psychiatric beds that have the ability to receive persons for evaluation, examination, admission, detention, or treatment pursuant to the provisions of the Commitment Law and meet the following criteria:

(a) Be accredited for psychiatric inpatient services by the Joint Commission on Accreditation of Healthcare Organizations or be certified by Medicare.

(b) Apply for designation.

(c) Be approved.

(d) Agree to forward reports of renewals of Joint Commission or Medicare accreditation immediately upon receipt as well as copies of any other Joint Commission or Medicare action that affects their accreditation status in any way.

(3) To be a non-hospital Designated Mental Health Facility for purposes of inpatient commitment and/or detaining a person in accordance with the Community Mental Health Officer Act, an agency must meet the following criteria.

(a) Be certified as a Community Mental Health Center.

(b) The location of the DMHF must be an adult residential program that is certified under 580-2-9-.18 (except for a Residential Care Home).

(c) Have the ability to receive persons for evaluation, examination, admission, detention, or treatment pursuant to the provisions of the Commitment Law.

(d) Have a staff member who is a licensed psychologist, licensed certified social worker, licensed professional counselor, or a nurse with a master's degree in psychiatric nursing with ready access to the Clinical Director or a consulting psychiatrist to perform an evaluation of the respondent and, at a minimum, address the following areas in writing.

1. The manner in which the security available in a residential program will meet the security needs of the respondent.

2. A determination that the respondent meets the admission criteria of the residential program.

3. The manner in which the treatment services available through the residential program will meet the identified treatment needs of the respondent.

4. The manner in which the respondent's need for nursing services can be met in the residential program.

5. The estimated need for seclusion and restraint.

(e) Have a representative who is required to report to the Probate Judge that the respondent can be appropriately served in the residential program.

(f) Have the community mental health center psychiatrist approve the admission to the residential program in writing if a person is committed to the residential facility following the final hearing.

(g) Be able to quickly transfer an involuntarily committed individual to a more secure/intensive environment by transfer to either a local or state hospital.

(h) Be able to bring in supplemental staff in cases where a consumer is awaiting transfer or otherwise needs additional supervision.

(i) Notify the Admission Office of the respective state hospital of the admission or transfer of a person who is involuntarily committed.

(j) Notify the committing Probate Court whenever an involuntarily committed individual is transferred from the designated mental health facility to another location.

(k) Be certified as a crisis residential program as set forth in section 580-2-9-.18(35) and conform to rule 580-2-9-.24 if seclusion and restraint are used.
Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: March 5, 2010; effective July 19, 2010.

580-2-9-.20 Consultation And Education.

(1) The agency shall provide public education, which may include written material on available services, how to access them, media and public presentations, and referral information on advocacy activities.

(2) The staff participate in cross-agency staffing/service coordination through meetings such as task forces, interagency committees, etc.

(3) The agency provides program consultation as requested by other agencies to assist the other in developing/changing services to its recipients.
Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: March 5, 2010; effective July 19, 2010.

580-2-9-.21 Assertive Community Treatment.

(1) The program description is approved by the board as specified in 580-2-9-.08(10)(b)and is consistent with the provisions of this section. The program description must include all of the following components:

(a) A description of the nature and scope of the program that includes at a minimum the provision of services as specified in this section and as indicated by individual consumer need.

(b) Discharge/transfer criteria and procedures.

(c) A description of the service area for the program.

(d) Admission criteria that include at least the following.

1. A psychiatric diagnosis.

2. Admission approval by a psychiatrist, licensed psychologist, or the clinical director.

(e) Reflects the following characteristics and philosophy of Assertive Community Treatment Teams.

1. Multi-disciplinary staff organized as a team in which members function interchangeably to provide treatment, rehabilitation, and support to persons with serious mental illness and severe functional disability.

2. The team is the primary provider of services and is responsible for helping consumers in all aspects of community living.

3. The majority of services occur in the community in places where consumers spend their time.

4. Services are highly individualized both among individual consumers and across time for each consumer.

5. Persistent, creative adaptation of services to be acceptable to consumers provided in a manner of unconditional support.

(2) The following services must be delivered within the program as indicated by consumer need.

(a) Intake.

(b) Physician assessment and treatment.

(c) Medication administration.

(d) Medication monitoring.

(e) Individual and/or group therapy.

(f) Case management.

(g) Crisis intervention and resolution.

(h) Mental health consultation.

(i) Family therapy.

(j) Family support and education.

(k) Basic living skills.

(3) There must be an assigned team that is identifiable by job title, job description, and job function. The team must have:

(a) Part-time psychiatric coverage.

(b) 3 full-time equivalent positions which include at least 1 full-time master's level clinician.

(c) At least .50 FTE registered nurse or licensed practical nurse, and

(d) A fulltime case manager (staff member who has completed an approved case management training curriculum).

(e) The remaining .5 FTE position may be filled at the agency's discretion by a master's level clinician, a nurse, or a case manager.

(4) The team must function in the following manner:

(a) Each member of the team must be known to the consumer.

(b) Each member of the team must individually provide services to each client in the team's caseload.

(c) The team will conduct staffing of all assigned cases at least twice weekly.

(d) The caseload cannot exceed a 1:12 staff to client ratio where the part-time psychiatrist is not counted as one staff member.

(5) The program coordinator must have a master's degree in a mental health related field and at least 2 years of post-master's direct service experience or be a registered nurse with a minimum of 2 years psychiatric experience.

(6) Services must be available and accessible, including effective communication access for consumers who are deaf, hard of hearing, or limited English proficient, to enrolled consumers 24 hours per day/7 days per week in a manner and at locations that are most conducive to consumers' compliance with treatment and supports. It is not necessary that a member of the ACT team be on call at all times.

(7) The program does not limit length of stay.

(8) The number of contacts as defined in 580-2-9-.21(2) by individual team members and totally for the team varies according to individual consumer need, but should be:

(a) A minimum of once per week for consumers in a maintenance phase up to several times per day for consumers who require it.

(b) Done in a manner to assure that all team members provide services to and are known to the consumer and are capable of stepping in when needed.

Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: March 5, 2010; effective July 19, 2010.

580-2-9-.22 Program for Assertive Community Treatment

(1) The program description is approved by the Board as specified in 580-2-9-.08(10)(b) and is consistent with the provisions of this rule. The program description must include all of the following components.

(a) A description of the nature and scope of the program that includes, at a minimum, the provision of services as specified in this chapter and as indicated by individual consumer needs.

(b) Discharge/transfer criteria and procedures that do not limit the amount of time a consumer is on the team, that permit the team to remain the contact point for all consumers as needed, and that require discharges to be mutually determined by the consumer and the team.

(c) A description of the geographic service area for the program.

(d) Admission criteria that includes, at least, the following:

1. Consumers with severe and persistent mental illnesses that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorder, or bipolar disorders. At least 80% of consumers have a diagnosis in the 295-296 Axis 1 range.

2. Functional impairments demonstrated by at least one of the following conditions.

(i) Inability to consistently perform the range of daily living tasks required for basic adult functioning in the community or persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or relatives.

(ii) Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role.

(iii) Inability to maintain a safe living situation.

3. Consumers with one or more of the following which are indicators of continuous high-service needs (greater than 8 hours per month).

(i) Two or more admissions per year to acute psychiatric hospitals or psychiatric emergency services.

(ii) Intractable, severe major symptoms (affective, psychotic, suicidal).

(iii) Co-existing substance use disorder of significant duration (greater than 6 months).

(iv) High risk of or recent criminal justice involvement.

(v) Inability to meet basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless.

(vi) Residing in an inpatient bed or in a supervised community residence, but clinically assessed as being able to live in a more independent living situation if intensive services are provided or requiring residential/inpatient placement if more intensive services are not available.

4. Admission approval by a psychiatrist, licensed psychologist, or the Clinical Director.

(e) The description reflects that the Program of Assertive Community Treatment (PACT) operates as follows.

1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified clients with sever and persistent mental illnesses.

2. Minimally refers consumers to outside service providers.

3. Provides services on a long-term care basis with continuity of caregivers over time.

4. Delivers 75% or more of the services outside program offices.

5. Emphasizes outreach, relationship building, and individualization of services.

(2) There must be an identifiable team with the following characteristics.

(a) Clinical staff to consumer ratio of 1:10, excluding the doctor and administrative assistant.

(b) Minimum team size of 10 Full-time Equivalents in urban areas, 5-7 Full-time Equivalents in rural areas.

(c) A psychiatrist(s) 16 hours per week per 36 consumers.

(d) Administrative Assistant of 1 FTE in urban areas and .5 Full-time Equivalents in rural areas.

(e) Full-time master's level clinician as team leader.

(f) At least 8 mental health professionals (MA, MSN, RN) in urban areas, 5 in rural areas.

(g) Substance Abuse specialist of, at least, 1 Full-time Equivalents(FTE).

(h) RN of, at least, 3 Full-time Equivalents in urban areas and 1.5 in rural areas.

(i) Vocational specialist of, at least, 1 Full-time Equivalents.

(j) Peer specialist of, at least, 1 Full-time Equivalents.

(k) Members that work as a team so that all team members know and work with all consumers.

(l) Program operates, at least, at 80% of full staffing for the past 12 months, or since program opening, if not in operation for 12 months.

(3) The team leader performs the following functions.

(a) Leads daily organizational team meetings.

(b) Leads treatment planning meetings.

(c) Is available to team members for clinical consultation.

(d) Provides one-to-one supervision.

(e) Functions as a practicing clinician.

(4) The psychiatrist performs the following functions.

(a) Conducts psychiatric and health assessments.

(b) Supervises the psychiatric treatment of all consumers.

(c) Provides psychopharmacologic treatment of all consumers.

(d) Supervises the medication management system.

(e) Provides individual supportive therapy.

(f) Provides crisis intervention on-site.

(g) Provides family interventions and psychoeducation.

(h) Attends daily organizational and treatment planning meetings.

(i) Provides clinical supervision.

(5) The registered nurses perform the following functions.

(a) Manage medication system, in conjunction with doctors.

(b) Administer and document medication treatment.

(c) Conduct health assessments.

(d) Coordinate services with other health providers.

(6) The vocational specialist performs the following functions.

(a) Acts as the lead clinician for vocational assessment and planning.

(b) Maintains liaison with Vocational Rehabilitation and training agencies.

(c) Provides the full range of vocational services (job development, placement, job support, career counseling).

(7) The substance abuse specialist performs the following functions.

(a) Serves on the individual treatment team of consumers with substance abuse.

(b) Acts as the lead clinician for assessing, planning, and treating substance abuse.

(c) Provides supportive and cognitive behavioral treatment individually and in groups.

(d) Uses a stage-wise model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence.

(8) The team provides outreach and continuity of care in the following manner.

(a) At least 75% of all contacts occur out of the office.

(b) Difficult-to-engage consumers are retained.

(c) Difficult-to-engage consumers are seen 2 times per month or more.

(d) Acutely hospitalized consumers are seen 2 times per week or more.

(e) Long-term hospitalized consumers are seen each week in the hospital.

(f) The team plans jointly with inpatient staff.

(9) The program provides the following intensity of services.

(a) The program size does not exceed 120 consumers in urban areas and 80 in rural areas.

(b) The staff to client ratio does not exceed 1 to 10.

(c) The consumers are contacted face-to-face an average of 3 times per week.

(d) Unstable consumers are contacted multiple times daily.

(10) The team operates during the following hours.

(a) The staff are on duty 7 days per week.

(b) The program operates 12 hours on weekdays.

(c) The program operates 8 hours on weekends/holidays.

(d) The team members are on-call all other hours in the urban model. In rural areas, team members can coordinate after-hours calls with other clinicians. A team member must brief the on-call staff relative to high-risk consumers. A team member must provide face-to-face services, if necessary.

(11) The team is organized and communicates in the following manner.

(a) Organizational team meetings are held daily, Monday through Friday.

(b) The daily meeting concludes within 45 - 60 minutes.

(c) The status of each consumer is reviewed via daily log and staff report.

(d) The team leader facilitates the discussion and treatment planning.

(e) Services and contacts are scheduled per treatment plans and triage.

(f) The shift manager determines the staff assignments.

(g) The shift manager prepares the daily staff assignment schedule.

(h) The shift manager monitors/coordinates service provision.

(i) All staff contacts with consumers are logged.

(12) The team performs assessment and treatment planning in the following manner.

(a) Baseline and ongoing assessments are documented in the following areas.

1. Psychiatric.

2. Vocational.

3. Activities of daily living and housing.

4. Social.

5. Family interaction.

6. Substance use and

7. Health.

(b) Assessments are performed by qualified staff.

(c) Individual treatment teams consist of from 3 to 5 staff per consumer.

(d) Treatment planning meetings are held weekly.

(e) Treatment planning meetings are led by senior staff.

(f) Consumers participate in formulating goals and service plans.

(g) All 5 diagnostic axes are completed on plans.

(h) Problems, goals, and plans are specific and measurable.

(i) The treatment plans are transferred to consumers' weekly schedules.

(j) The treatment planning schedule is posted 2 months in advance.

(k) The treatment plan is reviewed and modified at key events in the course of treatment but no less often than every 6 months.

(13) Case management services are provided as follows.

(a) A case manager is assigned for each consumer.

(b) Other individual treatment team staff back-up the case manager.

(c) The case manager provides supportive therapy, family support, education and collaboration, and crisis intervention.

(d) The case manager plans, coordinates, and monitors services.

(e) The case manager advocates for the consumer and provides social network support.

(f) All staff perform case management functions.

(14) Crisis assessment and intervention services are provided as follows.

(a) Crisis services are provided 24 hours per day.

(b) A team member is available by phone and face-to-face with back-up by team leader and psychiatrist in urban areas.

(c) After-hour services are provided in rural areas either by the team or through collaboration with other emergency service providers.

(15) Individual supportive therapy is provided as follows:

(a) Ongoing assessment of symptoms and treatment response.

(b) Education about the illness and medication effects.

(c) Symptom management education.

(d) Psychological support, problem solving, and assistance in adapting to illness.

(16) Medication management is provided as follows.

(a) The psychiatrist actively supervises/collaborates with the RN's.

(b) There is frequent psychiatrist assessment of consumer response.

(c) All team members monitor medication effects/response.

(d) Medication is managed in accordance with the policy and procedure manual.

(17) Substance abuse services are provided as follows.

(a) The team includes 1 or more designated substance abuse specialists.

(b) All team members assess and monitor substance use.

(c) Interventions follow an established co-occurring disorders treatment model.

(d) Individual interventions are provided.

(e) Group interventions are provided.

(18) Work-related services are provided as follows.

(a) Services include an assessment of interest and abilities and of effect of mental illness on employment.

(b) All team members provide vocational services that are coordinated by the team vocational specialist.

(c) An ongoing employment rehabilitation plan is developed.

(d) On-the-job collaboration with the consumer and supervisor is provided.

(e) Off-the-job work-related supportive services are provided.

(19) Services for activities of daily living include the following training.

(a) Self-care skills.

(b) Homemaking skills.

(c) Financial management skills.

(d) Use of available transportation.

(e) Use of health and social services.

(20) The team organizes leisure time activities. Services for social, interpersonal relationship, and leisure time include the following.

(a) Communication skill training.

(b) Interpersonal relations skill training.

(c) Social skills training.

(d) Leisure time skills training.

(e) Support to consumers in participating in social, recreational, educational, and cultural community activities.

(21) Support services are provided and include the following.

(a) Access to medical and dental services

(b) Assistance in finding and maintaining safe, clean affordable housing.

(c) Financial management support.

(d) Access to social services.

(e) Transportation and access to transportation.

(f) Legal advocacy.

(22) There shall be an advisory committee with the following membership and roles.

(a) At least, 51% of the members are consumers and family members with a minimum of 3 consumer members.

(b) The local NAMI affiliate, local consumer organizations, and the management of the provider organization should collaborate to determine the committee membership.

(c) The membership shall be culturally representative of the consumers served by the team.

(d) There should be, at least, 10 members but no more than 15.

(e) The Advisory Committee shall meet at least quarterly and as often as needed.

(f) The Advisory Committee is independent of, and communicates directly with, management level staff.

(g) The team leader and other staff, as necessary, meet with the Advisory Committee and provide administrative support to it.

(h) The members will advise the team on issues to make services relevant, culturally respectful, collaborative and desirable to consumers.

(i) The members will monitor evaluation data, including consumer complaints, relative to making performance improvement recommendations.

(j) The Advisory Committee will advocate for resources for consumers served by the team.

(k) The Advisory Committee will promote community understanding of the model and its goals, including community presentations.

(23) Consumers who are deaf or have limited English proficiency will have communication access provided by staff fluent in the consumer's preferred language or by a qualified interpreter. If the consumer is deaf, the staff member providing services shall have at least an Intermediate Plus level in the Sign Language Proficiency Interview. Programming

will be modified to provide effective participation for all consumers who are deaf.
Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: **New Rule:** March 5, 2010; effective July 19, 2010.

580-2-9-.23 Child and Adolescent Seclusion and Restraint. Because of the high-risk nature of seclusion and restraint procedures and the potential for harm to consumers, the DMH MI Division Policy on Restraint and Seclusion 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 Alabama Department of Mental Health have the right to be free of restraint and seclusion. Restraint and seclusion are safety procedures of last resort. Restraint and seclusion 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 Alabama Department of Mental Health 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) Seclusion refers to the placement of a consumer alone in any room from which the consumer is physically prevented from leaving.

(5) Restraint includes both physical restraint and chemical restraint.

(6) Physical Restraint is the direct application of physical force to a consumer without the consumer's permission to restrict his or her freedom of movement.

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

(8) Time-out means the restriction of a consumer for a period of time to a designated area from which the consumer is not physically prevented from leaving for the purpose of providing the consumer an opportunity to regain self-control.

(9) 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).

(10) The standards for restraint and seclusion 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 15 minutes or less in outpatient/non-residential programs.

(c) To time-out less than 15 minutes in length for residential programs and under 30 minutes in length for outpatient programs implemented in accordance with the procedures described in (35) (a)-(c) of this section.

(d) To instances when the consumer 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 policy(ies) and procedure(s). Organizational policies and procedures shall require that room restriction be for a specified time and be limited to no longer than 12 hours. Should the consumer decide not to comply and leave the

area, seclusion/restraint cannot be instituted unless the criteria are met.

(e) To protective equipment such as helmets, and

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

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

(a) Emphasize prevention of seclusion and restraint.

(b) Demonstrate restraint or seclusion 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 consumer 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 a written order.

(g) Seclusion and restraint may not be used in lieu of effective communication with consumers who are deaf, hard of hearing, or have limited English proficiency. In the case of consumers who are deaf and who use sign language to communicate, restraints must be applied in a way that leaves at least one hand free to sign.

(12) Non-physical interventions are always considered the most appropriate and preferred intervention. These may include redirecting the child/ adolescent’s focus, verbal de-escalation, or directing the child/ adolescent to take a time-out.

(13) Utilization of restraint, seclusion, timeouts, and other techniques associated with the safety of the consumer 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 consumer record. The consumer's parent/legal guardian will be asked at intake for the frequency with which they would like such information shared with them, and consumer records shall reflect that notifications conform with requests.

(14) The initial assessment of each consumer at the time of admission or intake assists in obtaining all of the following information about the consumer that could help minimize the use of restraint or seclusion. Such information is documented in the consumer 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 consumer control his or her behavior. When appropriate, the consumer and/or family/legal guardian assist in the identification of such techniques.

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

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

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

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

(f) The role of the family/legal guardian, including their notification of a restraint or seclusion episode, is discussed with the consumer and, as appropriate,

the consumer's family/legal guardian. An agreement will be made with the family/legal guardian at intake regarding notification.

(15) Seclusion/physical restraint may be authorized only by order of a licensed independent practitioner (LIP), preferably the one who is primarily responsible for the consumer'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 consumer record.

(a) A licensed independent practitioner is defined as 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.

(b) 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.

(c) A qualified Registered Nurse is one who has successfully completed a DMH approved psychiatric management course and who as at least one year psychiatric nursing experience.

(16) In the event that a consumer 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 consumer’s language of choice. If the consumer’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 consumer record. A consumer who is deaf must have at least one hand free during physical restraint.

(17) Orders for the use of restraint and seclusion have the following characteristics:

(a) Are limited to 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/restraint. It is documented that consumers are released as soon as the behavioral criteria are met.

(18) Agency written policies and procedures require every effort to be made to terminate seclusion/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/restraint shall be documented in the consumer's record including when seclusion/restraint is appropriately terminated sooner than the timeframe for the order ends.

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

(20) At the time the initial order for restraint or seclusion expires, the consumer receives an in-person re-evaluation conducted by a Licensed Independent Practitioner (LIP), preferably the one who is primarily responsible for the consumer's care or by a Qualified Registered Nurse. Documentation in the consumer record shall address all of the following requirements of the in-person evaluation:

(a) The consumer's psychological status.

(b) The consumer's psychological status.

(c) The consumer's physical status as assessed by a RN, MD, DO, CRNP, or PA.

(d) The consumer's behavior.

(e) The appropriateness of the intervention measures.

(f Any complications resulting from the intervention.

(g) The need for continued seclusion/restraint.

(h) The need for immediate changes to the consumer’s course of care such as the need for timely follow-up by the consumer’s primary clinician or the need for medical, psychiatric, or nursing evaluation for needed medication changes.

(21) If the restraint or seclusion is to be continued at the time of the re-evaluation, the following procedures must be followed and documented in the consumer record:

(a) A new written order 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 consumer.

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

(c) If the order is continued past the first hour, the case responsible licensed independent practitioner will be notified within 24 hours of the consumer’s status.

(22) Consumers in restraint or seclusion 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 consumer (spoken or signed), and trained in accordance with the standard. The items in (21) are checked and documented every 15 minutes. If the consumer is in restraint, a second staff person is assigned to observe him/her.

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

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

(b) Other staff and the consumer’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 consumer and the consumer’s personal representative(s).

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

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

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

3. Facilitate timely clinical follow-up with the consumer’s primary therapist as needed to address trauma.

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

(24) Within 24 hours after a restraint or seclusion has ended or the next business day in a community-based non-residential program, appropriate supervisory staff, administrative staff, and the case responsible Licensed Independent Practitioner 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 restraint or seclusion.

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

(c) Staff must document in the consumer’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 consumer's treatment plan that result from the review.

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

1. Multiple incidents of restraint and seclusion experienced by a consumer within a 12-hour timeframe.

2. The number of episodes for the consumer.

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

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

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

(25) In order to minimize the use of restraint and seclusion, all direct care staff as well as any other staff involved in the use of restraint and seclusion receive annual training in and demonstrate an understanding of the following before they participate in any use of restraint/seclusion:

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

(b) That sometimes a consumer 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 consumers they serve.

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

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

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

(26) Staff who are authorized to physically apply restraint or seclusion receive the training and demonstrate competency described in 580-2-9-.23(27). Staff who are authorized to physically apply restraint or seclusion receive annual training in and demonstrate competency every 6 months in the safe use of restraint, including physical holding techniques.

(27) Staff who are authorized to perform the 15 minute monitoring of individuals who are in restraint or seclusion 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 consumers in meeting behavior criteria for the discontinuation of restraint or seclusion.

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

(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 restraint or seclusion.

(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.

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

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

(30) Restraint and seclusion 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.

(31) Consumer records document that the use of restraint or seclusion 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 non-physical interventions.

(c) That consumers 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 restraint or seclusion, informing the consumer of the criteria, and assistance provided to the consumer to help him or her meet the behavioral criteria for discontinuation.

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

(h) Each in-person evaluation of the consumer signed by the staff person who provided the evaluation.

(i) Continuous monitoring to include 15-minute assessments of the consumer’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.

(32) Staffing numbers and assignments are adequate to minimize circumstances leading to seclusion and restraint and to maximize safety when restraint and seclusion are used. Staff qualification, 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.

(33) 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.

(34) 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 consumer injury or death.

(35) Time-out shall be implemented as follows:

(a) A consumer in time-out must never be physically prevented from leaving the time-out area.

(b) Time-out may take place away from the area of activity or from other consumers such as in the consumer's room (exclusionary) or in the area of activity of other consumers (inclusionary).

(c) Staff must monitor the consumer while he or she is in time-out.

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

1. Circumstances that lead to the use of time-out regardless of whether the time-out was consumer requested, staff suggested, or staff directed.

2. Name and credentials of staff who monitored the consumer throughout the time-out.

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

4. The length of time for which time-out was implemented.

5. Behavioral or other criteria for release from time-out if applicable.

6. The status of the consumer when time-out ended.

Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: March 5, 2010; effective July 19, 2010.

580-2-9-.24 Adult Seclusion And Restraint.

(1) Consumers treated in community programs certified by the Alabama Department of Mental Health have the right to be free of psychiatric restraint and seclusion. Restraint and seclusion are safety procedures to be used as a last resort.

(2) Consumers may be placed in seclusion or may be physically restrained only when psychiatrically necessary to prevent the consumer 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) Psychiatric seclusion is the involuntary confinement of a consumer alone in a room, from which the consumer is prevented from leaving for a prescribed period of time in order to control or limit his/her dangerous behavior.

(4) Psychiatric restraint is defined as follows:

(a) Use of a commercial physical or mechanical device to involuntarily restrain the movement of the whole or a portion of a consumer's body as a means of controlling his/her physical activities in order to protect him/her or others from injury.

(b) Use of medication that is not a standard treatment for the consumer's medical or psychiatric condition and is used to control behavior or restrict the consumer's freedom of movement. Medications used for the consumer's positive benefit as an integrated part of a consumers therapeutic plan of care and specific situation and representing standard treatment for the consumer's medical or psychiatric condition do not meet this restraint definition.

(5) Qualified physician is defined as follows:

(a) Psychiatrist.

(b) A licensed physician who has been granted privileges to order seclusion or restraint.

(6) Qualified registered nurse is defined as a registered nurse who has been granted privileges to implement seclusion or restraint.

(7) Adult residential programs, except for adult crisis residential programs and intermediate care programs, cannot seclude or restrain consumers.

(8) The following written policies must be Board approved and implemented if an adult crisis residential program includes psychiatric seclusion/restraint as part of its interventions.

(a) Psychiatric seclusion or restraint must be ordered by a qualified physician on the premises, except as noted in 580-2-9-.24(9)(b), only for the purpose of protecting the consumer from harming him/herself or others, and only for the period of time necessary for the consumer to no longer threaten his/her safety or that of other consumers and staff.

(b) Use of seclusion or restraint:

1. Shall not be for the purposes of punishment, discipline, staff convenience, coercion, or retaliation.

2. Shall not be used in place of appropriate mental health treatment.

3. Should not cause undue physical discomfort, harm, or pain to the consumer.

4. May not be used in lieu of effective communication with consumers who are deaf, hard of hearing, or have limited English proficiency. In the case of consumers who are deaf and who use sign language to communicate, restraints must be applied in a way that leaves at least one hand free to sign.

(c) PRN orders for seclusion or restraint are prohibited.

(d) Seclusion or restraint shall only be used after other, less restrictive interventions have been found ineffective.

(e) Consumers shall be respected as individuals. Their modesty and privacy shall be safeguarded. They shall be provided access to effective communication in the language of their choice (spoken or signed).

(f) The use of psychiatric restraint or seclusion must be in accordance with a written modification to the patient's plan of care. If the consumer is deaf and uses sign language, provision shall be made to assure access to effective communication and that techniques used will not deprive the consumer of a method to communicate in sign language.

(g) The provider must report to the Department of Mental Health (DMH) immediately, any death or injury that occurs while a patient is restrained or in seclusion, or where it is reasonable to assume that a consumer's death or injury is a result of restraint or seclusion.

(9) Seclusion or restraint must be initiated in accordance with the following procedures:

(a) Psychiatric seclusion or restraint, must be ordered by a qualified physician on the premises (except as noted in 580-2-9-.24(9)(b)).

(b) In situations when a qualified physician is not available, the use of psychiatric seclusion or restraint may be implemented for up to 1 hour to prevent a consumer from physically injuring himself/herself or others by a trained, experienced registered nurse who is physically present and who evaluates the consumer's physical condition to the extent feasible. This procedure may be followed only after determining that alternative interventions have been unsuccessful or would not be feasible.

(c) For an individual who is deaf or limited English proficient, communication in the language (spoken or signed) of the consumer's choice must be established within 1 hour by:

1. Staff fluent in the language the consumer prefers or, as appropriate, with an Intermediate Plus rating on the Sign Language Proficiency Interview.

2. A qualified interpreter.

(d) Orders for restraints must specify a type of restraint approved by the Medical Director and that the use must conform to the manufacturer's guidelines. For an individual who is deaf, at least one hand must be left free to communicate.

(e) A qualified physician should be notified immediately after the episode of psychiatric restraint or seclusion and a verbal order obtained by the RN. A physician must see the patient and evaluate the need for psychiatric restraint or seclusion within 1 hour after the initiation of this intervention. The episode of psychiatric restraint or seclusion may be extended up to 4 hours upon verbal order of a qualified physician (after the initial assessment within 1 hour of initiation) if necessary to prevent the patient from physically injuring himself/herself or others.

(f) All written orders for psychiatric restraint and seclusion shall be time-limited and include specific behavioral criteria for release at the earliest possible time. A clinical assessment of the patient and the alternative treatment interventions attempted shall be documented in the medical record.

(g) No order for seclusion or restraint shall exceed 4 hours.

(10) Continuation of seclusion and restraint shall be done in accordance with the following policies and procedures:

(a) When seclusion/restraint is initiated under a verbal order, a physician must see the patient and evaluate the need for restraint or seclusion within 1 hour after the initiation of this intervention and sign the verbal order.

(b) If the initial episode has extended for as long as 4 hours, the patient shall be released unless a qualified physician has examined the patient and has written a new order for psychiatric restraint or seclusion.

(c) When the behavioral criteria for release have been met or the time limit for the order reached, the patient must be released unless the patient is examined by a qualified physician who writes a new order.

(11) When seclusion/restraint procedures are implemented, the following procedures must be observed:

(a) The alternative treatment interventions attempted shall be documented in the clinical record.

(b) When the criteria for release are met, the consumer must be released.

(c) Continual observation shall be made of consumers in seclusion or restraint with documentation made at least every 15 minutes, including an assessment of the need to continue seclusion. Persons in restraint shall be on 1:1 supervision and observations will be documented at least every 15 minutes.

(d) Any special medical or behavioral concerns regarding the consumer shall be communicated in writing by the RN or physician to the person(s) observing the consumer.

(e) Documentation shall reflect that the consumer in seclusion or restraint was provided the opportunity for the following or reasons why it was clinically inappropriate to make the offer:

1. Hourly bathroom privileges.

2. Daily (every 24 hours) bath, or more frequently as needed.

3. Meals at regular meal times.

4. Hourly fluids.

5. Range of motion exercises for up to 10 minutes every 2 hours (restraint).

6. Circulation checks every 15 minutes (restraint).

7. Vital signs checked as clinically indicated.

(12) Staff who are involved in initiating and implementing seclusion and restraint procedures must meet the following training requirements:

(a) RN's must be specifically trained in the use of seclusion/restraint policies and procedures and must provide supervision to program staff involved in the administration of seclusion/restraint.

(b) All staff who have direct consumer contact must have annual education and training in the proper and safe use of restraint and seclusion application and techniques and alternative methods for handling behavior, symptoms, and situations.

(c) Each facility shall establish procedures to provide debriefing of consumers and staff involved in restraint or seclusion.

(13) If provider policy and procedure permit seclusion and/or restraint, the use must be reviewed as part of the agency PI Program.

(a) The organization must appropriately document all episodes of restraint and seclusion.

(b) The organization must collect data on all episodes of restraint and seclusion in order to monitor use of restraint and seclusion including the following:

1. Multiple instances of restraint or seclusion experienced by an individual within a 12 hour timeframe.

2. The number of episodes per individual.

3. Instances of restraint or seclusion that extend beyond 2 consecutive hours.

4. Use of psychoactive medications as an alternative for, or to enable discontinuation of, restraint and seclusion.

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

(d) The organization must demonstrate that procedures are in place to properly investigate and take

corrective action where indicated where seclusion/restraint result in consumer injury or death.

(14) Rooms in which consumers are secluded must be clean, neat, free of hazardous conditions, adequately ventilated (with heat or cooling as appropriate), adequately and appropriately lighted, reasonably spacious, and appropriately painted. All areas of the seclusion room must be visible from the viewing window.
Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: March 5, 2010; effective July 19, 2010.

580-2-9-.25 Therapeutic Individualized Rehabilitation Services (TIRS)

(1) The program description is approved by the board as specified in 580-2-9-.08(10)(b)and is consistent with the provisions of this section. The program description shall include all of the following components:

(a) A description of the nature and scope of the program that includes at a minimum the provision of services as specified in this section and as indicated by individual consumer need.

(b) A description of the geographic service area for the program.

(c) Admission criteria that include at least the following:

1. Presence of Serious Emotional Disturbance.

2. Age range from 5-18 years.

3. IQ of 70 or above.

4. Must have been screened and assessed for TIRS.

5. Must be receiving active case management in addition to TIRS.

6. Clearly documented need to sustain and maintain the child's placement in the home and community and prevent out of home placement for the consumer.

7. Admission is approved by a Licensed Independent Practitioner as specified in 580-2-9-.06(9)(g)6.

(d) Discharge/transfer criteria and procedures shall be considered for discharge from the program under any one of the following criteria:

1. The TIRS service time limit has been reached (not to exceed 7 days per event).

2. The treatment goals have been met to the extent that TIRS services are no longer needed.

3. The TIRS is unable to meet obvious, suspected or expressed needs of the consumer and/or their family.

4. Transfer or referral to a different program outside of TIRS will occur when it is determined that the transfer will better meet the needs of the consumer and their family. Transfer shall be considered under the following conditions.

(i) The child or adolescent and family are in need of more intensive services that the TIRS can provide.

(ii) The consumer is determined to be in need of less intensive services than those provided by TIRS.

(iii) The consumer and family become eligible for a similar service elsewhere and prefer it.

(2) The following services must be delivered within the program:

(a) A clinical assessment that demonstrates the need for this level of care.

(b) The needs determination must be based upon the approved DMH assessment tools.

(c) The consumer must be currently involved with community mental health services and receiving case management services at a minimum.

(d) The TIRS provider may provide age appropriate family support and education, parent training, basic living

skills, socialization opportunities, mentoring services, and advocacy as needed.

(e) TIRS shall be documented as a needed service on the Treatment Plan.

(3) The individual and the home have to be authorized to do so by the Alabama Department of Human Resources.

(4) Consumers who are deaf, hard of hearing, or limited English proficient shall have effective communication access to these services provided by:

(a) Staff fluent in the consumer's preferred language, or

(b) A qualified interpreter or staff working with consumers who are deaf shall have at least an Intermediate Plus level on the Sign Language Proficiency Interview.

(5) TIRS are supervised by a staff member who has a master's degree and 2 years of post-master's clinical experience. The record shall document a minimum of one hour of face-to-face staffing consultation with the supervisor weekly as documented in the consumer record and shall include any recommendations made.

(6) TIRS shall reflect the following characteristics and philosophy:

(a) TIRS is an hourly or daily care for children or adolescents which is time-limited (not to exceed 7 days per event).

(b) TIRS are intended to sustain the child and maintain the child's placement in the home and community.

(c) TIRS can include, but is not limited to, social skills, leadership skills, mentoring services, behavioral skills, and socialization opportunities.

(d) TIRS shall provide a community based mental health service that will increase the consumer's ability to build and establish adaptive social and emotional relationships.

(e) TIRS shall expand the consumer's continuum of care by providing services to families and child-serving systems to maintain children and adolescents in their local communities.

(f) TIRS shall provide an individualized mentoring activity which will increase the social, emotional, and psychological well-being of the consumer thereby reducing caregiver stress relate to the day-to-day responsibilities of caring for a consumer with severe emotional disturbance

Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: New Rule: March 5, 2010; effective July 19, 2010.

580-2-9-.26 Indigent Drug Program.

(1) A consumer in the Indigent Drug Program (IDP) must be under the care of a licensed physician who may be either in private practice or on the staff of a mental health center.

(2) Each consumer must have a psychiatric diagnosis established before any prescription is filled.

(3) Every consumer on the IDP must be an active consumer of the center even if medication is prescribed by a non-center physician.

(4) Each consumer should receive a direct service at least every 90 days. Case notes should be completed for each contact.

(5) All chemotherapy must be documented in the consumer records in accordance with section 580-2-9-.06. Additional comments may be made on the service record and in the case notes.

(6) All prescribed medication issued by the IDP is subject to review by the mental health center's Medical Director.

(7) All consumers receiving psychotropic drugs shall be seen and evaluated by a licensed physician at intervals not to exceed a 6 month period.

(8) Approved dispensing agencies must use the IDP financial and clinical eligibility criteria as published by the Alabama Department of Mental Health. Exception: One-time only for prescriptions from a state institution, crisis stabilization program, for a documented emergency, or until compassionate need medication can be obtained.

(9) Financial information as well as clinical documentation in sufficient detail to determine eligibility for participation in the Indigent Drug Program will be in the consumer records. This information will be updated at least on an annual basis.

(10) All consumers of the Indigent Drug Program must be screened for third party eligibility. Consumers who qualify for Medicaid, insurance or compassionate need programs will not be furnished drugs that are available through these other sources.

(11) The provider shall have a policy that prohibits the sale of drugs.

(12) The provider shall establish a nominal dispensing fee to cover the costs of dispensing medication, including salary of the pharmacist, cost of containers, labels, etc. An additional charge may be assessed if it is necessary to mail any prescriptions.

(13) All records required by state and federal laws governing the storage and handling of drugs must be maintained.

(14) All prescriptions filled with drugs furnished by the State of Alabama for use in the Indigent Drug Program must be filled exclusively within the confines of the mental health center or its satellite facilities.

(15) The provider shall follow Alabama Department of Mental Health operating procedures relative to ordering, storage, and accounting for medication obtained and dispensed through the IDP.

(16) Pharmacies used for the IDP are licensed by the Alabama State Board of Pharmacy and are staffed either part-time or full-time, by a pharmacist registered in Alabama.

(17) The registered pharmacist, as the legally responsible person, shall compound (fill) and/or dispense all prescriptions.

(18) The state office must be advised of any changes in key personnel involved with the Indigent Drug Program and appropriate in-service training by the Coordinator of Community Pharmacy Services will be available, if needed.

(19) Adequate clerical support must be provided to insure that the necessary reports, records, etc., are executed.

(20) The Coordinator of Community Pharmacy Services must be notified of any planned change in the location of a pharmacy.

(a) In case of change of address of the center, the following are to be notified when the date of change is final:

1. Alabama State Board of Pharmacy.

2. Drug Enforcement Administration.

(b) Old Drug Enforcement Order Forms should be returned to the Drug Enforcement Administration, Registration Branch.

(c) New order form book for new address must be requested before placing orders for any Schedule II items to be shipped to the new address.

(21) The mental health center director shall sign an assurance that any drugs paid for through the IDP will be used only for persons who meet the clinical and financial eligibility criteria for the IDP. No drugs will be ordered for a mental health center until there is a current assurance statement on file with the Department of Mental Health.

(22) Drugs for the Indigent Drug Program must be kept separate from any other drug stock(s) or any other center supplies.

(23) Access to the pharmacy must be limited to the pharmacist and only the pharmacist shall have keys to the pharmacy. Pharmacy assistants may be in the pharmacy at the same time as the pharmacist.

(24) Drugs can be received only by an authorized representative in the absence of the Pharmacist and must be stored in a place that can be securely locked outside the pharmacy.

(25) There should be entries in the general ledger for drugs received and dispensed by each center. The value of the drugs must be included as part of the center's revenues and, when dispensed, as part of the center's expenditures.

(26) A physical inventory of drugs on hand should be taken at the close of business September 30 of each year. The value of the drugs on hand, using the prices reflected on the invoices of the prime vendor or those available from the state office should be determined. This inventory must be verified by spot checks of selected items by someone designated by the Center Director other than Indigent Drug Program personnel.

(27) Any pharmacy involved in the loss of controlled substances must notify the DEA regional office, the State Board of Pharmacy, and the Coordinator of the Community Pharmacy Service upon discovery of theft or significant loss. The DEA office will furnish a form to be filled out, along with instructions for completing the form.

(28) A prescription will be limited to 5 refills, or 6 months, whichever occurs first, unless the prescribing physician indicates more stringent directions. The quantity issued at any one time will not exceed a 33 day supply.

Author: Division of Mental Illness, DMH
Statutory Authority: Code of Ala. 1975, §22-50-11.
History: **New Rule:** March 5, 2010; effective July 19, 2010.