

1 Department of Human Services
2 Addictions and Mental Health Division
3 Integrated Services and Supports Rule
4

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6

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1
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3 **Purpose and Scope**

4
5 **1) Purpose:** These rules prescribe minimum standards for the services and supports
6 provided by addictions and mental health providers approved by the Department of
7 Human Services, Addictions and Mental Health Division (AMH). These rules:

- 8
9 (a) Promote health and safety, independence, choice, resiliency, and recovery for
10 individuals receiving addictions and/or mental health services and supports.
11 (b) Specify standards for services and supports that are person-directed, youth guided,
12 family-driven, culturally competent, gender-specific and trauma-informed.
13 (c) Promote positive functional and rehabilitative outcomes for individuals throughout a
14 continuum of care that is developmentally appropriate.

15
16 **(2) Scope:** These rules specify standards for addictions and mental health services and
17 supports provided in:

- 18
19 (a) Outpatient Community Mental Health Services and Supports
20 (b) Residential Treatment Homes (RTH) and Residential Treatment Facilities (RTF)
21 (c) Intensive Community-based Treatment and Support Services (ICTS) and Intensive
22 Treatment Services (ITS)
23 (d) Outpatient and Residential Alcohol and Other Drug Treatment Programs
24 (e) Outpatient and Residential Problem Gambling Treatment Services

25
26
27 **xxx-xxx-xxxx**

28 **Definitions**

29
30 (1) "Abuse" of an **adult receiving mental health services** includes, but is not limited to:

- 31
32 (a) Any death caused by other than accidental or natural means or occurring in unusual
33 circumstances;
34 (b) Any physical injury caused by other than accidental means, or that appears to be at
35 variance with the explanation given of the injury;
36 (c) Willful infliction of physical pain or injury;
37 (d) Sexual harassment or exploitation including, but not limited to, any sexual contact
38 between an employee of a community facility, community program or provider, or other
39 caregiver and the individual. For situations other than those involving an employee,
40 provider, or other caregiver and an individual, sexual harassment or exploitation means
41 unwelcome verbal or physical sexual contact including requests for sexual favors and
42 other verbal or physical conduct directed toward the individual; and
43 (e) Neglect that leads to physical harm or significant mental injury through withholding
44 of services necessary to maintain health and well-being.
45 (f) Abuse also includes the following actions by a provider, employee, program staff or
46 volunteer:

1 (A) Failure to act and/or neglect that results in imminent danger of causing physical
2 injury, through negligent omission, treatment, or maltreatment of an individual, including
3 but not limited to failure by a provider or staff to provide an individual with adequate
4 food, clothing, shelter, medical care, supervision, or through tolerating or permitting
5 abusive conduct toward an individual by any other person. However, no individual will
6 be deemed neglected or abused for the sole reason that he or she voluntarily relies on
7 treatment through prayer alone in lieu of medical treatment;

8 (B) Verbal mistreatment by subjecting an individual to the use of derogatory names,
9 phrases, profanity, ridicule, harassment, coercion or intimidation, and threatening injury
10 or withholding of services or supports, including implied or direct threat of
11 discontinuation of services;

12 (C) Placement of restrictions, physical or implied, on an individual's freedom of
13 movement; and

14 (D) Financial exploitation including, but not limited to, unauthorized rate increases,
15 borrowing from or loaning money to individuals, witnessing wills in which a caregiver is
16 beneficiary, adding caregiver's name to an individual's bank account or other personal
17 property without written approval of the individual or his/her guardian or conservator and
18 planning team.

19 (E) Inappropriate expenditure of an individual's personal funds, theft of an individual's
20 personal funds, use of an individual's funds for caregiver's own benefit, commingling of
21 an individual's funds with caregiver or other individual's funds, or a caregiver becoming
22 guardian or conservator.

23 (g) Abuse does not include emergency manual restraints to prevent immediate injury to
24 an individual who is in danger of physically harming himself or herself or others,
25 provided only the degree of force reasonably necessary for protection is used for the least
26 amount of time necessary.

27
28 (2) "Abuse" of a child includes, but is not limited to:

29
30 (a) Any assault, as defined in ORS chapter 163, of a child and any physical injury to a
31 child which has been caused by other than accidental means, including any injury which
32 appears to be at variance with the explanation given of the injury.

33 (b) Any mental injury to a child, which shall include only observable and substantial
34 impairment of the child's mental or psychological ability to function caused by cruelty to
35 the child, with due regard to the culture of the child.

36 (c) Rape of a child, which includes but is not limited to rape, sodomy, unlawful sexual
37 penetration, and incest, as those acts are defined in ORS chapter 163.

38 (d) Sexual abuse, as defined in ORS chapter 163.

39 (e) Sexual exploitation which includes but is not limited to:

40 (A) Contributing to the sexual delinquency of a minor, as defined in ORS chapter 163,
41 and any other conduct which allows, employs, authorizes, permits, induces, or
42 encourages a child to engage in the performing for people to observe or the
43 photographing, filming, tape recording, or other exhibition which, in whole or in part,
44 depicts sexual conduct or contact, as defined in ORS 167.002 or described in ORS
45 163.665 and 163.670,

1 (B) Sexual abuse involving a child or rape of a child, but not including any conduct
2 which is part of any investigation conducted pursuant to ORS 419B.020 or which is
3 designed to serve educational or other legitimate purposes; or

4 (C) Allowing, permitting, encouraging or hiring a child to engage in prostitution, as
5 defined in ORS chapter 167.

6
7 (f) Negligent treatment of a child, which includes but is not limited to failure to provide
8 adequate food, clothing, shelter, or medical care that is likely to endanger the child's
9 health or welfare. Negligent treatment also includes, but is not limited to failure to
10 supervise a child, or failure to intervene when a child needs assistance or care, that is
11 likely to endanger the child's health or welfare.

12 (g) Maltreatment of child, which includes but is not limited to failure to provide adequate
13 food, clothing, shelter, or medical care that is likely to endanger the child's health or
14 welfare. Maltreatment also includes but is not limited to the willful infliction of pain or
15 injury, hitting, kicking, scratching, pinching, choking, spanking, pushing, slapping,
16 twisting of head, arms, or legs, tripping, exposure to domestic violence, the use of
17 unnecessary or excessive physical force, or other physical contact with a child
18 inconsistent with prescribed treatment or care, the use of derogatory names, phrases or
19 profanity, ridicule, harassment, coercion, or intimidation, that is likely to endanger the
20 child's health or welfare.

21 (h) Threatened harm to a child, which means subjecting a child to a substantial risk of
22 harm to the child's health or welfare.

23 (i) Buying or selling an individual under 18 years of age as described in ORS 163.537.

24 (j) Permitting an individual under 18 years of age to enter or remain in or upon premises
25 where methamphetamines are being manufactured.

26 (k) Unlawful exposure to a controlled substance, as defined in ORS 475.005, that subjects
27 a child to a substantial risk of harm to the child's health or safety.

28
29 (3) "Addictions and Mental Health Services and Supports" means the services and
30 supports that are listed in the scope of these rules and are regulated by these rules.

31
32 (4) "Administration of Medication" means administration of medicine or a medical
33 treatment to an individual as prescribed by a Licensed Medical Practitioner.

34
35 (5) "Adolescent" means an individual from 12 to 17 years of age, or those individuals
36 who are determined by the program to be developmentally appropriate for services
37 specific to adolescents.

38
39 (6) "Adult" means an individual 18 years of age or older, or for those with Medicaid
40 eligibility, 21 years of age or older.

41
42 (7) "Alcohol and Other Drug (AOD) Treatment Services" means outpatient and
43 residential treatment services for individuals with alcohol and other drug use disorders.

44
45 (8) "Alcohol and Other Drug Treatment Staff" means a person certified or licensed by a
46 health or allied provider agency to provide alcohol and other drug treatment services.

1
2 (a) For treatment staff holding a certification or license in addiction counseling,
3 qualifications for the certificate or license must have included at least:
4

5 (A) (750) hours of supervised experience in substance use counseling;

6 (B) 150 contact hours of education and training in substance use related
7 subjects; and

8 (C) Successful completion of a written objective examination or portfolio review by the
9 certifying body.
10

11 (b) For treatment staff holding a health or allied provider license, the license/registration
12 must have been issued by one of the following state bodies and the staff person must
13 possess documentation of at least 60 contact hours of academic or continuing
14 professional education in the treatment of alcohol and other drug-related disorders:
15

16 (A) Board of Medical Examiners;

17 (B) Board of Psychologist Examiners;

18 (C) Board of Clinical Social Workers;

19 (D) Board of Licensed Professional Counselors and Therapists; or

20 (E) Board of Nursing.
21

22 (9) "Assessment" means the process for obtaining all pertinent information, as identified
23 by the individual, family and collateral sources for determining a diagnosis and planning
24 individualized services and supports ([see also "provisional assessment."](#))
25

26 (10) "ASAM PPC-2R" means the American Society of Addiction Medicine Patient
27 Placement Criteria for the Treatment of Substance-related Disorders, Second Edition
28 Revised, April 2001, or subsequent revisions, which is a clinical guide used in matching
29 individuals to appropriate levels of care, and incorporated by reference in these rules.
30

31 (11) "*Behavior support*" means the individualized support strategies and techniques that
32 are used by the provider and family, if applicable, to facilitate positive behavior.
33

34 (12) "*Behavior support policy*" means the written policies and procedures adopted by the
35 provider that describe the process for determining individual support strategies to be
36 used by the provider and family, if applicable, to facilitate positive behavior.
37

38 (13) "Biopsychosocial Information" means the combination of biological, psychological,
39 social and cultural factors that influence the individual's development and functioning.
40

41 (14) "Care Coordination" means a process oriented activity that is part of ICTS to
42 provide ongoing communication and collaboration to meet multiple needs. Care
43 coordination includes facilitating communication between the family, natural supports,
44 community resources, and involved providers and agencies; organizing, facilitating and
45 participating in team meetings; and providing for continuity of care by creating linkages

1 to and managing transitions between levels of care and transitions for transition-age
2 young adults to adult services.

3
4 (15) "Care Coordinator" means a person employed by a local, regional or state allied
5 agency to provide care coordination as part of ICTS to meet multiple needs of the
6 individual and family.

7
8 (16) "Case Management" means the service provided to assist individuals, who reside in
9 a community setting, or are transitioning to a community setting, in gaining access to
10 needed medical, social, educational, entitlement and other applicable services.

11
12 (17) "Case Manager" means a person employed by a local, regional, or state allied agency
13 to provide case management services.

14
15 (18) "Chemical Restraint" means the administration of medication for the acute
16 management of potentially harmful behavior. Chemical restraint is prohibited in the
17 services regulated by these rules.

18
19 (19) "Child" or "Children" means a person or persons under the age of 18, or for those
20 with Medicaid eligibility, under the age of 21, who are determined to be developmentally
21 appropriate for services specific to children, adolescents and/or transition-age youth.

22
23 (20) "Child and Family Team" means those persons who are responsible for creating,
24 implementing, reviewing, and revising the service coordination section of the Individual
25 Service and Support Plan in ICTS programs. At minimum the team must be comprised of
26 the family, care coordinator, and child when appropriate. The team should also include
27 any involved child-serving providers and agencies and any other natural, formal, and
28 informal supports as identified by the family.

29
30 (21) "Children's Emergency Safety Intervention Specialist (CESIS)" means a QMHP who
31 is authorized to order, monitor, and evaluate the use of seclusion and restraint in
32 accredited and certified facilities providing psychiatric residential treatment services to
33 individuals under 21 years of age.

34
35 (22) "Clinical Formulation" means the documentation of the clinical judgments which
36 lead to decisions in regard to diagnosis, prognosis, the priority and sequences of
37 treatment objectives and to the type and intensity of services and supports described in
38 the Individual Service and Support Plan.

39
40 (23) "Clinical Supervision" means the documented oversight by a qualified Clinical
41 Supervisor of addiction and/or mental health services and supports provided according to
42 this rule, including ongoing evaluation and improvement of the effectiveness of those
43 services and supports.

44
45 (24) "Clinical Supervisor" means a person qualified to oversee and evaluate addiction
46 and/or mental health services and supports.

1
2 (a) For supervisors holding a certification or license in addiction counseling,
3 qualifications for the certificate or license must have included at least:

- 4
5 (A) 4000 hours of supervised experience in substance use counseling;
6 (B) 300 contact hours of education and training in substance use related subjects; and
7 (C) Successful completion of a written objective examination or portfolio review by the
8 certifying body.

9
10 (b) For supervisors holding a health or allied provider license, such license/registration
11 must have been issued by one of the following state bodies and the supervisor must
12 possess documentation of at least 120 contact hours of academic or continuing
13 professional education in the treatment of alcohol and other drug-related disorders:

- 14
15 (A) Board of Medical Examiners;
16 (B) Board of Psychologist Examiners;
17 (C) Board of Clinical Social Workers;
18 (D) Board of Licensed Professional Counselors and Therapists; or
19 (E) Board of Nursing.

20
21 (25) "COD" means co-occurring substance use and mental health disorders.

22
23 (26) "Community Mental Health Program (CMHP)" means an entity that is responsible
24 for planning and delivery of services for persons with substance use disorders, mental
25 health diagnosis, or developmental disabilities, operated in a specific geographic area of
26 the state under an intergovernmental agreement or direct contract with the Addictions and
27 Mental Health Division.

28
29 (27) "Conditional Release" means placement by a court or the PSRB, of a person who has
30 been found eligible under ORS 161.327(b) or 161.336, for supervision and treatment in a
31 community setting.

32
33 (28) "Continued Stay Criteria" means the diagnostic, behavioral and functional indicators
34 documented in the Individual Service and Support Plan to provide the clinical rationale
35 for an individual to remain in an intensive mental health treatment service.

36
37 (a) In alcohol and other drug treatment programs, "continued stay criteria" means the
38 criteria within the ASAM PPC-2R used to provide the clinical rationale for an individual
39 to remain in the same level of care.

40
41 (29) "Continuing Care" means the provision of an individual service and support plan
42 and organizational structure that will ensure that an individual receives the type of care
43 he/she needs at the time. The treatment program is thus flexible and tailored to the
44 shifting needs of the individual and his/her level of readiness to change.

45
46 (30) "Court" means the last convicting or ruling court unless specifically noted.

1
2 (31) "Criminal History Check" means the Oregon Criminal History Check and the
3 processes and procedures required by OAR 407-007-0000 through 407-007-0380.
4

5 (32) "Crisis" means either an urgent or emergency situation that occurs when an
6 individual's stability or functioning is disrupted and there is an immediate need to resolve
7 the situation to prevent a serious deterioration in the individual's condition or to prevent
8 referral to a significantly higher level of care.
9

10 (33) "Cultural Competence" Cultural competence refers to the process by which
11 individuals and systems respond respectfully and effectively to people of all cultures,
12 languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual
13 orientation and other diversity factors in a manner that recognizes, affirms, and values the
14 worth of individuals, families and communities and protects and preserves the dignity of
15 each.
16

17 (34) "Culturally Specific Program" means a program that is designed to meet the unique
18 service needs of a specific culture and that provides services to a majority of individuals
19 belonging to that culture.
20

21 (35) "Declaration for Mental Health Treatment" means a written statement of an
22 individual's decisions concerning his or her mental health treatment. The declaration is
23 made when the individual is able to understand and legally make decisions related to such
24 treatment. It is honored, as clinically appropriate, in the event the individual becomes
25 unable to make such decisions.
26

27 (36) "Department" means the State of Oregon, Department of Human Services.
28

29 (37) "Developmentally Appropriate" means services and supports that match emotional,
30 social and cognitive development rather than chronological age.
31

32 (38) "Diagnosis" means the principal mental health, substance use and/or problem
33 gambling diagnosis listed in the most recently published edition of the Diagnostic and
34 Statistical Manual of Mental Disorders (DSM). The diagnosis is determined through the
35 assessment and any examinations, tests or consultations suggested by the assessment, and
36 is the medically appropriate reason for services and supports.
37

38 (39) "Director" means the Director of the Department of Human Services or that person's
39 designee.
40

41 (40) "Division" means the Department of Human Services, Addictions and Mental Health
42 Division.
43

44 (41) "DSM" means the current edition of the *Diagnostic and Statistical Manual of Mental*
45 *Disorders*, published by the American Psychiatric Association.
46

1 (42) "Emergency" means the onset of symptoms requiring attention within 24 hours to
2 prevent serious deterioration in health and/or threat to safety.

3
4 (43) "Employee" means a person who provides a program service or who takes part in a
5 program service and who receives wages, a salary, or is otherwise paid by the program
6 for providing the service.

7
8 (44) "Entry" means the act or process of acceptance and entry into an addiction and/or
9 mental health service.

10
11 (45) "Family" means the biological or legal parents, siblings, other relatives, foster
12 parents, legal guardians, caregivers and other primary relations to the individual whether
13 by blood, adoption, legal or social relationships. Family also means any natural, formal or
14 informal support persons identified as important by the individual.

15
16 (46) "Family-driven" means families have a primary decision making role in the services
17 and supports provided to children, as well as the policies and procedures governing
18 services and supports in their community, state, tribe territory and nation. This includes
19 choosing supports, services and providers; setting goals; designing and implementing
20 programs; monitoring outcomes; and determining the effectiveness of all efforts to
21 promote the mental health and well being of children and youth.

22
23 (47) "Family Navigators" means those persons employed, or contracted, to support
24 individuals and families in accessing and coordinating (navigating) services and supports
25 in the community.

26
27 (48) "Family Support" means the provision of supportive services to persons defined as
28 family to the individual. It includes support to caregivers at community meetings,
29 assistance to families in system navigation and managing multiple appointments,
30 supportive home visits, peer support, parent mentoring and coaching, advocacy, and
31 furthering efforts to develop natural and informal community supports.

32
33 (49) "Fully Capitated Health Plan (FCHP)" means a prepaid health plan under contract
34 with the Division of Medical Assistance Programs to provide capitated physical and/or
35 behavioral health services.

36
37 (50) "Gender-specific Services" means those services that comprehensively address the
38 needs of a gender group and foster positive gender identity development. They
39 intentionally allow gender to affect and guide the services that are responsive to the
40 unique developmental issues and needs of the individuals receiving them.

41
42 (51) "Grievance" means a formal complaint submitted to a provider verbally, or in
43 writing, by an individual, or representative of the individual pertaining to the denial or
44 delivery of services and supports.

1 (52) "Guardian" means a legal guardian, person appointed by a court of law to act as
2 guardian of a minor or a legally incapacitated person.
3

4 (53) "Incident Report" means a written description and account of any occurrence
5 including, but not limited to, injury, major illness, accident, act of physical aggression,
6 use of seclusion or restraint, medication error, suspected abuse or neglect, or any unusual
7 incident involving an individual.
8

9 (54) "Individual" means any person being considered for or receiving services and
10 supports.
11

12 (55) "Individual Service and Support Plan" means a comprehensive plan for services and
13 supports provided to or coordinated for an individual and his/her family, as applicable,
14 that is reflective of the assessment and the desired outcomes of service.
15

16 (56) "Individual Service Note" means the written record describing the individual's
17 response to services and supports and progress toward desired outcomes. Individual
18 service notes provide a basis for reviewing the Individual Service and Support Plan
19 throughout the course of service.
20

21 (57) "Individual Service Record" means all of the documentation, written or electronic,
22 resulting from assessment, orientation, service and support planning, services and
23 supports provided, and service conclusion.
24

25 (58) "Informed Consent for Services" means that the services to be provided to the
26 individual have been explained to the individual and guardian, if applicable, in a manner
27 that they comprehend, and the individual and guardian, if applicable, have consented to
28 the services on, or prior to, the first date of service.
29

30 (59) "Intensive Community-based Treatment and Support Services (ICTS)" means a
31 specialized set of in-home and community-based supports and mental health treatment
32 services for children that are delivered in the most normative, least restrictive setting.
33 ICTS services include, but are not limited to, crisis prevention and intervention; care
34 coordination; case management; individual, group and family therapy; psychiatric
35 services; skills training; family support; respite care; and team-driven service
36 coordination planning.
37

38 ~~"Interim Referral and Information Services" means services provided by an alcohol and~~
39 ~~other drug treatment provider for individuals who are on a waiting list, to reduce the~~
40 ~~adverse health effects of alcohol and other drug use, promote the health of the individual,~~
41 ~~and reduce the risk of disease transmission.~~
42

43 ~~ICTS services include, but are not limited to, crisis prevention and intervention; care~~
44 ~~coordination; case management; individual, group and family therapy; psychiatric~~
45 ~~services; skills training; family support; respite care; and team-driven service~~
46 ~~coordination planning.~~

1
2 (60) "Intensive Treatment Services (ITS)" means the range of service components in the
3 system of care inclusive of treatment foster care, therapeutic group homes, psychiatric
4 day treatment, partial hospitalization, residential psychiatric treatment, or other services
5 as determined by the Division that provide active psychiatric treatment for children with
6 severe emotional disorders and their families.

7
8 (60) "Interim Referral and Information Services" means services provided by an alcohol
9 and other drug treatment provider for individuals who are on a waiting list, to reduce the
10 adverse health effects of alcohol and other drug use, promote the health of the individual,
11 and reduce the risk of disease transmission.

12
13 (61) "Interdisciplinary Team" means the group of people designated to provide services
14 to individuals in ITS programs and may include multiple disciplines or agencies.

15
16 (62) "Intern/Student" means a person who provides a paid or unpaid program service to
17 complete a credentialed or accredited educational program.

18
19 (63) "Juvenile Psychiatric Security Review Board (JPSRB)" means the entity consisting
20 of five members appointed by the Governor and subject to confirmation by the Senate
21 under *Section X, Article X* of the Oregon Constitution and described in *ORS XXX*.

22
23 (64) "Level of Care" means the range of available services provided from the least
24 restrictive and least intensive in a community-based setting to the most restrictive and
25 most intensive in an inpatient setting. As required in ORS 430.210(a), individuals are to
26 be served in the most normative, least restrictive, least intrusive level of care appropriate
27 to their needs, legal status, current symptoms and the extent of family or other supports.

28
29 (65) "Level of Need Determination" means the AMH approved process by which
30 children and youth are assessed for appropriate mental health services.

31
32 (66) "Licensed Health Care Professional" means a practitioner of the healing arts that is
33 licensed by a recognized governing board in Oregon.

34
35 (67) "Licensed Medical Practitioner (LMP)" means a person who meets the following
36 minimum qualifications as documented by the LMHA or designee:

37
38 (a) Holds at least one of the following educational degrees and a valid license:

39 (A) Physician licensed to practice in the State of Oregon;

40 (B) Nurse practitioner licensed to practice in the State of Oregon; or

41 (C) Physician's assistant licensed to practice in the State of Oregon

42 (b) In addition, whose training, experience and competence demonstrate the ability to
43 conduct a mental health assessment and provide medication management.

44 (c) For individuals receiving ICTS and ITS services, a "Licensed Medical Practitioner" or
45 "LMP" means a board-certified or board-eligible child and adolescent psychiatrist
46 licensed to practice in the State of Oregon.

1
2 (68) "Local Mental Health Authority (LMHA)" means the county court or board of
3 county commissioners of one or more counties who choose to operate a community
4 mental health program, or in the case of a Native American Reservation, the tribal
5 council, or if the county declines to operate or contract for all or part of a community
6 mental health program, the board of directors of a public or private corporation which
7 directly contracts with the Department to operate a CMHP for those counties.
8

9 (69) "Mandatory Reporter" means any public or private official who, while acting in an
10 official capacity, comes in contact with or has reasonable cause to believe that an
11 individual has suffered abuse, or that any person with whom the official comes in contact
12 with, while acting in an official capacity, has abused the individual. Pursuant to ORS
13 430.765(2) psychiatrists, psychologists, clergy and attorneys are not mandatory reporters
14 with regard to information received through communications that are privileged under
15 ORS 40.225 to 20.295.
16

17 (70) "Manual Restraint" means the act of involuntarily restricting movement by holding
18 the whole or a portion of the individual's body in order to protect the individual or others
19 from injury. *Except in emergency situations*, manual restraint can only be used with the
20 criteria specified for the individual as a Special Safety Procedure in the Individual
21 Service and Support Plan.
22

23 (71) "Mechanical Restraint" means the use of any physical device to involuntarily
24 restrain the movement of all or a portion of an individual's body as a means of
25 controlling his or her physical activities in order to protect the individual or other persons
26 from injury. Mechanical restraint is prohibited in the services regulated by these rules.
27

28 (72) "Medicaid" means the federal grant-in-aid program to state governments to provide
29 medical assistance to poor and indigent persons under Title XIX of the Social Security
30 Act.
31

32 (73) "Medical Director" means a physician licensed to practice medicine in the State of
33 Oregon and who is designated by a program to be responsible for the program's medical
34 services.
35

36 (74) "Medical Supervision" means an LMP's determination, at least annually, of the
37 medical appropriateness of rehabilitative mental health services for each individual.
38

39 (75) "Medically Appropriate" means services which are required for prevention
40 (including preventing a relapse), diagnosis or treatment of addictions and mental health
41 conditions and which are appropriate and consistent with the diagnosis.
42

43 (76) "Medication Administration Record (MAR)" means the documentation of written or
44 verbal orders for medication, laboratory and other medical procedures issued by a
45 Licensed Medical Practitioner employed by, or under contract with, the provider and

1 acting within the scope of his or her license. The provision of medication services is
2 documented in written Individual service notes and/or medication records.

3
4 (77) "Mental Health Organization (MHO)" means an approved organization that provides
5 most mental health services through a capitated payment mechanism under the Oregon
6 Health Plan. MHOs can be fully capitated health plans, community mental health
7 programs, private mental health organizations or combinations thereof.

8
9 (78) "Nurse" means a registered nurse or a psychiatric nurse practitioner licensed by the
10 Oregon Board of Nursing, but does not include a licensed practical nurse or a certified
11 nurse assistant.

12
13 (79) "Nurse Practitioner" means a registered nurse who has been certified by the board as
14 qualified to practice in an expanded specialty role within the practice of nursing.

15
16 (80) "Outreach" means the delivery of addictions and/or mental health services, referral
17 services and case management services in non-traditional settings, such as, but not
18 limited to, the individual's residence, shelters, streets, jails, transitional housing sites,
19 drop-in centers, single room occupancy hotels, child welfare settings, educational settings
20 or medical settings. It also refers to attempts made to engage or re-engage an individual
21 in services by such means as letters or telephone calls.

22
23 (81) "Outpatient Community Mental Health Services and Supports" means all outpatient
24 mental health services and supports provided to children, youth and adults, with the
25 exception of Intensive Community-based Treatment and Support Services (ICTS).

26
27 (82) "Peer Support Specialist" means a person providing peer support services, under the
28 supervision of a qualified Clinical Supervisor. A Peer Support Specialist must complete
29 an AMH approved training program and be a self-identified person currently or formerly
30 receiving mental health services and/or a person in recovery from a substance use
31 disorder, who meets the abstinence requirements for recovering staff in alcohol and other
32 drug treatment programs.

33
34 (83) "Peer Delivered Services" means an array of services designed to meet the needs of
35 individuals as they progress through various stages in their recovery. They include:

36
37 (a) Emotional support, including peer mentoring, peer coaching, and peer-led support
38 groups.

39 (b) Informational support, including peer-led life skills training, job skills training,
40 educational assistance, and health and wellness information.

41 (c) Instrumental support, including modeling and peer-assisted daily-life tasks such as
42 transportation to support groups, accessing quality childcare, completing job applications,
43 locating safe alcohol and drug free housing, obtaining vocational, educational, and self-
44 sufficiency supports, and navigating social service programs.

1 (d) Affiliation support, including strategies to help people in recovery establish a positive
2 peer culture that provides connections with others in recovery and prevents re-affiliation
3 with negative peer cultures.

4 (e) Family support, including educational, informational and affiliation services for
5 family members with relatives who are in recovery from substance use, mental health
6 and/or co-occurring substance use and mental health disorders.

7
8 (84) "Performance Improvement Plan" means a plan that describes the provider's quality
9 assessment and performance improvement strategies.

10
11 (85) "Person-directed" means the individual, and others involved in supporting the
12 treatment and recovery of the individual, are actively involved in assessment, planning
13 and revising services and supports and desired outcomes. Individuals are empowered
14 through this process to regain their health, safety and independence to the greatest extent
15 possible and in a manner that is holistic and specific to the individual, including
16 developmentally, culturally and gender appropriate.

17
18 (86) "Problem Gambling Treatment Services" means outpatient and residential treatment
19 services for individuals with gambling related problems and their families.

20
21 (87) "Problem Gambling Treatment Staff" means persons providing problem gambling
22 treatment services who meet QMHA requirements and have completed at least 30 hours
23 of problem gambling specific education within the past two years, or meet QMHP
24 requirements, or a hold a current certification in gambling treatment.

25
26 (88) "Program" means a particular type or level of service that is organizationally
27 distinct.

28
29 (89) "Program Administrator" means a person, with appropriate professional
30 qualifications and experience, appointed by the governing body to manage the operation
31 of the program.

32
33 (90) "Program Staff" means an employee or person who, by contract with the program,
34 provides a clinical service and who has the credentials required in this rule to provide the
35 clinical services.

36
37 (91) "Provider" means an organizational entity that is operated by or contractually
38 affiliated with, a community mental health program, and is responsible for the direct
39 delivery of addictions and/or mental health services to individuals.

40
41 (92) "Provisional Assessment" means an initial assessment that identifies a presenting
42 problem, provisional diagnosis and sufficient information to support the provisional
43 diagnosis.

44
45 (93) "Provisional ISSP" means an initial ISSP that includes short term objectives and
46 services sufficient to begin addressing presenting issues as related to the provisional

1 diagnosis and the medical appropriateness of services, including any engagement
2 strategies, crisis services and activities necessary to complete the assessment and the
3 ISSP.

4
5 (94) "Psychiatric Day Treatment Services (PDTS)" means the comprehensive,
6 interdisciplinary, non-residential, community based program certified under this rule
7 consisting of psychiatric treatment, family treatment and therapeutic activities integrated
8 with an accredited education program.

9
10 (95) "Psychiatric Residential Treatment Services (PRTS)" means the behavioral health
11 care programs certified under this rule to provide 24-hour, seven day per week active
12 mental health treatment under the direction of psychiatrist for children under age 21.
13 These services are associated with a Residential Treatment Program for children who can
14 benefit from a less restrictive residential psychiatric environment.

15
16 (96) "Psychiatric Security Review Board (PSRB)" means the entity consisting of five
17 members appointed by the Governor and subject to confirmation by the Senate under
18 Section Four, Article 111 of the Oregon Constitution and described in ORS 161.295
19 through 161.400.

20
21 (97) "Psychiatrist" means a physician licensed pursuant to ORS 677.010 to 677.450 by
22 the Board of Medical Examiners for the State of Oregon and who has completed an
23 approved residency training program in psychiatry.

24
25 (98) "Psychologist" means a psychologist licensed by the Oregon Board of Psychologist
26 Examiners.

27
28 (99) "Qualified Mental Health Associate (QMHA)" means a person delivering services
29 under the direct supervision of a Qualified Mental Health Professional (QMHP) and
30 meeting the following minimum qualifications as documented by the LMHA or designee:

31
32 (a) Bachelor's degree in a behavioral sciences field or a combination of at least three
33 years relevant work, education, training or experience; and

34 (b) Has the competencies necessary to:

35
36 (A) Communicate effectively;

37 (B) Understand mental health assessment, treatment and service terminology and to apply
38 the concepts; and

39 (C) Provide psychosocial skills development and to implement interventions prescribed
40 on an Individual Service and Support Plan within the scope of his or her practice.

41
42 (100) "Qualified Mental Health Professional (QMHP)" means a Licensed Medical
43 Practitioner (LMP) or any other person meeting the following minimum qualifications as
44 documented by the LMHA or designee:

1 (a) Graduate degree in social work, psychology, a behavioral science field or recreational,
2 art or music therapy; or

3 (b) Registered nurse licensed by the state of Oregon; or Bachelor's degree in
4 occupational therapy and licensed by the State of Oregon.

5 (c) And whose education and experience demonstrates the competencies to identify
6 precipitating events; gather histories of mental and physical disabilities, alcohol and drug
7 use, past mental health services and criminal justice contacts; assess family, social and
8 work relationships; conduct a mental status examination; document a multiaxial DSM
9 diagnosis; write and supervise an Individual Service and Support Plan; conduct a
10 Comprehensive Mental Health Assessment; and provide individual, family, and/or group
11 therapy within the scope of his or her practice.

12
13 (101) "Qualified Person" means a person who is a qualified mental health professional, or
14 a qualified mental health associate, is identified by the PSRB in the Conditional Release
15 Order and who is designated by the provider to deliver and/or arrange and monitor the
16 provision of required reports and services in this rule.

17
18 (102) "Quality Assessment and Performance Improvement" means the structured, internal
19 monitoring, and evaluation process to identify aspects of quality services and to improve
20 processes and service delivery to assure quality services and to sustain improvements.

21
22 (103) "Recovery" means a process of healing and transformation for a person to
23 achieve full human potential and personhood in leading a meaningful
24 life in communities of his or her choice.

25
26 (104) "Representative" means a person who acts on behalf of an individual, at the
27 individual's request, with respect to a grievance, including, but not limited to a relative,
28 friend, employee of the Division, attorney or legal guardian.

29
30 (105) "Residential Treatment Facility (RTF)" means a facility that is operated to provide
31 adult mental health services and supports on a 24-hour basis, including 24-hour staffing,
32 for six or more individuals.

33
34 (106) "Residential Treatment Home (RTH)" means a home that is operated to provide
35 adult mental health services and supports on a 24-hour basis to five or fewer individuals.

36
37 (107) "Resilience" means the universal capacity that a person uses to prevent,
38 minimize, or overcome the effects of adversity. Resilience reflects a person's strengths as
39 protective factors and assets for positive development.

40
41 (108) "Seclusion" means the involuntary confinement of an individual to an area or room
42 from which the individual is prevented from leaving. Seclusion can be used only in
43 programs licensed for this intervention and only with the criteria specified for the
44 individual as an approved Special Safety Procedure in the Individual Service and Support
45 Plan.

46

1 (109) "Self-Administration of Medication" means the act of an individual placing a
2 medication in or on their own body. The individual identifies the medication and the
3 times and manners of administration, and places the medication internally or externally
4 on their own body without assistance.

5
6 (110) "Service Conclusion" means the conclusion of services due the following
7 circumstances:

- 8
9 (a) Individual moved;
10 (b) Individual died;
11 (c) Individual requests termination of services;
12 (d) Termination is clinically appropriate;
13 (e) Individual is not expected to return to services;
14 (f) Individual transfers to another provider for same services; or
15 (g) Individual has not accessed services for an extended period.

16
17 Conclusion of an episode of care does not imply service conclusion when episodic
18 service utilization is likely.

19
20 (111) "Service Summary" means written documentation of the conclusion of services or
21 transfer of an individual from service under the circumstances described in (110) above.

22
23 (112) "Services" means those activities described in the Individual Service and Support
24 Plan which are intended to assist the individual to transition to recovery from an
25 addiction or mental health condition, and to promote resiliency and positive individual
26 and family outcomes.

27
28 (113) "Signature" means any written or electronic means of entering the name, date and
29 credentials of the person providing service.

30
31 (114) "Skills Training" means providing information and training to individuals and
32 families designed to assist with the development of skills in areas including, but not
33 limited to, anger management, stress reduction, conflict resolution, self-esteem, parent-
34 child interactions, peer relations, drug and alcohol awareness, behavior support, symptom
35 management, accessing community services and daily living.

36
37 (115) "Special Safety Procedures" means seclusion, manual restraint and experimental
38 practices and research projects that involve risk to an individual.

39
40 (116) "Substance Use Disorders" means disorders related to the taking of a drug of abuse
41 (including alcohol), to the side effects of a medication, and to a toxin exposure. The
42 disorders include substance dependency and substance abuse, alcohol dependence and
43 alcohol abuse, and substance induced disorder and alcohol induced disorders, as defined
44 in DSM criteria.

1 (117) "Supports" means those activities designed to enhance the service delivered to
2 individuals and families for the purpose of facilitating progress toward desired outcomes.

3
4 (118) "Supported Employment Services" means services delivered to individuals with
5 chronic mental health conditions to enable them to obtain and maintain paid employment,
6 including supervision, job training, on-the-job visitation, consultation with the employer,
7 job coaching, counseling, skills training and transportation.

8
9 (119) "Systems Integration" means the efforts by providers to work collaboratively with
10 other service systems including, but not limited to, schools, corrections, child welfare and
11 physical health providers, to coordinate and enhance services and supports, resulting in
12 the reduction of barriers to service delivery and improved outcomes.

13
14 (120) "Transfer" means the process of transferring an individual to the same level of care
15 with a different provider.

16
17 (121) "Transition-age Young Adult" means individuals who are developmentally
18 transitioning into independence consistent with characteristics of adults. This is typically
19 between the ages of 14 and 25.

20
21 (122) "Trauma-informed Services" means services that are reflective of the consideration
22 and evaluation of the role that trauma plays in the lives of people seeking mental health
23 and addictions services, including recognition of the traumatic effect of misdiagnosis and
24 coercive treatment. Services are responsive to the vulnerabilities of trauma survivors and
25 are delivered in a way that will avoid inadvertent re-traumatization and will facilitate
26 individual direction in services.

27
28 (123) "Treatment" means the planned, medically appropriate, individualized program of
29 medical, psychological, and/or rehabilitative procedures, experiences and activities
30 designed to remediate symptoms of DSM diagnosis that are included in the Individual
31 Service and Support Plan.

32
33 (124) "Urgent" means the onset of symptoms requiring attention within 48 hours to
34 prevent a serious deterioration in an individual's health and/or threat to safety.

35
36 (125) "Utilization Review" means a retrospective process through which a random
37 sample of cases is reviewed at periodic intervals established by the provider, to safeguard
38 against unnecessary or inappropriate use of rehabilitative mental health services.

39
40 (126) "Variance" means an exception from a regulation or provision of these rules,
41 granted in writing by the Department, upon written application from the provider.
42 Timelines for variances are determined on a case by case basis.

43
44 (127) "Volunteer" means an individual who provides a program service or who takes part
45 in a program service and who is not an employee of the program and is not paid for

1 services. The services must be nonclinical unless the individual has the required
2 credentials to provide a clinical service.

3
4 (128) “Youth Guided” means to value youth as experts, respect their voice and to treat
5 them as equal partners in creating system change at the individual, state and national
6 level.

7
8
9
10 xxx-xxx-xxxx

11 **Provider Policies**

12
13 (1) Personnel Policies: All providers will develop and implement written personnel
14 policies and procedures including, but not limited to:

15
16 (a) Hiring, Promotion, Disciplinary Procedures and Dismissal, including the use of
17 interns/students

18 (b) Personnel Qualifications and Credentialing

19 (c) Training

20 (d) Supervision

21 (e) *Mandatory abuse reporting, compliant with ORS 430.735-430.765 and 179.040*

22 (f) Harassment

23 (g) Non-discrimination

24 (h) Criminal Background Checks, compliant with OAR xxx-xxx-xxxx

25 (i) Use of Volunteers

26
27 (2) Service Delivery Policies: All providers will adopt written policies and procedures
28 that describe the provider’s mission statement and approach to services and supports and
29 procedures for the delivery of services and supports consistent with these rules. A
30 summary of the policies will be available to individuals and/or family members upon
31 request. Service delivery policies and procedures will include:

32
33 (a) Entry and Assessment;

34 (b) Service planning, coordination and documentation;

35 (c) Person-directed services, including cultural competency and developmentally
36 appropriate service planning and delivery;

37 (d) Service conclusion, Transfer and Continuity of Care;

38 (e) Wellness, Recovery and Resiliency Services and Supports;

39 (f) Trauma-informed Services, as defined in these rules;

40 (g) Confidentiality and compliance with the Health Insurance Portability and
41 Accountability Act (HIPAA) and Federal Confidentiality Regulations (42 CFR, Part 2);

42 (h) Grievances and Appeals;

43 (i) Individual Rights;

44 (j) Quality Assessment and Performance Improvement;

45 (k) *Behavior Support; and (clarify which service)*

46 (l) Crisis Prevention and Response, and Incident Reporting.

1
2 (3)Residential Program Policies: In addition to the personnel and service delivery policies
3 required of all providers, residential program providers will develop and implement
4 written policies and procedures for the following:

- 5
6 (a)Medical protocols including medication administration, storage and disposal
7 (b)Discontinuation of Residency
8 (c) Continued Stay Criteria
9 (d) Individual Belongings and Storage
10 (e) Fees and Funds Management
11 (f) Crisis Respite Services, if applicable
12 (g) Safety and Emergency Procedures
13

14
15 **XXX-XXX-XXXX**

16 **Individual Rights**
17

18 (1) Notification of Rights: The provider will give to the individual and, if appropriate, the
19 guardian, a document that describes the applicable individual's rights as follows:
20

- 21 (a) Information given to the individual must be in written form or, upon request, in an
22 alternative format or language appropriate to the individual's need.
23 (b) The rights, and how to exercise them, will be explained to the individual, and if
24 appropriate, her/his guardian.
25 (c) Individual rights will be posted in writing in a common area.
26

27 (2) In addition to all statutory & constitutional rights afforded to every person, every
28 individual receiving services has the right to:
29

30 (a) Choose from available services, provided in a setting and under conditions that are
31 least restrictive to the individual's freedom, that are least intrusive to the individual and
32 that provide for the greatest degree of independence.
33

34 (b) Be treated with dignity and respect.
35

36 (c) Participate in the development of a written Individual Service and Support Plan,
37 services consistent with that plan and periodic review and reassessment of service and
38 support needs, and to have a parent, guardian, advocate or representative assist in the
39 development of the plan.
40

41 (d) To have all services explained, including expected outcomes and possible risks, and
42 to receive a copy of the written ISSP.
43

44 (e) To give informed consent in writing prior to the start of services, except in a medical
45 emergency or as otherwise permitted by law. Minor children can give informed consent
46 in the following circumstances:
47

- 1 (A) Under age 18 and lawfully married.
2 (B) Age 16 or older and legally emancipated by the court.
3 (C) Age 14 or older for outpatient services only. For purposes of informed consent,
4 outpatient service does not include service provided in residential programs or in day or
5 partial hospitalization programs.
6
7 (f) Not participate in experimentation.
8
9 (g) Receive medication only for the individual’s diagnosed clinical needs.
10
11 (h) Receive prior notice, unless the circumstances necessitating service conclusion or
12 transfer pose a threat to health and safety.
13
14 (i) A humane service environment that affords reasonable protection from harm,
15 reasonable privacy and daily access to fresh air and the outdoors.
16
17 (j) Be free from abuse or neglect and to report any incident of abuse or neglect without
18 being subject to retaliation.
19
20 (k) Religious freedom.
21
22 (l) Be free from seclusion and restraint, except as outlined in xxx-xxx-xxxx.
23
24 (m) Be informed at the start of services, and periodically thereafter, of the rights
25 guaranteed by this section.
26
27 (n) Be informed of the policies and procedures, service agreements and fees applicable to
28 the services provided, and to have a custodial parent, guardian, or representative, assist
29 with understanding any information presented.
30
31 (o) Have access to and receive available educational services in the least restrictive
32 environment.
33
34 (p) Family involvement in service planning and delivery.
35
36 (q) Associate and communicate privately with any person the individual chooses,
37 including family members, friends, public or private rights protection programs or rights
38 advocates, clergy, and legal and medical professionals.
39
40 (r) To make a declaration of mental health service, when legally an adult.
41
42 (s) File grievances, including appealing decisions resulting from the grievance.
43
44 (t) Exercise all rights set forth in ORS 109 if the individual is a child, as defined by these
45 rules.
46

1 (u) Exercise all rights set forth in ORS 426.385 and 427.031 if the individual is
2 committed to the Department of Human Services.

3
4 (v) Exercise all rights described in this section without any form of reprisal or
5 punishment.

6
7 (3) In addition to the rights specified in (2) above, every individual receiving **residential**
8 **services** has the right to:

9
10 (a) A safe, secure and sanitary living environment.

11
12 (b) Keep and use personal clothing and belongings, and to have an adequate amount of
13 private, secure storage space, as defined in OAR xxx-xxx-xxxx.

14
15 (c) Manage his/her own money and financial affairs, when legally an adult, unless
16 restricted by court order.

17
18 (d) Express sexuality and sexual orientation in a socially appropriate and consensual
19 manner.

20
21 (e) Have access to and participate in social, religious and community activities.

22
23 (f) Send and receive personal mail unopened, unless contraindicated by the ISSP.

24
25 (g) Make and receive unmonitored personal phone calls, unless contraindicated by the
26 ISSP.

27
28 (h) To participate regularly in indoor and outdoor recreation.

29
30 (i) Not to be transferred or moved out of an **adult Residential Treatment Home, or**
31 **Residential Treatment Facility**, without 30 days' advance written notice, notification of
32 available sources to address service needs, and an opportunity for a hearing, unless
33 immediate transfer is required to ensure the safety of the individual or others.

34
35 (j) Adequate food and shelter as defined in OAR xxx-xxx-xxxx.

36
37 (k) A reasonable accommodation if, due to a disability, the housing and services are not
38 sufficiently accessible.

39
40
41 **xxx-xxx-xxxx**

42 **Personnel**

43
44 (1) Staff Qualifications: All staff must meet applicable credentialing or licensing
45 standards, as defined in these rules, for the following:

- 1 (a) Care Coordinator
- 2 (b) Case Manager
- 3 (c) Alcohol and Other Drug Treatment Staff
- 4 (d) Problem Gambling Treatment Staff
- 5 (e) Children's Emergency Services Intervention Specialist (CESIS)
- 6 (f) Clinical Supervisor
- 7 (g) Family Navigator
- 8 (h) Intern
- 9 (i) Licensed Medical Practitioner (LMP)
- 10 (j) Medical Director
- 11 (k) Paraprofessional
- 12 (l) Peer Support Specialist
- 13 (m) Program Administrator/Director
- 14 (n) Qualified Mental Health Associate (QMHA)
- 15 (o) Qualified Mental Health Professional (QMHP)
- 16 (p) Volunteer

17
18 (2) Staff Competencies: Providers must document that all staff have demonstrated the
19 ability to perform essential job duties as specified in the applicable job description.
20 Job descriptions must include competencies that are applicable to the specific population
21 for whom services will be planned, delivered or supervised. At minimum, competencies
22 for the following staff will include:

- 23
24 (a) Program Administrators/Directors must demonstrate competence in leadership;
25 program planning and budgeting, fiscal management, supervision of staff, personnel
26 management, employee performance assessment, data collection, reporting, program
27 evaluation, quality assurance, and developing and maintaining community resources.
28
29 (b) Clinical Supervisors in addiction and mental health programs must demonstrate
30 competence in leadership; oversight and evaluation of services; staff development;
31 Individual Service and Support Planning; case management and coordination; utilization
32 of community resources; group, family and individual therapy/counseling; documentation
33 and rationale for services to promote desired outcomes; and implementation of all
34 provider policies. In addition:
35
36 (A) Clinical Supervisors in alcohol and other drug treatment programs will be certified or
37 licensed by a health or allied provider agency, as defined in these rules, to provide
38 addiction treatment, and have one of the following qualifications:
39
40 (i) Five years of paid full-time experience in the field of alcohol and other drug
41 counseling; or
42 (ii) A Bachelor's degree and four years of paid full-time experience in the social services
43 field, with a minimum of two years of direct alcohol and other drug counseling
44 experience; or

1 (iii) A Master's degree and three years of paid full-time experience in the social services
2 field with a minimum of two years of direct alcohol and other drug counseling
3 experience.
4

5 (B)Clinical Supervisors in mental health programs will meet QMHP requirements and/or
6 be a licensed medical practitioner (LMP) as determined by a state licensing body, and
7 have completed two years of post-graduate clinical experience in a mental health
8 treatment setting.
9

10 (C)Clinical Supervisors in problem gambling treatment programs will meet QMHP
11 requirements and have completed 10 hours of gambling specific training within the
12 immediate past two years.
13

14 (c)Alcohol and other drug treatment staff must be certified, or licensed by a health or
15 allied provider agency, as defined in these rules, to provide addiction treatment within
16 one year of the hire date and must make application for certification no later than six
17 months following the hire date; and
18

19 (A) Demonstrate competence in treatment of substance-use disorders including individual
20 evaluation and individual, group, family and other counseling techniques; program
21 policies and procedures for case management and record keeping; and identification,
22 implementation and coordination of services identified to facilitate desired outcomes.
23

24 (d) Problem gambling treatment staff must meet QMHA requirements and have
25 completed at least 30 hours of problem gambling specific education within the past two
26 years, or be a QMHP, or a hold a current certification in gambling treatment.
27

28 (e)QMHA's must demonstrate the ability to communicate effectively; understand mental
29 health assessment, treatment and service terminology; apply each of these concepts;
30 implement skills development strategies; and identify, implement and coordinate services
31 identified to facilitate desired outcomes.
32

33 (f)QMHPs must demonstrate the ability to identify precipitating events; gather histories
34 of mental and physical disabilities; alcohol and other drug abuse; past mental health
35 services and criminal justice contacts; assess family, social and work relationships;
36 conduct a mental status examination; formulate and document a 5-axis DSM diagnosis;
37 write and supervise the implementation of a Individual Service and Support Plan; and
38 provide individual, family and/or group therapy within the scope of their training.
39

40 (3)Recovering Staff: Staff, contractors, volunteers and interns recovering from a
41 substance-use disorder, providing treatment services, or peer support services, in alcohol
42 and other drug treatment programs, must be able to document continuous abstinence
43 under independent living conditions, or recovery housing, for the immediate past two
44 years.
45

1 (4) Personnel Documentation: Providers must maintain a personnel file for each
2 employee that contains all of the following documentation:
3

- 4 (a) An employment application;
- 5 (b) For subject individuals, verification of a criminal history check consistent with OAR
6 407-007-0000 through 407-007-0380;
- 7 (c) A current job description;
- 8 (d) Copies of relevant licensure and/or certification, diploma, or transcripts indicating
9 that the employee meets applicable professional standards;
- 10 (e) Periodic performance appraisals;
- 11 (f) Staff orientation and development activities;
- 12 (g) Employee incident reports;
- 13 (h) Disciplinary documentation;
- 14 (i) Reference checks;
- 15 (j) Emergency contact information; and

16
17 (5) Non-employee Documentation: For providers utilizing contractors, interns or
18 volunteers, providers must maintain the following documentation, as applicable:
19

- 20 (a) a contract, or written agreement, if applicable;
- 21 (b) a signed confidentiality agreement; and
- 22 (c) Service-specific orientation documentation.
- 23 (d) For subject individuals, verification of a criminal history check consistent with OAR
24 407-007-0000 through 407-007-0380.

25
26 (6) Program Specific Employee Documentation: In addition to general employee
27 documentation requirements, providers must maintain additional documentation as
28 applicable.
29

30 (a) For all staff providing residential services:
31

- 32 (A) Results of a Hepatitis B screening as per OAR 333-071-0057; and
- 33 (B) Results of a Tuberculosis screening as per OAR 333-071-0057.

34
35 (7) Training: Providers will ensure that staff receive training applicable to the specific
36 population for whom services are planned, delivered, or supervised as follows:
37

- 38 (a) Pre-service training: The program will document appropriate orientation training for
39 each employee, or person providing services, within 30 days of the hire date. At
40 minimum, pre-service training for all staff will include, but not be limited to,
41
 - 42 (A) A review of individual crisis response procedures;
 - 43 (B) A review of emergency procedures;
 - 44 (C) A review of program policies and procedures;
 - 45 (D) A review of rights for individuals receiving services and supports;
 - 46 (E) A summary of information relevant to the job description;

- 1 (F) Mandatory abuse reporting procedures;
- 2 (G) Population-specific information; and
- 3 (H) An overview of applicable community resources.

4
5 (b) In-service Training: The program will provide or arrange no less than eight hours of
6 program-specific training annually.

7
8 (c) First Aid/CPR certification: Employees and persons providing residential services
9 must obtain First Aid/CPR certification within 30 days of the start date of service and
10 must maintain current certification.

11
12 (8) Supervision: Persons providing services to individuals in accordance with this rule
13 will receive supervision by a qualified Clinical Supervisor, as defined in these rules,
14 related to the development, implementation and outcome of services.

15
16 (a) The objective of clinical supervision is to assist staff and volunteers to increase their
17 skills, improve quality of services to individuals, and supervise program staff and
18 volunteers' compliance with program policies and procedures.

19
20 (b) Clinical Supervision will be specified through a current written agreement, job
21 description, or similar type of binding arrangement between the Clinical Supervisor and
22 the Provider which describes the Clinical Supervisor's oversight responsibility, including
23 documentation of supervision no less than two hours per month, including one hour of
24 face-to-face contact for each person supervised.

25
26 (c) Clinical supervision exceptions: The provider may modify the requirements specified
27 in these rules for supervision of independent contractors who are QMHPs and who are
28 licensed under existing Oregon Revised Statutes to conduct independent practice without
29 supervision.

30
31 (d) Medical Supervision: Medical supervision will be secured, when required, through a
32 current written agreement, job description, or similar type of binding arrangement
33 between a Licensed Medical Practitioner (LMP) and the provider, which describes the
34 LMP's responsibility in determining the medical appropriateness of services delivered.

35
36
37 XXX-XXX-XXXX

38 **Service Documentation**

39 40 (1) Required Documentation:

41
42 (a) Individual Service Record: All providers will develop and maintain an Individual
43 Service Record for each individual upon entry. Information contained in the record must
44 be appropriate in quality and quantity to meet professional standards applicable to the
45 provider and any additional standards for documentation in the provider's policies and
46 any pertinent contracts. At minimum, the Individual Service Record will include:

- 1
2 (A) Billing system entry data;
3 (B) Identifying information or documentation of attempts to obtain the information
4 including
5 ~~(i) including~~ T the individual's name, address, telephone number, date of birth, gender and
6 marital status (if applicable);
7 ~~(ii) E~~ Name, address, and telephone number of parent, legal guardian, ~~or~~ next of kin
8 and/or emergency contact;
9 ~~(iii) D~~ Name, address and telephone number of the individual's physician;
10 ~~(iv) E~~ Name and address of the individual's physical health plan;
11 (F) Informed Consent for Service, or documentation specifying why the provider could
12 not obtain consent by the individual and/or guardian as applicable;
13 (G) Other applicable consent forms;
14 (H) Assessments and updates to assessments as applicable;
15 (I) An Individual Service and Support Plan;
16 ~~(J) Documentation of individual and family direction, and collateral resources, in~~
17 ~~Individual Service and Support Planning~~;
18 (K) Individual service notes;
19 ~~(L) Incident reports, as applicable; and~~
20 (M) A Service summary, when required.

21
22 (b) Medical Service Records: When medical services are provided, the following
23 documents will be part of the Individual Service Record as applicable:
24

- 25 (A) Medication Administration Records as per xxx-xxx-xxx of these rules;
26 (B) Laboratory reports; and
27 (C) *Individual medical protocols*.

28
29 (c) Residential Mental Health Programs for Children and Adults: In addition to the
30 requirements for Individual Service Records, **residential mental health program**
31 providers will include the following documentation in the Individual Service Record:
32

- 33 (A) A personal belongings inventory updated every 90 days and on the date of service
34 conclusion;
35 ~~(B) Documentation indicating that the individual can exit the residence consistent with the~~
36 ~~program's evacuation plan~~;
37 (C) Documentation indicating the individual and guardian, as applicable, were provided
38 with the required orientation information upon entry.
39 (D) Available background information including strengths and interests, any previous
40 mental health and/or substance use and/or problem gambling assessments, previous living
41 arrangements, service history, behavioral support considerations, educational service
42 plans, including an IEP or 504 plan, if applicable, and family and other support
43 resources;
44 (E) Medical information including a brief history of any health conditions, documentation
45 from a Licensed Medical Practitioner or other qualified health care professional of the
46 individual's current physical condition, and a written record of any current or

- 1 recommended medications, services, dietary specifications, and aids to physical
2 functioning;
3 (F) Copies of documents relating to guardianship, conservatorship, commitment status,
4 advance directives, or any other legal considerations, as applicable;
5 (G) A copy of the individual’s most recent ISSP, if applicable, or in the case of an
6 emergency or crisis-respite entry, a summary of current addictions and/or mental health
7 services;
8 (H) Documentation of the individual’s ability to evacuate the home consistent with
9 the program’s evacuation plan developed in accordance with the Oregon Structural
10 Specialty Code and Oregon Fire Code; and
11 (I) Documentation of any safety risks.

12 (J) Incident reports

13
14
15 (d) PSRB and JPSRB Documentation: When the individual is under the jurisdiction of the
16 PSRB or JPSRB, providers will include the following additional documentation in the
17 Individual Service Record:

- 18
19 (A) Monthly reports;
20 (B) Interim reports, as applicable; and
21 (C) Evaluation
22 (D) For PSRB and JPSRB services, a copy of the Conditional Order of Release;

23
24 (e) Intensive Community-based Treatment and Support Services (ICTS) Documentation:
25 When ICTS services are delivered, providers will include the following additional
26 documentation in the Individual Service Record:

- 27
28 (A) Level of Need Determination; and
29 (B) Names and contact information of the members of the child and family team.

30
31 (2) Documentation Standards: ***Denotes standards, when not met, that could result in
32 Medicaid audit findings with financial implications for providers. Additional
33 requirements related to assessment, ISSP, individual service notes and service summary,
34 are AMH quality standards and have administrative implications rather than financial.*

35
36 (a) Assessment: Each assessment will include:

37
38 (A) Sufficient biopsychosocial information and documentation to support the presence of
39 a DSM diagnosis that is the medically appropriate reason for services.**

40
41 (B) *Screening for the presence of co-occurring substance use, problem gambling and
42 mental health disorders. ~~When COD is determined to be present, the provider will
43 include services as described in xxx-xxx-xxxx of this rule.~~*

44
45 (C) *Screening for presence of symptoms and problems related to psychological trauma.*
46

1 (D) For children age 0-5, diagnosis will be informed by treatment guidelines included in
2 the Health Services Commission prioritized list of paired conditions and treatments, and
3 will include:

- 4 (i) Direct observation of the child/parent/family interaction;
- 5 (ii) Neurodevelopment considerations; and
- 6 (iii) Parental and family biopsychosocial functioning within the context of the home,
7 community and culture.

8
9 (E) In addition to (A), ~~(B) and (C)~~ above, alcohol and other drug assessments will include
10 all of the dimensions described in the American Society of Addiction Medicine (ASAM)
11 Patient Placement Criteria (PPC)-2R, or most current edition, in the assessment and will
12 document a diagnosis and level of care determination consistent with the DSM and
13 ASAM PPC-2R, or most current edition.

14
15 (F) In addition to (A), ~~(B) and (C)~~ above, -problem gambling assessments will include
16 gambling history when applicable, (age of first use, gambling behavior patterns,
17 gambling venue preference, primary gambling location, gambling activity frequency,
18 stage of change, gambling thought process, previous gambling service history including
19 relapse history, current gambling triggers, etc.) and current financial status, in the
20 assessment.

21
22 *(G) In addition to (A) above, mental health assessments will include mental status exam,*
23 *risk assessment and clinical formulation.*

24
25 (b) Individual Service and Support Plan (ISSP): The ISSP will document the specific
26 services and supports to be provided, arranged or coordinated** to assist the individual
27 and her/his family, if applicable, to achieve desired service outcomes, including:

- 28
29 (A) Measurable or observable objectives;
- 30 (B) Applicable service delivery details including frequency and duration;
- 31 (C) Timelines for review of progress and ISSP updates, consistent with the level and
32 complexity of care provided.

33
34 (D) For ICTS services, the ISSP will include:

- 35 (i) A summary of related planning across all relevant life domains by the participating
36 child and family team members;
- 37 (ii) Proactive safety/crisis planning; and
- 38 (iii) Behavior support planning, consistent with xxx-xxx-xxxx of these rules.

39
40 (c) Individual Service Notes: Individual service notes will document the specific service
41 provided, duration of the service provided, the date on which the service was provided,
42 location of service and the name and signature, or initials, of the person who provided the
43 service.**

1 (A) Individual service notes will include periodic reviews of progress toward specific
2 objectives, any significant changes in the individual's life circumstances, and any
3 decisions to service conclusion or transfer an individual from service.
4

5 (d) Service Summary: The service summary will contain information sufficient to
6 promote continuity of care including:
7

8 (A) The date and reason for the conclusion of services or transfer;

9 (B) A summary statement that describes the effectiveness of services in assisting the
10 individual and his/her family to achieve desired outcomes identified in the ISSP;

11 (C) A Plan for personal wellness and resilience, including relapse prevention; and

12 (D) Identification of resources to assist the individual and family, if applicable, in
13 accessing recovery and resiliency services and supports.
14
15
16
17
18
19

20 **xxx-xxx-xxxx**

21 **Entry and Assessment**

22
23 (1) Entry Process: The program will utilize a written entry procedure to ensure the
24 following:
25

26 (a) Individuals will be considered for entry without regard to race, ethnicity, gender
27 (except when necessary due to room arrangement in residential programs), sexual
28 orientation, religion, creed, national origin, age (except when program eligibility is
29 restricted to child or adult), familial status, marital status, source of income, or disability.
30

31 (b) The following criteria will be established for the determination of entry eligibility
32 Intensive Treatment Services (ITS) and Intensive Community-based Treatment Services
33 (ICTS):
34

35 (A) Eligibility for entry in Psychiatric Residential Treatment Services (PRTS) will be
36 approved by an independent psychiatric review process, established by the Division and
37 the MHO, to certify the need for services.

38 (B) Eligibility for entry in Intensive Treatment Services will be based on the provider's
39 clinical review of the individual's functioning, of the severity and acuity of the
40 individual's psychiatric symptoms, and of documentation of the following:

41 (i) A completed 5-axis diagnosis current within 60 days of the entry date;

42 (ii) Pertinent biological, psychological and sociocultural factors influencing the
43 individual's development and functioning;

44 (iii) The acuity and severity of the individual's psychiatric symptoms as scored on
45 measures established by the Division;

46 (iv) The individual's functioning as scored on measures established by the Division; and

1 (v) Attempts to provide service to the individual in a less restrictive level of care.

2
3 (C) Eligibility for entry in ICTS programs will be determined by the Level of Need
4 Determination Process.

5
6 (c) Individuals will receive services in the most timely manner feasible reflective of the
7 presenting circumstances.

8
9 (d) For providers receiving Substance Abuse Prevention and Treatment (SAPT) Block
10 Grant funds, entry of pregnant women to services will occur no later than 48 hours from
11 the date of first contact, and no less than 14 days after the date of first contact for
12 individuals using substances intravenously. If services are not available within the
13 required timeframe, the provider will document the reason and provide interim referral
14 and informational services, consistent with xxx-xxx-xxxx of these rules, within 48 hours.

15
16 (e) Written informed consent for services will be obtained from the individual and/or
17 guardian, if applicable, prior to the start of services. If such consent is not obtained, the
18 reason will be documented and further attempts to obtain informed consent will be made
19 as appropriate.

20
21 (f) The provider will establish an Individual Service Record for each individual on the
22 date of entry.

23
24 (g) In accordance with Oregon Revised Statute (ORS) 179.505, 45 Code of Federal
25 Registry (CFR) Part 164, and 42 CFR Part 2, an authorization for the release of
26 information will be obtained for any confidential information concerning the individual
27 being considered for, or receiving, services.

28
29 (h) Orientation: At minimum, the program will give to the individual, and guardian if
30 applicable, written program orientation information at the time of entry, which includes:

31
32 (A) The program's philosophical approach to providing services and supports;

33 (B) A description of individual rights consistent with these rules;

34 (C) An overview of services available; and

35 (D) Policies concerning grievances and confidentiality.

36
37 (2) Entry Priority:

38
39 (a) Entry of adults in community-based mental health services will be prioritized in the
40 following order:

41
42 (A) Individuals who, in accordance with the assessment of professionals in the field of
43 mental health, are at immediate risk of hospitalization for the treatment of mental health
44 conditions or are in need of continuing services to avoid hospitalization or pose a
45 hazard to the health and safety of themselves, including the potential for suicide;

1 (B) Individuals who, because of the nature of their diagnosis, their geographic location
2 or their family income, are least capable of obtaining assistance from the private sector;
3 and

4 (C) Individuals who, in accordance with the assessment of professionals in the field of
5 mental health, are experiencing mental health conditions but will not require
6 hospitalization in the foreseeable future.

7
8 (b)Entry of children in community-based mental health services will be prioritized in the
9 following order:

10
11 (A) Children who are at immediate risk of psychiatric hospitalization or removal from
12 home due to emotional and mental health conditions;

13 (B) Children who Exhibit behavior which indicates high risk of developing conditions of
14 a severe or persistent nature;

15 (C) Children who have severe mental health conditions; and

16 (D) Any other child who is experiencing mental health conditions which significantly
17 affect the child’s ability to function in everyday life, but not requiring hospitalization or
18 removal from home in the near future.

19
20 (c)Entry of individuals whose services are funded by the SAPT Block Grant funds, will
21 be prioritized in the following order:

22
23 (A)Women who are pregnant and using substances intravenously;

24 (B)Women who are pregnant;

25 (C)Individuals who are using substances intravenously; and

26 (D)Women with dependent children.

27
28 (3)Assessment: When an individual is admitted for services, an assessment, consistent
29 with xxx-xxx-xxxx of these rules, will be completed prior to development of the
30 Individual Service and Support Plan.

31
32 (a) When ~~an full~~ assessment is not completed at entry, a provisional assessment, as
33 defined in these rules, will document the immediate medical appropriateness of services.
34 If services are continued, a full assessment will be completed within a timeframe that
35 reflects the level and complexity of services and supports to be provided.

36
37 (b) The assessment will be reflective of the level and complexity of the condition and
38 presenting issues of the individual.

39
40 (c) *If seeking any of the information required in the assessment presents a barrier to the*
41 *provision of services for the individual, any portion of the assessment may be left*
42 *incomplete provided the reason for the omission is clearly documented in the Individual*
43 *Service Record.*

44

1 (d) Clinical formulation of the assessment will be completed by a QMHP in mental health
2 programs, qualified treatment staff in alcohol and other drug treatment programs, and
3 qualified treatment staff in problem gambling treatment programs.
4

5 (e) Assessment Update: Providers will document updates to the assessment consistent
6 with the timelines specified in the ISSP and/or when pertinent information is available.
7

8 (f) *In addition to periodic assessment updates, any individual continuing to receiving
9 mental health services for one or more continuous years, will receive an annual
10 assessment by a QMHP, that has documented approval by an LMP.*
11

12
13 **XXX-XXX-XXXX**

14 **General Service Standards**

15
16 (1) Service delivery: All Addictions and Mental Health services and supports will be
17 provided in the least restrictive environment, and will be:
18

19 (a) Delivered with reasonable promptness;

20 (b) Trauma-informed and trauma-sensitive;

21 (c) Culturally competent;

22 (d) Matched to each individual's level of cognitive and emotional development;

23 (e) Comprehensive, as needed, to achieve desired outcomes.
24

25 (2) Individual Service and Support Planning and Coordination: The provider will deliver
26 or coordinate, for each individual, appropriate services and supports to collaboratively
27 facilitate desired service outcomes as identified by the individual, and family, when
28 applicable.
29

30 (a) Qualified program staff will facilitate a planning process, resulting in an Individual
31 Service and Support Plan (ISSP that will reflect the level and complexity of care
32 provided) and an assessment consistent with these rules.
33

34 (b) A provisional ISSP, including applicable crisis services, will be completed at the start
35 of services.
36

37 (c) If services are continued, a complete ISSP, consistent with xxx-xxx-xxxx will be
38 completed within a timeframe that reflects:
39

40 (A) The type and complexity of services and supports to be provided;

41 (B) ~~The completion of a complete~~ full assessment; and

42 (C) Engagement and agreement of the individual, and family if applicable, in the
43 development of the ISSP.
44

45 (e) Individuals, and family members, as applicable, will collaboratively participate in and
46 direct the development of the ISSP. ~~to the highest degree possible.~~

1
2 (f) Providers will fully inform the individual, in developmentally and culturally
3 appropriate language, and obtain informed consent from the individual, or guardian, for
4 the proposed services and supports.
5

6 (g) A licensed health care professional will sign the Individual Service and Support Plan
7 for each individual receiving mental health services.
8

9 (h) Providers will collaborate with community partners to coordinate or deliver services
10 and supports identified in the ISSP.
11

12 (i) *Providers will request authorization to exchange information with any applicable*
13 *physical health care providers for the individual, to collaborate in promoting regular and*
14 *adequate health care.*
15

16 (3) Individual service notes: A written individual service note, consistent with xxx-xxx-
17 xxxx of these rules, will be recorded each time a service is provided.
18

19 (a) Timelines for periodic review of progress will be determined on an individual basis,
20 reflective of the type and complexity of the services and supports provided.
21

22 (4) Family Involvement: When applicable, and with the consent of adults, providers will
23 demonstrate the involvement of family, as defined in this rule, in all phases of service
24 planning and delivery as follows:
25

26 (a) Demonstrate family involvement and participation in all phases of Assessment,
27 service planning, coordination and delivery by documenting the specific involvement in
28 the Assessment, ISSP, and Individual service notes.
29

30 (b) Include a section addressing family involvement in the provider's Person-directed
31 Services Policy that includes specific supports to family members to address and prevent
32 barriers to family involvement.
33

34 (c) Screening, referral and coordination of services will be provided to dependent children
35 of individuals receiving services and supports, as indicated.
36

37 (5) Peer Delivered Services: Providers will arrange for and coordinate peer delivered
38 services and supports, as defined in this rule, when indicated, including, but not limited
39 to, emotional support, informational support, instrumental support, affiliation support and
40 family support.
41

42 (6) Transition-age Young Adults: Services to transition-age young adults will be
43 delivered with the least possible disruption to positive relationships, and will incorporate
44 the following:
45

1 (a)The rapport between professional and individual will be given as much of an emphasis
2 in service planning as other case management approaches.

3 (b)Services will be coordinated with applicable adjunct programs serving both children
4 and adults.

5 (c)Services will be engaging and relevant to youth and young adults.

6 (d)Services will accommodate the critical role of peers and friends.

7 (e)The ISSP will include a safety component to ensure that identity development
8 challenges and boundary issues are not cause for discontinuing service.

9 (f)The ISSP will include a specific section addressing services and supports unique to the
10 developmental progress of transition-age young adults including school completion,
11 employment, independent living skills, budgeting, finding a home, making friends,
12 parenting and family planning, family relationships, and delinquency prevention.

13
14 (7) Co-Occurring Disorders: Services for individuals with COD will include:

15
16 (a) Case management services to provide the individual with a primary contact for
17 multiple health and social service systems to:

18
19 (A) Assist the individual to advocate for his or her needs;

20 (B) Assist the individual to transition through the continuum of care; and

21 (C) Assist the individual to access necessary services and recovery supports for both
22 substance use and mental health diagnosis, including dual-diagnosis recovery self-help
23 groups and programs.

24
25 (b) Screening and integrated assessments, including a full ASAM PPC-2R assessment;

26 (c) Service and support planning and delivery for substance use and mental health
27 diagnosis concurrently; and

28 (d)Ongoing intermittent contact with the individual by program staff including, but not
29 limited to, telephone outreach and home visits.

30
31
32 **xxx-xxx-xxxx**

33 **Program Specific Service Standards**

34
35 In addition to individualized service and support planning and coordination, providers of
36 each of the program-specific service areas below, will ensure that the following specified
37 services listed for that service area will be provided, including evidence-based and best
38 practices, as applicable:

39
40 (1)Outpatient Mental Health Services to Children and Adults:

41
42 (a) Crisis services will be available 24 hours per day and include the following:

43 (A) 24 hours, seven days per week telephone or face-to-face screening to determine a
44 individual's need for immediate community mental health services; and

45 (B) 24 hour, seven days per week capability to conduct, by or under the supervision of a
46 QMHP, an initial screening resulting in a provisional assessment and ISSP that includes

1 the crisis services necessary to assist the individual and family to stabilize and transition
2 to the appropriate level of care.

3 (c) Individual, family and group therapy provided by a QMHP; and

4 (d) Psychiatric services, including medication management as applicable, provided by a
5 LMP, either on-site or contracted.

6 (e) Case management services will be available and include the following:

7 (A) Assistance in applying for benefits to which the individual is entitled. Staff will assist
8 individuals in accessing and maintaining resources such as Social Security benefits,
9 General Assistance, food stamps, vocational rehabilitation, and housing. When needed,
10 staff will arrange transportation and/or accompany individuals to help them apply for
11 benefits.

12 (B) Assistance with completion of a declaration for mental health service with the
13 individual's participation and informed consent.

14 (C) Referral and coordination to help individuals gain access to services and supports
15 identified in the ISSP;

16 (D) When an individual receives residential services, the case manager will collaborate
17 with the program and family to coordinate services;

18 (E) When an individual resides in an Adult Foster Home, the case manager will assist in
19 the development of a Personal Care Plan. Additionally, the case manager will evaluate
20 the appropriateness of services in relation to the individual's assessed need and review
21 the Personal Care Plan every 180 days;

22 (F) When an individual is admitted to a hospital or nonhospital facility, the case manager
23 will make contact, in person or by telephone, with the individual within one working day
24 of entry. The individual's case manager will be actively involved with transition planning
25 from the hospital or nonhospital facility;

26 (G) If an individual is receiving treatment in a state funded long-term care psychiatric
27 facility, the case manager will, from the point of entry, be actively involved with
28 transitioning the individual from long term care; and

29 (H) Where significant health and safety concerns are identified, the case manager will
30 assure that necessary services or actions occur to address the identified health and safety
31 needs for the individual; and

32 (I) Skills training, as indicated.

33
34 (2) Psychiatric Security Review Board and Juvenile Psychiatric Security Review Board:

35 Services and supports will include all appropriate services determined necessary to assist
36 the individual in maintaining community placement and which are consistent with
37 Conditional Release Orders and the Agreement to Conditional Release.

38
39 (a) Providers of PSRB and JPSRB services acting through the designated Qualified
40 Person, will submit reports to the PSRB or JPSRB as follows:

41
42 (A) Orders for Evaluation: For individuals under the jurisdiction of the PSRB or the
43 JPSRB, providers will take the following action upon receipt of an Order for Evaluation:

44 (i) Within 15 days of receipt of the Order, schedule an interview with the individual for
45 the purpose of initiating or conducting the evaluation;

1 (ii) Appoint a qualified mental health professional (QMHP) to conduct the evaluation and
2 to provide an evaluation report to the PSRB or JPSRB;

3 (iii) Within 30 days of the evaluation interview, submit the evaluation report to the PSRB
4 or JPSRB responding to the questions asked in the Order for Evaluation; and

5 (iv) If supervision by the provider is recommended, notify the PSRB or JPSRB of the
6 name of the person designated to serve as the individual's Qualified Person, who will be
7 primarily responsible for delivering or arranging for the delivery of services and the
8 submission of reports under these rules.

9 (B) Monthly reports consistent with PSRB or JPSRB reporting requirements as
10 specified in the Conditional Release Order that summarize the individual's adherence to
11 Conditional Release requirements and general progress.

12 (C) Interim reports, including immediate reports by phone, if necessary, to ensure the
13 public's or individual's safety including:

14 (i) At the time of any significant change in the individual's health, legal, employment or
15 other status which may affect compliance with Conditional Release orders;

16 (ii) Upon noting major symptoms requiring psychiatric stabilization or hospitalization or
17 any other major change in the individual's ISSP.

18 (iii) Upon learning of any violations of the Conditional Release Order;

19 (iv) At any other time when, in the opinion of the Qualified Person, such an interim
20 report is needed to assist the individual.

21
22 (b) JPSRB providers will submit copies of all monthly reports and interim reports to both
23 the JPSRB and the Division.

24
25 (3) Adult Residential Treatment Homes and Adult Residential Treatment Facilities:

26
27 (a) A program representative will provide an orientation to each individual and guardian,
28 if applicable, that is developmentally appropriate and includes a complete tour of the
29 home, introductions to other individuals and staff, discussion of house agreements,
30 explanation of the laundry and food service schedule and policies, explanation of any fee
31 policies, discussion of the conditions under which residency would be discontinued, a
32 general description of available services and activities and a description of the home's
33 emergency procedures in accordance with xxx-xxx-xxxx.

34
35 (b) If applicable, the individual will be given an opportunity to complete advance
36 directives and/or a Declaration of Mental Health Service, and will be provided assistance
37 if requested.

38 (c) The program will develop reasonable house agreements outlining operating protocols
39 concerning, but not limited to, meal times, nighttime quiet hours, guest policies and
40 smoking.

41 (A) The house agreements will be consistent with the individual rights specified in these
42 rules and will be posted in an area readily accessible to individuals.

43 (B) House agreements will be reviewed and updated as necessary. Providers will
44 document that individuals provided input into any proposed changes to house agreements
45 before the revisions become effective.

46

1 (d) The following services will be available:
2

3 (A) Food service provided in accordance with OAR xxx-xxx-xxxx.

4 (B) Assistance and support, as necessary, to enable individuals to meet personal hygiene
5 and clothing needs;

6 (C) Housekeeping essential to the health and comfort of individuals;

7 (D) Activities and opportunities for socialization and recreation both within the home and
8 in the community;

9 (E) Health related services in accordance with OAR xxx-xxx-xxxx;

10 (F) Assistance with community navigation and transportation arrangements;

11 (G) Assistance with money management, when requested by an individual, to include
12 accurate documentation of all funds deposited and withdrawn when funds are held in
13 trust for the individual;

14 (H) Assistance with developing skills to live as independently as possible;

15 (I) Assistance with accessing community services, as needed; and

16 (J) Crisis-respite Services, when needed:

17 (i) Upon entry in crisis-respite services, the individual or guardian (as applicable) will be
18 informed of the planned date for discontinuation of services. This date may be extended
19 through mutual agreement between the program administrator and the individual or
20 guardian (as applicable).

21 (ii) Residential programs providing crisis-respite services will implement policies and
22 procedures that specify reasonable periods and the grounds for discontinuing crisis-
23 respite services earlier than the date planned.

24
25 (4) Enhanced Care Services:

26
27 (a) A day service program supervised by a QMHP and offered either off-site or at the
28 residential facility, if applicable;

29 (b) 12 hours-a-week of activities available during evenings and weekends provided or
30 arranged by the CMHP staff;

31 (c) Weekly meetings to review the ISSP, and to coordinate services and supports with
32 provider staff and related professionals;

33 (d) A crisis service staffed by a QMHP or the local CMHP available to the provider and
34 direct care staff 24 hours a day;

35 (e) Quarterly mental health in-service trainings delivered to the provider and related
36 personnel working with recipients of the Enhanced Care Services.

37
38 (5) Intensive Community-Based Treatment and Support Services (ICTS): ICTS services
39 may be delivered at a clinic, facility, home, school, other provider/allied agency location
40 or other setting as identified by the child and family team. In addition to services
41 specified by the ISSP and the standards for outpatient mental health services, ICTS
42 services will include:

43
44 (a) Care coordination provided by a QMHP or a QMHA supervised by a QMHP;

45 (b) A child and family team, as defined in these rules;

- 1 (c) Service coordination as specified in the service coordination section of the ISSP, to be
- 2 developed by the child and family team;
- 3 (d) Review of progress at each child and family team meeting to occur at a frequency
- 4 documented in the ISSP.
- 5 (e) Skills training provided by a QMHP or QMHA supervised by a QMHP;
- 6 (f) Family support and respite care, as indicated;
- 7 (g) Proactive safety/crisis planning that utilizes professional and natural supports to
- 8 provide 24 hours, seven days per week flexible response and is reflective of strategies to
- 9 avert potential crisis without placement disruptions; and
- 10 (h) Behavior support planning, consistent with xxx-xxx-xxx of these rules.

11 (6)Children’s Intensive Treatment Services (ITS): ITS providers will ensure that the

12 following services are available and accessible through direct service, contract or by

13 referral:

- 14 (a) Psychiatric services;
- 15 (b) Individual, group and family therapies provided by a QMHP. There will be no less
- 16 than one family therapist available for each 12 children.
- 17 (c) Medication evaluation, management and/or monitoring;
- 18 (d) Pre-vocational/vocational rehabilitation;
- 19 (e) Therapies supporting speech, language and hearing rehabilitation;
- 20 (f) Individual and group psychosocial skills development;
- 21 (g) Activity and recreational therapies;
- 22 (h) Nutrition;
- 23 (i) Physical health care services or coordination;
- 24 (j)Recreational and social activities consistent with individual strengths and interests; and
- 25 (k) Educational services coordination and advocacy.

26

27 (7)Program Specific Requirements for ITS providers: In addition to the general

28 requirements for all ITS providers listed, the following program-specific requirements

29 will be met:

30

31 (a) *Secure Inpatient Programs for Children up to age 14 (SCIP) and Adolescents under*

32 *the age of 21 (SAIP): These services are available to provide psychiatric stabilization*

33 *and treatment services to children who require a secure and intensive treatment setting*

34 *provided by the following:*

35

- 36 (A) *A staffing model that allows for the child’s frequent contact with the child psychiatrist*
- 37 *a minimum of one hour per week; psychiatric nursing staff 24 hours per day, and*
- 38 *provides a psychologist, psychiatric social workers, rehabilitation therapists and milieu*
- 39 *staff with specialized training in SCIP or SAIP 24 hours per day. Additionally a*
- 40 *psychologist with specialized training in forensic evaluations shall be available.*
- 41 (B) *Have the ability to provide mechanical restraint and injectable medications and shall*
- 42 *provide all medically appropriate psychiatric services necessary to meet the child’s*
- 43 *psychiatric care needs.*

1 (C) Provide secure psychiatric treatment services in a manner that ensures public safety
2 to youth who are under the care and custody of the Oregon Youth Authority (OYA); court
3 ordered for the purpose of psychiatric evaluation; or admitted by the authority of the
4 Juvenile Psychiatric Review Board (JPSRB).

5 (D) Not rely on external entities such as law enforcement or acute hospital care to assist
6 in the management of the SAIP or SCIP milieu.
7

8 (b) Stabilization and Treatment Services (STS): are enhanced program services for
9 children that may be utilized by ITS providers under the following conditions:
10

11 (A) In an effort to divert an individual referred for SCIP or SAIP entry by providing
12 additional services in a less restrictive setting when clinically indicated.

13 (B) To provide additional program services to a contracted provider, assisting them in
14 successfully transitioning a child from the SCIP or SAIP to a less restrictive setting.

15 (c) Psychiatric Residential Treatment Services (PRTS): These services are structured
16 treatment environments with daily 24-hour supervision and active psychiatric service for
17 children who require active treatment for a diagnosed mental health condition in a 24-
18 hour residential setting.

19 (A) Providers of Psychiatric Residential Treatment Services will maintain one or more
20 linkages with acute care hospitals and/or CMHP's to coordinate necessary inpatient care.

21 (B) PRTS services will be under the direction of a medical director who is a psychiatrist
22 as defined in these rules and delivered by an interdisciplinary team of board-certified or
23 board-eligible child and adolescent psychiatrists, registered nurses, psychologists, other
24 qualified mental health professionals, and other relevant program staff. A psychiatrist
25 will be available to the program 24-hours per day, seven days per week.

26 (d) Sub-Acute Psychiatric Care: These services are provided by nationally accredited
27 providers to children who need 24-hour intensive mental health service in a secure setting
28 to assess, evaluate and stabilize or resolve the symptoms of an acute episode that
29 occurred as the result of the diagnosed mental health condition. In addition to the services
30 provided as indicated by the assessment and specified in the ISSP, Sub-Acute Psychiatric
31 Care providers will:

32 (A) Provide psychiatric nursing at least 16 hours per day;

33 (B) Provide close nursing supervision and monitoring and psychiatric supervision at least
34 one to three times per week.

35 (C) Work actively with the child and family team and multi-disciplinary community
36 partners, to plan for the long-term, least restrictive emotional, behavioral, physical and
37 social needs of the child.
38

39 (e) Psychiatric Day Treatment: Psychiatric Day Treatment services will be provided to
40 children who will remain at home with a parent, guardian or foster parent, by qualified

1 mental health professionals and qualified mental health associates in consultation with a
2 psychiatrist.

3
4 (A) Psychiatric Day Treatment programs will be staffed to the acuity and severity of
5 admitted children at a clinical staffing ratio of at least one QMHP or QMHA for three
6 children.

7 (B) Children will remain in a psychiatric day treatment program only for the period of
8 time determined to be medically appropriate to treat the diagnosis identified in the
9 Assessment. Continued stay will be reviewed by the child and family team and approved
10 every 90 days.

11
12 (8) Alcohol and Other Drug Treatment and Recovery Services:

13
14 (a) Interim Referral and Informational Services: Programs will provide interim referrals
15 and information, to pregnant women and/or individuals using substances intravenously,
16 to reduce the adverse health effects of alcohol and other drug abuse, promote the health
17 of the individual, and reduce the risk of transmission of disease. At a minimum, interim
18 referral and informational services will include:

19
20 (A) Counseling and education about blood borne pathogens such as Hepatitis, HIV, and
21 Tuberculosis; about the risks of needle sharing and of transmission to sexual partners and
22 infants; and about steps that can be taken to ensure that HIV, TB and Hepatitis
23 transmission does not occur;

24 (B) Referral for HIV, TB or Hepatitis services if necessary;

25 (C) For pregnant women, counseling on the effects of alcohol, tobacco and other drug use
26 on the fetus, and referral for prenatal care.

27
28 (b) Culturally specific Programs: Programs approved and designated as culturally specific
29 programs will meet the following criteria:

30
31 (A) Serve a majority of individuals representing the culturally specific population.

32 (B) Governing Board: Develop and maintain a governing or advisory board that will:

33 (i) Have a majority representation of the culturally specific group being served;

34 (ii) Receive training concerning the significance of culturally relevant services and
35 supports;

36 (iii) Include at least 20% consumer representation; and

37 (iv) Meet at least quarterly.

38 (C) Maintain accessibility to culturally specific populations including:

39 (D) The physical location of the program will be within close proximity to the culturally
40 specific populations;

41 (E) Where available, public transportation will be within close proximity to the program;

42 (F) Hours of service, telephone contact, and other individual-related accessibility issues
43 will be appropriate for the population; and

44 (G) The physical facility within which the culturally specific services are delivered will
45 be psychologically comfortable for the group including:

46 (i) Materials displayed will be culturally relevant;

1 (ii) Mass media programming (radio, television, etc.) will be sensitive to cultural
2 background; and
3 (iii) Other cultural differences will be considered and accommodated when possible (e.g.,
4 the need or desire to bring family members to the facility, play areas for small children,
5 etc.).

6
7 (c) Adolescent Treatment Services: Programs approved to provide adolescent treatment
8 services or those with adolescent-designated service funding will meet the following
9 standards:

10
11 (A) Participation of Family/Agencies: Individual Service and Support Planning/case
12 management services will include participation of parents, other family members,
13 schools, children's services agencies, and juvenile corrections, as appropriate.

14 (B) Services will include:

- 15 (i) Family service;
- 16 (ii) Recreation and leisure time consistent with the individual's interests
- 17 (iii) Community and social skills training
- 18 (iv) Academic education services or referral;
- 19 (v) Smoking cessation service; and
- 20 (vi) Gender-specific service.

21 (C) Continuing Care: Continuing care services will be of appropriate duration, consistent
22 with ASAM PPC-2R criteria, and designed to maximize recovery opportunities. The
23 services will include:

- 24 (i) Reintegration services and coordination with family and schools;
- 25 (ii) Support groups and/or other peer support groups provided at school sites;
- 26 (iii) Youth dominated self-help groups where available;
- 27 (iv) Linkage to emancipation services when appropriate; and
- 28 (v) Linkage to physical or sexual abuse service when appropriate.

29 (C) Staffing: There will be employed a sufficient number of qualified treatment staff to
30 ensure a ratio of at least one treatment staff per eight individuals at all times.

31 (d) Women's Treatment Services: Programs approved and designated to provide treatment
32 services primarily to women will meet the following standards:

33
34 (A) Women-Specific Issues: The Assessment will contain an evaluation that identifies
35 and assesses problems specific to women's issues in service such as social isolation, self-
36 reliance, parenting issues, domestic violence, and housing and financial considerations.

37 (B) Individual Service and Support Plan: The Individual Service and Support Plan will
38 address areas identified above as well as alcohol and other drug abuse and other service
39 issues.

40 (C) The program will provide or coordinate services that meet the special
41 access needs of this population such as individual care, mental health services, and
42 transportation.

43 (D) Services and supports will include the following unless clinically
44 contraindicated:

- 45 (i) Gender specific service;

1 (ii) Family service, including therapeutic services for children in the custody of women in
2 treatment;

3 (iii) Reintegration with family services;

4 (iv) Smoking cessation service;

5 (v) Housing; and

6 (vi) Transportation.

7 (E) Individual Service and Support Planning and treatment will include the participation
8 of family and other agencies as appropriate (e.g., social service, individual welfare, or
9 corrections agencies).

10 (F) Referral Services: The program will coordinate services with the following, if
11 indicated:

12 (i) Sexual or physical abuse service; and

13 (ii) Parenting training; and

14 (iii) Domestic violence counseling.

15 (iv) Continuing Care: Continuing care service services will be consistent with the ASAM
16 PPC 2R and will include referrals to female dominated support groups where available.

17
18 (e) Community-based Services to Individuals in the Criminal Justice System: Services
19 and supports are for individuals who are under the supervision of a probation officer or
20 on parole/post-prison supervision or participating in a drug treatment court program or
21 otherwise under the direct supervision of the court.

22
23 (A) Services and supports will incorporate interventions and strategies that target
24 criminogenic risk factors and include:

25
26 (i) Cognitive behavioral interventions;

27 (ii) Motivational interventions;

28 (iii) Relapse prevention; and

29 (iv) Healthy relationships education.

30
31 (B) Providers will demonstrate coordination of services with criminal justice
32 partners through written protocols, staff activities, and clinical record documentation.

33
34 (C) Program Directors will have full time experience in community-based offender
35 programs for a minimum of three years and have specific training and experience
36 applying effective, evidence-based clinical strategies and services for individuals
37 receiving community-based offender services.

38
39 (D) Within the first six months of hire, program staff will receive training on effective
40 principles of evidenced based practices for individuals with criminogenic risk factors,
41 and;

42
43 (E) Within six months of hire, program staff will have documented knowledge, skills, and
44 abilities demonstrating treatment strategies for individuals with criminogenic risk factors.
45

1 (f) DUII Alcohol and Other Drug Rehabilitation Programs: In addition to the general
2 standards for alcohol and other drug treatment programs, programs approved to provide
3 DUII rehabilitation services shall meet the following standards:
4

5 (A) DUII Treatment Services: DUII rehabilitation programs will assess individuals
6 referred for treatment by the evaluation specialist. Placement, continued stay and service
7 conclusion of individuals will be based on the criteria described in the ASAM PPC-2R,
8 subject to the following additional terms and conditions:
9

10 (B) Abstinence: Individuals must demonstrate continuous abstinence for a minimum of
11 90 days prior to service conclusion as documented by urinalysis tests and other evidence.
12

13 (C) Treatment Completion: Only DUII rehabilitation programs may certify treatment
14 completion.
15

16 (D) Residential Treatment: Using the ASAM PPC-2R, the DUII program's assessment
17 may indicate that the individual requires treatment in a residential program. It will be the
18 responsibility of the DUII program to:

19 (i) Monitor the case carefully while the individual is in residential treatment by
20 confirming that the individual entered the program and that the individual completed the
21 program;

22 (ii) Provide or monitor outpatient and/or follow-up services when the individual is service
23 conclusion from the residential program; and

24 (iii) Verify completion of residential treatment and follow-up outpatient treatment.
25

26 (E) Urinalysis Testing: A minimum of two urinalysis samples shall be collected during
27 the period of service deemed necessary by a individual's DUII rehabilitation program:

28 (i) Using the process defined in these rules, the samples shall be tested for at least
29 three controlled drugs.

30 (ii) At least one of the two samples is to be collected and tested in the first two weeks of
31 the program and at least one is to be collected and tested in the last two weeks of the
32 program.

33 (iii) If the first sample is positive, two or more samples must be collected and tested,
34 including one sample within the last two weeks before service conclusion.

35 (iv) Programs may use methods of testing for the presence of alcohol and other drugs in
36 the individual's body other than urinalysis tests if they have obtained the prior review and
37 approval of such methods by the Division.
38

39 (F) Reporting: The program will report:

40 (i) To the Division on forms prescribed by the Division;

41 (ii) To the evaluation specialist within 30 days from the date of the referral by the
42 specialist. Subsequent reports must be provided within 30 days of service conclusion or
43 within 10 days of the time that the individual enters non compliant status; and

44 (iii) To the appropriate evaluation specialist, case manager, court, and/or other agency as
45 required when requested concerning individual cooperation, attendance, treatment
46 progress, utilized modalities, and fee payment.

1
2 (G) Certifying Completion: The program shall send a numbered Certificate of
3 Completion to the Department of Motor Vehicles to verify the completion of convicted
4 individuals. Payment for treatment may be considered completion. A certificate of
5 completion shall not be issued until the individual has satisfied the abstinence
6 requirements of (B) in this section.
7

8 (H) Records: The DUII rehabilitation program shall maintain in the permanent Individual
9 Service Record, urinalysis results and all information necessary to determine whether the
10 program is being, or has been, successfully completed.
11

12 (I) Separation of Assessment/Rehabilitation Functions: Without the approval of the
13 Administrator consistent with the criteria in OAR xxx-xxx-xxxx, no agency or person
14 may provide DUII rehabilitation to a individual who has also been referred by a Judge to
15 the same agency or person for a DUII related diagnostic assessment. Failure to comply
16 with this section will be considered a violation of ORS chapter 813. If the Administrator
17 finds such a violation the Administrator may deny, suspend, revoke, or refuse to renew a
18 letter of approval.
19

20 (9) Problem Gambling Treatment Services: Problem gambling treatment services include
21 group, individual and family treatment services consistent with the following
22 requirements:
23

24 (a) The first offered service appointment must be five business days or less from the date
25 of request for services.
26

27 (b) Service sessions must address the challenges of the individual(s) as they relate,
28 directly or indirectly, to the problem gambling behavior.
29

30 (c) Telephone counseling: Providers may provide telephone counseling when person-to-
31 person contact would involve an unwise delay, as follows:
32

33 (A) Individual must be currently enrolled in the problem gambling treatment program.

34 (B) Phone counseling must be provided by a qualified provider within their scope of
35 practice.

36 (C) Individual service notes must follow the same criteria as face-to-face counseling and
37 include that the session was conducted by phone and the clinical rationale for the phone
38 session.

39 (D) Telephone counseling must meet HIPAA/CFR 42 standards for privacy.

40 (E) There must be an agreement of informed consent for phone counseling that is
41 discussed with the individual and documented in the individual's service record.
42

43 (d) Family Counseling: Family counseling includes face-to-face or non face-to-face
44 service sessions between a provider staff member delivering the service and an individual
45 whose life has been negatively impacted by gambling. Service sessions must address the
46 problems of the individual as they relate, directly or indirectly to the problem gambling

1 behavior. Services to the family must be offered even if the individual identified as a
2 problem gambler is unwilling, or unavailable to accept services.

3
4 (e) 24-hour crisis response accomplished through agreement with other crisis services, on-
5 call staff or other arrangement acceptable to the Division.

6
7 *(10) Behavior Support Services: Behavior support services will be proactive, recovery-
8 oriented, individualized, and designed to facilitate positive alternatives to challenging
9 behavior, as well as to assist the individual in developing adaptive and functional living
10 skills. Providers in ICTS and ITS services will:*

11
12 *(a) Take into consideration the neurodevelopment challenges of the individual and not
13 assume negative behavior is volitional in nature;*

14 *(b) Develop and implement individual behavior support strategies, based on a functional,
15 or other clinically appropriate, assessment of challenging behavior. The strategies and
16 measures for tracking progress will be documented in the ISSP and will be regularly
17 monitored for effectiveness.*

18 *(c) Establish a framework, which assures individualized positive behavior support
19 practices throughout the program and articulates a rationale consistent with the
20 philosophies supported by the Division, including the Division's Trauma-informed
21 Services Policy.*

22 *(d) Obtain informed consent from the parent(s) or guardian in the use of behavior support
23 strategies, and communicate both verbally and in writing the information to the
24 individual and guardian in a developmentally appropriate manner;*

25 *(e) Establish tracking methods for behavior support strategies to inform planning of
26 proactive strategies and to assess progress in reducing or eliminating challenging
27 behavior.*

28 *(f) Require all staff to receive training in Collaborative Problem Solving, Positive
29 Behavior Support or other Evidence-based Practice to promote positive behavior
30 support.*

31 *(g) Review and update behavior support policies, procedures, and practices annually.*

32
33 *(11) Special Safety Procedures in ITS Programs: Providers of ITS services will adopt
34 policies and procedures for Special Safety Procedures as part of a Crisis Prevention and
35 Intervention Policy. The policy will be consistent with the provider's trauma-informed
36 and trauma-sensitive services policy and procedures. The provider will:*

37
38 *(a) Prohibit the use of mechanical restraint and chemical restraint as defined in these
39 rules.*

40
41 *(b) Establish a Special Safety Procedures Committee or designate this function to an
42 already established Quality Management Committee. The committee will:*

43
44 *(A) Monitor the use of special safety procedures to assure that individuals are
45 safeguarded and their rights are always protected;*

1 (B) Meet at least monthly and will report in writing to the provider's Quality
2 Management Committee at least quarterly regarding the committee's activities, findings
3 and recommendations;

4 (C) Conduct individual and aggregate review of incidents of manual restraint and
5 seclusion;

6 (D) Analyze special safety procedures to determine opportunities to prevent their use,
7 increase the use of alternatives, improve the quality of care of individuals receiving
8 services, and recommend whether follow up action is needed; and

9 (E) Review and approve other safety procedures including experimental practices other
10 than medications that are outside usual and customary clinical practices and research
11 projects. Experimental practices and research require review and approval by the
12 Division Institutional Review Board.

13 (F) Review and update special safety procedures policies and procedures annually.
14

15 (c) General Conditions of Manual Restraint and Seclusion:

16
17 (A) Manual restraint and seclusion will only be used in an emergency to prevent
18 immediate injury to an individual who is in danger of physically harming him or herself
19 or others in situations such as the occurrence of, or serious threat of violence, personal
20 injury or attempted suicide;

21 (B) Any use of manual restraint or seclusion will respect the dignity and civil rights of the
22 individual;

23 (C) The use of manual restraint or seclusion will be directly related to the immediate risk
24 related to the behavior of the individual and will not be used as punishment, discipline,
25 or for the convenience of staff;

26 (D) Manual restraint or seclusion will only be used for the length of time necessary for
27 the individual to resume self-control and prevent harm to the individual or others;

28 (E) If manual restraint and/or seclusion is considered as part of the individual's safety
29 needs, the crisis planning section of the ISSP will outline the approved use and specific
30 limitations of these interventions, and the proactive prevention strategies and
31 alternatives aimed at eliminating their use; and

32 (F) Each incident of manual restraint or seclusion will be documented in an incident
33 report. The documentation will specify less restrictive methods attempted prior to the
34 manual restraint, the required authorization, length of time the manual restraint was
35 used, the events precipitating the manual restraint, assessment of appropriateness of the
36 manual restraint based on threat of harm to self or others, assessment of physical injury,
37 and the individuals response to the intervention;

38 (G) A minimum of two staff, who have completed appropriate crisis intervention training,
39 will implement a manual restraint. If, in the event of an emergency, a single staff manual
40 restraint has occurred, the provider's on-call administrator will immediately review the
41 intervention;

42 (H) Authorization for seclusion will be obtained by a psychiatrist within 15 minutes of the
43 initiation of seclusion. Written orders for seclusion, compliant with the individual
44 specifications and limitations of the seclusion, will be completed for each instance of
45 seclusion and will be maintained in the Individual Service Record.

1 (I) A manual restraint intervention that exceeds 15 minutes will require an immediate
2 documented review and authorization by a QMHP and a psychiatrist or designee, and
3 a designated individual with clinical leadership responsibilities will review the manual
4 restraint documentation prior to the end of the shift in which the intervention occurred;
5 (J) If incidents of seclusion or manual restraint used with an individual cumulatively
6 exceed three interventions over a period of seven days, or a single episode of thirty
7 minutes, the psychiatrist or designee will within 24 hours convene by phone or in person
8 staff in the program with designated clinical leadership responsibilities to review the
9 individual's ISSP and make necessary revisions.

10 (K) Providers must be certified to use seclusion, as per OAR xxx-xxx-xxxx.

11
12 (12) Medical Protocols: When medical services are applicable, medical protocols will be
13 approved by a medical director under contract with a program and/or written reciprocal
14 agreement with a medical practitioner under managed care. The protocols will:

15
16 (a) Require, but not be limited to, the collection of medical histories as described in the
17 Assessment;

18 (b) Designate those medical symptoms that, when found, require further investigation,
19 physical examinations, service, or laboratory testing;

20 (c) Describe procedures for medical emergencies;

21 (d) Require that individuals admitted to the program who currently are injecting or
22 intravenously using a drug, or within the past 30 days have injected or intravenously used
23 a drug, or who are at risk of withdrawal from a drug, or who may be pregnant, must be
24 referred for a physical examination and appropriate lab testing within 30 days of entry to
25 the program. (These requirements may be waived by the medical director if these services
26 have been received within the past 90 days and documentation is provided);

27 (e) Require pregnant women be referred for prenatal care within two weeks of entry to
28 the program;

29 (f) Require that the program provide HIV/AIDS, tuberculosis, sexually transmitted
30 disease, hepatitis and other infectious disease information and risk assessment, including
31 any needed referral, within 30 days of entry; and

32 (g) Specify how follow up of admitted individual's will be handled in the event the
33 individual is found to have any major medical problem.

34 (h) Medication Administration Record (MAR): Written documentation of medications
35 prescribed for the individual by a LMP will be maintained in the Individual Service
36 Record. Documentation for each medication prescribed will include the following:

37 (A) A copy or detailed written description of the signed prescription order;

38 (B) The name of medication prescribed;

39 (C) The prescribed dosage and method of administration;

40 (D) The date medications were prescribed, reviewed, or renewed;

41 (E) The date, the signature and credentials of staff administering and/or prescribing
42 medications; and

43 (F) Medication records which contain:

44 (G) Observed side effects including laboratory findings;

45 (H) Medication allergies and adverse reaction; and

46 (I) Documentation that the individual was asked about possible adverse effects of

1 medications, including sexual dysfunction, and evaluation for tardive dyskinesia when
2 appropriate.

3 (i) Administration of Medications: The following guidelines must be followed in policies
4 on administration of medications:

5 (A) The Medication Administration Record (MAR) will include a written order signed by
6 a physician, or a program medical policy approved in writing by a licensed physician, is
7 required before any medication can be administered to, or self-administered, by any
8 individual;

9 (B) Medications prescribed for one individual will not be administered to, or self-
10 administered, by another individual or employee; and

11 (C) In the cases where an individual self-administers medication, self-administration will
12 be approved in writing by a physician, and closely monitored by the residential program
13 staff.

14 (j) Unused or Outdated Drugs: No unused, outdated, or recalled drugs will be kept in a
15 residential program. On a monthly basis, any unused, outdated, or recalled drugs will be
16 disposed of in a manner that assures they cannot be retrieved.

17 (k) Documentation of Drug Disposal: A written record of all disposals of drugs will be
18 maintained in the residential program and will include:

19 (A) A description of the drug, including the amount;

20 (B) The individual for whom the medication was prescribed;

21 (C) The reason for disposal; and

22 (D) The method of disposal.

23 (l) Storage of Prescription Drugs: All prescription drugs stored in the residential program
24 will be kept in a locked stationary container. Medications requiring refrigeration will be
25 stored in a refrigerator using a locked container.

26
27
28
29 **XXX-XXX-XXXX**

30 **Service Conclusion, Transfer, and Continuity of Care**

31
32 (1) Planned Service Conclusion: Planned service conclusion will be consistent with the
33 objectives stated in the ISSP and will be documented in a service summary.

34
35 (a) For alcohol and other drug treatment programs, planned service conclusion will be
36 consistent with the ASAM discharge criteria established in the assessment and indicated
37 in the ISSP.

38
39 (b) Decisions to conclude services or transfer individuals will be documented in an
40 individual service note. The documentation will include the reason for the transfer, or the
41 agreement that service conclusion is appropriate consistent with the objectives in the
42 ISSP, or the conditions defined in this rule.

43
44 (2) Service Conclusion Process: To assure that the individual and family have access to
45 appropriate peer and community support services, providers will:

1 (a)When applicable, coordinate and provide appropriate referrals for medical care and
2 medication management to individuals who leave through a planned service conclusion.
3 The discharging provider will identify the medical personnel who will provide continuing
4 care and will arrange an initial appointment with that provider;

5
6 (b)Coordinate recovery and ongoing support services for individuals and their families
7 including identifying resources and facilitating linkage to other service systems,
8 including community peer support services, necessary to sustain recovery;

9
10 (c)Complete a Service summary, consistent with xxx-xxx-xxxx of these rules, within 30
11 calendar days following a planned service conclusion and within 30 calendar days
12 following the date of service conclusion in the event of an unplanned service conclusion.
13

14 (d) When services are concluded due to the absence of the individual, the provider will
15 document outreach efforts made to locate or contact the individual, or document the
16 reason why such efforts were not made.

17
18 (e) If the individual is under the jurisdiction of the PSRB or JPSRB, the provider will
19 notify the PSRB or JPSRB immediately and provide a copy of the Service summary
20 within 30 days.

21
22 (3)Transfer Process: Providers will coordinate transfers as follows:

23
24 (a) All documentation contained in the Individual Service Record, that is requested by the
25 receiving provider, will be furnished, compliant with the provider's confidentiality
26 policies and procedures, within 14 days of entry to the new program.

27
28 (b) A complete service summary will be sent to the receiving provider within 30 days of
29 the transfer.
30

31
32
33 XXX-XXX-XXXX

34 **Quality Assessment and Performance Improvement**

35
36 (1)Quality Assessment and Performance Improvement: Providers will develop and
37 implement a structured and ongoing process to monitor, evaluate and improve the quality
38 and effectiveness of services provided to individuals and their families.

39
40 ~~(a) The quality assessment process will include **Provider Performance Objectives, a**~~
41 ~~**Quality Assessment Committee** and a Performance Improvement Plan.~~

42
43 ~~(2)Quality Assessment Committee: The quality assessment committee will develop and~~
44 ~~implement the Performance Improvement Plan and will facilitate ongoing strategies to~~
45 ~~improve individual outcomes and sustain service improvements.~~
46

1 ~~(a) The Quality Assessment Committee will be composed of:~~

2
3 ~~(A) One or more program staff who are representative of the scope of services delivered;~~

4 ~~(B) A clinical supervisor and/or a LMP;~~

5 ~~(C) Individuals and families served, constituting 20% of the makeup of the committee;~~

6 ~~(D) Other persons who have the ability to identify, design, measure, assess and~~
7 ~~implement policy and organizational changes.~~

8
9 ~~(b) The quality assessment and performance improvement process will~~
10 ~~Quality Assessment Committee will:~~

11
12 (A) Identify indicators of quality;

13 (B) Identify measurable and time-specific performance objectives and strategies to meet
14 objectives;

15 (C) Recommend policy and operational changes necessary to achieve performance
16 objectives; and

17 (D) Reassess and, if necessary, revise objectives and methods to measure performance on
18 an ongoing basis to ensure sustainability of improvements.

19 ~~(E) Ensure individual and family voice is included in the process, including a formal~~
20 ~~process for individuals and families to give input into the delivery of services.~~

21
22 ~~(e) The Quality Assessment Committee will meet at least quarterly.~~

23
24 ~~(d) A written summary of the pertinent decisions and actions resulting from each Quality~~
25 ~~Assessment Committee meeting will be maintained and be available for review by the~~
26 ~~Division, CMHP, MHO or FCHP.~~

27
28 ~~(23) Performance Improvement Plan: The Performance Improvement Plan will include:~~

29
30 (a) Performance objectives aimed at improving services;

31
32 ~~(A) Retention;~~

33 ~~(B) Engagement; and~~

34 ~~(C) Transitions in level of care.~~

35
36
37 (b) Strategies designed to meet the performance objectives and measure progress; and

38
39 ~~(e) Policies and procedures for:~~

40
41 ~~(A) Identifying and measuring performance objectives, including~~

42 ~~(B) A formal process for individuals to give input into the delivery of services~~

43 ~~(C) Initiating performance improvements~~

44 ~~(D) Ensuring sustainability of improvements;~~

45

1 (E) Managing utilization of services, including conducting written utilization reviews as
2 per OAR 309-016-0900.

3
4
5 xxx-xxx-xxxx

6 **Grievances and Appeals**

7
8 (1) Any individual receiving services, or guardian of the individual receiving services,
9 may file a grievance with the Provider, their managed care plan and/or the Division.

10
11 (2) For individuals whose services are funded by Medicaid, grievance and appeal
12 procedures outlined in xxx-xxx-xxxx, will be followed.

13
14 (3) For individuals whose services are not funded by Medicaid, providers will:

15
16 (a) Notify each individual, or guardian, of the grievance procedures by reviewing a
17 written copy of the policy upon entry.

18 (b) Assist individuals and/or guardians, as applicable, to understand and complete the
19 grievance process; and notify them of the results and basis for the decision.

20 (c) Encourage and facilitate resolution of the grievance at the lowest possible level;

21 (d) Complete an investigation on any grievance within 30 calendar days;

22 (e) Implement a procedure for accepting, processing and responding to grievances
23 including specific timelines for each;

24 (f) Designate a staff person to receive and process the grievance.

25 (g) Document any action taken on a substantiated grievance within a timely manner; and

26 (h) Document receipt, investigation, and action taken in response to the grievance.

27
28 (4) Grievance Process Notice. The provider will have a Grievance Process Notice, which
29 must be posted in a conspicuous place stating the telephone number of:

30
31 (a)The Division;

32 (b)The CMHP; and

33 (c)Disability Rights Oregon

34
35 (5) Expedited Grievances: In circumstances where the matter of the grievance is likely to
36 cause harm to the individual before the grievance procedures outlined in these rules are
37 completed, the individual, or guardian of the individual, may request an expedited
38 review. The administrator will review and respond in writing to the grievance within 48
39 hours. The written response will include information about the appeal process.

40
41 (6) Retaliation: A grievant, witness or staff member of a provider will not be subject to
42 retaliation by a provider for making a report or being interviewed about a grievance or
43 being a witness. Retaliation may include, but is not limited to, dismissal or harassment,
44 reduction in services, wages or benefits, or basing service or a performance review on the
45 action.

1 (7) Immunity: The grievance will have immunity from any civil or criminal liability with
2 respect to the making or content of a grievance made in good faith.

3
4 (8) Appeals: Individuals, their legal guardians, as applicable, will have the right to appeal
5 entry, service conclusion and grievance decisions as follows:

6
7 (a) If the individual, or guardian, if applicable, is not satisfied with the decision, the
8 individual or guardian may file an appeal in writing within ten working days of the date
9 of the program administrator's response to the grievance or notification of entry denial or
10 service conclusion(as applicable). The appeal will be submitted to the CMHP Director in
11 the county where the provider is located, or to the Division, as applicable.

12 (b) If requested, program staff will be available to assist the individual.

13 (c) The CMHP Director, or Division, will provide a written response within ten working
14 days of the receipt of the appeal.

15 (d) If the individual, or guardian, if applicable, is not satisfied with the appeal decision,
16 he/she may file a second appeal in writing within ten working days of the date of the
17 written response to the Administrator of the Department.

18
19
20 **xxx-xxx-xxxx**

21 **Variations**

22
23 (1) Criteria for a Variance: Variations may be granted to a Local Mental Health Authority
24 (LMHA), Community Mental Health Program (CMHP) or provider holding a certificate
25 directly with the Division, by the Division:

26
27 (a) If there is a lack of resources to implement the standards required in this rule; or

28 (b) If implementation of the proposed alternative services, methods, concepts or
29 procedures would result in services or systems that meet or exceed the standards in these
30 rules.

31
32 (2) Application for a Variance:

33
34 (a) CMHPs and other providers may submit their variance request directly to the
35 Division; and

36 (b) Providers, who hold Certificates of Approval jointly with CMHP's and the Division,
37 will submit their variance requests to the CMHP. The CMHP will then submit the
38 variance request, along with the CMHP's written support of the variance, if applicable, to
39 the Division.

40
41 (c) The LMHA, CMHP or provider requesting a variance will submit, in writing, an
42 application to the Deputy Assistant Director of the Division or designee, which contains
43 the following:

44
45 (A) The section of the rule from which the variance is sought;

46 (B) The reason for the proposed variance;

1 (C) The alternative practice, service, method, concept or procedure proposed;
2 (D) A description of the individual's opinion and participation in requesting the variance,
3 when available.

4 (E) A proposal for the duration of the variance. If applicable, a plan and timetable for
5 compliance with the section of the rule for which the variance applies, ~~except when not~~
6 ~~required, as specified in the approval of the variance.~~

7
8 (3) Division Review and Notification: The Deputy Assistant Director will approve or
9 deny the request for a variance and will notify the LMHA, CMHP and/or provider in
10 writing of the decision to approve or deny the requested variance, within 30 days of
11 receipt of the variance. The written notification will include the specific alternative
12 practice, service, method, concept or procedure that is approved and the duration of the
13 approval.

14
15 (4) Appeal Application: Appeal of the denial of a variance request will be made in
16 writing to the Assistant Director of the Division, whose decision will be final and will be
17 provided in writing within 30 days of receipt of the appeal.

18
19 (5) Written Approval: The LMHA, CMHP or provider may implement a variance only
20 after written approval from the Division.

21
22 (6) Duration of Variance: It is the responsibility of the LMHA, CMHP or the provider to
23 submit a request to extend a variance in writing prior to a variance expiring. Extension
24 must be approved in writing by the Division.

25
26 (7) Granting a variance does not set a precedent that must be followed by the Department
27 when evaluating subsequent requests for variance.