

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Statutory Authority: 16 Delaware Code, Chapter 22 (16 Del.C., Ch. 22)
16 DE Admin. Code 6001

FINAL

ORDER

DSSM 11006.3; Child Care Subsidy Program 6001 Substance Abuse Facility Licensing Standards

NATURE OF THE PROCEEDINGS

Delaware Health and Social Services (“Department”) / Division of Social Services initiated proceedings to provide information of public interest with respect to the Division of Substance Abuse and Mental Health’s (DSAMH) **Substance Abuse Facility Licensing Standards**. The Department’s proceedings were initiated pursuant to 16 Delaware Code Section Chapter 22.

The Department published its notice of public comment pursuant to 29 Delaware Code Section 10115 in the July 2010 Delaware Register of Regulations, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by July 31, 2010 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSED CHANGE

The proposed change described below amends DSAMH **Substance Abuse Facility Licensing** policies in the Division of Social Services Manual (DSSM) regarding **the licensure of substance abuse treatment facilities**.

Statutory Authority

45 CFR §98.40, *Compliance with applicable State and local regulatory requirements*

Summary of Proposed Change

DSAMH 6001 Substance Abuse Facility Licensing Standards: This change is proposed: 1) to amend current standards; and, 2) to add information and to reformat the text to further clarify the requirements for substance abuse licensure. The intent of the proposed amendment is to simplify language and improve readability.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES

Delaware Health and Social Services (“DHSS”) initiated proceedings to adopt the State of Substance Abuse Facility Licensing Standards. The DHSS proceedings to adopt regulations were initiated pursuant to 29 Delaware Code Chapter 101 and authority as prescribed by 16 Delaware Code, Chapter 79, ? 7903.

July 1, 2010 DHSS published in the *Delaware Register of Regulations* its notice of proposed regulations, pursuant to 29 Delaware Code Section 10115. It requested that written materials and suggestions from the public concerning the proposed regulations be delivered to DHSS by July 30, 2010, after which time the DHSS would review information, factual evidence and public comment to the said proposed regulations.

Written comments were received during the public comment period and evaluated. The results of that evaluation are summarized in the accompanying “Summary of Evidence.”

Summary of Evidence

A. Melissa Gentile with Claymont Recovery Center provided the following written comment:

“...regarding 14.3.2 ‘Upon admission the program shall issue each client a photo identification card’” If a program maintains a copy of the client’s driver’s license, what is the point of issuing another photo identification

card?

Agency Response: DSAMH concurs with Ms. Gentile's comment. The final order has been amended to say: *Upon Admission, the program shall obtain from or issue to each client a photo identification card.*

B. The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council For Persons With Disabilities(SCPD) provided the following written comments:

1. Section 3.0 definition of "clinical director", recites that it is someone who meets the requirements of §6.1.2.1. However, the regulations also use the term "clinical director" in the context of co-occurring treatment facilities (Part 16.0). The qualifications of a "clinical director" under §16.2.3 are inconsistent with the qualifications of a "clinical director" under §16.1.2.1 SCPD (and GACEC) recommends that the inconsistency be resolved.

Agency Response: DSAMH concurs with SCPD's and GACEC's comment. The final order has been amended to read: *"...clinical director" means an individual who, by virtue of education, training, and experience, satisfies the requirements of §6.1.2.1 and/or §16.2.3 of these regulations."*

2. Section 3.0, definition of "counseling", categorically limits counseling to "face-to-face" interaction. There are both pros and cons to this approach. One disadvantage is that telephonic or videoconferencing communication is precluded. For example, as a practical matter, if a spouse is in treatment, it may only be possible to "tie in" the other spouse (who may live or work 80 miles away) through electronic communication. DSAMH may wish to consider some exceptions based on extenuating circumstances. Parenthetically, the definition conflicts with §11.5.1.2.1 which specifically allow counseling by phone.

Agency Response DSAMH concurs with SCPD's and GACEC's comment. The final order has been amended to read: "Individual counseling is the face-to-face, video or telephone interaction between a Counselor I or Counselor II and an individual client for a specific therapeutic purpose."

3. Section 3.0, definition of "Nurse Practitioner", could be improved by using the Delaware licensing terminology, "advanced practice nurse" ("APN" consistent with Title 24 Del.C §1902 (b)(1). If amended, a conforming reference should also be added to the definition of "Qualified Psychiatric Practitioner" in §3.0.

Agency Response: The definition as written is intended to be a generic term to capture the various titles used from state to state as part of the National Licensure Compact (NLC). DSAMH appreciates the comment but will respectfully keep the standard as written.

4. Section 4.1 contemplates licensure under the regulations for "mixed" facilities (e.g. co-occurring substance abuse and mental health disorder programs). Both residential and non-residential entities are covered (§4.1.1). Unfortunately, there are major omissions throughout the regulations which ignore the application of statutory standards for facilities. For example, the residential facilities may be subject to the patient bill of rights codified at Title 16 Del.C §1121. See Title 16 Del.C. §1102(4). Moreover, the regulations omit any reference to the bill of rights codified in the Substance Abuse Treatment Act, Title 16 Del. C §2220. the bill of rights was co-authored by DSAMH. Moreover, with the June 29, 2010 enactment of H.B. 41, co-occurring substance abuse and mental health facilities are now subject to Community Mental Health Treatment Act. The regulations should incorporate many of the statutory standards which apply to both residential and non-residential treatment facilities. Compare 16 DE Admin Code Part 3315, Appendix B (Family Care Homes) for illustration of incorporation bill of rights into regulatory appendix. SCPD (and GACEC) will include some specific recommendations below:

Agency Response: DSAMH is in partial agreement with the comment. Section 7.1.2.1 has been amended as follows: *"All agencies shall ensure that clients' rights are fully protected as enumerated in Del.C. §2220 and , including the following:"* The other sections of 16 Del.C. mentioned fall under sections of the code that are specific to facilities that would not be considered residential or non-residential entities under these standards and regulatory activity does not fall under the purview of DSAMH (e.g. "Family Care Homes", MH Group Homes etc...) DSAMH appreciates the comment and will amend §7.1.2.1 as described above.

5. Section 4.3.3 reflects a \$15.00 application fee for a facility license. The Division may want to consider whether the fee is unduly modest.

Agency Response: DSAMH will keep the application fee at \$15.00 at this time but appreciates the suggestion and will consider raising the fee to come closer to covering the actual cost of the licensing process.

6. Sections 4.5.3 and 4.9 address the Division's access rights, cross referencing federal laws. The Division should consider including specific State law references such as Title 16 Del.C. §1107 (residential facilities.)

Agency Response: As commented on under suggestion # 4, this section of 16 Del.C falls under sections of the code that is specific to facilities that would not be considered residential or non-residential entities under these standards and regulatory functions do not fall under the DSAMH's purview (e.g. "Family Care Homes", MH Group Homes etc...) DSAMH appreciates the comment but will respectfully keep the standard as written.

7. Sections 4.6 and 4.7.1 could be problematic. By communication "deficiencies" solely through "recommendations", the Division may be inviting facilities to consider such notices as hortatory and encouraging but not binding.

Agency Response: Section 4.7.1 specifically states: "*Within ten (10) working days after the receipt of a survey summary report, the program shall submit a corrective action plan to the Division, addressing all areas where recommendations were made, unless otherwise directed by the Division.*" The word "shall" indicates that the standard is not hortatory. DSAMH appreciates the comment but will respectfully keep the standard as written.

8. Section 4.12.1.6 authorizes suspension or revocation of a license for violations of Title 16 Del.C Ch. 22. DSAMH should consider adding a reference to violations of Title 16 Del. C Ch. 22 (for residential facilities) and Title 16 Del.C. §5191 (for co-occurring facilities). See, e.g., Title 16 Del.C. §1138.

Agency Response: As commented on under suggestion # 4, this section of 16 Del.C falls under sections of the code that is specific to facilities that would not be considered residential or non-residential entities under these standards and regulatory functions do not fall under the DSAMH's purview (e.g. "Family Care Homes", MH Group Homes etc...) DSAMH appreciates the comment but will respectfully keep the standard as written.

9. The citation in §4.14.5 is incorrect. The citation should be to 29 Del.C. Chs. 100 and 101.

Agency Response: DSAMH concurs with SCPD's and GACEC's comment. The final order has been amended to read: "...29 Del.C. Chs. 100 and 101."

10. The Division proposes to delete the following sentence in 4.15.1: "*The waiver request shall be posted in a prominent place in the facility and outline a process approved by the Division whereby clients can offer comments and feedback specific to the waiver request.*" This provision has been inserted at the behest of the Council based on past commentary. The deletion is highly objectionable and demeans the value of input from consumers. A facility can simply avoid the application of any regulation through an ex parte to the Division. The consumers who are the protected class under the regulations would be "clueless" that their rights are being undermined through a waiver request. Consumer input on waiver request is authorized in analogous regulations. See, e.g. 16 DE Admin Code 3301, §9.1.5 (group homes for persons with AIDS).

Agency Response: DSAMH concurs with SCPD's and GACEC's comment. The final order has been amended to remove the strike through from §4.15.1

11. Section 5.1.1.1 contemplates each community-based agency including "representatives of the population it serves" on its "governing body and/or advisory council". This could be interpreted to mean 1 "token" representative or, since plural 2 representatives (e.g. 1 on a governing board and 1 on advisory council.) The Division may wish to clarify its expectations in this context.

Agency Response: The standard is intended to support and encourage the participation of consumers and their families on governing bodies and/or advisory councils as well as stakeholders who are familiar with the area the program serves. DSAMH appreciates the comment but will respectfully keep the standard as written.

12. Section 5.1.4.4.1.16 requires the facility policy and procedures manual to contain a protocol for making child abuse/neglect reports. The regulations contain no analogous requirements for a protocol to report adult abuse/neglect. There is a mandatory reporting duty for adults subjected to abuse/neglect. (Title 31 Del. C §3910, §1132, §2224, §5194 and newly enacted H.B. 41) PM 46 also requires "each Division that has, or contracts for operations of, residential facilities" to have standardized reporting procedures. The only reporting references in the

regulations pertain to licensing boards.

Agency Response: DSAMH concurs with SCPD's and GACEC comment. The final order has been amended to say: 16 Del.C. §§902 through 904, 3910, 1132, 2224, 5194 and 42 CFR § 2.12(c)(6)

13. Section 5.1.6 could be improved by requiring facilities to include a recital that there will be no retaliation against persons who report abuse, neglect, financial exploitation or mistreatment and reminding employees that there are penalties for failure to report.

Agency Response: DSAMH concurs with SCPD's and GACEC's comment. The final order has been amended to say *"Policies and procedures for making mandated reports of suspected child abuse or neglect in compliance with 16 Del.C. §§902 through 904, (3910, 1132, 2224, 5194) and 42 CFR § 2.12(c)(6) including non-retaliation policies when personnel report abuse and neglect."*

14. Section 5.1.7.1.1.2 requires staff training in reporting child abuse but not adult abuse. The training requirement should be expanded to cover reporting of adult abuse.

Agency Response: DSAMH concurs with SCPD's and GACEC's comment. The final order has been amended to say: *"Program policies and procedures regarding the reporting of cases of suspected child abuse or neglect and adult abuse/neglect in compliance with 16 Del.C. §§902 through 904, 3910, 1132, 2224, 5194 and 42 CFR § 2.12(c)(6)."*

15. In §6.1.3.1.2, the Division is deleting a requirement that the 5 years experience for a "clinical supervisor" be "clinical experience. This is odd since it would allow someone who has been a janitor in a facility for 5 years to meet the experience standards to be a "clinical supervisor."

Agency Response: Section 6.1.3.1.2 states: "...and five (5) years of documented experience in the substance abuse treatment field." "Treatment" is of a clinical nature and would preclude activities such as janitorial responsibilities from meeting the minimum criteria of 5 years of experience in the treatment field. DSAMH appreciates the comment but will respectfully keep the standard as written.

16. In §7.1.1.1, the extraneous words "unless such disability makes" should be deleted. There should be no exceptions.

Agency Response: DSAMH concurs with SCPD's and GACEC's comment. The final order has been amended by removing: unless such disability makes treatment offered by the program non-beneficial or hazardous.

17. In §7.1.1.3, a reference to the Equal Accommodations Act should be added.

Agency Response: Section 7.1.1.2 provides for equal access. DSAMH appreciates the comment but will respectfully keep the standard as written.

18. Section 7.1 titled "Client Rights" would be a logical place to insert information about the applicable bills of rights referenced above. Another option would be to include the bills of rights as an appendix to the regulations.

Agency Response: Section 7.1.2.1 has been amended as follows: *"All agencies shall ensure that clients' rights are fully protected as enumerated in Del.C. §2220 and, including the following:"* The other sections of 16 Del.C mentioned fall under sections of the code that are specific to facilities that would not be considered residential or non-residential entities under these standards and do not fall under DSAMH's purview (e.g. "Family Care Homes", MH Group Homes etc...) DSAMH appreciates the comment and will amend §7.1.2.1 only as described above.

19. Section 7.1.2.1.7 only provides an assurance that child abuse will be reported, not adult abuse.

Agency Response: DSAMH concurs with SCPD's and GACEC's comment. The amendment to the final order as stated in item #12 will include reporting adult abuse, neglect and mistreatment.

20. The grammar in §8.1.1.1.5.15 should be corrected to read: "Results of the client's diagnostic assessment, including the client's...Indicates what issues and areas of clinical concern are to be..."

Agency Response: DSAMH concurs with SCPD's and GACEC's comment. The final order has been amended to say: (§8.1.2.1.7.15) "...Indicates what issues and areas of clinical concern are to be:"

21. The grammar in §8.1.1.1.5.17 should be corrected and reference “signed”, “reviewed”, and “is completed.”

Agency Response: §8.1.1.1.5.17 does not occur in the Summary of Proposed Changes (the standard referred to does not exist.) DSAMH is unable to comment on this suggestion.

22. In §8.1.2.1.8.1 delete the extraneous “and” after the word “counselor.”

Agency Response: §8.1.2.1.8.1 does not occur in the Summary of Proposed Changes (the standard referred to does not exist.) DSAMH is unable to comment on this suggestion.

23. Section 8.1.4 requires facilities to maintain records for 12 months which would be subject to review by DHSS audit. DSAMH may wish to consider a longer time frame. Current records may reveal an on-going problem dating back more than a year and facilities could simply destroy or not produce older records.

Agency Response: Section 8.1.4 states: “...Programs shall develop a policy that clearly outlines timelines for record retention and storage for all records beyond the required audit period.” This standard requires 12 months of records available in house for the purpose of audit with a policy that discusses how the program will store records beyond the 12 month audit period and compels programs to present a policy that describes the retention of records beyond 12 months. DSAMH appreciates the comment but will respectfully keep the standard as written.

24. The grammar in §11.2.1.1.3.2.6 should be corrected to state: “A physical examination by qualified medical personnel that shall: ... completed at admission.”

Agency Response: §11.2.1.1.3.2.6 does not occur in the Summary of Proposed Changes (the standard referred to does not exist.) DSAMH is unable to comment on this suggestion.

25. Substitute “advice” for “advise” in §11.4.1.1.2.1 and §14.4.1.1.5.

Agency Response: The wording suggested does not exist in §11.4.1.1.2.1 and §14.4.1.1.5 does not occur in the Summary of Proposed Changes (does not exist), however the error does occur in §§11.3.1.2.1 and 14.3.1.1.5 and has been amended as suggested in the final order.

26. In §11.6.1.6.2.3.1, substitute “rationale” for “rational”.

Agency Response: §11.2.1.1.3.2.6 does not occur in the Summary of Proposed Changes (the standard referred to does not exist) however the error does occur in §§11.5.1.6.2.3.1 and 14.14.8.2 and has been amended as suggested in the final order.

27. In §12.1.1.7 there is a typographical error “eeach”.

Agency Response: The error referred to in §12.1.1.7 does not occur in the Summary of Proposed Changes. The correction is not indicated.

28. Section 12.2.4 would disallow clinical supervision meetings being conducted by videoconferencing unless “face-to-face”. It is unclear if “face-to-face” is meant to include electronic “face-to-face” communication. DSAMH may wish to consider videoconferencing.

Agency Response: “Face-to-face” communication includes videoconferencing.

29. The “therapeutically necessary” exception to visitation and phone usage in §12.4.2.2.1 is at odds with bills of rights, including Title 16 Del. C §§1121(11) and 5192(10). It is also at “odds” that a non-clinical administrator makes the therapeutic decision.

Agency Response: The limitations ability for an Administrator to pose limitations on visitation and phone call procedures is meant as a safety measure for residents in the residential treatment program and as such, considered to be part of the therapeutic program and therefore “therapeutic” in nature. The administrator need not be a clinician in order to make decisions about safety for the participants in the program, however, it would be erroneous to assume that Administrators are not themselves clinicians. DSAMH appreciates the comment but will respectfully keep the standard as written.

30. In §14.3.4.2, the word “individuals” should not be capitalized.

Agency Response: §14.3.4.2 does not occur in the Summary of Proposed Changes (the standard referred to does not exist.) DSAMH is unable to comment on this suggestion.

31. The hyphen is missing in “take-home” in §§14.8.1.8 and 14.8.1.10.

Agency Response: §§14.8.1.8 and 14.8.1.10 do not occur in the Summary of Proposed Changes (the standard referred to does not exist.) DSAMH is unable to comment on this suggestion.

32. If not reference elsewhere, §16.0 titled “Co-Occurring Treatment” would be a logical place to incorporate the new Community Mental Health Treatment Act provision included in the recently enacted H.B. 41.

Agency Response: DSAMH agrees that the amendments made to 16 Del. C Ch. 51 with the passage of H.B.41 should be incorporated into the final order, however, DSAMH believes that §2.0 is a more appropriate section to amend as it will compel all facilities to follow the amended code, not just co-occurring programs. DSAMH appreciates the comment and will amend §2.0 to read: “...These regulations shall apply to any facility as defined in 16 Del. C Ch. 22 and Ch. 51...”

33. While §16.5.1.3 requires a Qualified Psychiatric Practitioner to meet with a consumer at least every 6 months, §16.5.4 contemplates the Qualified Psychiatric Practitioner conducting a record review only every 12 months. DSAMH may wish to change the latter standard to every 6 months to match the schedule for meeting with the consumer.

Agency Response: Standard 16.5.1.3 requires that the Qualified Psychiatric Practitioner to “meet” with the consumer at a minimum, every 6 months for psychiatric appointments. Standard 16.5.4 differs in that it requires a “review” of the treatment and the record for the prior year. DSAMH appreciates the comment but will respectfully keep the standard as written.

34. In §16.5.8 DSAMH lists a variety of supports for consumers, including step groups and faith-based organizations. DSAMH may wish to consider adding references to physical exercise which is also correlated with improved affect and recovery and less reliance on medications.

Agency Response: Standard 16.5.8.3 states: “Co-occurring treatment programs shall offer...support groups. Groups shall include but not be limited to: ...” This standard would allow for referral to physical exercise programs when appropriate, however DSAMH sees no harm in including physical fitness programs as part of the list of community services. DSAMH appreciates the comment.

35. In §17.4.1 “DSMAH” should be corrected to “DSAMH”.

Agency Response: DSAMH concurs with SCPD’s and GACEC’s comment. “DSMAH” in §17.4.1 has been amended to “DSAMH”.

36. The regulations (§§17.0-19.0) authorize exemption from many of the standards for facilities with certain accreditation. There is no State statutory authority to exempt covered facilities from the application of patient rights and prescriptive statutory licensing standards. For example, if a State statute directs abuse/neglect reporting conforming to a specific protocol, that would supersede any national certification standard. DSAMH may wish to review applicable State statutory patient rights compilations, including Title 16 Del. C. §§1121, 2220 and 5192 to ensure that the regulations do not inadvertently exempt facilities from compliance.

Agency Response: The three accreditation bodies that are covered by “Deemed Status” in §§17.0 to 19.0 require programs to follow all state and federal guidelines for treating substance use and mental health diagnosed individuals. Imposing state licensing standards and the standards of national accreditation bodies would be redundant and cause undue strain on facilities that apply accreditation standards that often require more stringent protocols than those imposed by the state. DSAMH appreciates the comment but will respectfully keep the standard as written.

C. Glenn LeFevre of Gateway Foundation commented that §§12.1.1.4 and 12.1.1.7 require two individualized recovery plans within two days of each other. He suggested that DSAMH require an individual recovery plan either within 48 hours of admission OR 72 hours of admission rather than both.

Agency Response: DSAMH concurs with Mr. LeFevre’s comment. The final order has been amended to

strike the individualized recovery plan within 48 hours.

D. Bruce Johnson of PACE, Inc. commented that the education requirements in §§5.1.7.4.2 and 5.1.7.4.3 be consistent with credentialing criteria for national licensure and certification boards which require 3 hours of education specific to ethics every 2 years. He suggests making the 3 hours of training specific to cultural competency consistent with the ethics training requirement.

Agency Response: DSAMH concurs with Mr. Johnson's comment. The final order has been amended to require the 3 hours of ethics counseling and the 3 hours of cultural competence training in §§5.1.7.4.2 and 5.1.7.4.3 every two years.

E. Mr. Bruce Lorenz and Ms. Susan Harris of Thresholds, Inc. offer the following comments:

1. 6.1.2.1 This standard pulls out the word "clinical" when describing experience. We are concerned that it implies "clinical" is not important; yet it's important in almost every other staff qualification.

Agency Response: DSAMH concurs with Thresholds. The final order will remove the strike through in §6.1.2.1.

2. 6.1.2.1.2 Deleting the bachelor's degree and experience option as qualification for a Clinical Director is a problematic way to deal with a growing problem. The standards relating to this position don't rationally connect to the realities of the workplace nor do they square with workforce development activities recommended by SAMHSA or those in place in other states that regulate the licensing of treatment services. If you want to change the standard relating to Clinical Supervision then adopt the standards that indicate competent practice that is offered through ICRC. They are recognized by most of the states and they are cited in Technical Assistance Publication 21 (et seq.), published by SAMHSA.

Agency Response: DSAMH concurs with Thresholds. The final order will remove the strike through in §6.1.1.2.

3. 6.1.5.1.1 We would recommend that regulations move towards developing degree requirements. If the state is interested in moving in the direction of education requirements, it should do so in a way that is deliberate and long-term. Attempting to fix the workforce problem solely by altering regulations doesn't promise to have a lasting effect.

Agency Response: DSAMH's intent in this standard is to allow individuals who are pursuing higher education (e.g. student interns) and those who are pursuing credentialing to gain the training needed to obtain credentialing while working in the field. DSAMH appreciates the comment but respectfully keep the standard as written.

4. 8.1.2.1.8 Referring to what used to be called a "treatment plan" as a "recovery" plan is using language that doesn't make much sense to those who have not yet defined the problem, much less what to do about it. Since most of the individuals who seek treatment are not yet describing themselves as "in recovery", we suggest keeping the term "treatment" plan so that it better describes the services offered.

Agency Response: The term "recovery plan" is congruent with DSAMH's movement to client centered treatment that offers services for all areas of concern for an individual and their family (e.g. substance abuse disorders, mental health disorders, medical treatment etc...) DSAMH appreciates the comment but will respectfully keep the standard as written.

5. 6.1 and 16.2 Having 2 sets of staffing qualification standards (alcohol/drug abuse and co-occurring disorders) does not reflect the integration of treatment that DSAMH has been developing through the Co-occurring State Incentive Grant. Additionally, under the Co-Occurring standards, there are no definitions that distinguish a mental health clinician from a substance abuse counselor.

Agency Response: §16.0 Co-Occurring Treatment Standards requires a "cadre of staff" with qualifications that are outlined in §6.1 with the addition of staff meeting the requirements of §16.0. Programs pursuing licensure as a co-occurring provider shall incorporate the credentials in §§6.1 and 16.0 and in that manner, integrate staff and services. DSAMH appreciates the comment but will respectfully keep the standard as written.

F. Mr. David Parcher of Kent and Sussex County Counseling submitted the following comments:

1. Persons who have achieved the IC&RC Certified Clinical Supervisor (CCS) should be included in 6.1.2.1.1. This certification requires a minimum of Bachelors degree and rigorous commitment to IC&RC standards for clinical supervision.

Agency Response: DSAMH concurs with Mr. Parcher's comment. The following order has been amended to read: "...full certification as a certified alcohol and drug Counselor (CADC) or certified co-occurring disorder professional (CCDP) in the state of Delaware or by a nationally recognized organization in addictions counseling and five (5) years of documented experience in substance use services." *Nationally recognized organization would include IC&RC.*

2. It is essential that IC&RC credentialed persons already in this position(?) at the Bachelors level who have proven their capacity for the job should be grandfathered. Many people who have been doing this for many years are the best we have in the field. We need them to train the new ones.

From a workforce standpoint it is good that employers can hire someone who does not currently hold the IC&RC credential. However it should be required that these persons achieve the appropriate clinical credential within 1 year of hire.

Agency Response: The final order allows individuals to continue in their current position at the agency where they are working as of the publication of the final order. This is a grandfather clause that will allow agencies to continue employing existing staff. Agencies who would like to make credentialing mandatory within 1 year of hire are free to do so. DSAMH accepts all state and nationally recognized certification credentials and believes that the IC&RC credentials are captured as a "nationally recognized credential." DSAMH appreciates the comment but will respectfully keep the standard as written.

3. 6.1.3.1.1: The CCDP should be included in these standards since the state is emphasizing integrated treatment. That credential requires a Bachelors degree.

Persons holding the IC&RC Certified Clinical Supervisor (CCS) should be included in 6.1.3.1.1.

Agency Response: The addition of the CCDP credential has been completed throughout the final rule. In regards to the IC&RC credential: DSAMH accepts all state and nationally recognized certification credentials and believes that the IC&RC credentials are captured as a "nationally recognized credential."

G. Brandywine counseling submitted comments that summarized concerns around the agency's ability to meet the proposed standards with no specific suggestions as to how to address their concerns.

Agency Response: DSAMH is happy to provide technical assistance to any agency that believes the new rule will be difficult to implement in their agency as well as offer suggestions on how to go about making the necessary changes for standard compliance.

FINDINGS OF FACT

The Department finds that the proposed changes as set forth in the October, 2010 Register of Regulations should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Division of Substance Abuse and Mental Health's Standards for Substance Abuse Facilities is adopted and shall be final effective November, 2010.

Rita M. Landgraf, Secretary, DHSS
October 15, 2010

6001 Substance Abuse Facility Licensing Standards

1.0 Purpose

The Department is issuing these regulations to promote the health and well being of consumers/clients receiving services in substance abuse treatment facilities located within the State of Delaware. They are not intended to limit additional contract standards for substance abuse treatment facilities and programs with which a service provider may be expected to comply.

2.0 Authority and Applicability

The Department is authorized by 16 **Del.C.**, Ch. 22 to license and regulate substance use disorder abuse and co-occurring treatment facilities. These regulations shall apply to any facility as defined in 16 **Del.C.**, Ch. 22, **[and Ch. 51]** and address the minimum acceptable standards and programmatic conditions for consumers/clients receiving services in substance abuse use disorder and co-occurring disorder treatment facilities. No organization or entity shall manage or operate a substance abuse treatment facility within the State of Delaware unless it has been so licensed by the Department.

3.0 Definitions

The following words and terms, when used in these regulations, shall have the following meaning unless the context clearly indicates otherwise:

“Adjunct and alternative therapy” means a specific modality of therapy based on a specific valid body of knowledge, provision of which requires specific credentials. Examples include, but are not limited to, Psychodrama; Art Therapy; Music Therapy; Acupuncture; Massage Therapy; EMDR; etc.

“Administrator” means an individual who is authorized by the governing body to provide overall management of the agency.

“Admission” means the point in a client’s relationship with a program when the intake process has been completed and the program begins to provide additional services.

“Advisory Council” means a group of individuals approved by the governing body, to provide community input and recommendations to the governing body.

“Agency” means any partnership, corporation, association, or legal entity except for an individual practitioner, that provides, is seeking to provide, or holds itself out as providing alcohol and/or other drug treatment or rehabilitation services. An agency may operate more than one program.

“Applicant” means any agency that has submitted a written application for a license to operate an alcohol and/or other drug abuse treatment or rehabilitation program in Delaware.

“Client” means an individual who receives, or has received services from an agency.

“Client Record” means the official legal written file for each client containing all the information required by these regulations, and maintained to demonstrate compliance with these regulations.

“Clinical director” means an individual who, by virtue of education, training, and experience, satisfies the requirements of §6.1.2.1 **[and/or §16.2.3]** of these regulations and is authorized by the Administrator ~~and/or the governing body~~ to provide clinical oversight of the treatment program. The Clinical director may also serve as Clinical supervisor when directed to do so by the agency’s governing body.

“Clinical supervisor” means an individual who, by virtue of education, training, and experience, satisfies the requirements of §6.1.3.1 of these regulations; and is authorized by the Administrator and/or the governing body to provide clinical supervision for all clinical staff.

“Continuing care” means those services recommended to the client upon discharge from a program that support and increase the gains made during the client’s treatment at that program.

“Counseling” means the process in which a Counselor I or Counselor II works with a client, family, significant other, or a group of clients, families or significant others, to assist them to understand issues, consider alternatives, and change behaviors.

- Individual counseling is the face-to-face **[, video or telephone]** interaction between a Counselor I or Counselor II and an individual client for a specific therapeutic purpose.
- Family counseling is the face-to-face interaction between a Counselor I or Counselor II and the family member(s)/significant other(s) of a client for a specific therapeutic purpose.
- Group counseling is the face-to-face interaction between a Counselor I or Counselor II and two or more clients or clients’ families/significant others for a specific therapeutic purpose.

“Counselor I” means an individual who, by virtue of education, training, and experience meets the requirements of §6.1.4.1 of these regulations and functions under the supervision of a Clinical supervisor.

“Counselor II” means an individual who, by virtue of education, training, and experience, meets the requirements of §6.1.5.1 of these standards and functions under the supervision of a Clinical supervisor.

“Cultural Competence” means acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority populations. Culturally competent agencies work to hire unbiased employees, seek advice and consultation from the minority community, and actively decide what they are and are not capable of providing to minority clients. (March, 1989, Towards a Culturally Competent System of Care, Volume 1, National Technical Assistance Center for Children’s Mental Health, Georgetown University Child Development Center, p. 17.)

“Day” unless otherwise specified, one (1) day is a calendar day.

“Deemed status” means a licensure standing approved by DSAMH and bestowed upon programs that have been accredited by an accreditation body approved by DSAMH. Programs that have been granted Deemed Status will be inspected in accordance with ~~Section~~ §4.3.2 of these standards.

“Designee” means the person who is delegated tasks, duties, and responsibilities when such designation is permitted by these regulations.

“Discharge” means the point at which a client’s active involvement with an agency is terminated.

“Division/DSAMH” means the Delaware Division of Substance Abuse and Mental Health within the Delaware Department of Health and Social Services.

“Division Director” means the Director of the Delaware Division of Substance Abuse and Mental Health within the Delaware Department of Health and Social Services, or his/her designee.

“Documentation” means a written record acceptable as evidence to substantiate compliance with these regulations.

“DSM” means the Diagnostic and Statistical Manual of Mental Disorders, most recent edition, as published by the American Psychiatric Association.

“Facility” means the physical area, grounds, building(s) or portions thereof, under direct program administrative control.

“Follow-up” means the process for determining the status of an individual who has been referred to an outside resource for services or who has been discharged from services OR the process for determining an agency’s compliance with these standards after an agency audit has been completed.

“Governing Body” means the individual or individuals responsible for the overall management of an agency, responsible for ensuring compliance with 5.0 of these regulations.

"Initial Treatment Recovery Plan" means ~~a preliminary the first recovery plan that addresses the short term goals the program plans to achieve in the earliest days developed on the first day of treatment. The initial treatment plan shall be in effect until the Master Comprehensive Treatment Plan (MCTP) has been developed.~~ The initial recovery plan is a working document created with input from the client and program staff.

“Intake” means the gathering of personally identifying and clinical data required to determine whether a client should be admitted to a program.

“Intern” means a student who performs counseling functions under the supervision of a **Clinical supervisor**.

“License” means the document issued by the Division that authorizes a program to provide alcohol and/or other drug treatment or rehabilitation.

“Licensed Nurse” means a Registered Nurse or a Licensed Practical Nurse.

“Licensed Practical Nurse” means a person licensed by the State of Delaware as a Practical Nurse or a person licensed by a state that participates in the National Licensure Compact (NLC).

“Licensure” means the process by which the Division determines whether or not a program is in compliance with these regulations.

~~**“Master Comprehensive Treatment Plan”** means a treatment plan that is formulated from the comprehensive assessment as outlined in §8.1.2.1.2.14 and in the format outlined in §8.1.2.2.1.~~

“Medical history” means history of and any treatment of allergies, head injuries, nervous disease/ disorders, seizure disorder, or delirium tremens, surgery, major accidents, fractures, venereal diseases, cardiovascular, respiratory, endocrine, gastrointestinal diseases or disorders, and gynecological-obstetrical history, including current involvement in prenatal care and current medical treatment by a Primary Care Physician or other medical doctor.

“Needs Assessment” means a systematic evaluation of current system and programmatic operations and projected needs. This evaluation is performed as part of the Quality Assurance Plan and focuses on the changing needs of the community and population served.

“Nurse Practitioner” means a person licensed by the State of Delaware as a Nurse Practitioner or a person licensed by a state that participates in the National Licensure Compact (NLC).

“Periodic Treatment Recovery Plan Review/Revision” is a process whereby the clinical supervisor, and counselor, review prior ~~treatment recovery~~ plans and establish new goals based on the client's progress and/or changing needs through out treatment.

“Physician” means a person licensed to practice medicine in the State of Delaware.

“Physician Assistant” means a person licensed by the State of Delaware as a Physician Assistant.

“Policy” means a statement of the principles that guide and govern the activities, procedures and operations of a program.

“Procedure” means a series of activities designed to implement the policies of a program.

“Program” means the location or facility where an agency provides or offers to provide any of the various modalities of service when such services are provided or offered on a regularly scheduled basis. Clinical participation records of clients are EITHER stored on-site OR readily available to staff in electronic format using computer hardware that is installed or regularly available on-site.

“Protocols” means a written rule developed by an agency to govern specific procedures or certain activities.

“Provisional License” means the document issue by the Division that authorizes a program to provide alcohol and/or other drug treatment or rehabilitation for up to ~~two hundred forty (240)~~ one hundred and eighty (180) days when the applicant is not in compliance with these regulations or is applying for licensure for the first time.

“Public place” means an area accessible to clients, employees or visitors; the main entry or hallway; the reception area or foyer; or the dining or multipurpose room.

“Qualified Medical Personnel” means a physician, physician's assistant, or nurse practitioner, licensed by the State of Delaware.

“Qualified Psychiatric Practitioner” means a physician or nurse practitioner, licensed by the State of Delaware with specific clinical experience in the treatment of substance use disorders as well as mental health disorders. Qualified Psychiatric Practitioners must have specific training in the use of buprenorphine and Opioid antagonist medications as well as the use of psychotropic medications used with individuals who have a mental health diagnosis.

“Quality Assurance” means the process of objectively and systematically monitoring and evaluating the quality and appropriateness of client care to identify and resolve identified issues.

“Readmission” means the point in a client's relationship with an agency when a client has been discharged, subsequently reapplied for admission, intake has been completed, and the agency begins to provide services again.

“Registered Nurse” means a person licensed by the State of Delaware as a registered nurse or a person licensed by a state that participates in the National Licensure Compact (NLC).

“Shall” means a mandatory procedure, the only acceptable method under these regulations.

“**Signature/Signed**” means, at a minimum, the writers’ first initial, last name, title or credentials and date or an authentic digital signature OR the client or legal guardian’s first and last name and/or date when required.

“**Significant other**” means an individual, whether or not related by blood or marriage, on which another individual relies for support.

“**Staff**” means full-time and part-time employees, consultants and volunteers, students/interns.

“**Treatment**” means the process a client undergoes to understand his or her alcohol or drug use and/or mental health diagnosis and choices made to change his or her behavior.

“**Volunteer**” means a person who, without direct financial compensation, provides services to a program.

“**Waiver**” means the exemption from compliance with a requirement of these regulations.

4.0 License Application Procedures

4.1 Applicability

4.1.1 Any entity seeking to operate ~~an alcohol and/or other drug abuse treatment or rehabilitation~~ a substance use treatment program or a co-occurring, (substance use disorder with mental health disorders) treatment program shall be licensed in accordance with these regulations for each program it seeks to operate. Each facility's license shall list one or more categories of service that the facility is authorized to provide and the facility's location.

4.1.1.1 Program categories for which licenses may be issued are:

4.1.1.1.1 ~~Residential Detoxification,~~

4.1.1.1.2 ~~Non-Residential Detoxification;~~ substance use disorders

4.1.1.1.2 Ambulatory Detoxification (Amdetox):

4.1.1.1.3 ~~Outpatient Treatment;~~ substance use disorders or co-occurring disorders,

4.1.1.1.4 ~~Opioid treatment;~~ substance use disorders,

4.1.1.1.5 ~~Residential Treatment;~~ substance use disorders,

4.1.1.1.6 ~~Transitional residential treatment;~~ substance use disorders.

4.2 Application Procedures

4.2.1 The Division shall may supply an application packet to all applicants upon request. Applications can also be obtained by visiting the Division's website at: www.dhss.delaware.gov/dhss/dsamh/regs.html.

4.2.2 All persons and agencies applying for the first time for a license shall schedule a meeting with ~~Division~~ DSAMH Quality Assurance staff for the purpose of receiving needed technical assistance regarding the licensure criteria and procedures.

4.2.3 A separate application shall be completed for each program at each location at which an agency intends to operate a ~~substance abuse~~ substance use disorder and/or co-occurring program.

4.2.4 The applicant may withdraw the application at any time by notifying the Division in writing.

4.3 Required Information

4.3.1 An applicant for licensure shall submit the following information on forms provided by the Division:

4.3.1.1 Name and address of the applicant;

4.3.1.2 Name, address and qualifications of the agency director, ~~Administrator~~ program director and/or partners, including copies of the professional licenses each has been issued by the State of Delaware;

4.3.1.3 Articles of incorporation and bylaws, and/or partnership agreement;

4.3.1.4 Name and address, occupation and place of employment, of the ~~Administrator~~ program director, board members, advisory board members, and officers.

4.3.1.5 A chart of the staff organization with names and qualifications;

- 4.3.1.6 A description of the services to be provided by the program, including a statement of the program philosophy, goals, and objectives and a description of the methodology for each service element;
- 4.3.1.7 A copy of the program's complete proposed policies and procedures manual if the application is for initial licensure;
- 4.3.1.8 Documentation of applicable insurance coverage, including protection of the physical and financial resources of the program; coverage for all people, buildings and equipment; professional and general liability insurance; workers' compensation; fidelity bonding sufficient to cover all client funds, property and interests; and automobile insurance when vehicles owned by the program are used for client transportation;
- 4.3.1.9 A floor plan for any facility not previously licensed;
- 4.3.1.10 For residential and detoxification facilities, the maximum client capacity requested; and
- 4.3.1.11 A copy of the program's business license, if required.
- 4.3.2 Applicants applying for Deemed Status shall meet all standards as outlined in ~~Sections 16.0 and §17.0 (as applicable), §18.0 and §19.0~~ of these standards (as applicable).
- 4.3.3 Applicants shall supply all information requested on the application. The completed application shall be accompanied by a \$15.00 fee in accordance with 16 **Del.C.** §2205. The Division shall not consider any application until it is properly completed and payment has been received.
- 4.4 Application Processing
 - 4.4.1 The Division shall determine whether an application is complete and shall notify the applicant in writing if additional information is required to complete the application or determine the applicant's compliance with these regulations.
 - 4.4.2 The Division shall investigate and consider each completed application. An applicant for renewal shall submit its completed application at least ninety (90), but not more than one hundred and twenty (120), days before its current license expires.
- 4.5 Investigations and Inspections
 - 4.5.1 By applying for or accepting a license, an applicant or licensee authorizes the Division and its representatives to conduct the inspections and investigations necessary to determine compliance with applicable licensing standards.
 - 4.5.2 Agencies applying for licensure shall have the following information available for inspection by the Division:
 - 4.5.2.1 Materials demonstrating compliance with all related Federal, State and local statutes, ordinances, rules and regulations [e.g., fire, health, building, American's with Disabilities Act] applicable to the facility being licensed,
 - 4.5.2.2 A copy of the program's policies and procedures manual as required in §5.1.4;
 - 4.5.2.3 Materials demonstrating compliance with the relevant sections of ~~Part III~~, Provisions Regarding Modalities of these regulations; and
 - 4.5.2.4 Materials demonstrating compliance with all other applicable licensing authorities and accreditation authorities when applicable.
 - 4.5.3 Investigations and inspections may include on-site inspections of the program and its operation; inspection and copying (in accordance with 42 CFR Part 2 and HIPAA 45 CFR Parts 160 and 164) of program records, clinical records and other documents maintained by the program; and acquisition of other information, including otherwise privileged or confidential information from any other persons who may have information bearing on the applicant's or licensee's compliance or ability to comply with these regulations.
 - 4.5.4 The Division shall review, update and when necessary, amend these regulations no less than every three (3) years.
- 4.6 Division Report

- 4.6.1 Upon completion of any inspection, the Division shall compile a Survey Summary Report citing strengths and recommendations for addressing deficiencies in meeting these standards.
- 4.6.2 The Division shall schedule an exit interview with each program for review of the Survey Summary Report.
- 4.7 Corrective action plans
 - 4.7.1 Within ten (10) working days after the receipt of a survey summary report, the program shall submit a corrective action plan to the Division, addressing all areas where recommendations were made, unless otherwise directed by the Division.
 - 4.7.2 The corrective action plan shall include a description of the corrective measures the program will take to address the regulation cited in the survey summary report, a target date for implementation of each corrective measure, and a description of the preventive measures implemented to ensure ongoing compliance with these regulations.
 - 4.7.3 The Division may perform follow-up on-site inspections to review the implementation of corrective action plan(s).
- 4.8 Actions on applications for licensure
 - 4.8.1 On the basis of the information supplied by the applicant and any other information acquired during its investigation and inspection, the Division may take any one of the following actions:
 - 4.8.1.1 Issue or renew a full license for a period of up to two years when the Division determines a program is in *substantial compliance* with Chapter 22 of Title 16 **Del.C.**, and these regulations, and/or has been granted Deemed Status or
 - 4.8.1.2 Issue or renew a full license for a period of up to one year when the Division determines a program is in *compliance* with Chapter 22 of Title 16 **Del.C.**, and these regulations;
 - 4.8.1.3 Issue or renew a full license for a period of up to one year when the Division determines a program that has been granted Deemed Status is not in compliance with Chapter 22 of Title 16 **Del.C.** and these regulations or regulations set forth by the accreditation body; or
 - 4.8.1.4 Issue a provisional license for up to ~~two hundred forty (240)~~ one hundred and eighty (180) days when the applicant program is not in compliance with Chapter 22 of Title 16 **Del.C.**, or regulations set forth by the accreditation body upon which Deemed Status has been granted (when applicable) and the applicant's failure to meet the requirements of Chapter 22 of Title 16 **Delaware Code** and these regulations does not jeopardize the health, safety and well-being of clients. The Division may issue one renewal of a provisional license for a period not to exceed ~~two hundred forty (240)~~ ninety (90) days. (The Division's decision to issue a provisional license instead of a full license is final and not subject to administrative appeal;) or
 - 4.8.1.5 Issue a temporary license for up to ninety (90) days when additional time is required by the Division to inspect or investigate the applicant program, additional time is required by the applicant to undertake remedial measures or complete a corrective action plan, when the applicant's program's failure to meet the requirements of Chapters 22 **[and 51]** of Title 16 **Delaware Code**, and these regulations does not jeopardize the health, safety and well-being of clients. A temporary license is not renewable and shall expire automatically without notice or hearing. (The Division's decision to issue a temporary license instead of a full or provisional license is final and not subject to administrative appeal,) or
 - 4.8.1.6 Revoke, suspend or deny a license in accordance with §4.9 and §4.10.
 - 4.8.2 The Division may issue a single renewal of a license, for ~~no longer than the term of the current license~~ one (1) year, without an on site inspection by the Division.
 - 4.8.3 The Division shall notify the applicant program by mail, phone, email or any combination of the above of its licensure decision.
- 4.9 Access by the Division

- 4.9.1 A program is subject to review, which may include on site inspection, with or without notice, by the Division.
- 4.9.2 The Division's right to monitor shall include complete access to all clients, ~~and staff, and board members,~~ and to all client, staff, financial and administrative program records needed for the purposes of monitoring or evaluation of the program's compliance with these regulations, financial auditing or for research. The Division may review and copy records in accordance with 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164.
- 4.10 Nonassignability; Change in circumstances; Posting
 - 4.10.1 A license for the operation of a substance ~~abuse~~ use program applies to both the ~~applicant~~ program and the premises upon which the program operates. Licenses are not transferable, remain the property of the Division, and shall be returned upon request.
 - 4.10.2 A program's current license shall be posted in a public place at its facility.
 - 4.10.3 The Division issues each license on the basis of information available to it on the date the license is issued. An ~~applicant~~ program or licensee shall give written notice to the Division of any change of program name, ownership, governing authority, premises or location a minimum of thirty (30) days before such change takes effect. The Division will determine within fifteen (15) days whether a new application is required.
 - 4.10.4 Any person or entity acquiring a licensed substance ~~abuse~~ use program shall apply for a new license in accordance with these regulations.
 - 4.10.5 A licensee shall notify the Division in writing sixty (60) days prior to a voluntary closure of any program it is operating. The notice shall detail how the licensee will comply with ~~8-1-1-2~~ §8.1.4.
 - 4.10.6 The licensee shall provide written notice to clients no less than thirty (30) days prior to closure and shall make reasonable efforts to place clients in appropriate programs in compliance with §8.1.3.
- 4.11 Relationship to funding
 - 4.11.1 The issuance of a license to a program is not a commitment ~~of~~ by the Division to fund the program.
- 4.12 Reasons for denial, suspension or revocation of license
 - 4.12.1 A license may be denied, suspended or revoked for one or more of the following reasons:
 - 4.12.1.1 ~~When an applicant or~~ program submits false information to the Division for licensing purposes;
 - 4.12.1.2 ~~When an applicant or~~ program fails to cooperate with the Division in connection with a licensing inspection or investigation;
 - 4.12.1.3 ~~When an applicant or~~ program has deviated from the category of service listed on its license;
 - 4.12.1.4 When an applicant or program fails to be in compliance with the requirements of these regulations for the types of services for which application was made or for which the program was licensed, as outlined in ~~§4.81~~.
 - 4.12.1.5 When an applicant or program fails to implement the corrective action plan it submitted pursuant to §4.7, unless the Division approves an extension or modification of the corrective action plan;
 - 4.12.1.6 When an ~~applicant or~~ program has violated any part of Title 16 **Del.C.**, Chapter 22 or these regulations;
 - 4.12.1.7 When an ~~applicant or~~ program has a history of, or currently demonstrates, financial insolvency, such as
 - 4.12.1.7.1 Filing for bankruptcy;
 - 4.12.1.7.2 Being subjected to foreclosure, eviction for failure to pay rent, or termination of utility services for failure to pay bills; or
 - 4.12.1.7.3 Failing to pay such taxes as employment or social security in a timely manner.
 - 4.12.1.8 When the ~~applicant~~ program is in violation of a safety or sanitation law or regulation and fails to correct the violation;

- 4.12.1.9 When the applicant program, its governing body or owner participates in, condones or is associated with fraud, deceit, coercion, misrepresentation or any other illegal act;
 - 4.12.1.10 When the applicant program, or any of its personnel or governing body violate professional ethics;
 - 4.12.1.11 When the applicant program, or any of its personnel or governing body, permits, aids or abets the commission of an unlawful act within its facilities or permits, aids or abets the commission of an unlawful act involving chemical substances within the program; or
 - 4.12.1.12 When the applicant program, or any of its personnel or governing body, has participated in, condoned, associated with or knows or should have known and has permitted the continuation of any other practice that jeopardizes the safety or health or well being of any client.
- 4.13 Procedure when a license is denied, suspended or revoked
- 4.13.1 In accordance with 16 **Del.C.** §2208, when the Division determines that an applicant or licensee fails to meet minimum compliance with the requirements of these regulations for the types of services for which application was made or for which the program was licensed or has committed an act or engaged in conduct or practices justifying denial, suspension or revocation of licensure:
 - 4.13.1.1 The Division shall notify the applicant or licensee by certified mail, return receipt requested, of its intent to deny, suspend or revoke the license. The "Notice of Intended Action" shall include the particular reason(s) for the proposed action and provision for a fair hearing.
 - 4.13.2 Within ten (10) days after receipt of the "Notice of Intended Action," an applicant or licensee may request a hearing by delivering a written request to the Division Director in person or by certified mail, return receipt requested. If no such request is made within ten (10) days, the Secretary of the Department shall proceed to deny, revoke or suspend said license as set forth in the notice of proposed action.
 - 4.13.3 Within fifteen (15) days after receipt of an applicant's or licensee's request for a hearing, the Division Director shall issue a "Notice of Hearing" to the applicant or licensee and to the public. The "Notice of Hearing" shall include a statement of the time, place and nature of the hearing, a statement of the legal authority and jurisdiction under which the hearing is to be held; a reference to the particular provisions of the statutes and rules involved; and a short and plain statement of the matters asserted.
 - 4.13.4 All hearings conducted under this subsection shall be governed by procedures authorized by rules of the Department; the Department or its agent may take testimony concerning any matter within its jurisdiction and may administer oaths, summons or subpoenas for any witness and subpoenas duces tecum, which shall be served and returned as provided by law.
 - 4.13.5 At the hearing, the applicant or licensee shall have the right to cross-examine witnesses against it, produce witnesses in its favor and to appear personally or by counsel.
 - 4.13.6 All hearings shall be open to the public and a full record and transcript of the proceedings shall be prepared. The Secretary of the Department shall make a determination, which shall specify the Department's findings of fact and conclusions. A copy of the determination shall be sent by certified mail, return receipt requested, or be personally served upon the applicant or licensee.
 - 4.13.7 Copies of the transcription may be obtained by any interested party on payment of the cost of preparing such copies.
- 4.14 Procedure for reinstatement of suspended or revoked license
- 4.14.1 If the licensee has not previously had a license revoked or suspended under these rules, it may, at any time after the suspension or revocation determination is final, request a hearing for the purpose of showing that the reasons for revocation or suspension of the license have been corrected and that the license should be reinstated.
 - 4.14.2 No licensee who has previously had a license suspended or revoked under these rules may request a hearing to reinstate the license prior to one year after the determination becomes final.

- 4.14.3 The request for a hearing shall be in writing and shall be delivered to the Secretary of the Department in person or by certified mail, return receipt requested.
- 4.14.4 Any hearing conducted under this subsection shall not operate to stay or supersede any decision revoking or suspending a license.
- 4.14.5 Hearings under this subsection shall be conducted in accordance with 29 **Del.C.** Chps. 100 and 101 and 4.13 of these regulations.

4.15 Waiver

- 4.15.1 An application for a waiver from a requirement of these regulations shall be made in writing to the Division's ~~Licensing Unit~~ Director of Quality Assurance; it shall specify the regulation from which waiver is sought, demonstrate that each requested waiver is justified by substantial hardship, and describe the alternative practice(s) proposed. ~~The [waiver request shall be posted in a prominent place in the facility and outline a process approved by the Division whereby clients can offer comments and feedback specific to the waiver request. The~~ **The waiver request shall be posted in a prominent place in the facility and outline a process approved by the Division whereby clients can offer comments and feedback specific to the waiver request. The** Division's ~~Licensing~~ Director of Quality Assurance Unit shall make a recommendation of action on the application ~~after reviewing the waiver request and any client input to the Division Director or designee. Only the Division Director shall grant waivers. The~~ Division Director or designee will review the request and recommendations and make final waiver request decisions.
- 4.15.2 No waiver shall be granted if such action would result in an activity or condition that would endanger the health, safety or well-being of a client.
- 4.15.3 ~~RESERVED.~~
- 4.15.4 A waiver granted under these regulations shall be in effect for the term of the applicant's license. ~~unless the approval of the waiver specifies, If a shorter term. All waivers not otherwise approved for a shorter term shall expire at the end of the term~~ waiver is required for an additional period of the license and new waiver(s) must be time, it shall be requested as part of the licensure renewal process in accordance with §4.15.
- 4.15.5~~4~~ An adverse decision by the Division on a request for a waiver may be appealed in accordance with §4.13.
- 4.15.6~~5~~ The granting of a waiver does not constitute a modification of any requirement of these regulations.
- 4.15.7~~6~~ Licensees shall notify the Division within ten (10) working days when a waiver granted by the Division is no longer needed.
- 4.15.8~~7~~ The Division Director may revoke a waiver when the alternative practice proposed in the application for waiver is determined to be ineffectual.
- 4.15.9~~8~~ The Division Director may revoke the waiver when the program fails to implement the alternative practice as proposed in the application for waiver.

Part II--General Provisions

5.0 Standards Applicable to all Facilities and Programs

5.1 Governance

5.1.1 Governing Body/Advisory Council.

5.1.1.1 Every community-based agency shall have a governing body and/or advisory council that includes representatives of the population it serves.

5.1.1.2 The governing body shall be legally responsible for overseeing all management and operations of the agency and for ensuring compliance with applicable laws and regulations by approving all of the agency's staffing, documentation and overall operations:

5.1.1.2.1 Written by-laws;

- 5.1.1.2.2 Mission;
 - 5.1.1.2.3 Goals;
 - 5.1.1.2.4 Policies and Procedures; and
 - 5.1.1.2.5 Budget.
 - 5.1.1.3 The authority and duties of the governing body shall include:
 - 5.1.1.3.1 Ensuring that the agency director, ~~Administrators~~ program directors, clinical supervisors and Counselors employed by the agency meet the requirements of §6.1 of these regulations.
 - 5.1.1.3.2 Establishing and reviewing:
 - 5.1.1.3.2.1 Policies and procedures governing the overall management of the program including:
 - 5.1.1.3.2.1.1 Policies and procedures manual; (§5.1.4),
 - 5.1.1.3.2.1.2 Fiscal management policies and procedures; (§5.1.5),
 - 5.1.1.3.2.1.3 Personnel policies and procedures; (§5.1.6.2), and
 - 5.1.1.3.2.1.4 Compliance with these regulations.
 - 5.1.1.4 The Governing Body will meet, at a minimum, one (1) time per year. Documentation of its annual review shall be entered into the minutes of its meeting.
- 5.1.2 Meetings and minutes of meetings.
 - 5.1.2.1 Minutes of all meetings shall include:
 - 5.1.2.1.1 Names of members who attended;
 - 5.1.2.1.2 Names of members absent;
 - 5.1.2.1.3 Date of meeting;
 - 5.1.2.1.4 Topics discussed and decisions reached.
 - 5.1.2.2 The minutes shall be available for review by the Division.
- 5.1.3 Administrative Staff
 - 5.1.3.1 Administrator
 - 5.1.3.1.1 The governing body shall appoint an agency director.
 - 5.1.3.1.2 The qualifications, authority, and duties of the agency director shall be defined in writing.
 - 5.1.3.1.3 The Governing body shall ensure that, at the time of employment, the agency director is familiar with the job description and job responsibilities of the position, these regulations, and the agency's policies and procedures as maintained in compliance with §5.1.4.
- 5.1.4 Policies and procedures manual:
 - 5.1.4.1 Each program shall have a manual of written policies from which written procedures have been derived to address operations and services. The program's policies and procedures manual shall be:
 - 5.1.4.1.1 A complete document;
 - 5.1.4.1.2 Readily available to staff.
 - 5.1.4.2 The program's policies and procedures manual shall be reviewed at least annually by the governing body or its designee.
 - 5.1.4.3 The review shall be documented in the meeting minutes.
 - 5.1.4.4 The manual shall include:
 - 5.1.4.4.1 A statement of program philosophy and goals, including:
 - 5.1.4.4.1.1 Geographical area to be served;
 - 5.1.4.4.1.2 Population to be served;
 - 5.1.4.4.1.3 Types of services offered;
 - 5.1.4.4.1.4 Organization chart,

- 5.1.4.4.1.5 Policies and procedures to ensure compliance with §5.1.5, Fiscal management;
 - 5.1.4.4.1.6 ~~Policies and procedures to ensure compliance with 5.1.6.2, Personnel;~~
Personnel files
 - 5.1.4.4.1.7 The intake procedures
 - 5.1.4.4.1.8 The diagnostic assessment procedure established by the ~~Administrator~~
program director in compliance with ~~8-1-2-1-2-14~~ §8.1.2.1.7.
 - 5.1.4.4.1.9 Referral criteria policies and procedures.
 - 5.1.4.4.1.10 Admission criteria policies and procedures;
 - 5.1.4.4.1.11 Discharge criteria policies and procedures that specify conditions under which clients may be involuntarily discharged, including client behavior that constitutes grounds for discharge by the program.
 - 5.1.4.4.1.12 Established procedures consistent with 42 CFR §2.12(c)(5) and HIPAA 45 CFR parts 160 and 164 that staff shall follow when discharging a client involved in the commission of a crime on the premises of the program or against its staff, including designation of the person who shall make a report to the appropriate law enforcement program;
 - 5.1.4.4.1.13 Established procedures consistent with 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164 that staff shall follow when a client leaves against medical or staff advice and the client may be dangerous to self or others;
 - 5.1.4.4.1.14 Confidentiality policy and procedures that comply with 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164;
 - 5.1.4.4.1.15 Policies and procedures in regard to completion and utilization of all forms used by the program;
 - 5.1.4.4.1.16 Policies and procedures for making mandated reports of suspected child abuse or neglect in compliance with 16 **Del.C.** §§902 through 904, **[3910, 1132, 2224, 5194]** and 42 CFR § 2.12(c)(6) **[(including non-retaliation policies when personnel report abuse and neglect.)]** ;
 - 5.1.4.4.1.17 Policies and procedures for communicating with law enforcement personnel when a client commits or threatens to commit a crime on program premises or against program personnel, in compliance with 42 CFR § 2.12(c)(5) and HIPAA 45 CFR parts 160 and 164;
 - 5.1.4.4.1.18 Policies and procedures for mandated reporting of infectious or contagious diseases, in compliance with state law and 42 CFR Part 2 and HIPAA 45 CFR Parts 160 and 164;
 - 5.1.4.4.1.19 Medication policies and procedures, in compliance with the Delaware State Boards of Medical Practice, Nursing, and Pharmacy;
 - 5.1.4.4.1.20 Policies and procedures, as applicable, for the collection of urine specimens;
 - 5.1.4.4.1.21 Policies and procedures for responding to medical emergencies;
 - 5.1.4.4.1.22 Policies and procedures regarding clients' rights
 - 5.1.4.4.1.23 Code of ethics; and
 - 5.1.4.4.1.24 Policies and procedures for reporting any violations of law or codes of ethics to the appropriate certification and/or licensure boards.
- 5.1.5 Fiscal management policies and procedures and record keeping
- 5.1.5.1 Each program shall establish written policies and procedures regarding fiscal management that shall be maintained in compliance with generally accepted accounting principles.
- 5.1.6 Personnel policies and procedures.
- 5.1.6.1 Each program shall develop and maintain a written personnel manual that shall include:
 - 5.1.6.1.1 Staff rules of conduct consistent with due process including:

- 5.1.6.1.21.1.1 Examples of conduct that constitute grounds for disciplinary action;
- 5.1.6.1.31.1.2 Examples of unacceptable performance that constitute grounds for disciplinary action;
- 5.1.6.1.41.1.3 Policies and procedures on mental health, and alcohol and drug abuse problems of staff (including staff member assistance policies and procedures);
- 5.1.6.1.52 Safety and health of staff, including:
- 5.1.6.1.63 Rules about any required medical examinations and rules about communicable diseases that could affect the health or safety of the program's clients or staff.
- 5.1.6.2 Each agency shall maintain a separate personnel file for each staff member in a manner that ensures the privacy of agency staff.
- 5.1.6.3 The personnel file shall include at a minimum:
 - 5.1.6.3.1 the name and telephone number of a person the agency can contact in an emergency;
 - 5.1.6.3.2 The current job title and job description signed by the staff member;
 - 5.1.6.3.3 Either:
 - 5.1.6.3.3.1 an application for employment signed by the staff member; or
 - 5.1.6.3.3.2 a resume;
 - 5.1.6.3.4 A copy of the staff member's license and/or current alcohol or other drug eCounselor certification and/or Co-Occurring Counselor's certification.
 - 5.1.6.3.5 The results of reference investigations and verification of experience, training and education, including:
 - 5.1.6.3.5.1 primary source verification of the staff member's educational degree certificate(s), based on job description;
 - 5.1.6.3.5.2 primary source verification of the staff member's license(s), and/or certification(s), as applicable, based on job description;
 - 5.1.6.3.5.3 A statement signed by the staff member acknowledging that s/he understands the requirements of 42 USC §290dd-2, 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164;
 - 5.1.6.3.5.4 Documentation of the staff member's annual written performance evaluation;
 - 5.1.6.3.5.54.1 Any disciplinary actions taken against the staff member;
 - 5.1.6.3.5.64.2 Formal corrective action taken, that:
 - 5.1.6.3.5.64.2.1 The staff member has signed;
 - 5.1.6.3.5.64.2.2 His/her immediate supervisor has signed;
 - 5.1.6.3.5.75 A copy of the staff member's training plan, as required in §5.1.7.1;
 - 5.1.6.3.5.86 Documentation of the staff member's abilities to provide culturally competent services; and
 - 5.1.6.3.5.97 Documentation of in-service training and continuing education as required in by §5.1.7.
 - ~~5.1.6.3.6 Criminal background checks and previous, substantiated reports to the Adult Abuse and Child Abuse registries;~~
- 5.1.6.4 Counselor II's personnel files shall also include:
 - 5.1.6.4.1 Documentation that the Counselor II is working toward meeting the requirements of §6.1.5; and
 - 5.1.6.4.2 Documentation of Supervision as required in ~~6.1.5.2 and 6.1.5.3~~ §12.2.4.
- 5.1.6.5 Records documenting all required staff member health clearances, including any medical test results required by agency policy shall be made available to the Division upon request.
- 5.1.7 Staff training and development

- 5.1.7.1 Each program shall establish a written staff training and development plan. The plan shall include:
- 5.1.7.1.1 An orientation curriculum, that will ensure that all staff are familiar with the agency policies and procedures, and have a working knowledge of at least the following:
 - 5.1.7.1.1.1 Personnel policies and procedures, regarding the health and safety of staff, established in compliance with ~~5.1.6.1.5~~ §5.1.6.1.2;
 - 5.1.7.1.1.2 Program policies and procedures regarding the reporting of cases of suspected child abuse or neglect in compliance with 16 Del.C. §§902 through 904 and ~~16 Del.C. §2224~~ **[3910, 1132, 2224, 5194 and 42 CFR § 2.12(c)(6), including non-retaliation policies when personnel report abuse and neglect].;**
 - 5.1.7.1.1.3 Program policies and procedures regarding client's rights established in compliance with ~~7-0~~ §7.1, as applicable;
 - 5.1.7.1.1.4 Instruction and training in the elements of the fire plan in compliance with §9.2;
 - 5.1.7.1.1.5 Program policies and procedures regarding the obligation to report violations of law and applicable codes of ethics to the appropriate certification and/or licensure boards, established in compliance with §5.1.4.4.1.24.
 - 5.1.7.1.1.6 Program policies and procedure regarding the training of all staff regarding culturally competent practices.
 - 5.1.7.2 Programs shall annually establish an individual training plan for each staff member based on the staff member's skill level, education, experience, current job functions, and job performance.
 - 5.1.7.3 Programs providing co-occurring services shall include training and education specific to co-occurring disorders in the training plan for each staff member, based on the staff member's skill level, education and experience, job functions and job performance.
 - 5.1.7.4 Clinical supervisors and all staff providing counseling services to clients shall complete at least twenty (20) hours of training annually, including:
 - ~~5.1.7.34.1~~ Ten (10) hours specific to training and education in the treatment of alcohol and other drugs of abuse; ~~and~~
 - 5.1.7.4.1.1 When providing co-occurring services the ten (10) hours of training will be a combination of substance use disorders as well as mental health disorders.
 - ~~5.1.7.34.2~~ Three (3) hours specific to training and education in providing culturally competence services **[every two years]** ; ~~and~~
 - ~~5.1.7.34.3~~ Three (3) hours of training specific to ethics training and education **[every two years]**.
 - 5.1.7.45 Adjunctive and Alternative Therapies
 - 5.1.7.45.1 Every program utilizing any modalities of adjunct or alternative therapy shall ensure:
 - 5.1.7.45.1.1 Adjunctive or ~~A~~lternative ~~T~~herapies are approved by the ~~Administrator~~ program director or designee prior to utilization;
 - 5.1.7.45.1.2 ~~i~~ndividuals providing the services of Adjunctive or ~~A~~lternative ~~T~~herapies have received specific training and/or credentials applicable to each modality; ~~;~~
 - 5.1.7.56 All staff, trainees and volunteers shall receive training within the first year of employment about:
 - 5.1.7.56.1 Hepatitis;
 - 5.1.7.56.2 HIV/AIDS;
 - 5.1.7.56.3 Tuberculosis;
 - 5.1.7.56.4 Other sexually transmitted diseases;
 - 5.1.7.6.5 Infectious Control.
- 5.1.8 Quality Assurance
- 5.1.8.1 Every agency shall have a written quality assurance plan.

- 5.1.8.2 The plan shall be reviewed and revised annually.
- 5.1.8.3 The quality assurance plan shall provide for the review of:
 - 5.1.8.3.1 Clinical services to include:
 - 5.1.8.3.1.1 The provision of culturally competent services including:
 - 5.1.8.3.1.1.1 An annual self assessment that focuses on the needs of the community which the agency serves;
 - 5.1.8.3.2 Professional services;
 - 5.1.8.3.3 Administrative services;
 - 5.1.8.3.4 Infection Control; and
 - 5.1.8.3.5 Environment of Care.
- 5.1.8.4 The results of quality assurance review shall document:
 - 5.1.8.4.1 The problem(s) identified;
 - 5.1.8.4.2 The recommendations made;
 - 5.1.8.4.3 The action(s) taken;
 - 5.1.8.4.4 The individual(s) responsible for implementation of actions; and
 - 5.1.8.4.5 Any follow-up.
- 5.1.8.5 Every agency shall develop and implement performance indicators and assess outcome measures.
- 5.1.8.6 Every program shall provide a mechanism to collect opinions from service recipients, personne and other stakeholders regarding the quality of service provided. Information shall be submitted to the appropriate committee for quality assurance review.
- 5.1.8.7 Every program shall conduct a needs assessment at a minimum of every five (5) years. The results of the needs assessment should determine staffing patterns and types of services to be provided with changes and updates recorded as part of the agency's quality assurance plan.

6.0 Standards Applicable to all Facilities and Programs

- 6.1 Staff Qualifications for Substance use Disorders Treatment Staff
 - 6.1.1 Qualifications for the Position of Administrator
 - 6.1.1.1 Each agency shall have an administrator responsible for the overall management of the agency and/or program and staff.
 - 6.1.1.2 Each administrator hired or promoted on or after the date these regulations become effective shall have at a minimum:
 - 6.1.1.2.1 A Bachelor's Degree from an accredited college or university with at least 5 years of documented experience in human services including:
 - 6.1.1.2.1.1 at least two (2) years of experience in substance abuse treatment; and
 - 6.1.1.2.1.2 at least two (2) years of management experience.
 - 6.1.2 Qualifications for the Position of Clinical Director
 - 6.1.2.1 Each individual, hired or promoted, to the position of Clinical Director on or after the date these regulations become effective shall have, at a minimum:
 - 6.1.2.1.1 A master's degree ~~with a major in chemical dependency, psychology, social work, in counseling, nursing or a related field of study discipline~~ and five (5) years of documented **[clinical clinical]** experience in human services, at least three (3) years of which shall be in substance ~~abuse use~~ services; ~~or,~~
 - 6.1.2.1.2 ~~[A Bachelor's Degree from an accredited college or university with a major in chemical dependency, psychology, social work, counseling, nursing or a related field, full certification as an alcohol and drug counselor and five (5) years of clinical experience in the substance abuse treatment field, including two years of management experience. A Bachelor's Degree from an accredited college or~~

university with a major in chemical dependency, psychology, social work, counseling, nursing or a related field, full certification as a certified alcohol and drug counselor (CADC) or certified co-occurring disorder professional (CCDP) in the state of Delaware or by a nationally recognized organization in addictions counseling and five (5) years of documented experience in substance use services.]

6.1.3 Qualifications for the Position of Clinical Supervisor

6.1.3.1 Each individual authorized, hired, or promoted, to provide clinical supervision on or after the date these regulations become effective shall meet one of the following:

6.1.3.1.1 A Bachelor's Degree from an accredited college or university with a major in chemical dependency, psychology, social work, counseling, or nursing or a related field of study and full certification as a certified alcohol and drug counselor (CADC) **[or certified co-occurring disorder professional (CCDP)]** in the state of Delaware or by a nationally recognized organization in addictions counseling; or

6.1.3.1.2 A Bachelor's Degree from an accredited college or university with a major in chemical dependency, psychology, social work, counseling, or nursing or a related field of study and five (5) years of documented ~~clinical~~ **clinical** experience in the substance abuse treatment field.

6.1.4 Qualifications for the Position of Counselor I

6.1.4.1 Each individual hired or promoted on or after the date these regulations become effective shall meet one of the following requirements:

6.1.4.1.1 Full certification as a certified alcohol and drug counselor (CADC) in the state of Delaware; or

6.1.4.1.2 Full certification by a nationally recognized body in addictions counseling or co-occurring counseling; or

6.1.4.1.3 Five (5) years of ~~documented~~ clinical experience working in the field of substance abuse treatment.

6.1.5 Counselor II

6.1.5.1 Qualifications for the Position of Counselor II

6.1.5.1.1 A person who does not meet the educational and experiential qualifications for the position of Counselor I as set forth in §6.1.4 may be employed as an Counselor II if the ~~individual holds a minimum of a high school diploma or its equivalent and meets requirements of~~ at least one of the following paragraphs are met:

6.1.5.1.1.1 The individual has ~~has less than five (5) years of documented clinical experience working~~ worked in the substance abuse treatment field for less than five years.

6.1.5.1.1.2 The individual is a student enrolled in a course of study while completing a practicum or internship;

6.1.5.1.1.3 The individual is working toward full certification in addictions counseling or co-occurring counseling by the Delaware Certification Board or a nationally recognized certification organization ~~in addictions counseling.~~

6.1.5.2 ~~The individual~~ Counselor IIs must receive clinical supervision by the clinical supervisor a minimum of one (1) hour per every twenty (20) hours of clinical services provided to clients.

6.1.5.3 The clinical supervisor must review all documentation developed by the Counselor II for accuracy and clinical appropriateness.

6.1.5.3.1 The review shall be documented and placed in the Counselor II's personnel file.

~~6.1.6 Individuals appropriately hired, authorized or promoted to function as a Clinical Director, Clinical Supervisor or Counselor I or II prior to the date these regulations become effective and who met the standard(s) for such functions existing prior to the date these regulations become effective, but who do not meet the requirements set forth in this section, may continue to function in their current role as a Clinical Director, Clinical Supervisor or Counselor I or II.~~

7.0 Standards Applicable to all Facilities and Programs

7.1 Clients' Rights

7.1.1 Nondiscrimination policy

- 7.1.1.1 No program shall deny any person equal access to its facilities or services on the basis of race, color, religion, ancestry, sexual orientation, gender expression, national origin, or disability ~~[unless such disability makes treatment offered by the program non-beneficial or hazardous].~~
- 7.1.1.2 No program shall deny any person equal access to its facilities or services on the basis of age or gender, except those programs that specialize in the treatment of a particular age group (such as adolescents) or gender (such as mothers and infants).
- 7.1.1.3 All agencies shall ensure that they comply with the federal Americans with Disabilities Act, 28 U.S.C. §§12101 et seq. and 28 Code of Federal Regulations, Part 36 (July 1991) and 16 **Del.C.** §2220.

7.1.2 Enumerated Rights

- 7.1.2.1 All agencies shall ensure that clients' rights are fully protected [**as enumerated in Del.C. §2220 and**] , including the following:
 - 7.1.2.1.1 To be free from retaliation for exercising any enumerated right;
 - 7.1.2.1.2 To file a grievance or complaint with the program in accordance with its policy and procedures. Procedures for receiving, investigating, hearing, considering, responding to and documenting grievances shall:
 - 7.1.2.1.2.1 Include a procedure for receipt of grievances from clients or persons acting on their behalf;
 - 7.1.2.1.2.2 Provide for the investigation of the facts supporting or disproving the grievance;
 - 7.1.2.1.2.3 Identify the staff responsible for receipt and investigation of grievances;
 - 7.1.2.1.2.4 Be posted in a public place;
 - 7.1.2.1.3 Participate, and/or have others of his/her choice participate, in an informed way in the grievance process.
 - 7.1.2.1.4 To be informed that participation in treatment is voluntary, except as provided in 16 **Del.C.** §§2211, 2212, 2213 and 2215;
 - 7.1.2.1.5 To refuse service, except as provided in 16 **Del.C.** §§2211, 2212, 2213 and 2215. If consequences, such as termination from other services, may result from such refusal, that fact shall be:
 - 7.1.2.1.5.1 Documented in the client's file.
 - 7.1.2.1.6 To be free of any exploitation or abuse by any program personnel or any member of the governing body.
 - 7.1.2.1.7 To be assured that any incident of abuse; neglect or mistreatment will be reported in accordance with §5.1.4.4.1.16.
 - 7.1.2.1.8 To communicate with legal counsel.
 - 7.1.2.1.9 To confidentiality of all records, correspondence and information relating to assessment, diagnosis and treatment in accordance with 42 U.S.C. § 290dd-2, 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164.
 - 7.1.2.1.10 To review his/her own records in accordance with 42 U.S.C. § 290dd-2, 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164.
 - 7.1.2.1.11 Client request for review and a summary of the review if granted shall be documented in the client's record.
- 7.1.2.2 Participation in experimental or research programs

- 7.1.2.2.1 No client shall participate in any experimental or research project without the full knowledge, understanding and written consent of that client (and/or legal guardian, when appropriate).
- 7.1.2.2.2 All experimental or research projects shall be conducted in full compliance with applicable state and federal laws, regulations and guidelines.
- 7.1.3 Barriers to treatment:
 - 7.1.3.1 The program shall make reasonable modifications in policies, practices and procedures and/or provide assistive services to accommodate clients who are unable to participate in treatment due to language, cultural, literacy barriers or disabilities, unless doing so would fundamentally alter the nature of the services offered.

8.0 Standards Applicable to all Facilities and Programs

- 8.1 Clinical records
 - 8.1.1 Maintenance of client records
 - 8.1.1.1 Programs shall:
 - 8.1.1.1.1 Maintain a record for each client that is
 - 8.1.1.1.1.1 Accurate,
 - 8.1.1.1.1.2 Legible and
 - 8.1.1.1.1.3 Signed by the staff member who provided the service.
 - 8.1.1.1.2 Maintain a standardized client record-keeping system, with client records that are uniform in format and content;
 - 8.1.1.1.3 Establish and maintain a system that permits easy identification of and access to individual client records by authorized program staff;
 - 8.1.1.1.4 Comply fully with the provisions of 42 U.S.C. § 290dd-2 and 42 CFR Part 2 and HIPAA 45 CFR parts 160 and 164;
 - 8.1.1.1.5 Update each record within twenty-four (24) hours of delivery of a service unless otherwise specified in these regulations.
 - 8.1.1.2 Any program that discontinues operations, or is merged with, or acquired by another program is responsible for ensuring compliance with the requirements of 42 CFR § 2.19, and HIPAA 45 CFR parts 160 and 164 whichever is applicable. The program shall document in writing to the Division:
 - 8.1.1.2.1 How it will adhere to 42 CFR § 2.19 and HIPAA 45 CFR parts 160 and 164 at the time it notifies the Division of the program closure in accordance with §4.10.5 of these regulations; and
 - 8.1.1.2.2 How it will adhere to §8.0 of these regulations.
 - 8.1.2 Content of Client records
 - 8.1.2.1 A record shall be established for each client upon admission and shall include:
 - 8.1.2.1.1 A Consent to Treatment form signed by the client and, if the client is a minor, the client's parent or guardian, except as provided in 16 Del.C. §2210(b).
 - 8.1.2.1.2 An up-to-date face sheet including the client's:
 - 8.1.2.1.2.1 Date of admission;
 - 8.1.2.1.2.2 Name;
 - 8.1.2.1.2.3 Address;
 - 8.1.2.1.2.4 Telephone number;
 - 8.1.2.1.2.5 Gender;
 - 8.1.2.1.2.6 Date of birth;
 - 8.1.2.1.2.7 The client's significant medical history documenting:
 - 8.1.2.1.2.7.1 Current medical conditions;

- 8.1.2.1.2.7.2 Any medications the client is currently prescribed;
- 8.1.2.1.2.7.3 Any medications the client is currently taking;
- 8.1.2.1.2.7.4 Allergies,
- 8.1.2.1.2.8 The name and telephone number of the person to contact in an emergency;
- 8.1.2.1.2.9 An attached Consent to Release Information form permitting the program to make that contact;
- ~~8.1.2.1.2.10 Appropriate Consent to Release Information forms.~~
- 8.1.2.1.2.11 Documentation, signed by the client:
 - ~~8.1.2.1.2.11.1 Acknowledging receipt of the notice of clients' rights;~~
 - ~~8.1.2.1.2.11.2 Acknowledging his/her understanding of the agency's agreement with the confidentiality requirements of 7.1.2.1.9;~~
 - ~~8.1.2.1.2.11.3 Acknowledging receipt of the program's procedures when an emergency occurs outside of the program's hours of operation.~~
- ~~8.1.2.1.2.12 Copies of any laboratory reports and drug tests ordered by the program.~~
- ~~8.1.2.1.2.13 Informed consent regarding prescribed pharmacotherapy obtained from the client prior to delivery of the medication prescription.~~
- 8.1.2.1.2.14 Results of the client's assessment, including the client's:-
 - 8.1.2.1.2.14.1 mental health status;
 - 8.1.2.1.2.14.2 psychiatric history;
 - 8.1.2.1.2.14.3 medical history (including allergies);
 - 8.1.2.1.2.14.4 education;
 - 8.1.2.1.2.14.5 work history;
 - 8.1.2.1.2.14.6 criminal justice history;
 - 8.1.2.1.2.14.7 substance use history, including:
 - 8.1.2.1.2.14.7.1 types;
 - 8.1.2.1.2.14.7.2 quantity;
 - 8.1.2.1.2.14.7.3 route;
 - 8.1.2.1.2.14.7.4 frequency of substances used;
 - 8.1.2.1.2.14.7.5 age of first use;
 - 8.1.2.1.2.14.7.6 date of last use;
 - 8.1.2.1.2.14.7.7 duration and patterns of use, including:
 - 8.1.2.1.2.14.7.7.1 periods of abstinence; and
 - 8.1.2.1.2.14.7.7.2 previous treatment episodes and type of discharge;
 - 8.1.2.1.2.14.8 reason(s) for seeking treatment;
 - 8.1.2.1.2.14.9 identification and evaluation of the client's needs
 - 8.1.2.1.2.14.10 Family History including:
 - 8.1.2.1.2.14.10.1 psychiatric history;
 - 8.1.2.1.2.14.10.2 use of alcohol and other drugs by family members and significant others;
- 8.1.2.1.2.15 Copies of all correspondence related to the client;
- ~~8.1.2.1.2.16 A diagnostic assessment summary of the client's status that addresses the client's:~~
 - ~~8.1.2.1.2.16.1 strengths;~~
 - ~~8.1.2.1.2.16.2 limitations; and~~
 - ~~8.1.2.1.2.16.3 goals;~~
- 8.1.2.1.2.17 Indicates which issues and areas of clinical concern are to be:
 - 8.1.2.1.2.17.1 treated;

- 8.1.2.1.2.17.2 ~~deferred; or~~
- 8.1.2.1.2.17.3 ~~referred;~~
- 8.1.2.1.2.18 ~~Includes the client's:~~
 - 8.1.2.1.2.18.1 ~~primary language;~~
 - 8.1.2.1.2.18.2 ~~cultural background;~~
 - 8.1.2.1.2.18.3 ~~attitudes toward alcohol and other drug use; and spiritual or religious beliefs;~~
- 8.1.2.1.2.19 ~~the rationale for placement recommendations; and is:~~
 - 8.1.2.1.2.19.1 ~~signed by the counselor completing the assessment;~~
 - 8.1.2.1.2.19.2 ~~reviewed, as indicated by the signature of the clinical supervisor; and~~
 - 8.1.2.1.2.19.3 ~~is completed prior to the development of the comprehensive treatment plan.~~
- 8.1.2.1.2.20 ~~Name, address and telephone number of most recent primary care provider.~~
- 8.1.2.1.2.10 Name, address and telephone number of most recent primary care provider.
- 8.1.2.1.3 Appropriate Consent to Release Information forms.
- 8.1.2.1.4 Documentation, signed by the client:
 - 8.1.2.1.4.1 Acknowledging receipt of the notice of clients' rights;
 - 8.1.2.1.4.2 Acknowledging his/her understanding of the agency's agreement with the confidentiality requirements of §7.1.2.1.9;
 - 8.1.2.1.4.3 Acknowledging receipt of the program's procedures when an emergency occurs outside of the program's hours of operation.
- 8.1.2.1.5 Copies of any laboratory reports and drug tests ordered by the program.
- 8.1.2.1.6 Informed consent regarding prescribed pharmacotherapy obtained from the client prior to delivery of the medication prescription.
- 8.1.2.1.7 Results of the client's diagnostic assessment, including the client's:
 - 8.1.2.1.7.1 Mental health status;
 - 8.1.2.1.7.2 Psychiatric history;
 - 8.1.2.1.7.3 Medical history (including allergies);
 - 8.1.2.1.7.4 Education;
 - 8.1.2.1.7.5 Work history;
 - 8.1.2.1.7.6 Criminal justice history;
 - 8.1.2.1.7.7 Substance use history, including:
 - 8.1.2.1.7.7.1 Types;
 - 8.1.2.1.7.7.2 Quantity;
 - 8.1.2.1.7.7.3 Route;
 - 8.1.2.1.7.7.4 Frequency of substances used;
 - 8.1.2.1.7.7.5 Age of first use;
 - 8.1.2.1.7.7.6 Date of last use;
 - 8.1.2.1.7.7.7 Duration and patterns of use, including:
 - 8.1.2.1.7.7.7.1 Periods of abstinence;
 - 8.1.2.1.7.8 Past supports and resources that were effective in previous recovery attempts;
 - 8.1.2.1.7.9 Previous treatment episodes and type of discharge;
 - 8.1.2.1.7.10 Reason(s) for seeking treatment;
 - 8.1.2.1.7.11 Identification and evaluation of the client's needs;
 - 8.1.2.1.7.12 History of other addictive disorders.

- 8.1.2.1.7.13 Family History including:
 - 8.1.2.1.7.13.1 Psychiatric history;
 - 8.1.2.1.7.13.2 Use of alcohol and other drugs by family members and significant others.
- 8.1.2.1.7.14 A diagnostic assessment summary of the client's status that addresses the client's:
 - 8.1.2.1.7.14.1 strengths;
 - 8.1.2.1.7.14.2 barriers to treatment; and
 - 8.1.2.1.7.14.3 goals.
- 8.1.2.1.7.15 Indicates which [what] issues and areas of clinical concern are to be:
 - 8.1.2.1.7.15.1 Treated;
 - 8.1.2.1.7.15.2 Deferred; or
 - 8.1.2.1.7.15.3 Referred.
- 8.1.2.1.7.16 Includes the client's:
 - 8.1.2.1.7.16.1 Primary language;
 - 8.1.2.1.7.16.2 Cultural background;
 - 8.1.2.1.7.16.3 Attitudes toward alcohol and other drug use; and
 - 8.1.2.1.7.16.4 Spiritual or religious beliefs.
- 8.1.2.1.7.17 The rationale for placement recommendations:
 - 8.1.2.1.7.17.1 Signed by the Counselor completing the assessment;
 - 8.1.2.1.7.17.2 Reviewed, as indicated by the signature of the clinical supervisor; and
 - 8.1.2.1.7.17.3 Is completed prior to the development of the initial Recovery Plan.
- 8.1.2.1.7.18 Copies of all correspondence related to the client.
- 8.1.2.1.8 An individualized Recovery Plan, developed in partnership with the client, shall be completed no later than the time required in these regulations for the modality for which the program is licensed.
- 8.1.2.1.9 The recovery plan shall:
 - 8.1.2.1.9.1 Identify the date the plan is to be effective;
 - 8.1.2.1.9.2 Identify the client's:
 - 8.1.2.1.9.2.1 Strengths;
 - 8.1.2.1.9.2.2 Barriers to treatment; and
 - 8.1.2.1.9.2.3 Goals.
 - 8.1.2.1.9.3 Address the goals as derived from the assessment process:
 - 8.1.2.1.9.3.1 To be treated.
 - 8.1.2.1.9.3.2 Identify objectives that:
 - 8.1.2.1.9.3.2.1 Address the goals;
 - 8.1.2.1.9.3.2.2 Are specific;
 - 8.1.2.1.9.3.2.3 Are measurable;
 - 8.1.2.1.9.3.2.4 Are time limited; and
 - 8.1.2.1.9.3.2.5 Specify the treatment regimen, including:
 - 8.1.2.1.9.3.2.5.1 Which services and/or activities will be used to achieve each recovery plan objective;
 - 8.1.2.1.9.3.2.5.2 The frequency of each service and/or activity to meet the goals/objectives;
 - 8.1.2.1.9.3.2.5.3 Goals/objectives to be referred;
 - 8.1.2.1.9.3.2.5.4 Goals/objectives to be deferred;
 - 8.1.2.1.9.3.3 Be signed by:
 - 8.1.2.1.9.3.3.1 The client;

8.1.2.1.9.3.3.2 The staff who developed the recovery plan; and

8.1.2.1.9.3.3.3 The clinical supervisor.

8.1.2.1.10 Periodic Recovery Plan Review/Revision

8.1.2.1.10.1 Recovery plans shall be reviewed and revised by the client and his/her counselor, and no less often than the intervals specified for the modality for which the program is licensed and shall address the issues remaining to be treated as derived from and recovery plan review.

8.1.2.1.11 Progress notes

8.1.2.1.11.1 Each contact made with or on behalf of the client in accordance with the interventions prescribed on the recovery plan shall be documented in the client file; and

8.1.2.1.11.1.1 Be written to include:

8.1.2.1.11.1.1.1 The type(s) of service provided;

8.1.2.1.11.1.1.2 The date of the service(s) provided;

8.1.2.1.11.1.1.3 The length of the service(s) provided; and

8.1.2.1.11.1.1.4 A description of the client's response to the session including:

8.1.2.1.11.1.1.4.1 Facts (a description of the service and/or activity and the client's participation in the service and/or activity);

8.1.2.1.11.1.1.4.2 Clinical impressions (the counselor 's assessment of the client's response or lack of response to the service and/or activity and the client's progress or lack of progress toward achieving the objectives prescribed in the recovery plan);

8.1.2.1.11.1.1.4.3 Plan for future sessions (anticipated implementation, by the counselor, of services and/or activities as prescribed in the recovery plan.)

8.1.2.1.12 Clinical Supervision

8.1.2.1.12.1 The clinical supervisor shall review each individual client record with the client's counselor as often as necessary, and in conjunction with recovery plan review and revision and no less often than at the intervals specified by each modality for which the program is licensed.

8.1.2.1.12.2 The clinical supervisor shall provide specific, written clinical recommendations on how to proceed with the case.

8.1.2.1.12.3 The clinical supervisor shall sign the recovery plan revision/review.

8.1.2.1.13 Discharge Plan

8.1.2.1.13.1 In anticipation of successful completion or planned interruption of a client's treatment, the treatment staff and client shall jointly develop a discharge plan.

8.1.2.1.14 Discharge Summary

8.1.2.1.14.1 For every client that is discharged, the program shall complete a discharge summary within seventy-two (72) hours of a planned discharge and within ninety-six (96) hours of an unplanned discharge.

8.1.2.1.14.2 The narrative discharge summary shall include the client's:

8.1.2.1.14.2.1 Name;

8.1.2.1.14.2.2 Discharge address;

8.1.2.1.14.2.3 Discharge telephone number;

8.1.2.1.14.2.4 Admission date;

8.1.2.1.14.2.5 Discharge date;

8.1.2.1.14.2.6 A summary of the client's progress toward treatment plan objectives;

8.1.2.1.14.2.7 A summary of the client's participation in treatment;

8.1.2.1.14.2.8 The reasons for discharge;

8.1.2.1.14.2.9 Any unresolved issues;

8.1.2.1.14.2.10 Recommendations regarding the need for additional treatment services.

8.1.2.1.14.3 When the discharge is planned, the discharge summary shall be signed by:

8.1.2.1.14.3.1 The client

8.1.2.1.14.3.2 The counselor, and

8.1.2.1.14.3.3 The clinical supervisor.

8.1.3 Programs shall provide a list of referral sources for the client's various needs when the agency is unable to meet the client's needs internally. The agency shall be responsible for assisting the client in enrolling in services at other agencies.

8.1.4 Programs shall provide a minimum of twelve (12) months of records up until and including the expiration date of the current license for the purposes of licensure audit. Programs shall develop a policy that clearly outlines timelines for record retention and storage for all records beyond the required audit period.

9.0 Standards Applicable to all Facilities and Programs

9.1 Facility Standards

9.1.1 Unless otherwise specified programs shall be in compliance with the regulations in this section.

9.1.2 Each agency shall provide facilities that:

9.1.2.1 Provide privacy of for communications between clients and staff members;

9.1.2.2 Provide waiting areas and meeting spaces that are welcoming to diverse populations and cultures;

9.1.2.3 Include rest rooms for clients, visitors and staff.

9.1.3 Agencies shall maintain up-to-date documentation verifying that they have a certificate of occupancy and meet applicable federal, state and local building, zoning, fire, and safety and accessibility requirements.

9.1.4 Agencies shall maintain facilities in neat and clean condition, and eliminate any hazardous conditions that endanger the health or safety of clients, visitors or staff.

9.1.5 Agencies shall not permit tobacco use in program facilities.

9.1.6 Agencies shall post a current fee schedule in a public place within the facility.

9.1.7 Agencies shall post hours of operation in a public place within the facility.

9.2 Fire Prevention and Safety

9.2.1 Agencies shall display up to date certificates or approval/inspection by Fire Department authorities whenever this is required/available in the specific community where the program is located.

9.3 Emergency policies and procedures.

9.3.1 Each agency shall establish a plan of action in the event of emergencies or disasters, based on the program's capability and limitations. The plan shall include provisions:

9.3.1.1 For responding to severe weather, loss of power or water or other natural disaster;

9.3.1.2 For evacuation plans with specific primary and alternative evacuation routes;

9.3.1.3 For posting evacuation routes in areas visible to staff, clients and visitors;

9.3.1.4 For responding to accidents that result in injury or death;

9.3.1.5 Governing how available resources will be used to continue client care;

9.3.1.6 Governing how the program will effectively activate community resources to prevent or minimize the consequences of a disaster;

9.3.1.7 Concerning staff preparedness and the designation of roles and functions;

9.3.1.8 Concerning criteria for the cessation of nonessential services and client transfer determinations; and

9.3.1.9 Governing how it will protect the safety of clients and staff and the security of its records.

9.3.2 All treatment programs shall develop procedures for handling a client who is exhibiting behavior that is threatening to the life or safety of the client or others.

- 9.3.3 All treatment programs shall have a staff member on site at all times trained in:
 - 9.3.3.1 Crisis intervention; and
 - 9.3.3.2 The standard Red Cross first aid class and CPR certification, or its equivalent.

Part III--Provisions Regarding Modalities

10.0 Standards Applicable to Residential Detoxification

- 10.1 Services Required:
 - 10.1.1 In addition to the requirements applicable to all programs, a Medically Monitored Residential Detoxification program shall provide:
 - 10.1.1.1 Meals in accordance with §12.3.
 - 10.1.1.2 Housing in accordance with §12.4.
 - 10.1.1.3 Admission assessment by qualified medical personnel or licensed nurse prior to admission to determine need for detoxification.
 - 10.1.2 There shall be no administration of prescription or non-prescription drugs until qualified medical personnel have examined the client, or qualified medical personnel have been consulted.
 - 10.1.3 Physical examination conducted by qualified medical personnel within twenty-four (24) hours of admission.
 - 10.1.4 A medical care plan within twenty-four (24) hours of admission based on the findings of the physical examination in §10.1.3 and including:
 - 10.1.4.1 A brief screening to identify:
 - 10.1.4.1.1 Motivation for treatment;
 - 10.1.4.1.2 Relapse potential;
 - 10.1.4.1.3 Recovery environment at discharge.
 - 10.1.5 Within Seventy-two (72) hours of admission, diagnostic assessment in accordance with ~~8.1.2.1.2.14~~ §8.1.2.1.7.
 - 10.1.6 Within seventy-two (72) hours of admission, ~~treatment~~ recovery planning in accordance with ~~8.1.2.2~~ §8.1.2.1.8.
 - 10.1.7 ~~Treatment~~ Periodic recovery plan review/revision in accordance with ~~8.1.2.3~~ §8.1.2.1.10.
 - 10.1.7.1 By the seventh (7th) day, and
 - 10.1.7.2 Every fifth (5th) day thereafter.
 - 10.1.8 For those clients not medically restricted individual counseling that shall include at least one (1) ~~thirty minute (30)~~ (fifteen) 15 minute counseling ~~session~~ contact per day ~~led by~~ with a Counselor I or Counselor II.
 - 10.1.9 Group counseling that shall include at least one (1) sixty-minute (60) counseling session per day with a Counselor I or Counselor II.
 - 10.1.10 Emergency medical and hospital services at a licensed hospital, as needed.
- 10.2 Required Additional Policies and Procedures
 - 10.2.1 The program shall have protocols developed and supported by a physician knowledgeable in addiction medicine setting forth:
 - 10.2.1.1 A medication policy that complies with §5.1.4.4.1.19.
 - 10.2.1.2 The protocol staff should take to respond to medical complications throughout the detoxification process.
 - 10.2.1.3 The circumstances under which medical intervention is required.
- 10.3 Operation, Staffing and Staff Schedules
 - 10.3.1 The program shall operate seven (7) days per week, twenty-four (24) hours per day.
 - 10.3.2 The program shall have written affiliation agreements for the provision of services required by this section, when those services are not provided in house.

- 10.3.3 A physician(s) shall provide on-site services as necessary and on-call services twenty-four (24) hours a day.
- 10.3.4 When clients are present, there shall be qualified medical personnel or a licensed nurse on site who has knowledge of the complications associated with withdrawal.
- 10.3.5 When clients are present, there shall be staff on duty and awake at all times.
- 10.3.6 A counselor shall be available on site to clients at least eight (8) hours a day, seven (7) days a week and available on call twenty-four (24) hours a day.
- 10.4 Monitoring and documenting the client's condition
 - 10.4.1 Upon admission, the program shall record:
 - 10.4.1.1 Client's blood pressure;
 - 10.4.1.2 Client's pulse;
 - 10.4.1.3 Client's respiration;
 - 10.4.1.4 Presence of bruises, lacerations, cuts or wounds;
 - 10.4.1.5 Any medications carried by the client or found on the client's person.
 - 10.4.1.6 Documentation, at a frequency prescribed by Qualified Medical Personnel, but no less than three times in the first eight hours after admission of:
 - 10.4.1.6.1 Blood Pressure;
 - 10.4.1.6.2 Pulse;
 - 10.4.1.6.3 Respiration;
 - 10.4.1.6.4 Type and amount of fluid intake;
 - 10.4.1.6.5 Physical state, including the presence of tremors, ataxia, or excessive perspiration, restlessness, and sleep disturbances;
 - 10.4.1.6.6 Mental state, including the presence of confusion, hallucinations, and orientation to person, place, and time;
 - 10.4.1.6.7 Emotional state, including the presence of anxiety, depression.

~~11.0 Standards Applicable to Non-Residential Detoxification~~

~~Services required as determined by the Division of Substance Abuse and Mental Health.~~

11.0 Standards Applicable to Ambulatory Detoxification (Amdetox):

In addition to these standards, all programs providing Amdetox services shall be in full compliance with Federal Regulations regarding the dispensing and handling of all medications used in the detoxification of substance use disorders.

11.1 Services Required

11.1.1 In addition to the requirements applicable to all programs, an Amdetox program shall provide:

11.1.1.1 An initial screening, documentation of which shall include:

11.1.1.1.1 Verification of an applicant's identity, including:

11.1.1.1.1.1 Name;

11.1.1.1.1.2 Address;

11.1.1.1.1.3 Date of birth; and

11.1.1.1.1.4 Photographic identification.

11.1.1.1.2 Determination of current physiologic dependence and/or history of dependence upon opium, morphine, heroin or any derivative or synthetic drug of that group, in accordance with DSM criteria, by medical examination performed by qualified medical personnel.

11.1.1.1.3 Determination of current physiologic dependence and/or history of dependence on alcohol or other substances known to result in physical dependence in accordance with DSM criteria.

- 11.1.1.1.3.1 Documentation to support that determination shall include:
 - 11.1.1.1.3.1.1 Qualified medical personnel statement that treatment is medically necessary;
 - 11.1.1.1.3.1.2 The five-axis DSM diagnosis (most current DSM edition.);
 - 11.1.1.1.3.1.3 A description of behavior(s) supportive of a diagnosis of dependence;
 - 11.1.1.1.3.1.4 Determination of the duration of substance dependence.
- 11.1.1.1.3.2 A physical examination by qualified medical personnel that shall:
 - 11.1.1.1.3.2.1 Include documentation of the client's general appearance with a focus on the clinical signs and symptoms of addiction;
 - 11.1.1.1.3.2.2 Document vital signs;
 - 11.1.1.1.3.2.3 Include a complete medical history;
 - 11.1.1.1.3.2.4 Include the client's family medical history;
 - 11.1.1.1.3.2.5 Include medications currently being taken; and
 - 11.1.1.1.3.2.6 Completed at admission.
- 11.1.1.1.3.3 Determination by qualified medical personnel that the person's history and current symptomatology support Amdetox as the most appropriate level of care.
- 11.1.1.1.4 Laboratory tests including serology and other tests deemed necessary by the program physician.
- 11.1.1.1.5 A biological test for pregnancy for all women of child-bearing age.
- 11.1.1.1.6 HIV testing should be encouraged, with the client's signed consent.
- 11.1.1.2 A client enrolled in an Opioid Treatment program or another Amdetox program shall not be permitted to enroll in treatment in any other Amdetox program except in exceptional circumstances as determined by the medical director. Exceptions shall be:
 - 11.1.1.2.1 Noted in the client's record.

11.2 Admission procedures

- 11.2.1 In addition to the procedures described in §8.1.2. Amdetox programs shall provide:
 - 11.2.1.1 A medical care plan within twenty-four (24) hours of admission based on the findings of the physical examination in §11.1.1.3.2.
 - 11.2.1.2 Diagnostic assessment in accordance with §8.1.2.1.7 within twenty-four (24) hours of admission.
 - 11.2.1.2.1 An Initial Recovery Plan as derived by the diagnostic assessment in §11.2.1.7 of these standards and the medical care plan in §11.2.1.1 of these standards within twenty-four (24) hours of admission.
 - 11.2.1.2.2 Recovery plan updates/revisions shall occur:
 - 11.2.1.2.2.1 As needed based on the changes of intensity level of treatment for each client and:
 - 11.2.1.2.2.1.1 No later than the seventh (7h) day; AND
 - 11.2.1.2.2.1.2 Every seven (7) days thereafter.
 - 11.2.1.3 Procedures for referral to a licensed hospital or residential detoxification program when a more or less intensive level of care is indicated.

11.3 Client Orientation

- 11.3.1 In addition to the requirements of §8.1.2.1.4 the Amdetox program shall inform clients of:
 - 11.3.1.1 The facts concerning the use of buprenorphine, naltrexone, chlorthalidone or other detoxification medications dispensed by the program, including, but not limited to:
 - 11.3.1.1.1 An explanation of the interaction between the detoxification medication(s) dispensed by the program and other medications, and medical procedures;

- 11.3.1.1.2 Any potential adverse reactions, including those resulting from interactions with other prescribed or over-the-counter pharmacological agents, other medical procedures; and
- 11.3.1.1.3 The importance of notifying the client's primary care physician of their admission to and discharge from the program.
- 11.3.1.2 The facts concerning withdrawal from the use of, buprenorphine, naltrexone, chlordiazepoxide or other detoxification medications dispensed by the program, including, but not limited to:
 - 11.3.1.2.1 Policies and procedures regarding voluntary, involuntary, and against medical **advice** withdrawal from detoxification medications;
 - 11.3.1.2.2 An explanation of the potential interaction between withdrawal from the detoxification medication(s) dispensed by the program and other medications, medical procedures and;
 - 11.3.1.2.3 Any potential adverse reactions as a result of withdrawal from detoxification medications, including those resulting from interactions with other prescribed or over-the-counter pharmacological agents, other medical procedures; and
 - 11.3.1.2.4 The importance of notifying the client's primary care physician of withdrawal from the program.

11.4 Clinical Services

11.4.1 In addition to the requirements of §8.0 the Amdetox program shall provide:

- 11.4.1.1 Individual counseling that shall include at least one (1) sixty (60) minute counseling session per week by a Counselor I or Counselor II.
- 11.4.1.2 Daily counseling contact by a Counselor I or Counselor II that shall include at a minimum:
 - 11.4.1.2.1 One (1) fifteen (15) minute face-to-face or phone contact to:
 - 11.4.1.2.1.1 Engage the client;
 - 11.4.1.2.1.2 Help the client cope with withdrawal; and
 - 11.4.1.2.1.3 Continue in ongoing treatment services.
 - 11.4.1.2.2 Group Counseling that shall include at least two (2) ninety (90) minute counseling session per week.
 - 11.4.1.2.3 The discharge plan outlined in §8.1.2.1.13 and discharge summary outlined in §8.1.2.1.14 of these standards.
 - 11.4.1.2.4 Referral to a more or less intensive level of care as outlined in §8.1.3 of these standards.

11.5 Administrative Procedures

11.5.1 In addition to the requirements of §4.0 of these standards the Amdetox program shall develop policies and procedures that describe:

- 11.5.1.1 The program's medical/nursing monitoring schedule including:
 - 11.5.1.1.1 Monitoring on the first day to determine the response to detoxification medication;
 - 11.5.1.1.2 Monitoring of vital signs throughout the detoxification process;
 - 11.5.1.1.3 Monitoring of symptom history within the most recent 24 hours.
- 11.5.1.2 The program's drug-screening procedure;
- 11.5.1.3 The program's Amdetox medication dispensing procedure;
- 11.5.1.4 The program's rules including non-compliance, and discharge procedures, to include:
 - 11.5.1.4.1 Administrative detoxification medication withdrawal;
 - 11.5.1.4.2 The signs and symptoms of overdose; and
 - 11.5.1.4.3 When to seek emergency assistance.
- 11.5.1.5 The emergency procedures maintained by the program as required in §5.1.4.4.1.21 shall be available whenever clients are present at the program.

- 11.5.1.6 The program shall have protocols developed and supported by a physician knowledgeable in addiction medicine setting forth:
 - 11.5.1.6.1 The requirement for qualified staff to obtain waivers allowing qualified physicians to dispense or prescribe specifically approved Schedule III, IV, and V narcotic medications for the treatment of Opioid addiction in treatment settings other than the traditional Opioid Treatment Program (i.e., methadone clinic) in accordance with the Drug Addiction Treatment Act of 2000 (DATA 2000.)
 - 11.5.1.6.2 A medication policy that complies with §5.1.4.4.1.19 and includes:
 - 11.5.1.6.2.1 Induction protocols and policies for:
 - 11.5.1.6.2.1.1 Day one (1) and day two (2) of Opioid detoxification;
 - 11.5.1.6.2.1.2 Day three (3) of Opioid detoxification and forward.
 - 11.5.1.6.2.2 Induction protocols and policies for all other medications used in detoxification.
 - 11.5.1.6.2.3 Stabilization that includes:
 - 11.5.1.6.2.3.1 Documentation and rationale for changes in medication dosage;
 - 11.5.1.6.2.3.2 Average length of stay criteria; and
 - 11.5.1.6.2.3.3 Criteria for linkage to outpatient treatment.
 - 11.5.1.6.2.4 Protocols for the decrease and/or discontinuance of detoxification medications to include:
 - 11.5.1.6.2.4.1 Protocols for decreasing or discontinuing detoxification meds when the client requests;
 - 11.5.1.6.2.4.2 Protocols for decreasing or discontinuing when the program determines that maximum benefit has been achieved; and
 - 11.5.1.6.2.4.3 Protocols for decreasing or discontinuing when being administratively discharged or if the client chooses no further treatment.
 - 11.5.1.6.2.5 The protocol staff should follow to respond to medical complications throughout the detoxification process.

12.0 Residential Treatment

12.1 Services Required

- 12.1.1 In addition to the requirements applicable to all programs, a Residential Treatment program shall provide:
 - 12.1.1.1 Medical assessment by qualified medical personnel on the day of admission.
 - 12.1.1.2 A physical examination in accordance with §8.1.2.1.2.1.7 within seventy-two (72) hours of admission, unless the client presents a copy of a physical examination completed by qualified medical personnel within ninety (90) days prior to admission.
 - 12.1.1.3 A TB test and urine drug screen within seventy-two (72) hours of admission or documentation of a TB test performed within one (1) year prior to admission.
 - 12.1.1.4 ~~[An initial treatment individualized recovery plan within forty-eight (48) hours of admission-RESERVED]~~
 - 12.1.1.5 ~~Diagnostic~~ assessment in accordance with ~~8-1-2-1-2-14~~ §8.1.2.1.7 within forty-eight (48) hours of admission.
 - 12.1.1.6 The ~~treatment recovery~~ planning required by ~~8-1-2-2~~ §8.1.2.1.8 within seventy-two (72) hours of admission.
 - 12.1.1.7 ~~Treatment Recovery~~ plan review/revision and update in accordance with ~~8-1-2-3 on the fourteenth (14) day after the effective date of the first treatment plan.~~ §8.1.2.1.10 as needed based on changes in functioning for each client and at a minimum:
 - 12.1.1.8 ~~1 Treatment plan review/revision and update in accordance with 8-1-2-3 on the thirtieth (30) day; and~~

12.1.1.7.2 Every thirty (30) days thereafter.

~~12.1.1.9 A schedule for individual counseling in accordance with the clients individual needs that is reviewed and updated at the time of the treatment plan review.~~

~~12.1.1.10 A schedule for group and family counseling in accordance with the clients individual needs that is reviewed and updated at the time of the treatment plan review.~~

12.2 Hours of Operation, Staffing and Staff Schedules

12.2.1 Residential programs shall operate twenty-four (24) hours per day, seven (7) days per week.

12.2.2 There shall be staff on duty and awake at all times.

12.2.3 A counselor shall be on site at least eight (8) hours a day, seven (7) days a week and available on call twenty-four (24) hours a day.

12.2.4 Counselor I's and Counselor II's shall meet face-to-face with clinical supervisors a minimum of one (1) hour per Counselor per week for clinical supervision.

12.3 Nutritional Services

12.3.1 Programs shall establish a written plan for meeting the basic nutritional needs, as well as any special dietetic needs, of clients. Plans shall:

12.3.1.1 Include a varied and nutritious diet of at least three (3) meals a day, seven (7) days per week;

12.3.1.2 Include snacks as part of the overall dietary plan;

12.3.1.3 Include food substitutions, (as applicable);

12.3.1.4 Be reviewed by a registered dietitian annually and when they are changed.

12.4 Facility Standards

12.4.1 All residential programs shall provide:

12.4.1.1 Separation of sleeping quarters serving male and female clients;

12.4.1.2 Separation of bathroom facilities serving male and female clients;

12.4.1.3 Privacy for personal hygiene;

12.4.1.4 Secure closet and storage space for clients' personal property;

12.4.1.5 Security for valuables, including an inventory and receipt system;

12.4.1.6 Laundry facilities for clients; and

12.4.1.7 Space for solitude.

12.4.2 All agencies operating residential programs shall ensure that in addition to the clients' rights enumerated in §7.0, these additional clients' rights are fully protected:

12.4.2.1 The right to visitation with family and friends, subject to written visiting rules and hours established by the program, except as provided in this subsection.

12.4.2.2 The right to conduct private telephone conversations, subject to written rules and hours established by the program, except as provided in this subsection.

12.4.2.2.1 The Administrator or designee may impose limitations on any of the, visitation and/or phone call procedures when in the judgment of the Administrator, such limitations are therapeutically necessary. Limitations shall be recorded in the client's record.

12.4.2.3 The right to send and receive uncensored and unopened mail. Program may require the client to open mail or package(s) in the presence of program staff for inspection.

12.4.2.4 The right to wear his/her own clothing subject to written program rules.

12.4.2.5 The right to bring personal belongings, subject to limitation or supervision by the program.

12.4.2.6 The right to communicate with their personal physician.

12.4.2.7 The right to practice their personal religion or attend religious services, within the program's policies and written policies for attendance at outside religious services.

13.0 Transitional residential treatment

13.1 Services Required

- 13.1.1 In addition to the requirements applicable to all programs, a Transitional residential treatment program shall provide:
- 13.1.1.1 Meals in accordance with §12.3.
 - 13.1.1.2 Housing in accordance with §12.4.
 - 13.1.1.3 Physical examination by qualified medical personnel within seventy-two (72) hours of admission unless the client has had a physical examination completed by qualified medical personnel within ninety-days (90) prior to admission.
 - 13.1.1.4 Within seven (7) days of admission, diagnostic assessment in accordance with ~~8.1.2.1.2-14~~ §8.1.2.1.7.
 - 13.1.1.5 Within seven (7) days of admission, Treatment recovery planning in accordance with ~~8.1.2.2~~ §8.1.2.1.8.
 - 13.1.1.6 Treatment Recovery plan review/revision in accordance with ~~8.1.2.3~~ §8.1.2.1.9 as needed based on changes in functioning for each client and at a minimum:
 - 13.1.1.6.1 Every thirty (30) days.
 - ~~13.1.1.7 A schedule for individual counseling in accordance with the clients individual needs that is reviewed and updated at the time of the treatment plan review.~~
 - ~~13.1.1.8 A schedule for group and family counseling in accordance with the clients individual needs that is reviewed and updated at the time of the treatment plan review.~~
 - ~~13.1.1.9 Medical evaluation and consultation by a licensed physician, as needed.~~
 - ~~13.1.1.10 Emergency medical and hospital services at a licensed hospital, as needed.~~
 - 13.1.1.7 Medical evaluation and consultation by a licensed physician, as needed.
 - 13.1.1.8 Emergency medical and hospital services at a licensed hospital, as needed.
- 13.1.2 Operation, Staffing and Staff Schedules
- 13.1.2.1 The program shall operate twenty-four (24) hours per day, seven (7) days per week.
 - 13.1.2.2 The program shall have written affiliation agreements for the provision of services required by the recovery plan in §8.1.2.1.9.3.2.5.3 of these standards, when these services are not provided in house.
 - 13.1.2.3 When clients are present, there shall be staff on site and on duty at all times.
 - 13.1.2.4 A Counselor shall be available to clients twenty-four (24) hours a day, seven (7) days per week.

14.0 Opioid Treatment Services:

In addition to these standards, all programs providing Opioid treatment services shall be in full compliance with Federal Regulations regarding Opioid treatment.

~~14.1 Services Required~~

- ~~14.1.1 A program offering Opioid treatment (OTP) services may provide its clients with a variety of treatment services. It shall provide the services required of residential programs in 12.0 and/or the services required of outpatient programs in 15.0 in addition to the following services:~~
 - ~~14.1.1.1 An initial screening, documentation of which shall include:

 - ~~14.1.1.1.1 Verification of an applicant's identity, including:

 - ~~14.1.1.1.1.1 name;~~
 - ~~14.1.1.1.1.2 address;~~
 - ~~14.1.1.1.1.3 date of birth;~~
 - ~~14.1.1.1.1.4 government issued photographic identification.~~~~
 - ~~14.1.1.1.2 Determination of current physiologic dependence and/or history of dependence upon opium, morphine, heroin or any derivative or synthetic drug of that group, in accordance with DSM criteria, by medical examination performed by qualified medical personnel. Documentation to support that determination shall include:~~
 - ~~14.1.1.1.3 Program physician statement that treatment is medically necessary;~~~~

- 14.1.1.1.4 The five-axis DSM diagnosis (most current DSM edition.);
- 14.1.1.1.5 A description of behavior(s) supportive of a diagnosis of dependence;
- 14.1.1.1.6 Determination by qualified medical personnel that the person became addicted at least one (1) year before admission to treatment;
- 14.1.1.1.7 Completion of a urine drug screen provided that when Opioid dependence is verified through other indicators, a negative urinalysis shall not preclude admission to the program; and
- 14.1.1.1.8 Determination of the duration of substance dependence.
- 14.1.1.1.9 A physical examination by qualified medical personnel that shall:
 - 14.1.1.1.9.1 Include documentation of the client's general appearance with a focus on the clinical signs and symptoms of addiction;
 - 14.1.1.1.9.2 Document vital signs;
 - 14.1.1.1.9.3 Include a complete medical history;
 - 14.1.1.1.9.4 Include the client's family medical history;
 - 14.1.1.1.9.5 Include medications currently being taken;
 - 14.1.1.1.9.6 Be completed prior to admission; and
 - 14.1.1.1.9.7 Be tetanus immunization review;
- 14.1.1.1.10 Laboratory tests including serology and other tests deemed necessary by the program physician within 14 days of admission:
 - 14.1.1.1.10.1 complete blood count and differential;
 - 14.1.1.1.10.2 investigation of the organ systems for infectious diseases including:
 - 14.1.1.1.10.2.1 documentation of administration and results of intracutaneous PPD within the twelve (12) months prior to admission;
 - 14.1.1.1.10.2.2 documentation of the results of the intracutaneous PPD within the twelve (12) months prior to admission;
 - 14.1.1.1.10.2.3 chest x ray if intracutaneous PPD results are positive;
 - 14.1.1.1.10.2.4 HIV testing should be encouraged, with the client's signed consent;
 - 14.1.1.1.10.2.5 a biological test for pregnancy for all women of child-bearing age;
 - 14.1.1.1.10.2.6 tetanus immunization review;
 - 14.1.1.1.10.2.7 documentation of administration and results of intracutaneous PPD within the twelve (12) months prior to admission;
 - 14.1.1.1.10.2.8 documentation of the results of the intracutaneous PPD within the twelve (12) months prior to admission;
 - 14.1.1.1.10.2.9 chest x ray if intracutaneous PPD results are positive;
 - 14.1.1.1.10.2.10 HIV testing should be encouraged, with the client's signed consent;
 - 14.1.1.1.10.2.11 a biological test for pregnancy for all women of child-bearing age;
 - 14.1.1.1.10.2.12 tetanus immunization review;
 - 14.1.1.1.10.3 Completed within fourteen (14) days of admission;
 - 14.1.1.1.10.4 Completed annually thereafter.
- 14.1.1.2 An assessment of each client every ninety (90) days conducted by the program physician. The physician's documentation of this assessment shall include:
 - 14.1.1.2.1 An evaluation of the client's progress in treatment;
 - 14.1.1.2.2 The appropriateness of the client's treatment plan, as indicated by the physician's dated signature;
 - 14.1.1.2.3 Review current medication(s) and dosage(s) to include:
 - 14.1.1.2.3.1 review of appropriateness of and need for continued use of each medication;
 - 14.1.1.2.3.2 presence of side effects, unusual effects, or contra-indications;
 - 14.1.1.2.3.3 use of multiple medications and drug interactions;

- 14.1.1.2.3.4 determination of the client's need to be seen face to face by the physician;
 - 14.1.1.2.3.5 Re-writing all orders for the client's medication(s) and dosage(s).
 - 14.1.1.2.3.6 Individual, group and family counseling appropriate to the client's needs.
- 14.2 ~~Special admission populations (where the absence of physiological dependence shall not be an exclusion criterion with a clinically justifiable admission) shall include:~~
- 14.2.1 ~~Persons recently released from a penal institution; (within six (6) months after release.)~~
 - 14.2.2 ~~Pregnant clients; (Program physician shall certify pregnancy)~~
 - 14.2.3 ~~Previously treated clients; (Up to two (2) years after discharge)~~
 - 14.2.4 ~~Adolescents, provided that:~~
 - 14.2.4.1 ~~Individuals under the age of 18 have had two documented attempts at short-term medically supervised withdrawal (detoxification) or drug-free treatment to be eligible for maintenance treatment;~~
 - 14.2.4.2 ~~in addition to the consent of the client, Individuals under 18 years old, unless otherwise permitted by 16 Del.C. §2210 to consent to treatment, have had a parent or legal guardian complete and sign the agency's consent to Methadone Treatment.~~
- 14.3 ~~Admission procedures in addition to the admission procedures described in 8.1.2.~~
- 14.3.1 ~~If an applicant for Opioid treatment services has been discharged within seven (7) years from treatment at another OTP, the admitting program shall document that a good faith effort was made to review whether or not the client is enrolled in any other OTP.~~
 - 14.3.2 ~~A client enrolled in another program shall not be permitted to enroll in treatment in any other OTP except in exceptional circumstances as determined by the medical director. Exceptions shall be:~~
 - 14.3.2.1 ~~Noted in the client's record.~~
- 14.4 ~~Client Orientation~~
- 14.4.1 ~~In addition to the requirements of 8.1.2.1.2.11 OTPs shall inform clients of:~~
 - 14.4.1.1 ~~The facts concerning the use of Methadone, Buprenorphen, Levo-alpha-acetyl-methadol (LAAM) or other Opioid treatment medications dispensed by the program, including, but not limited to:~~
 - 14.4.1.1.1 ~~an explanation of the interaction between the Opioid treatment medication(s) dispensed by the program and other medications, medical procedures and food;~~
 - 14.4.1.1.2 ~~any potential adverse reactions, including those resulting from interactions with other prescribed or over the counter pharmacological agents, other medical procedures and food; and~~
 - 14.4.1.1.3 ~~the importance of notifying the client's primary care physician of their admission to and discharge from the program;~~
 - 14.4.1.1.4 ~~The facts concerning the withdrawal from the use of Methadone, Buprenorphen, LAAM, or other Opioid treatment medications dispensed by the program, including, but not limited to:~~
 - 14.4.1.1.4.1 ~~policies and procedures regarding voluntary, involuntary, and against medical advise withdrawal from Opioid treatment medications;~~
 - 14.4.1.1.4.2 ~~an explanation of the potential interaction between withdrawal from the Opioid treatment medication(s) dispensed by the program and other medications, medical procedures and food;~~
 - 14.4.1.1.4.3 ~~any potential adverse reactions as a result of withdrawal from Opioid treatment medications, including those resulting from interactions with other prescribed or over the counter pharmacological agents, other medical procedures and food; and~~
 - 14.4.1.1.4.4 ~~the importance of notifying the client's primary care physician of withdrawal from the program.~~
 - 14.4.2 ~~The program's drug screening procedure;~~

- 14.4.3 The program's Opioid treatment medication dispensing procedure, including the days and hours of operation;
- 14.4.4 The program's rules including non-compliance, and discharge procedures, to include administrative Opioid treatment medication withdrawal;
- 14.4.5 The signs and symptoms of overdose and when to seek emergency assistance;
- 14.4.6 The emergency procedures maintained by the program as required in 5.1.4.4.1.21 shall be available twenty four (24) hours per day.
- 14.4.7 Safe storage practices for take-home Opioid treatment medications;
- 14.4.8 The financial aspects of treatment, including the consequences of nonpayment of required fees.
- 14.4.9 Upon admission, the program shall issue each client a photo identification card.
- 14.5 Client Re-admissions
 - 14.5.1 A client re-admitted to the same program within thirty (30) days need not receive a medical examination and laboratory tests if s/he received a medical examination and laboratory tests within the previous year.
 - 14.5.2 All other requirements of this section, governing the screening and admission of applicants for Opioid treatment, shall apply to individuals seeking readmission to Opioid treatment.
- 14.6 Client Transfers
 - 14.6.1 A client transferring to a different program, need not receive a repeat medical examination and laboratory tests if:
 - 14.6.1.1 all of the information in 14.3.1 has been completed within the past year, and
 - 14.6.1.2 all of the information in 14.3.1 is provided to the receiving program, by the transferring program, prior to admission of the client.
 - 14.6.2 The receiving program physician shall have a transfer summary directly from the transferring program that includes:
 - 14.6.2.1 a medical summary that indicates any significant medical problems;
 - 14.6.2.2 current dosage;
 - 14.6.2.3 dosage regimen for the past twelve (12) months.
 - 14.6.3 All other requirements of 14.0 governing the screening, admission, annual physical examination, and annual laboratory tests required of applicants for Opioid treatment, shall apply to individuals transferring to a OTP, effective as of the date of admission.
 - 14.6.4 The receiving program shall document disclosure of its prescriptive practices and dosing policy to the transferring program at the initial contact regarding transfer of a client.
- 14.7 Non-admissions
 - 14.7.1 Programs shall maintain documentation identifying the following:
 - 14.7.1.1 Each person who was screened or assessed for admission but not admitted;
 - 14.7.1.2 The reason(s) for each non-admission;
 - 14.7.1.3 The specific referrals the program made for each person who was screened or assessed for admission but not admitted.
 - 14.7.2 The reasons for non-admission must be made available in writing to the client upon request.
 - 14.7.2.1 Documentation of the written response to the non-admitted client must be entered into the client file.
- 14.8 Programs that plan to relocate shall:
 - 14.8.1 Inform clients of the date of the move;
 - 14.8.2 Inform clients of the new program location; and
 - 14.8.3 Facilitate transfers of those clients for whom the new program location is not convenient.
- 14.9 Hours of Operation, Staffing, and Staff Orientation

- 14.9.1 ~~OTPs shall operate six (6) days per week, with at least two (2) hours of medicating time accessible daily outside the hours of 8 a.m. to 5 p.m. Monday through Friday, and three (3) hours on Saturday or Sunday.~~
- 14.9.2 ~~Each OTP shall post medication dispensing and counseling hours in a public place within the facility.~~
- 14.9.3 ~~Each OTP shall have the services of licensed medical personnel. Staff shall include:~~
 - 14.9.3.1 ~~A designated medical director, who is a physician, responsible for the administration of all medical services performed by the program and for compliance with all federal, state and local laws, rules and regulations regarding medical treatment of narcotic dependence;~~
 - 14.9.3.2 ~~At all times when the clinic is open, if a physician is not on site, a physician shall be available for consultations and emergency attendance;~~
 - 14.9.3.3 ~~Prior to services delivery, in addition to training requirements in 5.1.7.1, OTPs shall provide new staff orientation, including:~~
 - 14.9.3.3.1 ~~clinical and pharmacotherapy issues;~~
 - 14.9.3.3.2 ~~overdose, and other emergency procedures;~~
 - 14.9.3.3.3 ~~provision of services to special populations such as adolescents, pregnant women, and senior citizens.~~
- 14.10 ~~Minimum urine drug screen testing Drug Abuse Testing~~
 - 14.10.1 ~~In addition to the initial urine drug screening required in 14.1.1.1.7 the program shall adhere to the following schedule:~~
 - 14.10.1.1 ~~Three (3) random screens on each client during the first ninety (90) days;~~
 - 14.10.1.2 ~~Nine (9) additional random screens during the next nine months;~~
 - 14.10.1.3 ~~Eight (8) random screens on each client in maintenance treatment for each subsequent year; and~~
 - 14.10.1.4 ~~Monthly random screens on each client receiving a six (6) day supply of take home Opioid treatment medication.~~
 - 14.10.2 ~~The program shall place any client who has a positive urine drug screen back on the urine drug screen schedule set forth in 14.10 beginning with 14.10.1.1.~~
 - 14.10.3 ~~Clients' urine samples shall be tested for any other drugs or alcohol, as indicated by the client's use patterns, or that are heavily used in the locale.~~
 - 14.10.4 ~~Programs shall utilize only laboratories licensed by Federal and State regulatory authorities.~~
 - 14.10.5 ~~Urine testing Drug abuse testing shall be used as a clinical tool for the purposes of diagnosis and in the development of treatment plans.~~
 - 14.10.6 ~~Urine drug screen Drug abuse test results shall not be used as the sole criterion to involuntarily discharge any client.~~
 - 14.10.7 ~~Programs shall place clients transferring from other OTPs on urine surveillance schedule in accordance with subsection 14.10.1.~~
- 14.11 ~~Administration of Opioid treatment medication~~
 - 14.11.1 ~~No dose of Opioid treatment medication shall be administered until the client has been identified and the dosage compared with the currently ordered and documented dosage level.~~
 - 14.11.2 ~~Only a licensed professional authorized by law may administer or dispense Opioid treatment medication.~~
 - 14.11.3 ~~Ingestion shall be observed and verified by the personnel authorized to administer the Opioid treatment medication.~~
 - 14.11.4 ~~There shall be only one client in the dispensing area at a time.~~
 - 14.11.5 ~~A physician shall obtain a detailed history of drug use within the last twenty four (24) hours prior to initial dose, and,~~
 - 14.11.5.1 ~~Determine the client's initial dosage after a physical examination;~~
 - 14.11.5.2 ~~The initial dose of Methadone shall not exceed thirty (30) mg.;~~

- 14.11.5.3 Additional medication shall not be administered, unless:
 - 14.11.5.3.1 after three (3) hours of observation, the physician documents in the client's record that the initial dose did not suppress opiate abstinence symptoms; and
 - 14.11.5.3.2 the physician writes orders for additional medication.
- 14.11.5.4 The initial total daily dose of Methadone for the first day shall not exceed forty (40) mg., unless the physician documents justification for a higher dosage in the client record that forty (40) mg did not suppress opiate abstinence symptoms.
- 14.11.5.5 The initial dose of any other Opioid treatment medications shall not exceed federal regulations, guidelines or medical protocol.
- 14.11.5.6 The program physician shall justify any deviations from dosages, frequencies, and conditions of usage described in the approved product labeling.
- 14.11.6 A physician shall determine all subsequent dosage levels and shall:
 - 14.11.6.1 Document each order change on the physician's medication orders;
 - 14.11.6.2 Sign each order change; and
 - 14.11.6.3 Date the order.
- 14.11.7 Programs shall dispense Methadone in an oral form, in accordance with federal and state law and regulations in containers conforming to 42 CFR (Part VIII) Section 12.(i)(5).
- 14.11.8 Any Opioid treatment medication error or adverse drug reaction shall be reported promptly to the medical director and an entry made in the client's record.
- 14.11.9 The medical director shall ensure that significant adverse drug reactions are reported to the Federal Food and Drug Administration and to the manufacturer in a manner that does not violate the client's confidentiality.
- 14.11.10 Each program shall develop a written emergency procedure to be implemented in the case of an employee strike, fire or other emergency situation that would stop or substantially interfere with normal dispensing operations. The emergency procedure shall comply with 9.3 and also include:
 - 14.11.10.1 Arrangements with a security provider for immediate security of Opioid treatment medications;
 - 14.11.10.2 Written agreements, updated annually, with back up licensed professionals authorized by law, for the coverage of dispensing and other medical needs if regular personnel are not available;
 - 14.11.10.3 A reliable system for confirming the identities of clients before dispensing; and
 - 14.11.10.4 Written agreements, updated annually, for the use of an alternate program, hospital or other site for dispensing during an emergency period.
- 14.12 Opioid treatment medication schedules; Unsupervised or "take-home use":
 - 14.12.1 Treatment program decisions on dispensing unsupervised or "take-home" medications shall be determined by the medical director. The medical director shall consider the following criteria to determine whether a patient is responsible in handling drugs for unsupervised use:
 - 14.12.1.1 Regularity of program attendance;
 - 14.12.1.2 Absence of recent abuse of drugs, including alcohol;
 - 14.12.1.3 Regularity of clinic attendance;
 - 14.12.1.4 Absence of serious behavioral problems at the clinic.
 - 14.12.1.5 Absence of known recent criminal activity (e.g. drug and drug related arrests, etc.
 - 14.12.1.6 Progress in meeting treatment plan goals;
 - 14.12.1.7 Length of time in treatment;
 - 14.12.1.8 Responsibility in the handling, and plan for the safe storage, of take-home Opioid treatment medications;
 - 14.12.1.9 Stability of the client's home environment and social relationships.
 - 14.12.1.10 When it is determined that a patient is responsible in handling Opioid drugs, the Federal Regulations for take home privileges shall be applied.

14.12.2 OTPs shall maintain current procedures adequate to identify the theft or diversion of take-home medications, including:

14.12.2.1 labeling containers with the OTP's name, address, and telephone number; and

14.12.2.2 requiring patients to come to the clinic on a randomly-scheduled basis for drug testing and checking the amount of take-home medication used to that point.

14.12.3 Programs shall also ensure that take-home supplies are packaged in a manner that is designed to reduce the risk of accidental ingestion, including child-proof containers.

14.13 Revocation of take-home privileges.

14.13.1 The program medical director will determine if a client's conduct warrants revocation or suspension of take-home privileges.

14.13.1.1 Documentation of the rationale for revoking or suspending take-home privileges will be entered into the client's record by the medical director.

14.14 Exceptions.

14.14.1 If, in the judgment of the program physician:

14.14.1.1 a client has a physical disability that interferes with his or her ability to conform to the applicable mandatory attendance schedule, the program physician may permit a reduced attendance schedule, provided that the physician comply with 14.12.1 and documents reasons for permitting take-home medication.

14.14.1.2 a client is unable to conform to the applicable mandatory attendance schedule because of exceptional circumstances such as illness, personal or family crises, travel, or other hardship, the program physician may permit a temporarily reduced schedule, provided that the client is responsible in handling Opioid treatment medications. In such cases, the program physician shall record or verify the rationale for the exception in the client's record and date and sign the record.

14.14.2 Employed clients may apply for an exception to these requirements if the dispensing hours of the clinic conflict with working hours of the client. In such cases, the client may receive take-home medications after verifying work hours through reliable means, provided that the physician complies with 14.12.1 and documents reasons for permitting take-home medication.

14.14.3 Any client who transfers from one (1) OTP to another shall be eligible for placement on the same take-home schedule. Before initiating take-home privileges for a client transferring from other maintenance treatment programs, the program physician shall comply with subsection 14.12.1 and documents reasons for permitting take-home medication.

14.15 Voluntary Medical withdrawal from Opioid treatment Medication

14.15.1 Voluntary medical withdraw from Opioid treatment medication shall include:

14.15.1.1 A request signed and dated by the client, for voluntary medication withdrawal.

14.15.1.2 Documentation of the physician's rationale for initiation of withdrawal.

14.15.1.3 Documentation of the physician's rationale for continuing the withdrawal if there is any change in the physician's orders.

14.15.1.4 Documentation signed and dated by the client, that the withdrawal will be discontinued and maintenance resumed at the client's request.

14.15.1.5 A biological test for pregnancy for all women of child-bearing age prior to the initiation of withdrawal.

14.15.1.6 Revision of the treatment plan with an increase in counseling and other support services in relation to medication dosage changes.

14.15.1.7 Provisions for continuing care after the last dose of Opioid treatment medication.

14.16 Withdraw against medical advice

14.16.1 Withdrawal against medical advice shall include:

14.6.1.1 Documentation of all efforts taken by staff members to discourage initiation and continuation of withdrawal against medical advice.

14.6.1.2 Documentation of the reasons the client is seeking withdrawal against medical advice.

14.17 Involuntary withdrawal:

- 14.17.1 Involuntary withdrawal from an Opioid treatment medication shall be conducted in accordance with a dosage reduction schedule prescribed by the physician.
- 14.17.2 Clients being involuntarily discharged shall be referred to other treatment, as clinically indicated.
- 14.17.3 OTPs shall document the reasons for initiation of involuntary withdrawal in the client's record.
- 14.17.4 Prior to the beginning of involuntary withdrawal, efforts should be documented regarding referral or transfer of the client to a suitable, alternative treatment program.
- 14.17.5 Involuntary withdrawal shall be considered a planned discharge and shall comply with 8.1.2.7 regarding the planned discharge of a client.
- 14.17.6 Documentation during withdrawal shall include:
 - 14.17.6.1 Documentation by the physician of the schedule for withdrawal and any changes made to the schedule by the physician during the withdrawal.
 - 14.17.6.2 Counseling designed to promote the continuation of services following medical withdrawal.

14.18 Detoxification treatment

- 14.18.1 An OTP shall maintain procedures that are designed to ensure that qualified medical personnel admit clients to short or long term detoxification treatment.
- 14.18.2 Patients with two or more unsuccessful detoxification episodes within a twelve (12) month period shall be assessed by the OTP physician for other forms of treatment.
- 14.18.3 A program shall not admit a client for more than two (2) detoxification treatment episodes in one year.

14.19 Pregnant Clients

- 14.19.1 In addition to the other requirements of this section, for pregnant clients the following shall apply:
 - 14.19.1.1 OTPs shall provide priority in initiating treatment.
 - 14.19.1.2 The physician shall document in the client record all clinical findings supporting the certification of the pregnancy prior to the administration of an initial dose of Opioid treatment medication.
 - 14.19.1.3 The initial dose of Methadone shall not exceed 40 mg.
 - 14.19.1.4 The program physician shall evaluate dosing of pregnant women weekly during the last trimester of the pregnancy.
 - 14.19.1.5 If there is simultaneous use of alcohol and/or other drugs the program shall document:
 - 14.19.1.5.1 Education of the client regarding the potential impact of substance use on the fetus.
 - 14.19.1.5.2 Attempts to encourage the client to cease use of substances other than those prescribed by a physician.
 - 14.19.1.5.3 Referrals made to appropriate levels of care.
 - 14.19.1.6 Pregnant clients shall be given the opportunity for prenatal care either by the program or by referral to appropriate health care providers.
 - 14.19.1.7 The program shall document all attempts to assist the client with obtaining prenatal care.
 - 14.19.1.8 The program shall offer prenatal instruction on:
 - 14.19.1.8.1 Education on fetal development;
 - 14.19.1.8.2 Care for the newborn;
 - 14.19.1.8.3 Breastfeeding;
 - 14.19.1.8.4 Effects of maternal drug use on the fetus;
 - 14.19.1.8.5 Information on parenting;
 - 14.19.1.8.6 Importance of sound maternal nutritional practices.
- 14.19.2 OTP's shall give priority to pregnant women seeking admission to treatment.

- 14.19.3 ~~OTP's shall maintain current policies and procedures that reflect the special needs of patients who are pregnant. Prenatal and other gender specific services shall be provided either by the OTP or by referral to appropriate health care providers.~~
- 14.19.4 ~~Medical withdrawal of the pregnant, Opioid—addicted woman from Opioid treatment medication is not indicated or recommended. No pregnant client shall be involuntarily medically withdrawn from an Opioid treatment medication.~~
- 14.19.5 ~~Pregnant individuals who choose to withdraw from treatment against medical advice shall do so under the direct supervision of the program physician in conjunction with an obstetrician who can monitor the effects on the fetus.~~
- 14.19.6 ~~If a pregnant client refuses direct treatment, referral for treatment, or referral for other services, the program physician shall have the client acknowledge said refusal in writing. Documentation of the refusal shall be recorded in the client's record.~~
- 14.19.7 ~~The program physician shall request the physician, hospital, or program to which the individual is referred, to provide reports of prenatal care, and a summary of the delivery and treatment outcome for the client and baby. Documentation of the request(s) shall be included in the client's record.~~
- 14.19.8 ~~Within three (3) months after termination of the pregnancy, the program physician shall evaluate the individual's treatment status and document whether she should remain in the comprehensive maintenance program or be detoxified.~~
- 14.20 Programs shall be accredited by an accreditation body approved by SAMSHA and registered with the DEA, as required.
- 14.1 Admission procedures in addition to the admission procedures described in §8.1.2:
- 14.1.1 If an applicant for Opioid treatment services has been discharged within seven (7) years from treatment at another OTP, the admitting program shall document that a good faith effort was made to review whether or not the client is enrolled in any other OTP.
- 14.1.2 A client enrolled in another program shall not be permitted to enroll in treatment in any other OTP except in exceptional circumstances as determined by the medical director. Exceptions shall be:
- 14.1.2.1 Noted in the client's record.
- 14.2 Special admission populations (where the absence of physiological dependence shall not be an exclusion criterion with a clinically justifiable admission) shall include:
- 14.2.1 Persons recently released from a penal institution; (within six (6) months after release.)
- 14.2.2 Pregnant clients; (Program physician shall certify pregnancy)
- 14.2.3 Previously treated clients; (Up to two (2) years after discharge)
- 14.2.4 Adolescents, provided that:
- 14.2.4.1 Individuals under the age of 18 have had two documented attempts at short-term medically supervised withdrawal (detoxification) or drug-free treatment to be eligible for maintenance treatment;
- 14.2.4.2 In addition to the consent of the client, Individuals under 18 years old, unless otherwise permitted by 16 Del.C. §2210 to consent to treatment, have had a parent or legal guardian complete and sign the agency's consent to OTP Treatment.
- 14.3 Client Orientation
- 14.3.1 In addition to the requirements of §8.1.2.1.4 OTPs shall inform clients of:
- 14.3.1.1 The facts concerning the use of methadone, buprenorphine, or other Opioid treatment medications dispensed by the program, including, but not limited to:
- 14.3.1.1.1 An explanation of the interaction between the Opioid treatment medication(s) dispensed by the program and other medications, medical procedures and food;
- 14.3.1.1.2 Any potential adverse reactions, including those resulting from interactions with other prescribed or over-the-counter pharmacological agents, other medical procedures and food; and
- 14.3.1.1.3 The importance of notifying the client's primary care physician of their admission to and discharge from the program;

14.3.1.1.4 The facts concerning the withdrawal from the use of methadone, buprenorphine, or other Opioid treatment medications dispensed by the program, including, but not limited to:

14.3.1.1.5 Policies and procedures regarding voluntary, involuntary, and against medical ~~advise~~ **advice** withdrawal from Opioid treatment medications:

14.3.1.1.6 An explanation of the potential interaction between withdrawal from the Opioid treatment medication(s) dispensed by the program and other medications, and medical procedures:

14.3.1.1.7 Any potential adverse reactions as a result of withdrawal from Opioid treatment medications, including those resulting from interactions with other prescribed or over-the-counter pharmacological agents, other medical procedures; and

14.3.1.1.8 The importance of notifying the client's primary care physician of withdrawal from the program.

14.3.1.2 The program's drug-screening procedure:

14.3.1.3 The program's Opioid treatment medication dispensing procedure, including the days and hours of operation:

14.3.1.4 The program's rules including non-compliance, and discharge procedures, to include administrative Opioid treatment medication withdrawal:

14.3.1.5 The signs and symptoms of overdose and when to seek emergency assistance:

14.3.1.6 The emergency procedures maintained by the program as required in §5.1.4.4.1.21 shall be available twenty-four (24) hours per day.

14.3.1.7 Safe storage practices for take-home Opioid treatment medications:

14.3.1.8 The financial aspects of treatment, including the consequences of nonpayment of required fees.

14.3.2 Upon admission, the program shall **[obtain from or]** issue **[to]** each client a photo identification card.

14.4 Client Re-admissions

14.4.1 A client re-admitted to the same program within thirty (30) days need not receive a medical examination and laboratory tests if s/he received a medical examination and laboratory tests within the previous year.

14.5 Hours of Operation, Staffing, and Staff Orientation

14.5.1 OTPs shall operate six (6) days per week, with at least two (2) hours of medicating time accessible daily outside the hours of 8 a.m. to 5 p.m. Monday through Friday, and three (3) hours on Saturday or Sunday.

14.5.2 Each OTP shall post medication dispensing and counseling hours in a public place within the facility.

14.5.3 Each OTP shall have the services of licensed medical personnel including:

14.5.3.1 A designated medical director, who is a physician, responsible for the administration of all medical services performed by the program and for compliance with all federal, state and local laws, rules and regulations regarding medical treatment of narcotic dependence:

14.5.3.2 At all times when the clinic is open, if a physician is not on site, a physician shall be available for consultations and emergency attendance:

14.5.3.3 Prior to services delivery, in addition to training requirements in §5.1.7.1, OTPs shall provide new staff orientation, including:

14.5.3.3.1 Clinical and pharmacotherapy issues.

14.5.3.3.2 Overdose, and other emergency procedures.

14.5.3.3.3 Provision of services to special populations such as adolescents, pregnant women, and senior citizens.

14.6 Administration of Opioid treatment medication

- 14.6.1 No dose of Opioid treatment medication shall be administered until the client has been identified and the dosage compared with the currently ordered and documented dosage level.
- 14.6.2 Only a licensed professional authorized by law may administer or dispense Opioid treatment medication.
- 14.6.3 Ingestion shall be observed and verified by the personnel authorized to administer the Opioid treatment medication.
- 14.6.4 There shall be only one client in the dispensing area at a time.
- 14.6.5 A physician shall obtain a detailed history of drug use within the last twenty-four (24) hours prior to initial dose, and,
 - 14.6.5.1 Determine the client's initial dosage after a physical examination;
 - 14.6.5.2 The initial dose of Methadone shall not exceed thirty (30) mg.;
 - 14.6.5.3 Additional medication shall not be administered, unless:
 - 14.6.5.3.1 After three (3) hours of observation, the physician documents in the client's record that the initial dose did not suppress opiate abstinence symptoms; and
 - 14.6.5.3.2 The physician writes orders for additional medication.
 - 14.6.5.4 The initial total daily dose of methadone for the first day shall not exceed forty (40) mg., unless the physician documents justification for a higher dosage in the client record that forty (40) mg did not suppress opiate abstinence symptoms.
 - 14.6.5.5 The initial dose of any other Opioid treatment medications shall not exceed federal regulations, guidelines or medical protocol.
 - 14.6.5.6 The program physician shall justify any deviations from dosages, frequencies, and conditions of usage described in the approved product labeling.
 - 14.6.5.7 Qualified medical personnel shall determine all subsequent dosage levels and shall:
 - 14.6.5.7.1 Document each order change on the physician's medication orders;
 - 14.6.5.7.2 Sign each order change; and
 - 14.6.5.7.3 Date the order.
 - 14.6.5.8 Programs shall dispense methadone in an oral form, in accordance with federal and state law and regulations in containers conforming to 42 CFR (Part VIII) Section 12.(i)(5). .
 - 14.6.5.9 Any Opioid treatment medication error or adverse drug reaction shall be reported promptly to the medical director and an entry made in the client's record.
 - 14.6.5.10 The medical director shall ensure that significant adverse drug reactions are reported to the Federal Food and Drug Administration and to the manufacturer in a manner that does not violate the client's confidentiality.
 - 14.6.5.11 Each program shall develop a written emergency procedure to be implemented in the case of an employee strike, fire or other emergency situation that would stop or substantially interfere with normal dispensing operations. The emergency procedure shall comply with 9.3 and also include:
 - 14.6.5.12 Arrangements with a security provider for immediate security of Opioid treatment medications;
 - 14.6.5.13 Written agreements, updated annually, with back-up licensed professionals authorized by law, for the coverage of dispensing and other medical needs if regular personnel are not available;
 - 14.6.5.14 A reliable system for confirming the identities of clients before dispensing; and
 - 14.6.5.15 Written agreements, updated annually, for the use of an alternate program, hospital or other site for dispensing during an emergency period.
- 14.7 Opioid treatment medication schedules; Unsupervised or "take-home use":
 - 14.7.1 Treatment program decisions on dispensing unsupervised or "take-home" medications shall be determined by the medical director. The medical director shall consider the following criteria to determine whether a patient is responsible in handling drugs for unsupervised use:

- 14.7.1.1 Regularity of program attendance;
 - 14.7.1.2 Absence of recent abuse of drugs, including alcohol;
 - 14.7.1.3 Regularity of clinic attendance;
 - 14.7.1.4 Absence of serious behavioral problems at the clinic.
 - 14.7.1.5 Absence of known recent criminal activity (e.g. drug and drug related arrests, etc...)
 - 14.7.1.6 Progress in meeting treatment plan goals;
 - 14.7.1.7 Length of time in treatment;
 - 14.7.1.8 Responsibility in the handling, and plan for the safe storage, of take home Opioid treatment medications;
 - 14.7.1.9 Stability of the client's home environment and social relationships.
 - 14.7.1.10 When it is determined that a patient is responsible in handling Opioid drugs, the Federal Regulations for take home privileges shall be applied.
 - 14.7.1.11 OTPs shall maintain current procedures adequate to identify the theft or diversion of take-home medications, including:
 - 14.7.1.11.1 labeling containers with the OTP's name, address, and telephone number; and
 - 14.7.1.11.2 requiring patients to come to the clinic on a randomly scheduled basis for drug testing and checking the amount of take-home medication used to that point.
 - 14.7.1.12 Programs shall also ensure that take-home supplies are packaged in a manner that is designed to reduce the risk of accidental ingestion, including child-proof containers.
- 14.8 Revocation of take-home privileges.
- 14.8.1 The program medical director will determine if a client's conduct warrants revocation or suspension of take-home privileges.
 - 14.8.2 Documentation of the rationale for revoking or suspending take-home privileges will be entered into the client's record by the medical director.
- 14.9 Exceptions.
- 14.9.1 If, in the judgment of the program physician:
 - 14.9.1.1 A client has a physical disability that interferes with his or her ability to conform to the applicable mandatory attendance schedule, the program physician may permit a reduced attendance schedule.
 - 14.9.1.2 A client is unable to conform to the applicable mandatory attendance schedule because of exceptional circumstances such as illness, personal or family crises, travel, or other hardship, the program physician may permit a temporarily reduced schedule, provided that the client is responsible in handling Opioid treatment medications. In such cases, the program physician shall record or verify the rationale for the exception in the client's record and date and sign the record. No client may receive more than a two (2) week supply of Opioid treatment medication at any one time.
 - 14.9.1.3 Employed clients may apply for an exception to these requirements if the dispensing hours of the clinic conflict with working hours of the client. In such cases, the client may receive take-home medications after verifying work hours through reliable means, provided that the physician documents reasons for permitting take home medication.
 - 14.9.1.4 Any client who transfers from one (1) OTP to another shall be eligible for placement on the same take-home schedule. Before initiating take-home privileges for a client transferring from other maintenance treatment programs, the program physician shall document reasons for permitting take home medication.
- 14.10 Voluntary Medical withdrawal from Opioid treatment Medication
- 14.10.1 Voluntary medical withdraw from Opioid treatment medication shall include:
 - 14.10.1.1 A request signed and dated by the client, for voluntary medication withdrawal.
 - 14.10.1.2 Documentation of the physician's rationale for initiation of withdrawal.

- 14.10.1.3 Documentation of the physician's rationale for continuing the withdrawal if there is any change in the physician's orders.
- 14.10.1.4 Documentation signed and dated by the client that the withdrawal will be discontinued and maintenance resumed at the client's request.
- 14.10.1.5 A biological test for pregnancy for all women of child-bearing age prior to the initiation of withdrawal.
- 14.10.1.6 Revision of the treatment plan with an increase in counseling and other support services in relation to medication dosage changes.
- 14.10.1.7 Provisions for continuing care after the last dose of Opioid treatment medication.
- 14.11 Withdrawal against medical advice
 - 14.11.1 Withdrawal against medical advice shall include:
 - 14.11.1.1 Documentation of all efforts taken by staff members to discourage initiation and continuation of withdrawal against medical advice.
 - 14.11.1.2 Documentation of the reasons the client is seeking withdrawal against medical advice.
 - 14.11.2 Involuntary withdrawal:
 - 14.11.2.1 Involuntary withdrawal from an Opioid treatment medication shall be conducted in accordance with a dosage reduction schedule prescribed by the physician.
 - 14.11.2.2 Clients being involuntarily discharged shall be referred to other treatment, as clinically indicated.
 - 14.11.2.3 OTPs shall document the reasons for initiation of involuntarily withdrawal in the client's record.
 - 14.11.2.4 Prior to the beginning of involuntary withdrawal, efforts should be documented regarding referral or transfer of the client to a suitable, alternative treatment program.
 - 14.11.2.5 Involuntary withdrawal shall be considered a planned discharge and shall comply with §8.6 regarding the planned discharge of a client.
 - 14.11.2.6 Documentation during withdrawal shall include:
 - 14.11.2.6.1 Documentation by the physician of the schedule for withdrawal and any changes made to the schedule by the physician during the withdrawal.
 - 14.11.2.6.2 Counseling designed to promote the continuation of services following medical withdrawal.
 - 14.11.3 Detoxification treatment
 - 14.11.3.1 An OTP shall maintain procedures that are designed to ensure that qualified medical personnel admit clients to short- or long-term detoxification treatment.
 - 14.11.3.2 Patients with two or more unsuccessful detoxification episodes within a twelve (12) month period shall be assessed by the OTP physician for other forms of treatment.
 - 14.11.3.3 A program shall not admit a client for more than two (2) detoxification treatment episodes in one year.
 - 14.11.4 Pregnant Clients
 - 14.11.4.1 In addition to the other requirements of this section, for pregnant clients the following shall apply:
 - 14.11.4.1.1 OTPs shall provide priority in initiating treatment.
 - 14.11.4.1.2 The physician shall document in the client record all clinical findings supporting the certification of the pregnancy prior to the administration of an initial dose of Opioid treatment medication.
 - 14.11.4.1.3 The initial dose of Methadone shall not exceed 40 mg.
 - 14.11.4.1.4 The program physician shall evaluate dosing of pregnant women weekly during the last trimester of the pregnancy.
 - 14.11.4.1.5 If there is simultaneous use of alcohol and/or other drugs the program shall document:

- 14.11.4.1.5.1 Education of the client regarding the potential impact of substance use on the fetus.
- 14.11.4.1.5.2 Attempts to encourage the client to cease use of substances other than those prescribed by a physician.
- 14.11.4.1.5.3 Referrals made to appropriate levels of care.
- 14.11.4.1.6 Pregnant clients shall be given the opportunity for prenatal care either by the program or by referral to appropriate health care providers.
- 14.11.4.1.7 The program shall document all attempts to assist the client with obtaining prenatal care.
- 14.11.4.1.8 The program shall offer prenatal instruction on:
 - 14.11.4.1.8.1 Education on fetal development;
 - 14.11.4.1.8.2 Care for the newborn;
 - 14.11.4.1.8.3 Breastfeeding;
 - 14.11.4.1.8.4 Effects of maternal drug use on the fetus;
 - 14.11.4.1.8.5 Information on parenting;
 - 14.11.4.1.8.6 Importance of sound maternal nutritional practices.
- 14.11.4.2 OTP's shall give priority to pregnant women seeking admission to treatment.
- 14.11.4.3 OTP's shall maintain current policies and procedures that reflect the special needs of patients who are pregnant. Prenatal and other gender specific services shall be provided either by the OTP or by referral to appropriate health care providers.
- 14.11.4.4 Medical withdrawal of the pregnant, Opioid - addicted woman from Opioid treatment medication is not indicated or recommended. No pregnant client shall be involuntarily medically withdrawn from an Opioid treatment medication.
- 14.11.4.5 Pregnant individuals who choose to withdraw from treatment against medical advice shall do so under the direct supervision of the program physician in conjunction with an obstetrician who can monitor the effects on the fetus.
- 14.11.4.6 If a pregnant client refuses direct treatment, referral for treatment, or referral for other services, the program physician shall have the client acknowledge said refusal in writing. Documentation of the refusal shall be recorded in the client's record.
- 14.11.4.7 The program physician shall request the physician, hospital, or program to which the individual is referred, to provide reports of prenatal care, and a summary of the delivery and treatment outcome for the client and baby. Documentation of the request(s) shall be included in the client's record.
- 14.11.4.8 Within three (3) months after termination of the pregnancy, the program physician shall evaluate the individual's treatment status and document whether she should remain in the comprehensive maintenance program or be detoxified.

14.12 Accreditation

- 14.12.1 Programs shall be accredited by an accreditation body approved by The Substance Abuse and Mental Health Services Administration (SAMSHA) and registered with the Drug Enforcement Agency (DEA), as required.

15.0 Outpatient Treatment

15.1 Services Required

- 15.1.1 In addition to the requirements applicable to all programs, an Outpatient Treatment program shall provide:
 - 15.1.1.1 Documentation of a physical examination by qualified medical personnel within ninety (90) days prior to admission.

- 15.1.1.1.1 When documentation of a physical examination by qualified medical staff is not made available to the program, the program shall document a good faith effort in referring the client for a physical and/or efforts made to obtain documentation of a physical.
- 15.1.1.2 Diagnostic assessment in accordance with ~~8.1.2.1.2.14~~ §8.1.2.1.7 within thirty (30) days of admission.
- 15.1.1.3 Treatment Recovery planning in accordance with ~~8.1.2.2~~ §8.1.2.1.8 within thirty (30) days of admission or by the fourth (4th) counseling session, whichever occurs first.
- 15.1.1.4 Treatment Recovery plan review/revision in accordance with ~~8.1.2.3~~ 8.1.2.1.10 as needed based on changes in functioning for each client and at a minimum:
 - 15.1.1.4.1 Every ninety (90) days after the effective date of the first treatment plan.
 - 15.1.1.5 ~~A schedule for individual, group and family counseling in accordance with the clients individual needs that is reviewed and updated at the time of the treatment plan review.~~
- 15.2 Any time that services are offered at locations other than the program's main building, the program will assure that all requirements of §9.0 of these regulations are met in full.

Part IV—Provisions Regarding Deemed Status

16.0 Commission on Accreditation of Rehabilitation Facilities (CARF)

- 16.1 ~~Deemed Status Categories~~
 - 16.1.1 ~~Programs with Three Year Accreditation will qualify for a two (2) year license.~~
 - 16.1.2 ~~Programs with One Year Accreditation will qualify for a one (1) year license or less (at the discretion of the Division Director).~~
 - 16.1.3 ~~Programs with Provisional Accreditation will qualify for Deemed Status at the discretion of the Division Director.~~
 - 16.1.4 ~~Programs with Provisional Accreditation must submit all corrective action reports prepared for CARF to DSAMH at the same time they are submitted to CARF.~~
 - 16.1.5 ~~Programs with Provisional Accreditation must submit copies of progress reports prepared for CARF to DSAMH at the time they are sent to CARF until the program is granted a Three Year or One Year Accreditation. Deemed Status will be re-evaluated annually when the program holds Provisional Accreditation status and is not guaranteed year to year.~~
 - 16.1.6 ~~Programs that are accredited as part of a merger, consolidation or acquisition must submit verification that CARF will extend accreditation to the new entity.~~
- 16.2 ~~Notification of Audit:~~
 - 16.2.1 ~~Programs must inform DSAMH of all CARF visits whether announced or unannounced. The DSAMH Licensing Unit should be notified in writing of a scheduled visit no less than 30 days prior to the visit. The Licensing and Medicaid Certification Unit should be notified by phone or email of an unannounced visit within 24 hours of the first day of the visit.~~
- 16.3 ~~Reporting to DSAMH~~
 - 16.3.1 ~~Programs must notify DSAMH of any immediate threat to life that is discovered by CARF during the visit within 24 hours of the day the threat to life is discovered.~~
 - 16.3.2 ~~Programs must report all other *significant events* to DSAMH within 24 hours accompanied by the investigation report; action plan and action plan follow up activity reports prepared according to CARF guidelines.~~
 - 16.3.3 ~~Programs must submit to DSAMH any corrective action to address significant events at the same time they are submitted to CARF.~~
 - 16.3.4 ~~Programs must submit to DSAMH any other correspondence required by CARF during the course of the Accreditation period and/or between each CARF review.~~
- 16.4 ~~Deemed Status Revocation~~
 - 16.4.1 ~~DSMAH can revoke Deemed Status standing at any time, but specifically when:~~

- 16.4.1.1 A program is unsuccessful in receiving Three Year, One Year, or Provisional Accreditation from GARF;
- 16.4.1.2 In response to a significant event;
- 16.4.1.3 When reporting to DSAMH does not occur in accordance with the time table established above;
- 16.4.1.4 Following a survey by DSMAH when it is determined that the program is not operating under the GARF guidelines and/or DSAMH licensure standards.
- 16.4.2 Once revoked, a program must wait one (1) year before reapplying for Deemed Status. DSAMH must conduct a site review before restoring Deemed Status.
- 16.5 Program Exemptions:
 - 16.5.1 Programs are exempt from the Division of Substance Abuse and Mental Health standards for Substance Abuse Treatment Programs with the exception of:
 - 16.5.1.1 **Standards Applicable to all Programs:**
 - 16.5.1.1.1 Section 5.0: Programs with Deemed status must be in compliance with the following subsections of section 5.0:
 - 16.5.1.1.1.1 Subsection 5.1.3.1;
 - 16.5.1.1.1.2 Subsections 5.1.6.3.5.3., 5.1.6.3.5.5., 5.1.6.3.5.6., 5.1.6.3.5.7., 5.1.6.3.5.8., 5.1.6.3.5.9;
 - 16.5.1.1.1.3 Subsection 5.1.6.4;
 - 16.5.1.1.1.4 Subsection 5.1.6.5;
 - 16.5.1.1.1.5 Subsection 5.1.7.4.
 - 16.5.1.1.2 Section 6.0: Programs must be in compliance with all of section 6.0.
 - 16.5.1.1.3 Section 8.0: Programs with Deemed Status are exempt from sub-section 8.1.2 of section 8.0. When client records are reviewed, DSAMH will accept documents in section 8.1.2 in the format accepted by GARF. Programs must be in compliance with all other subsections of section 8.0.
 - 16.5.1.1.4 Section 9.0: Programs must be in compliance with standard 9.1.5: "smoke free facility".
 - 16.5.1.2 Standards Applicable to Specific Settings and Modalities
 - 16.5.1.2.1 Programs must be in compliance with all standards specific to the modality for which the program is being licensed with the exception of:
 - 16.5.1.2.1.1 Section 14: Opioid Treatment: Opioid Treatment programs with Deemed Status are exempt from all requirements of section 14 with the exception of:
 - 16.5.1.2.1.1.1 Subsection 14.3;
 - 16.5.1.2.1.1.2 Subsection 14.4;
 - 16.5.1.2.1.1.3 Subsection 14.9;
 - 16.5.1.2.1.1.4 Subsection 14.11;
 - 16.5.1.2.1.1.5 Subsections 14.12 through 14.20.

16.0 Co-Occurring Treatment

- 16.1 In addition to the requirements applicable to all programs and §15.0 of these standards, a Co-Occurring Treatment program shall provide a cadre of staff and services to meet the psychiatric and substance use disorder needs of clients. Staffing shall be flexible and meet the changing needs of the population served.
- 16.2 Staffing
 - 16.2.1 Qualifications for the Position of Medical Director
 - 16.2.1.1 Each Medical Director shall be a person with a Medical Degree or Doctor of Osteopathy degree; licensed to practice medicine in the state of Delaware and has completed (or is

enrolled in) an accredited residency training program in psychiatry, internal medicine or family practice.

16.2.2 Qualifications for the Position of Qualified Psychiatric Practitioner

16.2.2.1 Qualified Psychiatric Practitioners shall meet the criteria for Qualified Medical Personnel as defined in §3.0 of these standards; AND

16.2.2.2 Have a minimum of three (3) years of documented clinical experience in the field of mental health.

16.2.3 Qualifications for the Position of Clinical Director

16.2.3.1 Each individual hired or promoted to provide clinical supervision on or after the date these regulations become effective shall, at a minimum, meet the following criteria:

16.2.3.1.1 A master's degree with a major in psychology, social work, counseling, nursing or a related field of study and six (6) years of clinical experience in human services, three (3) of which shall be in substance abuse treatment services; OR

16.2.3.1.2 A master's degree from an accredited college or university with a major in chemical dependency, psychology, social work, counseling, nursing or a related field of study and full certification as a Certified Co-Occurring Disorders Professional in the state of Delaware (CCDP); OR

16.2.3.1.3 A master's degree from an accredited college or university with a major in chemical dependency, psychology, social work, counseling, nursing or a related field of study and full certification as a Certified Co-Occurring Disorders Professional by a nationally recognized body.

16.2.3.2 Clinical supervisor as defined in §6.1.3 will not meet the criteria for Clinical supervisor for a co-occurring treatment program.

16.2.4 Qualifications for the Position of Mental Health Clinician

16.2.4.1 Each individual hired or promoted to the position of Mental Health Clinician on or after the date these regulations become effective shall meet the following criteria at a minimum:

16.2.4.1.1 A master's degree in psychology, counseling, social work, nursing, rehabilitation or related field of study from an accredited college or university.

16.2.5 Qualifications for the Position of Associate Mental Health Clinician:

16.2.5.1 Each individual hired or promoted to the position of Associate Mental Health Clinician on or after the date these regulations become effective shall, at a minimum, meet the following criteria:

16.2.5.1.1 Full certification as a Certified Co-Occurring Disorders Professional in the state of Delaware (CCDP);OR

16.2.5.1.2 Full certification as a Certified Co-Occurring Disorders Professional by a nationally recognized body; OR

16.2.5.1.3 A bachelor's degree from an accredited college or university in psychology, social work, counseling, or nursing and five (5) years of documented clinical experience working in the field of mental health

16.2.6 Qualifications for the position of Case Manager

16.2.6.1 Co-occurring treatment programs that employ Case Managers shall hire or promote staff on or after the date these regulations become effective that meet the following criteria:

16.2.6.1.1 A bachelor's degree from an accredited college or university in chemical dependency, psychology, social work, counseling, or nursing and five (5) years of documented clinical experience working in the field of mental health and/or addictions counseling.

16.2.6.2 Qualifications for the position of Assistant Clinician:

16.2.6.2.1 Each individual hired or promoted to the position of Assistant Clinician on or after the date these regulations become effective shall meet the following criteria:

16.2.6.2.1.1 A bachelor's degree from an accredited college or university in psychology, social work, counseling or nurse with less than five (5) years of documented clinical experience working in the field of mental health counseling; OR

16.2.6.2.1.2 The individual is a student enrolled in a course of study while completing a practicum or internship.

16.2.7 Programs may employ staff that dually meets the staffing requirements in §6.0 and §16.1 of these standards with the exception of §16.1.3: Clinical supervisor.

16.3 Staff Training

16.3.1 In addition to staff training and development in §5.1.7 of these standards, co-occurring treatment programs shall include:

16.3.1.1 At orientation:

16.3.1.1.1 Training in the relationship between substance use disorders and mental health disorders;

16.3.1.1.2 Training in the use of medication with co-occurring disorder clients including the use of buprenorphine, and other Opioid antagonist medications; and

16.3.1.1.3 Training in DSM five (5) Axis Diagnosis.

16.3.1.2 Annually thereafter:

16.3.1.2.1 Ten (10) hours of training specific to the treatment of clients with co-occurring mental health and substance use disorders.

16.3.1.2.2 Ongoing training specific to co-occurring disorder treatment as part of the staff member's individualized training plan required in §5.1.7.2 of these standards.

16.4 Clinical Supervision

16.4.1 Staff who meet the criteria for Assistant Clinician in §16.1.6.2 of these standards shall receive clinical supervision in accordance with §6.1.5.2 and §6.1.5.3 of these standards.

16.5 Services

16.5.1 Qualified Psychiatric Practitioner

16.5.1.1 Qualified Psychiatric Practitioners shall be available to staff at all times.

16.5.1.2 Qualified Psychiatric Practitioners shall conduct a psychiatric evaluation within thirty (30) days of admission to the co-occurring treatment program to include:

16.5.1.2.1 Psychiatric history;

16.5.1.2.2 Medication history ;

16.5.1.2.3 Mental Status; AND

16.5.1.2.4 DSM five (5) Axis Diagnosis.

16.5.1.3 Qualified Psychiatric Practitioners shall meet with consumers for regularly scheduled appointments at intervals determined to be most beneficial for the consumer, but no less than every six months.

16.5.2 Medication monitoring

16.5.2.1 A Qualified Psychiatric Practitioner will explain to the consumer the rationale for each medication prescribed as well as the medication's risks/benefits.

16.5.2.1.1 Informed consent shall be obtained for each medication prescribed at the time it is prescribed.

16.5.2.1.2 Informed consent shall be updated, at a minimum, annually in concert with the annual psychiatric evaluation.

16.5.2.2 Rationale for all changes in medication orders shall be documented in the Qualified Psychiatric Practitioner's notes.

16.5.2.3 All medication orders in the consumer's case record shall include:

16.5.2.3.1 Name of the medication;

16.5.2.3.2 Dosage;

16.5.2.3.3 Route of administration;

- 16.5.2.3.4 Frequency of administration;
- 16.5.2.3.5 Signature of the Qualified Psychiatric Practitioner prescribing the medication; and
- 16.5.2.3.6 All known allergies.
- 16.5.2.4 Medication orders shall be documented on a medication order form and include:
 - 16.5.2.4.1 Date of initiation;
 - 16.5.2.4.2 Date of discontinuance;
 - 16.5.2.4.3 Name of medication;
 - 16.5.2.4.4 Route of administration;
 - 16.5.2.4.5 Frequency of administration; AND
 - 16.5.2.4.6 Signature of the person documenting the orders.
- 16.5.2.5 All medication orders shall be reviewed at each face-to-face meeting with the consumer and the review shall be reflected in the progress notes written by a Qualified Psychiatric Practitioner at the time of the consumer's visit.
- 16.5.3 A Qualified Psychiatric Practitioner's progress note shall be completed after each meeting with a consumer and include but not be limited to:
 - 16.5.3.1 The consumer's report of progress;
 - 16.5.3.2 The content of the meeting;
 - 16.5.3.3 The Qualified Psychiatric Practitioner opinion of the consumer's status;
 - 16.5.3.4 Current DSM five (5) Axis Diagnosis; AND
 - 16.5.3.5 Continuation of the plan of treatment in conjunction with the consumer's treatment plan.
- 16.5.4 Annual review by Qualified Psychiatric Practitioner
 - 16.5.4.1 Qualified Psychiatric Practitioner shall review each consumer's record annually and provide documentation of:
 - 16.5.4.1.1 A clinical review of the consumer's progress over the year;
 - 16.5.4.1.2 Any changes noted;
 - 16.5.4.1.3 Mental status exam;
 - 16.5.4.1.4 Observations;
 - 16.5.4.1.5 Impressions;
 - 16.5.4.1.6 DSM five (5) Axis Diagnosis; AND
 - 16.5.4.1.7 Plan.
- 16.5.5 Staff shall monitor and document consumer tolerance, compliance in following prescribed medication treatment and medication side effects to include the following:
 - 16.5.5.1 Laboratory studies for all medications which require laboratory monitoring as recommended in the most current Physician's Desk Reference.
 - 16.5.5.1.1 Laboratory studies shall be reviewed and signed by a Qualified Psychiatric Practitioner or RN within two (2) days of receipt.
 - 16.5.5.1.2 Results of laboratory studies shall be documented in the consumer's chart within thirty (30) days.
 - 16.5.5.2 AIMS (Abnormal Involuntary Movement Scale) shall be performed no less than annually for consumers whose medication includes Tardive Dyskinesia as possible side effects of the medication.
 - 16.5.5.3 Monitoring of vital signs at each visit with a Qualified Psychiatric Practitioner shall include:
 - 16.5.5.3.1 Temperature;
 - 16.5.5.3.2 Blood pressure;
 - 16.5.5.3.3 Pulse; and
 - 16.5.5.3.4 Respiration.
- 16.5.6 Screening and Assessment

16.5.6.1 Co-Occurring treatment programs will utilize a screening tool approved by DSAMH to screen all consumers for substance use disorders and mental health symptoms at intake, and annually thereafter.

16.5.6.2 Based on the screening results:

16.5.6.2.1 Assessment will be conducted using tools approved by DSAMH; AND

16.5.6.2.2 Clients will be placed in appropriate levels of care to meet their substance use and mental health needs.

16.5.7 Case Management

16.5.7.1 Based on the needs of the client, case management coordination shall include:

16.5.7.1.1 Coordination of medical services with the consumer's primary care physician when needed;

16.5.7.1.2 Linkage to medical services when a primary care physician has not been identified;

16.5.7.1.3 Coordination of crisis intervention and stabilization services as appropriate;

16.5.7.1.4 Assistance with achieving goals for independence as defined by the consumer;

16.5.7.1.5 Linkage to resources and opportunities through:

16.5.7.1.5.1 Support groups including but not limited to:

16.5.7.1.5.1.1 Sober support groups that meet the needs of co-occurring consumers;

16.5.7.1.5.1.2 Peer support/peer mentoring networks;

16.5.7.1.5.1.3 Social support networks;

16.5.7.1.5.1.4 Social skills training networks;

16.5.7.1.5.1.5 Family support networks; and

16.5.7.1.5.1.6 Other community services as needed.

16.5.7.1.6 Safe/decent/affordable housing when needed;

16.5.7.1.7 Entitlements;

16.5.7.1.8 Education and vocational services;

16.5.7.1.9 Transportation to and from the program; and

16.5.7.1.10 Other activities carried out in collaboration with the consumer.

16.5.7.2. When a Case Manager meeting the criteria of §16.2.6 of these standards is the sole provider of case management services, case loads shall not exceed a one to forty (1:40) staff: consumer ratio.

16.5.8 Psycho-Education and Counseling

16.5.8.1 Programs shall provide psycho-education for all consumers and family members on:

16.5.8.1.1 The efficacy of medications used for mental health diagnosis and the effects of substances on these medications; and

16.5.8.1.2 The treatment and maintenance of co-occurring disorders.

16.5.8.2 When appropriate, programs shall provide counseling that includes:

16.5.8.2.1 Group therapy that will support maintenance and stability of the consumer's psychiatric and substance use disorder;

16.5.8.2.2 Individual therapy to address all therapeutic issues that will support maintenance and stability of the consumer's psychiatric and substance use disorder; and

16.5.8.2.3 Family therapy to address therapeutic issues within the family that will support maintenance and stability of a consumer's psychiatric and substance use disorder.

16.5.8.3 Co-occurring treatment programs shall offer ample opportunity to consumers to attend community support groups that will enhance treatment for both mental health diagnosis and substance use disorders. Groups shall include but not be limited to:

16.5.8.3.1 In-house support groups provided by the co-occurring treatment program; and/or

16.5.8.3.2 Linkage to-12 step groups that support dual recovery for mental health diagnosis and substance use disorders (e.g. "Double Trouble"); and/or

16.5.8.3.3 Linkage to faith-based or other community networks [including education programs, physical fitness programs, etc...] that support dual recovery for mental health diagnosis and substance use disorders.

Part IV: Deemed Status

17.0 Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)

17.1 Deemed Status Categories:

- 17.1.1 Programs with Full Accreditation ~~will~~ may qualify for a ~~two (2)~~ year license.
- 17.1.2 ~~Programs with Provisional Accreditation will qualify for a one (1) year license or less (at the discretion of the Division Director).~~
- 17.1.3 ~~Programs with Conditional Accreditation will qualify for Deemed Status at the discretion of the Division Director.~~
- 17.1.4 ~~Programs with Provisional Accreditation must submit all corrective action reports prepared for JCAHO to DSAMH at the same time they are submitted to JCAHO.~~
- 17.1.5 ~~Programs with Conditional Accreditation must submit copies of progress reports prepared for JCAHO to DSAMH at the time they are sent to JCAHO until the program is granted a Three-Year or One-Year Accreditation. Deemed Status will be re-evaluated annually when the program holds Provisional Accreditation status and is not guaranteed year to year.~~
- 17.1.6~~2~~ Programs that are accredited as part of a merger, consolidation or acquisition must submit verification that JCAHO will extend accreditation to the new entity.

17.2 Notification of Audit:

- 17.2.1 Programs must inform DSAMH of all JCAHO visits whether announced or unannounced. The ~~DSAMH Licensing Quality Assurance Unit~~ should ~~shall~~ be notified in writing of a scheduled visit no less than 30 days prior to the visit. The ~~Licensing and Medicaid Certification Quality Assurance Unit~~ should ~~shall~~ be notified by phone or email of an unannounced visit within twenty-four (24) hours of the first day of the visit.

17.3 Reporting to DSAMH

- 17.3.1 Programs must notify DSAMH of any immediate threat to life that is discovered by JCAHO during the visit within 24 hours of the day that the threat to life is discovered.
- 17.3.2 Programs must report all *sentinel events* to DSAMH within twenty-four (24) hours accompanied by the root cause analysis, action plan and action plan follow up activity reports prepared according to JCAHO guidelines.
- 17.3.3 Programs must submit to DSAMH any corrective action to address *sentinel events* at the same time they are submitted to JCAHO.
- 17.3.4 Programs must submit to DSAMH any other correspondence required by JCAHO during the course of the Accreditation period and/or between each JCAHO review.

17.4 Deemed Status Revocation

- 17.4.1 DSAMH can ~~revoke~~ revoke Deemed Status standing at any time, but specifically when:

- 17.4.1.1 A program is unsuccessful in receiving Accreditation, or Provisional Accreditation from JCAHO;
- 17.4.1.2 In response to a sentinel event;
- 17.4.1.3 When reporting to DSAMH does not occur in according with the time table established above;
- 17.4.1.4 Following a survey by DSMAH when it is determined that the program is not operating under the JCAHO guidelines and/or DSAMH licensure standards.

- 17.4.2 Once revoked, a program must wait one (1) year before reapplying for Deemed Status. DSAMH must conduct a site review before restoring Deemed Status.

17.5 Program Exemptions:

17.5.1 Programs are exempt from the Division of Substance Abuse and Mental Health standards for Substance Abuse Treatment Programs with the exception of:

17.5.1.1 Standards Applicable to all Programs:

17.5.1.1.1 Section §5.0:

17.5.1.1.1.1 Subsection §5.1.2.1;

17.5.1.1.1.2 Subsection §5.1.4;

17.5.1.1.1.3 Subsection §5.1.7.1;

17.5.1.1.1.4 Subsection §5.1.7.2;

17.5.1.1.1.5 Subsection §5.1.7.3;

17.5.1.1.1.6 Subsection §5.1.8;

17.5.1.2 Section §6.0: Programs must be in compliance with all of section §6.0.

17.5.1.3 Section §8.0: Programs with Deemed Status are exempt from sub-section §8.1.2 of section §8.0. When client records are reviewed, DSAMH will accept documents in section §8.1.2. In the format accepted by JCAHO. Programs must be in compliance with all other subsections of section §8.0.

17.5.2 Section §9.0: Programs with Deemed Status are exempt from all standards in section §9.0. with the exception of §9.1.5. "smoke free facility".

17.6 Standards Applicable to Specific Settings and Modalities

17.6.1 Programs must be in compliance with all standards specific to the modality for which the program is being licensed ~~with the exception of:~~

~~17.6.1.1 Section 14.0: Opioid Treatment: Opioid Treatment programs with Deemed Status are exempt from all requirements of section 14.0 with the exception of:~~

~~17.6.1.1.1 Subsection 14.3;~~

~~17.6.1.1.2 Subsection 14.4;~~

~~17.6.1.1.3 Subsection 14.9;~~

~~17.6.1.1.4 Subsection 14.11;~~

~~17.6.1.1.5 Subsections 14.12 through 14.20.~~

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18.0 Commission on Accreditation of Rehabilitation Facilities (CARF)

18.1 Deemed Status Categories

18.1.1 Programs with Three-Year Accreditation may qualify for a two (2) year license.

18.1.2 Programs that are accredited as part of a merger, consolidation or acquisition must submit verification that CARF will extend accreditation to the new entity.

18.2 Notification of Audit:

18.2.1 Programs must inform DSAMH of all CARF visits whether announced or unannounced. The Quality Assurance Unit should be notified in writing of a scheduled visit no less than 30 days prior to the visit. The Quality Assurance Unit should be notified by phone or email of an unannounced visit within 24 hours of the first day of the visit.

18.3 Reporting to DSAMH

18.3.1 Programs must notify DSAMH of any immediate threat to life that is discovered by CARF during the visit within twenty-four (24) hours of the day the threat to life is discovered.

18.3.2 Programs must report all other significant events to DSAMH within twenty-four (24) hours accompanied by the investigation report; action plan and action plan follow up activity reports prepared according to CARF guidelines.

18.3.3 Programs must submit to DSAMH any corrective action to address significant events at the same time they are submitted to CARF.

18.3.4 Programs must submit to DSAMH any other correspondence required by CARF during the course of the Accreditation period and/or between each CARF review.

18.4 Deemed Status Revocation

18.4.1 DSAMH can revoke Deemed Status standing at any time, but specifically when:

18.4.1.1 A program is unsuccessful in receiving Three-Year, or One-Year, Accreditation from CARF;

18.4.1.2 In response to a significant event;

18.4.1.3 When reporting to DSAMH does not occur in accordance with the time table established above;

18.4.1.4 Following a survey by DSAMH when it is determined that the program is not operating under the CARF guidelines and/or DSAMH licensure standards.

18.4.2 Once revoked, a program must wait 1 year before reapplying for Deemed Status. DSAMH must conduct a site review before restoring Deemed Status.

18.5 Program Exemptions:

18.5.1 Programs are exempt from the Division of Substance Abuse and Mental Health standards for Substance Abuse Treatment Programs with the exception of:

18.5.1.1 Standards Applicable to all Programs:

18.5.1.1.1 Section §5.0: Programs with Deemed status must be in compliance with the following subsections of section §5.0:

18.5.1.1.1.1 Subsection §5.1.3.1;

18.5.1.1.1.2 Subsections § 5.1.6.3.5.3., §5.1.6.3.5.5., §5.1.6.3.5.6., §5.1.6.3.5.7., §5.1.6.3.5.8., §5.1.6.3.5.9;

18.5.1.1.1.3 Subsection §5.1.6.4;

18.5.1.1.1.4 Subsection §5.1.6.5;

18.5.1.1.1.5 Subsection §5.1.7.4.

18.5.1.1.2 Section §6.0: Programs must be in compliance with all of section §6.0.

18.5.1.1.3 Section §8.0: Programs with Deemed Status are exempt from sub-section §8.1.2 of section §8.0. When client records are reviewed, DSAMH will accept documents in section §8.1.2 in the format accepted by CARF. Programs must be in compliance with all other subsections of section §8.0.

18.5.1.1.4 Section §9.0: Programs must be in compliance with standard §9.1.5: "smoke free facility".

18.5.1.2 Standards Applicable to Specific Settings and Modalities

18.5.1.2.1 Programs must be in compliance with all standards specific to the modality for which the program is being licensed.

19.0 Council on Accreditation (COA)

19.1 Deemed Status Categories

19.1.1 Programs with Three-Year or Four-Year Accreditation may qualify for a 2 year license.

19.1.2 Programs that are accredited as part of a merger, consolidation or acquisition must submit verification that COA will extend accreditation to the new entity.

19.2 Notification of Audit:

19.2.1 Programs must inform DSAMH of all COA visits whether announced or unannounced. The Quality Assurance Unit should be notified in writing of a scheduled visit no less than 30 days prior to the visit. The Quality Assurance Unit should be notified by phone or email of an unannounced visit within 24 hours of the first day of the visit.

19.3 Reporting to DSAMH

19.3.1 Programs must notify DSAMH of any immediate threat to life that is discovered by COA during the visit within 24 hours of the day the threat to life is discovered.

19.3.2 Programs must report all other hazardous or emergency situations to DSAMH within 24 hours accompanied by the investigation report; action plan and action plan follow up activity reports prepared according to COA guidelines.

19.3.3 Programs must submit to DSAMH any corrective action to address hazardous or emergency situations at the same time they are submitted to COA.

19.3.4 Programs must submit to DSAMH any other correspondence required by COA during the course of the Accreditation period and/or between each COA review.

19.4 Deemed Status Revocation

19.4.1 DSMAH can revoke Deemed Status standing at any time, but specifically when:

19.4.1.1 A program is unsuccessful in receiving Three-Year or Four-Year Accreditation from COA;

19.4.1.2 In response to a hazardous or emergency event;

19.4.1.3 When reporting to DSAMH does not occur in accordance with the time table established above;

19.4.1.4 Following a survey by DSMAH when it is determined that the program is not operating under the COA guidelines and/or DSAMH licensure standards.

19.4.2 Once revoked, a program must wait 1 year before reapplying for Deemed Status. DSAMH must conduct a full site review before restoring Deemed Status.

19.5 Program Exemptions:

19.5.1 Programs are exempt from the Division of Substance Abuse and Mental Health standards for Substance Abuse Treatment Programs with the exception of:

19.5.1.1 Standards Applicable to all Programs:

19.5.1.1.1 Section §5.0: Programs with Deemed status must be in compliance with the following subsections of section 5.0:

19.5.1.1.1.1 Subsection §5.1.3.1;

19.5.1.1.1.2 Subsections §5.1.6.3.5.3, §5.1.6.3.5.5, §5.1.6.3.5.6, §5.1.6.3.5.7, §5.1.6.3.5.8, §5.1.6.3.5.9;

19.5.1.1.1.3 Subsection §5.1.6.4;

19.5.1.1.1.4 Subsection §5.1.6.5;

19.5.1.1.1.5 Subsection §5.1.7.4.

19.5.1.1.2 Section §6.0: Programs must be in compliance with all of section §6.0.

19.5.1.1.3 Section §8.0: Programs with Deemed Status are exempt from sub-section 8.1.2.1.1 of section 8.0. When client records are reviewed, DSAMH will accept documents in section 8.1.2 in the format accepted by COA. Programs must be in compliance with all other subsections of section §8.0.

19.5.1.1.4 Section §9.0: Programs must be in compliance with standard §9.1.5: "smoke free facility".

19.5.1.2 Standards Applicable to Specific Settings and Modalities

19.5.1.2.1 Programs must be in compliance with all standards specific to the modality for which the program is being licensed.