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) /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.

(IV) The provider can demonstrate appropriate response to consumers for whom a petition for involuntary commitment has been issued and/or who have been hospitalized at a state psychiatric hospital.

(ii) At the end of the first year of operation, the agency must have served at least 100 consumers and the services provided should be proportionate to the average of those agencies that are similarly certified.
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-.02 Governing Authority. Repealed

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: February 21, 2020. **Effective:** May 15, 2020.

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 Repealed

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: March 11, 2020. **Effective:** May 15, 2020. **Repealed:** Filed March 20, 2023. **Effective:** August 14, 2023.

580-2-9-.04 Consumer Protection. (Repealed)

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.
Repealed: Filed October 16, 2018; effective November 30, 2018.

580-2-9-.05 Reserved
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-.06 Consumer Records. (Repealed)

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.
Repealed: Filed: January 20, 2023; effective March 14, 2023.

580-2-9-.07 Performance Improvement.(Repealed)

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.
Repealed: Filed October 16, 2018; effective November 30, 2018.

580-2-9-.08 General Clinical Practice. (Repealed)

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.
Repealed: Filed: January 20, 2023; effective March 14, 2023.

580-2-9-.09 General Outpatient.

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. **Repealed**: Filed March 20, 2023. **Effective:** August 14, 2023.

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

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. **Repealed**: Filed March 20, 2023. **Effective:** August 14, 2023.

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

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. **Repealed**: Filed March 20, 2023. **Effective:** August 14, 2023.

580-2-9-.12 Emergency Services.
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. **Repealed**: Filed March 20, 2023. **Effective:** August 14, 2023.

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

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:** March 11, 2020. **Effective:** May 15, 2020. **Repealed**: Filed March 20, 2023. **Effective:** August 14, 2023.

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

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: March 11, 2020. **Effective:** May 15, 2020. **Repealed:** Filed March 20, 2023. **Effective:** August 14, 2023.

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

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: March 11, 2020. **Effective:** May 15, 2020. **Repealed:** Filed March 20, 2023. **Effective:** August 14, 2023.

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

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: March 11, 2020. **Effective:** May 15, 2020. **Repealed:** Filed March 20, 2023. **Effective:** August 14, 2023.

580-2-9-.17 Case Management.

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: March 11, 2020. **Effective:** May 15, 2020. **Repealed:** Filed March 20, 2023. **Effective:** August 14, 2023.

580-2-9-.18 Residential Services.
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: March 11, 2020. **Effective:** May 15, 2020. **Repealed:** Filed March 20, 2023. **Effective:** August 14, 2023.

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.

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.
Repealed: Filed March 20, 2023. **Effective:** August 14, 2023.

580-2-9-.22 Program for Assertive Community Treatment

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.
Repealed: Filed March 20, 2023. **Effective:** August 14, 2023.

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.

(a) TIRS can include, but is not limited to, social skills, leadership skills, mentoring services, behavioral skills, and socialization opportunities.

(b) 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.

(c) 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.

(d) 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.