Behavioral Health Agency Rulemaking Workshop - Notes
September 7, 2021

Agenda:

- Recap and follow-up from last workshop – go through comments and changes made on draft WAC language.
- Finish draft WAC language review from last workshop
- ID services that are inconsistent re: amount regulations compared to other sections
- Nesting document review

Residential and inpatient services:
JT –We received comment about adding rules for pregnant and postpartum women and that it may help people access those services if they are included. Reached out to partners about potential education and outreach opportunities or if we need to add rule option. More to come.
Joan B. *- FYI- PPW used to be defined in regs but was removed when RSN left and BHO started. BHO decided ALL providers could do PPW.*
JT – Subsection (2)(a) – adding other DSHS facility types. After discussion and thought we have decided not to add because of complexity and overlapping with policy standards.
JT – We discussed the certification standards for residential SUD and MH. Under subsection (1)(d) – specific to inpatient SUD. Should it also include residential and inpatient MH?
Joan B. *– Yes of course.*
Becky O. - *Might be ok to leave this vague as wouldn't it also include other social determinants of health?*
JT – ok to leave vague.
Aimee C. *– Yes. I don't people should have differential access to this list based on where they get service.*
JT – if it applies to both I'll move it up to the certification standards section.

Subsection (5) specific to SUD services for youth:
JT –Includes staff training requirements and then includes group meetings, leisure, structured recreation, and education. Should this just be for SUD only?
Joan B. - *Language is part of CLIP programs.*
Becky O*. - This is another place in WAC where the specificity for SUD is more than the MH (which is more vague.)*
JT – are mental health providers already doing this aside from the CLIP programs that are doing it?
Joan B. *- My vote is for both SUD and MH. I do know of one MH youth program that does do these things.*
Remi S. - *We ensure our MH staff have all of the training (i) thru (vii)*
Mark L. *- Should apply to both SUD and MH*
JT – we may need to consider cost in our small business economic impact statement.
Joan M. *- I'll check with Council members on Thursday!*
JT – thank you that would be perfect! We will include for now as both SUD and MH and will wait to hear what the Behavioral Health Council thinks.
Becky O. *– Some of the items will need further definitions. We might offer a training that includes more in a package. The piece that is most impactful will be the certified teacher (5)(e).*
JT – Becky can you email me a specific list of impacts that would be great.

Residential and inpatient mental health services):
JT – (1)(b) - what are the methods of individual care – what does that mean?
Joan B. *- No clue. Interesting find Julie. I'm curious too.*
JT – I can follow up internally to see what this meant historically. If not needed, I'll remove it.
JT – Training in this section. Is this for involuntary only?
Brooke E. *- Yes, this needs to be for both involuntary and voluntary.*
Michael C. *- It applies to both voluntary and involuntary*
Amy S. *- We have a CLIP facility that trains all staff regardless of the client legal status*
Becky O. *- Both...you can restrain and seclude voluntary patients/clients*
Julia L. *- Does the state require documents for restrain and seclusion?*
JT – yes there are documentation requirements for that. Currently the rules point to statute but need to make sure there is mention of that in this section.
JT – Subsection (4)(a)(iii) – is the consideration of less restrictive alternative treatment at the time of admission for involuntary only?
Becky O. *- That one is in RCW...it applies to invol.*
Michael C. *- Less restrictive alternatives are for both vol and invol*
Joan B. *- Always must consider less restrictive*
Julea L*. - Should it be in this document?*
JT – yes
Brooke E. *- Yes, should still be considering less restricted - voluntary and involuntary.*
Julea L. *- What is the definition of seclusion?*
Becky O. - *best practice to consider but necessary for RCW.*
Julea L. *- Don't you want to make sure that they are?*
JT – yes.
Julea L. *– will this change this area?*
JT – based on what I'm hearing, these things would stay in this section and it wouldn't change anything. These are the current requirements.
Joan B. *- WAC 246-337-110 talks about use of seclusions and restraints as well.*

JT – Subsection (4)(b) - Last workshop someone asked about MH advanced directives. We only mention this once in our WAC, I looked up the RCW, if we think it's appropriate, we could include this in the individual rights that apply to all BHAs. Right now, it's only residential and mental health agency WAC. Should it apply to outpatient too? If so, we should bump this up to the general individual rights section.
Melanie G. *- There is a WAC that lists a bunch of policies that each agency has to have and one of them is Advanced Directives. I can't remember the number off the top of my head.*
G'Nell A. *- When the SBH-ASO was the SBHO we (SUD- OP) was required to address Behavioral Health Advanced Directives.*
JT – Most of the language is not new. It's copied and pasted existing requirements. I'm highlighting questions about existing language.

Clinical withdrawal/Medically supported withdrawal management services:
JT –Reached out and am waiting to hear back from providers. I've learned about challenges that may lead to different options. I'll have follow-up conversations and am doing some additional work before we discuss this section.
Joan B. *- The federal Patient Self-Determination Act (PSDA), enacted in 1991, dictates that health care institutions certified by Medicare and/or Medicaid must take steps to educate all adult patients and the larger community on their right to accept or refuse medical care.(1) This law also directs facilities to inquire on admission whether a patient has made an advance directive, maintain policies and procedures*

on advance directives, and provide this information to patients upon admission. Organizations must comply with the PSDA in order to receive reimbursement through the Medicare and Medicaid programs.
Melanie G. - *I found that WAC number: WAC 246-341-0420 on Agency Policies and Procedures says all BHAs need to have a policy on Advanced Directives.*

Crisis stabilization unit and triage:
JT – Subsection (6) Involuntary – do not need to follow these requirements? They would be transferred to an evaluation and treatment, which is why they would not need to meet the requirements in -0640. Does this make sense?
Wendy S. *The licensure of crisis stabilization units varies. Ours is lic as an RTF. This allows the RTF to also deal with involuntary and is some overlap. That facility licensure may allow us to do involuntary work.*
JT – would it make sense if you also have an evaluation and treatment certification?
Wendy S. – *71.05 and RTF rules overlap. There was at least one RTF that was not cert as an ET during COVID. There was overlap with ITA law and licensure to allow involuntary treatment work.*
JT – Thank you for that.
Becky O. – *If I operate a facility that can provide involuntary services, that I'm not required to meet the clinical record content WAC? If that is so, what do I need to meet? Are they anywhere else? You can be a voluntary or involuntary triage facility but what should be in the clinical record. They should both be held to the same clinical record content expectation. Shouldn't be caught on the client's legal status. Regardless of length of stay there should be a plan.*
JT – that is a good question. -0640 includes an assessment. The other items include discharge information. It looks like a change in the language but not in practice. If you want to provide ITA, you would need to evaluation and treatment services. There is a gap in our rules.
Wendy S. *- Thinking more about 0640...this may be an issue with clients who are crisis only that haven't has a full psychosocial assessment*
Wendy S. *- Why does CLIP require a psychiatrist as opposed to a psychiatric provider?*
JT – I don't know the answer to that. It may be because of contract language with HCA. We could check into this.
Amy S. *- Our CLIP has a contracted Psychologist and on staff psychiatrist.*
JT – sounds like we have outdated language. We can fix that. I'll send it to HCA so they can take a look.
Allie F. - I agree with Becky's comments.
JT – anyone opposed to the draft language in this section?
Attendees *– no comment.*

Involuntary certification standards:
JT –– includes evaluation and treatment and secure withdrawal management. Language pulled from different sections of WAC – see comment bubbles. There were zero changes. Any questions?

Evaluation and treatment - individual services standards:
JT –Long-term Evaluation and treatment services – CLIP is separate. We could combine this under this section. Does this work?

JT – Back to the top of the draft WAC language. Recommendation to remove the word "care" from (1)(b) so I did that.

Behavioral health support services:
JT – Subsection (1)(e). Instead of rehabilitative case management, I broadened to case management. Feedback that it may be confusing. Rehab case management – do not need an assessment in the clinical

record but as I was talking through internally, it sounded like for general case management that there would be at least a copy of a biopsychosocial assessment in the clinical record. Do we want to a carve out for rehab assessment is not required to be documented?
Joan B. *- I still disagree that clients seeking support or case management should be provided to disclose their biopsychosocial assessment. A simple referral from the agency should suffice. I'm thinking of client's right to privacy and HIPAA "limited need to know basis"*
Christopher D*. - Rehab case management should be pulled out and addressed separately. An assessment should still be on file if an agency is providing rehab case management.*
Kelli M*. - Do we really need a carve out for Case Management? Perhaps for SUD, but for mental health, Case Management falls under Individual Treatment and that is not a specific section.*
JT – we don't have individual service standards; we wouldn't have to include it.
Joan B. *- Correction sorry. I meant "required" not "provided"*
Becky O. *– Def of rehab case management. How can this be done without an assessment? Could be a copy.*
Joan B*. - Rehab case management should be separate and seems OK to require assessment but not general case management/support. Is certification as a case management agency REQUIRED for reimbursement?*
JT – only for rehabilitative case management. Since DOH got the rules. They came over without general case management. Assume that it is not required.
Kelli M. *- The rule for not needing an assessment stems from old RSN days when agencies could take a referral from the state hospital and get credit for discharge planning before their Medicaid was reinstated. It is a non-Medicaid reimbursable code.*
JT – Subsection (2) comment re: discharge requirements – added language "but must instead meet the requirements in subsection (3)." This aligns with other WAC language. Copied the discharge information from -0640 to this section.
Ann P. *- Jumped on late so my comment may be out of context to the rehab case management question/discussion. For the Outpatient mental health provider, there is no requirement for an assessment to provide rehab case management, as typically the outpatient provider is working with the inpatient facility to support care coordination and discharge planning; assume any requirement for an assessment falls on the inpatient side. Once individual is in the outpatient arena, then they must enroll (complete an Intake/assessment) in order to receive case management supports.*
Attendees *– no issue with the discharge language.*

Crisis support services:
JT – Subsection (2) – added language to point to documentation requirements. Impacts?
Stephanie T. *- No, this would be a huge addition of work for BHA's and staff. These services are intended to be very focused on stabilizing the crisis at hand. For these reasons, the assessment and ISP are not necessary.*
Christopher D. *- No, does not make sense that all these elements be required. The crisis assessment should dictate the services and coordination of care.*
JT – I'm hearing we need to have the existing carve out for this service.
JT – comment that throughout our WAC that we mention that certain SUD services that staff complete training but mention that DCRs don't have to have 40 hours. It is only mentioned in the State Medicaid Plan related to withdrawal management services and not for other SUD services. Why do we have this attached to other services? We have a separate DCR certification – stand alone. What seems appropriate? Do we keep the 40 hour and mention that DCRs don't have to have this or??

Becky O. *- It may have come from the original conversion from CDMHP to DCR. This was part of the pilot for this about 15 years ago.*
Joan B. *- From a co-occurring background, I would hope there is SOME requirement for SUD training.*
JT – does it need to be 40 hours?
Anne P*. - Advise SUD and crisis training but not quantify the requirement.*
Joan B. *- Not 40 hours. More like completed types of training.*
JT – will take this into consideration. Also mentioned in crisis services. I'll make sure we come up with something appropriate.

Behavioral health intervention, assessment and treatment:
JT – Collapsed language got too complicated. I decided that wasn't going to work and instead added subsection (2) language to follow -0640. Moved carve out under ISS.
JT – Alcohol and drug information school (ADIS). Majority of cases people do have an assessment but not always the case. Subsection (5) modified language to accommodate the situation where the individual does not have an assessment.

Outpatient crisis behavioral health services:
JT – Outreach in the community and intervention/observation – changed to intervention instead of observation. SUD and mental health would keep a list of resources.

JT – if we have two services (crisis outreach and crisis intervention) – what would we want to put in rule for the observation services? Included the language from the community-based services that may apply to both (1) and (2). Maybe (d) and (e) only apply?
Linda G. *- Not sure I understood ADIS. Don't want to DO an assessment if this is only for court-ordered education.*
JT – correct there would be no assessment required for the education.
Sarah B. - Can an SUDPT also respond or will only an SUDP be required?
JT – WAC says the SUDPT can, but I can check to see if it is outside of their scope. Likely based on supervision requirements.
Wendy S. *- The forty hours of training is still an issue for DCR's, who are often the ones responding in rural communities.*
JT – I think we are going to change that.
Linda G*. - SUDPs sign off on Trainee assessments*
Becky O*. - we should see about the new-ish certification attached to MH licensure...*
JT – I think that is what we are trying to get at with this highlighted language.
Sarah B. *- I support SUDPT, just looking under c not highlighted says an SUDP*
Joan B. *- Ideal for face to face in crisis for sure BUT is this a future reality given more emphasis on zoom and other technology...do we need to put in exceptions like we did during the pandemic VS mandatory face to face? BH staff shortages may cause some challenges too.*
JT – anywhere face-to-face is mentioned we will discuss next week to see if that makes sense.
G'Nell A. *- Take into account that SUDPT's might have a higher level of education than an SUDP... as well as having an SUDP signing off all services.*
Joan B. *- Plus the new safety challenges for crisis responders who will not have police support*
Becky O*. – Co-occurring disorder enhancement. More about professional licensure. Provides a separation that may not be our future reality. The person in crisis doesn't always specify.*
Joan B. *- Can we use language from other WAC like "or other authorized/licensed professional?"*
JT – yes

JT – any other requirements highlighted in pink that would be appropriate for crisis int or observation requirements?
Joan B. *- Maybe "collateral information" be mentioned somewhere.*
JT – 23-hour crisis services – the Qs that came up were around are they required to provide meals or a snack, limit to number of recliners, a shower, should all have a place to be while receiving services? We don't have rules to address this. Should there be a minimum standard for an individual that would be there for 23 hours?
Sarah B. *- No, those should be defined within the agency policies*
Becky O. *- yes to standards: access to phone, access to bathroom, access to water*
Keli M. *- I would be hesitant to require things like snacks, bathing, etc. That is a cost that not all agencies can absorb. It should be us to the agencies.*
JT – access to water for drinking?
Becky O. *- I'm thinking that we need to ensure basic human needs are able to attend to.*
Holly B. *- # of chairs would be regulated by the DOH facility rules (i.e. RTF requires specific square footage for specific activities).*
JT – no construction review requirements for outpatient facilities.
Joan B. *- This subject area could become VERY large and lot of discussion w/providers 1t*
Becky O. *- The only facility requirements would be those under BHA.*
JT – this service is already allowed but we can keep it basic for now and as the service becomes more common, if there is an identified need, we can do some rulemaking around that.
Anne P. *- Resources vary and often limited in the rural and/or small providers. Crisis responders do not necessarily have control of the environment they are providing the crisis response. Basic needs contingent available resources.*

CERTIFICATION AND INDIVIDUAL SERVICE STANDARDS FOR BEHAVIORAL HEALTH INFORMATION, ASSISTANCE AND REFERRAL SERVICES

246-341-XXX1
Behavioral health information, assistance and referral—Certification Standards.

(1) Agencies certified for behavioral health information, assistance and referral services provide information, assistance and referral services that are considered nontreatment behavioral health services that support an individual who has a need for interventions related to behavioral health. Behavioral health information, assistance and referral services under this certification include services such as:
(a) Crisis telephone support in accordance with the individual services standards in WAC 246-341-XXX2; and
(b) Emergency service patrol in accordance with the individual service standards in WAC 246-341-XXX3.

(2) Agencies providing information, assistance and referral services are not required to meet the requirements under WAC 246-341-0640.

(3) Agencies providing information and assistance services must maintain and provide a list of resources, including self-help groups, behavioral health services referral options, legal, employment, education, interpreter, and social and health services that can be used by staff members to refer an individual to appropriate services.

246-341-XXX2

Telephone support services- Individual service standards.

Crisis telephone support services are services provided as a means of first contact to an individual in crisis. These services may include de-escalation and referral.

(1) An agency providing telephone support services must:

(a) Have services available 24 hours per day, seven days per week;

(b) Assure communication and coordination with the individual's mental health ~~care~~ or substance use treatment provider, if indicated and appropriate;

(c) Remain on the phone with the individual in crisis in order to provide stabilization and support until the crisis is resolved or referral to another service is accomplished;

(d) As appropriate, refer individuals to voluntary or involuntary treatment facilities for admission on a seven-day-a-week, twenty-four-hour-a-day basis, including arrangements for contacting the designated crisis responder;

(2) Documentation of a telephone crisis service must include the following:

(a) A brief summary of each crisis service encounter, including the date, time, and duration of the encounter;

(b) The names of the participants;

(c) A follow-up plan or disposition, including any referrals for services, including emergency medical services;

(d) Whether the individual has a crisis plan and any request to obtain the crisis plan; and

(e) The name and credential, if applicable, of the staff person providing the service.

(3) An agency providing telephone services for mental health is not required to follow the consultation requirement in WAC **246-341-0515**(3).

(4) An agency providing telephone services for substance use disorder must:

(a) Ensure each staff member completes forty hours of training that covers substance use disorders before assigning the staff member unsupervised duties; and

(b) Ensure a substance use disorder professional or a substance use disorder professional trainee is available or on staff twenty-four hours a day, seven days a week.

246-341-XXX3

Emergency service patrol- Individual service standards.

Emergency service patrol services provide transport assistance to an intoxicated individual in a public place when a request has been received from police, merchants, or other persons. An agency providing emergency service patrol services must:

(1) Ensure the staff member providing the service:

(a) Has proof of a valid Washington state driver's license;

(b) Possesses annually updated verification of first-aid and cardiopulmonary resuscitation training; and

(c) Has completed forty hours of training in substance use disorder crisis intervention techniques and alcoholism and drug abuse, to improve skills in handling crisis situations.

(2) Respond to calls from police, merchants, and other persons for assistance with an intoxicated individual in a public place;

(3) Patrol assigned areas and give assistance to an individual intoxicated in a public place;

(4) Conduct a preliminary screening of an individual's condition related to the state of their impairment and presence of a physical condition needing medical attention;

(5) Transport the individual to their home or shelter or to a substance use disorder treatment program if the individual is intoxicated, but subdued and willing to be transported;

(6) Make reasonable efforts to take the individual into protective custody and transport the individual to an appropriate treatment or health care facility, when the individual is incapacitated, unconscious, or has threatened or inflicted harm on another person;

(7) Call law enforcement for assistance if the individual is unwilling to be taken into protective custody; and

(8) Maintain a log, including:

(a) The date, time and origin of each call received for assistance;

(b) The time of arrival at the scene;

(c) The location of the individual at the time of the assist;

(d) The name of the individual transported;

(e) The results of the preliminary screening;

(f) The destination and address of the transport and time of arrival; and

(g) In case of nonpickup of a person, documentation of why the pickup did not occur.

CERTIFICATION AND INDIVIDUAL SERVICE STANDARDS FOR BEHAVIORAL HEALTH SUPPORT SERVICES

246-341-XXX4

Behavioral health support services—Certification standards

(1) Agencies certified for behavioral health support provide services to promote socialization, recovery, self-advocacy, development of natural supports, and

maintenance of community living skills for individuals with a behavioral health diagnosis. Behavioral health support services under this certification include services such as:

(a) Supported employment in accordance with the individual service standards in WAC 246-341-XXX5;
(b) Supportive housing in accordance with the individual service standards in WAC 246-341-XXX6;
(c) Peer support;
(d) Consumer-run clubhouse in accordance with the individual service standards in WAC 246-341-XXX7;
(e) Case management;
(f) Psychiatric medication monitoring in accordance with the individual service standards in WAC 246-341-XXX8;
(g) Day support; and
(h) Crisis support in accordance with the individual service standards in WAC 246-31-XXX9.

(2) An agency certified to provide behavioral health support services is not required to meet the requirements in WAC 246-341-0640, but must instead meet the requirements in subsection (3).

(3) An agency providing any behavioral health support service must maintain an individual's health record that contains documentation of the following:
(a) The name of the agency or other sources through which the individual was referred, if applicable;
(b) A copy of an assessment conducted by a licensed behavioral health agency or appropriately credentialed professional. If the agency conducts assessments on individuals the agency must become certified for assessment, treatment and intervention services in accordance with WAC 246-341-XX10.
(c) A copy an individual service plan conducted by a licensed behavioral health agency or appropriately credentialed professional indicating the appropriateness of the support services based on the individual's needs and goals~~, except when providing medication monitoring services.~~
(d) Any referral made to a more intensive level of care when appropriate;
(e) Consent to include the individual's family members, significant others, and other relevant treatment providers as necessary to provide support to the individual;
(f) A brief summary of each service encounter, including the date, time, and duration of the encounter;
(g) Names of participant(s), including the name of the individual who provided the service; and
(h) Any information or copies of documents shared by or with a behavioral health agency or credentialed behavioral health professional.
(i) Discharge information as follows:

(i) A discharge statement if the individual left without notice; or
(ii) Discharge information for an individual who did not leave without notice, completed within seven working days of the individual's discharge, including:

Commented [TJ(1]: Current WAC, specific to Rehab case management, says no assessment required. Not even a copy of one. For general case management it seems a copy of an assessment is required. Does there need to be a carve out for rehab case management or are agencies already documenting a copy of the assessment?

Commented [TJ(2]: Fix. Must provide D/C.

Commented [TJ(3]: What if the individual is referred from somewhere that only provides assessments and the support services agency doesn't have providers credentialed to do ISPs? Perhaps like at a Clubhouse. Could they develop a support services plan instead of a full ISP? Ex. (c) A copy of an individual service plan conducted by a licensed behavioral health agency or appropriately credentialed professional, or a plan developed by the agency indicating how the support services will assist the individual in meeting their behavioral health needs and goals.

Commented [TJ(4]: Moved exception down under ISS.

Commented [TJ(5]: This is from 0640 and a current requirement. Does this make sense or need to be modified.

(A) The date of discharge; and
(B) Continuing care plan.

(4) An agency may operate through an agreement with another a licensed behavioral health agency that provides certified intervention, assessment and treatment services in order to meet the requirements in (3)(b). The agreement must specify the responsibility for initial assessments, the determination of appropriate services, individual service planning, and the documentation of these requirements.

Commented [TJ(6]: See suggestion

(5) Agencies certified for support services may also choose to provide behavioral health information, assistance and referral services without additional certification in accordance with the applicable certification and individual service requirements.

246-341-XXX5

Supported employment mental health and substance use disorder services- Individual service standards.

Supported employment mental health and substance use disorder services assist in job search, placement services, and training to help individuals find competitive jobs in their local communities.

(1) A behavioral health agency that provides supported employment services must have knowledge of and provide individuals access to employment and education opportunities by coordinating efforts with one or more entities that provide other rehabilitation and employment services, such as:

(a) The department of social and health services' division of vocational rehabilitation (DVR);
(b) The department of social and health services' community services offices;
(c) State board for community and technical colleges;
(d) The business community;
(e) WorkSource, Washington state's official site for online employment services;
(f) Washington state department of employment security; and
(g) Organizations that provide job placement within the community.

(2) A behavioral health agency that provides supported employment services must:

(a) Ensure all staff members who provide direct services for employment are knowledgeable and familiar with services provided by the department of social and health services' division of vocational rehabilitation;

(b) Conduct and document a vocational assessment in partnership with the individual that includes work history, skills, training, education, and personal career goals;

(c) Assist the individual to create an individualized job and career development plan that focuses on the individual's strengths and skills;

(d) Assist the individual to locate employment opportunities that are consistent with the individual's skills, goals, and interests;

(e) Provide and document any outreach, job coaching, and support at the individual's worksite when requested by the individual or the individual's employer; and

(f) If the employer makes a request, provide information regarding the requirements of reasonable accommodations, consistent with the Americans with Disabilities Act (ADA) of 1990 and Washington state antidiscrimination law.

246-341-XXX6

Supportive housing mental health and substance use disorder services-Individual service standards.

Supportive housing mental health and substance use disorder services support an individual's transition to community integrated housing and support the individual to be a successful tenant in a housing arrangement.

(1) A behavioral health agency that provides supportive housing services must have knowledge of and provide housing related collaborative activities to assist individuals in identifying, coordinating, and securing housing or housing resources with entities such as:

(a) Local homeless continuum of care groups or local homeless planning groups;

(b) Housing authorities that operate in a county or city;

(c) Community action councils;

(d) Landlords of privately owned residential homes; and

(e) State agencies that provide housing resources.

(2) A behavioral health agency that provides supportive housing services must:

(a) Ensure all staff members who provide direct services for supportive housing are knowledgeable and familiar with fair housing laws;

(b) Conduct and document a housing assessment in partnership with the individual that includes housing preferences, affordability, and barriers to housing;

(c) Conduct and document a functional needs assessment in partnership with the individual that includes independent living skills and personal community integration goals;

(d) Assist the individual to create an individualized housing acquisition and maintenance plan that focuses on the individual's choice in housing;

(e) Assist the individual to locate housing opportunities that are consistent with the individual's preferences, goals, and interests;

(f) Provide any outreach, tenancy support, and independent living skill building supports at a location convenient to the individual;

(g) Provide the individual with information regarding the requirements of the Fair Housing Act, Americans with Disabilities Act (ADA) of 1990, and Washington state antidiscrimination law, and post this information in a public place in the agency; and

(h) Ensure the services are specific to each individual and meant to assist in obtaining and maintaining housing in scattered-site, clustered, integrated, or single-site housing as long as the individual holds a lease or sublease.

246-341-XXX7

Consumer-run Clubhouses- Individual service standards.

(1) A clubhouse is a community-based program that provides rehabilitation services.

(2) The clubhouse may be peer-operated and must:

(a) Be member-run with voluntary participation;

(b) Be recovery-focused;

(c) Focus on strengths, talents, and abilities of its members;

(d) Have a clubhouse director who:

(i) Engages members and staff in all aspects of the clubhouse operations; and

(ii) Is ultimately responsible for the operation of the clubhouse.

(e) Be comprised of structured activities including:

(i) Personal advocacy;

(ii) Help with securing entitlements;

(iii) Information on safe, appropriate, and affordable housing;

(iv) Community resource development;

(v) Connecting members with adult education opportunities in the community;

(vi) An active employment program that assists members to gain and maintain employment in full- or part-time competitive jobs. Employment related activities may include resume building, education on how employment will affect benefits, information on other employment services, and information regarding protections against employment discrimination; and

(vii) An array of social and recreational opportunities.

(f) Use a work-ordered day to allow all members the opportunity to participate in all the work of the clubhouse including:

(i) Administration;

(ii) Research;

(iii) Intake and orientation;

(iv) Outreach;

(v) Training and evaluation of staff;

(vi) Public relations;

(vii) Advocacy; and

(viii) Evaluation of clubhouse effectiveness.

(g) Provide in-house educational programs that significantly utilize the teaching and tutoring skills of members and assist members by helping them to take advantage of adult education opportunities in the community.

(3) "Work-ordered day" means a model used to organize clubhouse activities during the clubhouse's normal working hours.

(a) Members and staff are organized into one or more work units which provide meaningful and engaging work essential to running the clubhouse.

(b) Activities include unit meetings, planning, organizing the work of the day, and performing the work that needs to be accomplished to keep the clubhouse functioning.

(c) Members and staff work side-by-side as colleagues as evidenced by both the member and the staff signature on progress towards goals.

(d) Members participate as they feel ready and according to their individual interests.
(e) Work in the clubhouse is not intended to be job-specific training, and members are neither paid for clubhouse work nor provided artificial rewards.
(f) Work-ordered day does not include medication clinics, day treatment, or other therapy programs.

246-341-XXX8

Psychiatric medication monitoring services- Individual service standards.

(1) Medication monitoring services occur face-to-face and:
(a) Include one-on-one cueing, observing, and encouraging an individual to take medication as prescribed;
(b) Include reporting any pertinent information related to the individual's adherence to the medication back to the agency that is providing psychiatric medication services; and
(c) May take place at any location and for as long as it is clinically necessary.
(2) An agency providing medication monitoring services must:
(a) Ensure that the staff positions responsible for providing either medication monitoring, or delivery services, or both, are clearly identified in the agency's medication monitoring services policy;
(b) Have appropriate policies and procedures in place when the agency providing medication monitoring services maintains or delivers medication to the individual that address:
(i) The maintenance of a medication log documenting the type and dosage of medications, and the time and date;
(ii) Reasonable precautions that need to be taken when transporting medications to the intended individual and to assure staff safety during the transportation; and
(iii) The prevention of contamination of medication during delivery, if delivery is provided.
(c) Ensure that the individual's health record includes documentation of medication monitoring services.
(3) An individual service plan is not required when providing psychiatric medication monitoring services.

WAC 246-341-XXX9

Crisis support services- Individual service standards.

Crisis support services include short-term (less than two weeks per episode) face-to-face assistance with life skills training and understanding of medication effects on an individual.

(1) An agency providing crisis support services must:
(a) Assure communication and coordination with the individual's mental health care or substance use treatment provider, if indicated and appropriate;

Commented [TJ(7]: Is it appropriate for crisis support services to have documentation of an assessment, ISP, Discharge? Currently not required in WAC. Carve out from all of 0640.

(b) If an individual is found to be experiencing an acute crisis, ~~R~~remain with the individual ~~in crisis~~ in order to provide stabilization and support until the crisis is resolved or referral to another service is accomplished;

(c) As appropriate, refer individuals to voluntary or involuntary treatment facilities for admission on a seven-day-a-week, twenty-four-hour-a-day basis, including arrangements for contacting the designated crisis responder; and

(d) Transport or arrange for transport of an individual in a safe and timely manner, when necessary

(2) In addition to the documentation requirements in WAC 246-341-XXX4 (3), ~~D~~documentation of crisis support services must include the following:

~~(a) A brief summary of each crisis service encounter, including the date, time, and duration of the encounter;~~

~~(b) The names of the participants;~~

(a~~c~~) A follow-up plan or disposition, including any referrals for services, including emergency medical services;

(b~~d~~) Whether the individual has a crisis plan and any request to obtain the crisis plan; and

(c~~e~~) The name and credential, if applicable, of the staff person providing the service.

(3) An agency providing crisis support services for mental health is not required to follow the consultation requirement in WAC **246-341-0515**(3).

(4) An agency providing crisis support services for substance use disorder must:

(a) Ensure each staff member completes forty hours of training that covers substance use disorders before assigning the staff member unsupervised duties; and

(b) Ensure a substance use disorder professional or a substance use disorder professional trainee is available or on staff twenty-four hours a day, seven days a week.

(5) When services are provided in a private home or nonpublic setting the agency must:

(a) Have a written plan for training, staff back-up, information sharing, and communication for staff members who respond to a crisis in an individual's personal residence or in a nonpublic setting;

(c) Ensure that a staff member responding to a crisis is able to be accompanied by a second trained individual when services are provided in the individual's personal residence or other nonpublic location;

(d) Ensure that any staff member who engages in home visits is provided access, by their employer, to a wireless telephone or comparable device for the purpose of emergency communication as described in RCW 71.05.710;

Commented [TJ(8]: Included in the certification standards

Commented [TJ(9]: Only mentioned in SMP related to WDM services. DCRs don't need 40 hours. Keep, modify, or ???

(e) Provide staff members who are sent to a private home or other private location to evaluate an individual in crisis prompt access to information about any history of dangerousness or potential dangerousness on the individual they are being sent to evaluate that is documented in a crisis plan(s) or commitment record(s). This information must be made available without unduly delaying the crisis response.

CERTIFICATION AND INDIVIDUAL SERVICE STANDARDS FOR BEHAVIORA HEALTH INTERVENTION, ASSESSMENT AND TREATMENT SERVICES

246-341-XX10
Behavioral health intervention, assessment and treatment services—Certification Standards.

(1) Agencies certified for intervention, assessment and treatment services provide individualized intervention, assessment and treatment for mental health, substance use, or co-occuring disorders. Intervention, assessment, and treatment services under this certification include services such as:

(a) Assessments;
(b) Counseling and therapy; and
(c) Medication management in accordance with the individual service standards in WAC 246-341-XX11.

(2) Agencies providing intervention, assessment and treatment services must follow the requirements in WAC 246-341-0640. Agencies providing assessment only services are not required to meet the individual service plan or discharge requirements.

~~(2) Agencies providing intervention, assessment and treatment services must have a clinical record that includes:~~

~~(a) If counseling or therapy is provided, documentation the individual received a copy of counselor disclosure requirements as required for the counselor's credential.~~

~~(b) Identifying information.~~

~~(c) An assessment which is an age-appropriate, strengths-based psychosocial assessment that considers current needs and the individual's relevant behavioral and physical health history according to best practices, completed by a person appropriately credentialed or qualified to provide the type of assessment pertaining to the service(s) being sought, which includes:~~

~~(i) Presenting issue(s);~~

~~(ii) An assessment of any risk of harm to self and others, including suicide, homicide, and a history of self-harm and, if the assessment indicates there is such a risk, a referral for provision of emergency/crisis services;~~

~~(iii) Treatment recommendations or recommendations for additional program-specific assessment; and~~

~~(iv) A diagnostic assessment statement, including sufficient information to determine a diagnosis supported by the current and applicable *Diagnostic and*~~

Commented [TJ(10]: Move back to -0640 and just reference the requirement

Statistical Manual of Mental Disorders (DSM-5) or a placement decision, using ASAM criteria dimensions, when the assessment indicates the individual is in need of substance use disorder services.

(d) Individual service plan, unless providing assessment only or psychiatric medication management services, that:

(i) Is completed or approved by a person appropriately credentialed or qualified to provide mental health, substance use, or co-occurring services.

(ii) Addresses issues identified in the assessment and by the individual or, if applicable, the individual's parent(s) or legal representative;

(iii) Contains measurable goals or objectives and interventions;

(iv) Must be mutually agreed upon and updated to address changes in identified needs and achievement of goals or at the request of the individual or, if applicable, the individual's parent or legal representative;

(v) Must be in a terminology that is understandable to the individuals and the individual's family or legal representative, if applicable.

(e) If treatment is not court-ordered, documentation of informed consent to treatment by the individual or individual's parent, or other legal representative.

(f) If counseling or therapy is provided, progress and group notes including the date, time, duration, participant's name, response to interventions or clinically significant behaviors during the group session, and a brief summary of the individual or group session and the name and credential of the staff member who provided it.

(g) If treatment is for a substance use disorder, documentation that ASAM criteria was used for admission, continued services, referral, and discharge planning and decisions.

(h) Discharge information as follows:

(i) A discharge statement if the individual left without notice; or

(ii) Discharge information for an individual who did not leave without notice, completed within seven working days of the individual's discharge, including:

(A) The date of discharge;

(B) Continuing care plan; and

(C) If applicable, current prescribed medication.

(2) When the following situations apply, the clinical record must include:

(a) Documentation of confidential information that has been released without the consent of the individual under:

(i) RCW **70.02.050**;

(ii) The Health Insurance Portability and Accountability Act (HIPAA); and

(iii) RCW **70.02.230** and **70.02.240** if the individual received mental health treatment services;

(iv) 42 C.F.R. Part 2.

(b) Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with chapters **26.44** and **74.34** RCW has occurred.

(c) If treatment is court-ordered, a copy of the order.

(d) Medication records.

(e) Laboratory reports.

(f) Properly completed authorizations for release of information.

Commented [TJ(11]: Moved under ISS

~~(g) Documentation that copies of documents pertinent to the individual's course of treatment were forwarded to the new service provider with the individual's permission.~~

~~(h) A copy of any report required by entities such as the courts, department of corrections, department of licensing, and the department of health, and the date the report was submitted.~~

~~(i) Documentation of coordination with any systems or organizations the individual identifies as being relevant to treatment, with the individual's consent or if applicable, the consent of the individual's parent or legal representation.~~

~~(j) A crisis plan, if one has been developed.~~

(3) Agencies providing intervention, assessment and treatment services may choose to provide involuntary or court-ordered outpatient services to individuals for:

(a) Outpatient less restrictive alternative or conditional release under chapters 71.05 or 71.34 RCW in accordance with the individual service standards in WAC 246-341-XX14;

(b) Counseling, assessment and education under chapter 46.61 RCW including:

(i) Substance use disorder counseling in accordance with the individual service standards in WAC 246-341-XX15;

(ii) Driving under the influence (DUI) substance use assessment in accordance with the individual service standards in WAC 246-341-XX16; and

(iii) Alcohol and drug information school in accordance with the individual service standards in WAC 246-341-XX13; or

(c) Deferred prosecution under RCW 10.05.150 in accordance with the individual service standards in WAC 246-341-XX12.

(4) Agencies choosing to provide outpatient involuntary or court-ordered services must report noncompliance, in all levels of care, for an individual ordered into substance use disorder treatment by a court of law or other appropriate jurisdictions in accordance with RCW **71.05.445** and chapter **182-538D** WAC for individuals receiving court-ordered services under chapter **71.05** RCW, RCW **10.05.090** for individuals under deferred prosecution, or RCW **46.61.5056** for individuals receiving court-ordered treatment for driving under the influence (DUI). Additionally, agencies providing services to individuals under a court-order for deferred prosecution under RCW **10.05.090** RCW or treatment under RCW **46.61.5056** must:

(a) Report and recommend action for emergency noncompliance to the court or other appropriate jurisdiction(s) within three working days from obtaining information on:

(i) An individual's failure to maintain abstinence from alcohol and other nonprescribed drugs as verified by individual's self-report, identified third-party report confirmed by the agency, or blood alcohol content or other laboratory test;

(ii) An individual's report of subsequent alcohol or drug related arrests; or

(iii) An individual leaving the program against program advice or an individual discharged for rule violation;

(b) Report and recommend action for nonemergency, noncompliance to the court or other appropriate jurisdiction(s) within ten working days from the end of each reporting period, upon obtaining information on:

(i) An individual's unexcused absences or failure to report, including failure to attend mandatory self-help groups; or

(ii) An individual's failure to make acceptable progress in any part of the treatment plan.

(c) Transmit information on noncompliance or other significant changes as soon as possible, but no longer than ten working days from the date of the noncompliance, when the court does not wish to receive monthly reports;

(d) Report compliance status of persons convicted under chapter **46.61** RCW to the department of licensing.

(5) Agencies certified for intervention, assessment and treatment services may also choose to provide behavioral health information, assistance and referral and support services without additional certification and in accordance with the certification and individual service standards.

246-341-XX11

Individual service requirements—Psychiatric medication management services.

Psychiatric medication management services are a variety of activities related to prescribing and administering medication, including monitoring an individual for side effects and changes as needed.

(1) An agency providing psychiatric medication management services must:

(a) Ensure that medical direction and responsibility are assigned to a:

(i) Physician who is licensed to practice under chapter **18.57** or **18.71** RCW, and is board-certified or board-eligible in psychiatry;

(ii) Psychiatric advanced registered nurse practitioner (ARNP) licensed under chapter **18.79** RCW; or

(iii) Physician assistant licensed under chapter **18.71A** or **18.57A** RCW working with a supervising psychiatrist.

(b) Ensure that the services are provided by a prescriber licensed by the department who is practicing within the scope of that practice;

(c) Ensure that all staff administering medications are appropriately credentialed;

(d) Have a process by which the medication prescriber informs either the individual, the legally responsible party, or both, and, as appropriate, family members, of the potential benefits and side effects of the prescribed medication(s);

(e) Must ensure that all medications maintained by the agency are safely and securely stored, including assurance that:

(i) Medications are kept in locked cabinets within a well-lit, locked and properly ventilated room;

(ii) Medications kept for individuals on medication administration or self-administration programs are clearly labeled and stored separately from medication samples kept on-site;

(iii) Medications marked "for external use only" are stored separately from oral or injectable medications;

(iv) Refrigerated food or beverages used in the administration of medications are kept separate from the refrigerated medications by the use of trays or other designated containers;

(v) Syringes and sharp objects are properly stored and disposed of;

(vi) Refrigerated medications are maintained at the required temperature; and

(vii) If the individual gives permission for disposal, outdated medications are disposed of in accordance with the regulations of the pharmacy quality assurance commission and no outdated medications are retained.

(2) An agency providing psychiatric medication management services may utilize a physician or ARNP without board eligibility in psychiatry if unable to employ or contract with a psychiatrist. In this case, the agency must ensure that:

(a) Psychiatrist consultation is provided to the physician or ARNP at least monthly; and

(b) A psychiatrist or psychiatric ARNP is accessible to the physician or ARNP for emergency consultation.

(c) Ensure that the individual's health record contains documentation of medication management services.

(3) An individual service plan is not required when providing psychiatric medication management services.

246-341-XX12
Deferred prosecution under RCW 10.05.150- Individual service standards

(1) An agency providing treatment services for deferred prosecution under RCW **10.05.150** must:

(a) Ensure that services include a minimum of seventy-two hours of treatment services within a maximum of twelve weeks, which consist of the following during the first four weeks of treatment:

(i) At least three sessions each week, with each session occurring on separate days of the week;

(ii) Group sessions that must last at least one hour; and

(iii) Attendance at self-help groups in addition to the seventy-two hours of treatment services.

(b) There must be approval, in writing, by the court having jurisdiction in the case, when there is any exception to the requirements in this subsection;

(c) The agency must refer for ongoing treatment or support upon completion of intensive outpatient treatment, as necessary~~; and~~

~~(d) The agency must report noncompliance with the court mandated treatment in accordance with WAC **246-341-0800**.~~.

Commented [TJ(12]: Covered in cert. standards above

246-341-XX13
Alcohol and drug information school- Individual service standards.

Alcohol and drug information school services provide an educational program about substance use. These services are for an individual referred by a court or other jurisdiction(s) who may have been assessed and determined not to require treatment. An agency providing alcohol and drug information school services must:

(1) Ensure courses are taught by a substance use disorder professional, a substance use disorder professional trainee, or a person who has received documented training in:

(a) Effects of alcohol and other drugs;

(b) Patterns of use;

(c) Current laws and regulations pertaining to substance use violations, and consequences of the violations; and

(d) Available resources and referral options for additional services that may be appropriate for the individual.

(2) Ensure the curriculum:

(a) Provides no less than eight hours of instruction for each course;

(b) Includes a post-test for each course after the course is completed;

(c) Includes a certificate of completion; and

(d) Covers the following topics:

(i) Information about the effects of alcohol and other drugs;

(ii) Patterns of use; and

(iii) Current laws, including Washington state specific laws and regulations, and consequences related to substance use violations.

(3) Ensure each student be advised that there is no assumption the student has a substance use disorder and that the course is not a therapy session;

(4) Ensure each individual student record contains:

(a) An intake form, including demographics;

(b) The hours of attendance, including dates; and

(c) A copy of the scored post-test.

(5) An agency providing alcohol and drug information school must include a copy of an assessment, if the individual was assessed, that indicates the individual does not have a substance use disorder in the clinical record but does not need to include an individual service plan.

246-341-XX14

Outpatient less restrictive alternative (LRA) or conditional release support behavioral health services- Individual service standards.

An agency serving individuals on a less restrictive alternative (LRA) or conditional release court order shall provide or monitor the provision of court-ordered services, including psychiatric, substance use disorder treatment, and medical components of community support services. An agency providing court-ordered LRA support and conditional release services shall:

(1) Have a written policy and procedure that allows for the referral of an individual to an involuntary treatment facility twenty-four hours a day, seven days a week.

(2) Have a written policy and procedure for an individual who requires involuntary detention that includes procedures for:

(a) Contacting the designated crisis responder (DCR) regarding revocations or extension of an LRA or conditional release; and

(b) The transportation of an individual, in a safe and timely manner, for the purpose of:

(i) Evaluation; or

(ii) Evaluation and detention.

(3) Ensure the individual is provided everything their rights afford them to and protect them from under chapter **71.05** or **71.34** RCW, as applicable.

(4) Include in the clinical record a copy of the less restrictive alternative court order or conditional release and a copy of any subsequent modification.

(5) Ensure the individual service plan addresses the conditions of the less restrictive alternative court order or conditional release and a plan for transition to voluntary treatment.

(6) Ensure that the individual receives medication services including an assessment of the need for and prescription of medications to treat mental health or substance use disorders, appropriate to the needs of the individual as follows:

(a) At least one time in the initial fourteen days following release from inpatient treatment for an individual on a ninety-day or one hundred eighty-day less restrictive alternative court order or conditional release, unless the individual's attending physician, physician assistant, or psychiatric advanced registered nurse practitioner (ARNP) determines another schedule is more appropriate and documents the new schedule and the reason(s) in the individual's clinical record; and

(b) At least one time every thirty days for the duration of the less restrictive alternative court order or conditional release, unless the individual's attending physician, physician assistant, or psychiatric ARNP determines another schedule is more appropriate and documents the new schedule and the reason(s) in the individual's clinical record.

(7) Keep a record of the periodic evaluation of each committed individual for release from, or continuation of, an involuntary treatment order. Evaluations must occur at least every thirty days for the duration of the commitments and include documentation of the evaluation and rationale:

(a) For requesting a petition for an additional period of less restrictive or conditional release treatment under an involuntary treatment order; or

(b) Allowing the less restrictive court order or conditional release to expire without an extension request.

246-341-XX15

Substance use disorder counseling for RCW 46.61.5056- Individual service standards.

An agency providing certified substance use disorder counseling services to an individual convicted of driving under the influence or physical control under RCW **46.61.5056** must ensure treatment is completed as follows:

(1) Treatment during the first sixty days must include:

(a) Weekly group or individual substance use disorder counseling sessions according to the individual service plan;

(b) One individual substance use disorder counseling session of not less than thirty minutes duration, excluding the time taken for a substance use disorder assessment, for each individual, according to the individual service plan;

(c) Alcohol and drug basic education for each individual;

(d) Participation in recovery oriented, community-based self-help groups according to the individual service plan. Participation must be documented in the individual's clinical record; and

(e) Individuals who complete intensive inpatient substance use disorder treatment services must attend, at a minimum, weekly outpatient counseling sessions for the remainder of their first sixty days of treatment according to the individual service plan.

(2) The next one hundred twenty days of treatment at a minimum shall include:

(a) Group or individual substance use disorder counseling sessions every two weeks according to the individual service plan;

(b) One individual substance use disorder counseling session of not less than thirty minutes duration, every sixty days according to the individual service plan; and

(c) Referral of each individual for ongoing treatment or support, as necessary, using ASAM criteria, upon completion of one hundred eighty days of treatment.

(3) An individual who is assessed with insufficient evidence of a substance use disorder must be referred to alcohol and/drug information school.

246-341-XX16

Driving under the influence (DUI) substance use disorder assessment services- Individual service standards.

Driving under the influence (DUI) assessment services, as defined in chapter **46.61** RCW, are provided to an individual to determine the individual's involvement with alcohol and other drugs and determine the appropriate course of care or referral.

(1) An agency certified to provide DUI assessment services:

(a) Must review, evaluate, and document information provided by the individual;

(b) May include in the assessment information from external sources such as family, support individuals, legal entities, courts, and employers;

(c) Is not required to meet the individual service plan requirements in WAC **246-341-0640** (1)(d); and

(d) Must maintain and provide a list of resources, including self-help groups, and referral options that can be used by staff members to refer an individual to appropriate services.

(2) An agency certified to provide DUI assessment services must also ensure:

(a) The assessment is conducted in person; and

(b) The individual has a summary included in the assessment that evaluates the individual's:

(i) Blood or breath alcohol level and other drug levels, or documentation of the individual's refusal at the time of the arrest, if available; and

(ii) Self-reported driving record and the abstract of the individual's legal driving record.

(3) When the assessment findings do not result in a substance use disorder diagnosis, the assessment must also include:

(a) A copy of the police report;

(b) A copy of the court originated criminal case history;

(c) The results of a urinalysis or drug testing obtained at the time of the assessment; and

(d) A referral to alcohol and drug information school.

(4) If the information in subsection (3)(a) through (d) of this section is required and not readily available, the record must contain documentation of attempts to obtain the information.

(5) Upon completion of the DUI assessment, the individual must be:

(a) Informed of the results of the assessment; and

(b) Referred to the appropriate level of care according to ASAM criteria.

CERTIFICATION AND INDIVIDUAL SERVICE STANDARDS FOR BEHAVIORAL HEALTH OUTPATIENT CRISIS SERVICES

246-341-XX17
Outpatient crisis behavioral health services—certification standards.

(1) Agencies certified for outpatient crisis behavioral health provide services to stabilize an individual in crisis to prevent further deterioration, provide immediate treatment or intervention in a location best suited to meet the needs of the individual, and provide treatment services in the least restrictive environment available. Outpatient behavioral health crisis services under this certification include services such as:

(a) Behavioral health crisis outreach in accordance with the individual service standards in WAC 246-341-XX18; and
(b) Behavioral health crisis intervention~~observation~~.

(2) An agency certified for outpatient crisis behavioral health services does not need to meet the requirements in WAC 246-341-0640.

(3) An agency providing any outpatient crisis behavioral health service must:
(a) Require that trained staff remain with the individual in crisis in order to provide stabilization and support until the crisis is resolved or referral to another service is accomplished;
(b) Determine if an individual has a crisis plan and request a copy if available;
(c) As appropriate, refer individuals to voluntary or involuntary treatment facilities for admission on a seven-day-a-week, twenty-four-hour-a-day basis, including arrangements for contacting the designated crisis responder;
(d) Maintain a current list of local resources for legal, employment, education, interpreter, and social and health services.

(ed) Transport or arrange for transport of an individual in a safe and timely manner, when necessary;
(fe) Be available twenty-four hours a day, seven days a week; and
(gf) Include family members, significant others, and other relevant treatment providers, as necessary, to provide support to the individual in crisis.
(4) Documentation of a crisis service must include the following, as applicable to the crisis service provided:
(a) A brief summary of each crisis service encounter, including the date, time, and duration of the encounter;
(b) The names of the participants;
(c) A follow-up plan or disposition, including any referrals for services, including emergency medical services;
(d) Whether the individual has a crisis plan and any request to obtain the crisis plan; and
(e) The name and credential, if applicable, of the staff person providing the service.

(5) An agency providing SUD crisis services must:
(a) Ensure each staff member completes forty hours of training that covers substance use disorders before assigning the staff member unsupervised duties;
(b) Ensure a substance use disorder professional or a substance use disorder professional trainee is available or on staff twenty-four hours a day, seven days a week; and;
(c) Maintain a current directory of all certified substance use disorder service providers in the state.; and
~~(d) Maintain a current list of local resources for legal, employment, education, interpreter, and social and health services.~~

(6) Agencies certified for behavioral health crisis services may choose to provide information, assistance and referral and behavioral health support services without additional certification in accordance with the certification and individual service standards.

246-341-XX18

Behavioral health crisis outreach services—individual service standards.

Behavioral health crisis outreach services are face-to-face intervention services provided to assist individuals in a community setting. A community setting can be an individual's home, an emergency room, a nursing facility, or other private or public location.

(1) An agency certified to provide crisis outreach services must:

(a) Provide crisis telephone screening.

(b) For mental health crisis, ensure face-to-face outreach services are provided by a mental health professional or a department-credentialed staff person with documented training in crisis response.

Commented [TJ(13]: Forty hours

(c) For an SUD crisis, ensure face-to-face outreach services are provided by an SUDP, SUDPT, or individual who has completed forty hours of training that covers substance use disorders.

(d) Resolve the crisis in the least restrictive manner possible.

(2) An agency utilizing certified peer counselors to provide crisis outreach services must:

(a) Ensure services are provided by a person recognized by the health care authority as a peer counselor, as defined in WAC **246-341-0200**;

(b) Ensure services provided by a peer counselor are within the scope of the peer counselor's training and credential;

(c) Ensure that a peer counselor responding to an initial crisis visit is accompanied by a mental health or substance use disorder professional as appropriate to the crisis;

(d) Develop and implement policies and procedures for determining when peer counselors may provide follow-up crisis outreach services without being accompanied by a mental health professional or substance use disorder professional; and

(e) Ensure peer counselors receive annual training that is relevant to their unique working environment.

(3) In addition to the documentation requirements in WAC **246-341-0900**, documentation must include:

(a) The nature of the crisis;

(b) The time elapsed from the initial contact to the face-to-face response;

(c) The outcome, including the basis for a decision not to respond in person.

(4) When services are provided in a private home or nonpublic setting the agency must:
(a) Have a written plan for training, staff back-up, information sharing, and communication for staff members who respond to a crisis in an individual's personal residence or in a nonpublic setting;
(b) Ensure that a staff member responding to a crisis is able to be accompanied by a second trained individual when services are provided in the individual's personal residence or other nonpublic location;
(c) Ensure that any staff member who engages in home visits is provided access, by their employer, to a wireless telephone or comparable device for the purpose of emergency communication as described in RCW 71.05.710;
(d) Provide staff members who are sent to a private home or other private location to evaluate an individual in crisis prompt access to information about any history of dangerousness or potential dangerousness on the individual they are being sent to evaluate that is documented in a crisis plan(s) or commitment record(s). This information must be made available without unduly delaying the crisis response.

246-341-XXXX

Behavioral health crisis intervention services—individual service standards.

Commented [TJ(14]: Forty hours

Commented [TJ(15]: Apply to outreach and Intervention? Move under Cert. Standards

Commented [TJ(16]: Apply to outreach and intervention? Move under Cert. standards

PDF **246-341-0810**

~~Involuntary and court-ordered—~~Designated crisis responder (DCR) services- Certification standards~~.~~

Designated crisis responder (DCR) services are services provided by a DCR to evaluate an individual in crisis and determine if involuntary services are required. An agency providing DCR services must meet the general requirements for crisis services in WAC **246-341-0900** and must do all of the following:

(1) Ensure that services are provided by a DCR.

(2) Ensure staff members utilize the protocols for DCRs required by RCW **71.05.214**.

(3) Document that services provided to the individual were in accordance with the requirements in chapter **71.05** or **71.34** RCW, as applicable.

CERTIFICATION AND INDIVIDUAL SERVICE STANDARDS FOR BEHAVIORAL HEALTH RESIDENTIAL AND INPATIENT SERVICES

246-341-XX19
Behavioral health residential and inpatient services—certification standards.

(1) Agencies certified for behavioral health residential and inpatient services provide voluntary behavioral health intervention, assessment, and treatment services in a residential treatment facility or hospital. Residential and inpatient services under this certification include services such as:

(a) Residential and inpatient mental health treatment in accordance with the individual service standards in WAC 246-341-XX21; and
(b) Residential and inpatient substance use disorder treatment in accordance with the individual service standards in WAC 246-341-XX20.

(2) Agencies certified for behavioral health residential and inpatient services must:
(a) Be a facility licensed by the department as:

(i) A hospital licensed under chapter **70.41** RCW;

(ii) A private psychiatric and alcoholism hospital licensed under chapter **71.12** RCW;

(iii) A private alcohol and substance use disorder hospital licensed under chapter **71.12** RCW; or

(iv) A residential treatment facility licensed under chapter **71.12** RCW;

(b) Must ensure access to necessary medical treatment, including emergency life-sustaining treatment and medication;

(c) Must review the individual's crisis or recovery plan, if applicable and available;

Commented [TJ(17]: Discussed adding other DSHS facility types, but clarified that would be providing BH services in a residential setting versus providing residential BH services. Opted not to add other facility types due to adding complexity to overlapping policy.

(d) Must determine the individual's risk of harm to self, others, or property;
(e) Must coordinate with the individual's current treatment provider, if applicable, to assure continuity of care during admission and upon discharge;
(f) Must develop and provide to the individual a discharge summary that must include:
(i) A continuing care recommendation; and
(ii) Scheduled follow-up appointments, including the time and date of the appointment(s), when possible;
(h) If providing services to adults and minors, an agency must:
(i) Ensure that a minor who is at least age thirteen but not yet age eighteen is served with adults only if the minor's clinical record contains:
(A) Documentation that justifies such placement; and
(B) A professional judgment that placement in an inpatient facility that serves adults will not harm the minor;
(ii) Ensure the following for individuals who share a room:
(A) An individual fifteen years of age or younger must not room with an individual eighteen years of age or older;
(B) Anyone under thirteen years of age must be evaluated for clinical appropriateness before being placed in a room with an individual thirteen to sixteen years of age; and
(C) An individual sixteen or seventeen years of age must be evaluated for clinical appropriateness before being placed in a room with an individual eighteen years of age or older.
(3) An agency providing residential or inpatient mental health or substance use disorder services to youth must follow these additional requirements:
(a) Allow communication between the youth and the youth's parent or if applicable, a legal guardian, and facilitate the communication when clinically appropriate.
(b) Notify the parent or legal guardian within two hours of any significant decrease in the behavioral or physical health status of the youth and document all notification and attempts of notification in the clinical record.
(c) Discharge the youth to the care of the youth's parent or if applicable, legal guardian. For an unplanned discharge and when the parent or legal guardian is not available, the agency must contact the state child protective services.
(d) Ensure a staff member who demonstrates knowledge of adolescent development and substance use disorders is available at the agency or available by phone.
(4) Agencies certified for behavioral health residential and inpatient services may choose to provide information, assistance and referral, behavioral health support services, intervention, assessment and treatment services, or outpatient behavioral health crisis services without additional certification in accordance with the applicable certification and individual service standards.

246-341-XX20

Residential and inpatient substance use disorder treatment services—Individual service standards.

Residential substance use disorder treatment services provide substance use disorder treatment for an individual in a facility with twenty-four hours a day supervision.

(1) An agency providing residential and inpatient substance use disorder treatment services must:

(a) Provide education to each individual admitted to the treatment facility on:

(i) Substance use disorders;

(ii) Relapse prevention;

(iii) Bloodborne pathogens;

(iv) Tuberculosis (TB);

(v) Emotional, physical, and sexual abuse; and

(vi) Nicotine use disorder.

(b) Maintain a list or source of resources, including self-help groups, and referral options that can be used by staff to refer an individual to appropriate services; and

Commented [TJ(18]: MH too?

(c) Develop and implement written procedures for:

(i) Urinalysis and drug testing, including laboratory testing; and

(ii) How agency staff members respond to medical and psychiatric emergencies.

(3) An agency that provides services to a pregnant woman must:

(a) Develop and implement a written procedure to address specific issues regarding the woman's pregnancy and prenatal care needs;

(b) Provide referral information to applicable resources; and

(c) Provide education on the impact of substance use during pregnancy, risks to the developing fetus, and the importance of informing medical practitioners of chemical use during pregnancy.

(4) An agency that provides an assessment to an individual under RCW **46.61.5056** must also meet the requirements for driving under the influence (DUI) assessment providers in WAC **246-341-0820**.

(5) An agency that provides substance use disorder residential services to youth must:

Commented [TJ(19]: MH too?

(a) Ensure staff members are trained in safe and therapeutic techniques for dealing with a youth's behavior and emotional crisis, including:

(i) Verbal deescalation;

(ii) Crisis intervention;

(iii) Anger management;

(vi) Suicide assessment and intervention;

(v) Conflict management and problem solving skills;

(vii) Management of assaultive behavior;

(viii) Proper use of therapeutic physical intervention techniques; and

(ix) Emergency procedures.

(b) Provide group meetings to promote personal growth.

(c) Provide leisure, and other therapy or related activities.

(d) Provide seven or more hours of structured recreation each week, that is led or supervised by staff members.

(e) Provide each youth one or more hours per day, five days each week, of supervised academic tutoring or instruction by a certified teacher when the youth is

unable to attend school for an estimated period of four weeks or more. The agency must:

(i) Document the individual's most recent academic placement and achievement level; and

(ii) Obtain school work from the individual's school, or when applicable, provide school work and assignments consistent with the individual's academic level and functioning.

(f) Conduct random and regular room checks when an individual is in their room, and more often when clinically indicated.

(g) Ensure each individual's clinical record:

(i) Contains any consent or release forms signed by the youth and their parent or legal guardian;

(ii) Contains the parent's or other referring person's agreement to participate in the treatment process, as appropriate and if possible; and

(iii) Documents any problems identified in specific youth assessment, including any referrals to school and community support services, on the individual service plan.

(6) Inform individuals of their treatment options so they can make individualized choices for their treatment. This includes, as applicable, the initiation, continuation, or discontinuation of medications for substance use disorders.

(7) For individuals choosing to initiate or continue medications for their substance use disorder, make available on-site or facilitate off-site access to continue or initiate Federal Drug Administration (FDA)-approved medication for any substance use disorder, when clinically appropriate as determined by a medical practitioner.

(8) Provide continuity of care that allows individuals to receive timely and appropriate follow-up services upon discharge and, if applicable, allows the individual to continue medications with no missed doses.

(9) Document in the clinical record:

(a) The individual being informed of their treatment options including the use of medications for substance use disorder;

(b) The continuation or initiation of FDA-approved medication for substance use disorder treatment that has been provided on-site or facilitated off-site, if applicable;

(c) Referrals made to behavioral health providers including documentation that a discharge summary was provided to the receiving behavioral health provider as allowed under 42 C.F.R. Part 2; and

(d) Contact or attempts to follow up with the individual post-discharge including the date of correspondence.

(10) An agency may not deny admission based solely on an individual taking FDA-approved medications, under the supervision of a medical provider, for their substance use disorder or require titration of dosages in order to be admitted or remain in the program.

Commented [TJ(20]: MH too?

Commented [TJ(21]: MH too?

246-341-XX21

Residential and inpatient Mental health services—Individual service standards.

(1) An agency providing residential and inpatient mental health services must develop and implement an individualized annual training plan for agency staff members, to include at least:

(a) Least restrictive alternative options available in the community and how to access them;

(b) Methods of individual care; and

(c) Deescalation training and management of assaultive and self-destructive behaviors, including proper and safe use of seclusion and restraint procedures.

(3) If contract staff are providing direct services, the facility must ensure compliance with the training requirements outlined in subsection (12) of this section.

(4) A behavioral health agency providing mental health inpatient services must:

(a) Document that each individual has received evaluations to determine the nature of the disorder and the treatment necessary, including:

(i) A health assessment of the individual's physical condition to determine if the individual needs to be transferred to an appropriate hospital for treatment;

(ii) Examination and medical evaluation within twenty-four hours of admission by a licensed physician, advanced registered nurse practitioner, or physician assistant;

(iii) Consideration of less restrictive alternative treatment at the time of admission; and

(iv) The admission diagnosis and what information the determination was based upon.

(b) Ensure the rights of individuals to make mental health advance directives, and facility protocols for responding to individual and agent requests consistent with RCW **71.32.150**.

(c) Ensure examination and evaluation of a minor by a children's mental health specialist occurs within twenty-four hours of admission.

CERTIFICATION STANDARDS FOR CLINICAL WITHDRAWAL MANAGEMENT

246-341-XX22

Medically supported withdrawal management- certification standards.

Medically supported substance use disorder withdrawal management services are provided to assist in the process of withdrawal from psychoactive substances in a safe and effective manner that includes medical intervention.

(1) An agency certified for medically supported withdrawal management services must:

(a) Ensure the individual receives a substance use disorder screening before admission;

(b) Provide counseling to each individual that addresses the individual's:

(i) Substance use disorder and motivation; and

(ii) Continuing care needs and need for referral to other services.

(c) Have a medical provider or nursing staff on-site for a minimum of 8 hours per day or more, and otherwise on-call 24/7, as appropriate to the level of care provided.

(d) Maintain a list of resources and referral options that can be used by staff members to refer an individual to appropriate services; and

Commented [TJ(22]: What does this include?

Commented [TJ(23]: Involuntary only?

Commented [TJ(24]: Involuntary only?

Commented [TJ(25]: Should this be added to individual rights for all BHAs, inpt and outpt?

Commented [TJ(26]: More conversations about this. May not be necessary.

Commented [TJ(27]: See comment above

(e) Post any rules and responsibilities for individuals receiving treatment, including information on potential use of increased motivation interventions or sanctions, in a public place in the facility.

(2) Ensure that each staff member providing withdrawal management services to an individual, with the exception of substance use disorder professionals, substance use disorder professional trainees, physicians, physician assistants, advanced registered nurse practitioners, or person with a co-occurring disorder specialist enhancement, completes a minimum of forty hours of documented training before being assigned individual care duties. This personnel training must include the following topics:

(a) Substance use disorders;

(b) Infectious diseases, to include hepatitis and tuberculosis (TB); and

(c) Withdrawal screening, admission, and signs of trauma.

(3) An agency certified for clinical withdrawal management services must meet the certification standards for residential and inpatient behavioral health services in WAC 246-341-XX19 and the individual service requirements for inpatient and residential substance use disorder services in WAC 246-341-XX20.

(4) An agency certified for clinical withdrawal services may choose to provide information, assistance and referral, behavioral health support services, intervention, assessment and treatment services, outpatient behavioral health crisis services, or residential or inpatient behavioral health treatment services without additional certification in accordance with the applicable certification and individual service standards.

CERTIFICATION STANDARDS FOR CRISIS STABILIZATION UNIT AND TRIAGE SERVICES

246-341-XX23

Crisis stabilization unit and triage- certification standards.

An agency certified to provide crisis stabilization unit or triage services must meet all of the following criteria:

(1) A triage facility must be licensed as a residential treatment facility under chapter 71.12 RCW.

Commented [TJ(28]: From 1140

(2) If a crisis stabilization unit or triage facility is part of a jail, the unit must be located in an area of the building that is physically separate from the general population. "Physically separate" means:

(a) Out of sight and sound of the general population at all times;

(b) Located in an area with no foot traffic between other areas of the building, except in the case of emergency evacuation; and

(c) Has a secured entrance and exit between the unit and the rest of the facility.

(3) Ensure that a mental health professional is on-site at least eight hours per day, seven days a week, and accessible twenty-four hours per day, seven days per week.

(4) Ensure a mental health professional assesses an individual within three hours of the individual's arrival at the facility.

(5) An agency certified to provide crisis stabilization unit or triage services must meet the individual service standards for residential and inpatient mental health services in WAC 246-341-XX21.

(6) An agency providing crisis stabilization unit or triage services to involuntary individuals must meet the certification standards for involuntary behavioral health residential and inpatient services in WAC 246-341-XX24 and are not required to meet the requirements in WAC 246-341-0640.

(7) An agency certified crisis stabilization unit or triage services may choose to provide information, assistance and referral, behavioral health support services, intervention, assessment and treatment services, outpatient behavioral health crisis services, or residential or inpatient behavioral health treatment services without additional certification in accordance with the applicable certification and individual service standards.

Commented [TJ(29]: From 1140 and 1118. Does this apply to involuntary CSU and triage??
Current language: (5) For persons admitted to the crisis stabilization unit or triage facility on a voluntary basis, the clinical record must meet the clinical record requirements in WAC 246-341-0640.

CERTIFICATION AND INDIVIDUAL SERVICE STANDARDS FOR INVOLUNTARY BEHAVIORAL HEALTH RESIDENTIAL AND INPATIENT SERVICES

246-341-XX24

Involuntary behavioral health residential and inpatient services-certification standards.

(1) Agencies certified for involuntary behavioral health residential and inpatient services provide behavioral health intervention, assessment, and treatment services in a residential treatment facility or hospital to individuals under a civil commitment or court-order. Residential and inpatient services under this certification include the following services:

(a) Evaluation and treatment in accordance with the individual service standards in WAC 246-341-XX25; and
(b) Secure withdrawal management in accordance with the individual service standards in WAC 246-341-XX26.

(2) An agency providing services under chapter 71.05 or 71.34 RCW must:

(a) Follow the applicable statutory requirements in chapter 71.05 or 71.34 RCW;

(b) Ensure that services are provided in a secure environment. "Secure" means having:

(i) All doors and windows leading to the outside locked at all times;

(ii) Visual monitoring, in a method appropriate to the individual;

(iii) A space to separate persons who are violent or may become violent from others when necessary to maintain safety of the individual and others;

Commented [TJ(30]: From 1060

(iv) The means to contact law enforcement immediately in the event of an elopement from the facility; and

(v) Adequate numbers of staff present at all times that are trained in facility security measures;

(c) Provide services, including admissions, seven days a week, twenty-four hours a day;

(d) Ensure that a mental health professional, substance use disorder professional, if appropriate, and physician, physician assistant, or psychiatric advanced registered nurse practitioner (ARNP) are available twenty-four hours a day, seven days a week for consultation and communication with the staff that provide direct care of individuals;

(e) Ensure at least daily contact between each involuntary individual and a mental health professional, substance use disorder professional, or person with a co-occurring disorder specialist enhancement as appropriate, for the purpose of evaluation as to:

(i) The need for further treatment;

(ii) Whether there is a change in involuntary status; or

(iii) Possible discharge;

(f) For an individual who has been delivered to the facility by a peace officer for evaluation the clinical record must contain:

(i) A statement of the circumstances under which the individual was brought to the unit;

(ii) The admission date and time;

(iii) Determination of whether to refer to a designated crisis responder (DCR) to initiate civil commitment proceedings;

(iv) If evaluated by a DCR, documentation that the evaluation was performed within the required time period, the results of the evaluation, and the disposition of the person.

(2) Upon discharge of the individual the agency shall provide notification to the DCR office responsible for the initial commitment, which may be a federally recognized Indian tribe or other Indian health care provider if the DCR is appointed by the health care authority, and the DCR office that serves the county in which the individual is expected to reside.

(3) Agencies certified for involuntary behavioral health residential and inpatient services must also follow the certification standards for residential and inpatient behavioral health services in WAC 246-341-XX19.

(4) An agency certified for involuntary behavioral health residential and inpatient services may choose to provide information, assistance and referral, behavioral health support services, intervention, assessment and treatment services, outpatient behavioral health crisis services, residential or inpatient behavioral health treatment services, or crisis stabilization unit or triage services without additional certification in accordance with the applicable certification and individual service standards.

246-341-XX25

Evaluation and treatment services-Individual service standards.

Commented [TJ(31]: Incorporated CLIP

Commented [TJ(32]: From 1134

Commented [TJ(33]: From 1138. Combining with E&T certification.

(1) Evaluation and treatment services are provided for individuals who are held for one hundred twenty-hour detention or on fourteen, ninety, or one hundred eighty-day civil commitment orders according to chapters **71.05** and 71.34 RCW. An agency providing evaluation and treatment services may choose to serve individuals who are held for one hundred twenty-hour detention, or on short-term commitment orders (fourteen-day), long-term commitment orders (ninety-day and one hundred eighty-day), or all three. Agencies providing evaluation and treatment services may also provide services for individuals who are not detained or committed.

(2) An agency providing long-term evaluation and treatment services for youth must be a contracted child long-term inpatient treatment facility (CLIP). The CLIP facility must develop a written plan for assuring that services provided are appropriate to the developmental needs of children, including all of the following:

(a) If there is not a child psychiatrist on the staff, there must be a child psychiatrist available for consultation.

(b) There must be a psychologist with documented evidence of skill and experience in working with children available either on the clinical staff or by consultation, responsible for planning and reviewing psychological services and for developing a written set of guidelines for psychological services.

(c) There must be a registered nurse, with training and experience in working with psychiatrically impaired children, on staff as a full-time or part-time employee who must be responsible for all nursing functions.

(d) There must be a social worker with experience in working with children on staff as a full-time or part-time employee who must be responsible for social work functions and the integration of these functions into the individual treatment plan.

(e) There must be an educational/vocational assessment of each resident with appropriate educational/vocational programs developed and implemented or assured on the basis of that assessment.

(f) There must be an occupational therapist licensed under chapter **18.59** RCW available who has experience in working with psychiatrically impaired children responsible for occupational therapy functions and the integration of these functions into treatment.

(g) There must be a registered recreational therapist under chapter **18.230** RCW available who has had experience in working with psychiatrically impaired children responsible for the recreational therapy functions and the integration of these functions into treatment.

(h) Disciplinary policies and practices must be stated in writing and all of the following must be true:

(i) Discipline must be fair, reasonable, consistent and related to the behavior of the resident. Discipline, when needed, must be consistent with the individual treatment plan.

(ii) Abusive, cruel, hazardous, frightening or humiliating disciplinary practices must not be used. Seclusion and restraints must not be used as punitive measures. Corporal punishment must not be used.

(iii) Disciplinary measures must be documented in the clinical record.

(i) Residents must be protected from assault, abuse and neglect. Suspected or alleged incidents of nonaccidental injury, sexual abuse, assault, cruelty or neglect to a child must be reported to a law enforcement agency or to the department of children, youth, and families and comply with chapter **26.44** RCW.

(j) Orientation material must be made available to any facility personnel, clinical staff or consultants informing practitioners of their reporting responsibilities and requirements. Appropriate local police and department phone numbers must be available to personnel and staff.

(k) When suspected or alleged abuse is reported, the clinical record must reflect the fact that an oral or written report has been made to the child protective services of the department of children, youth, and families or to a law enforcement agency within the timelines identified in chapter **26.44** RCW. This note must include the date and time that the report was made, the agency to which it was made and the signature of the person making the report. Contents of the report need not be included in the medical record.

(l) Agencies that provide child long-term inpatient treatment services are exempt from the requirement in WAC **246-341-1060** to admit individuals needing treatment seven days a week, twenty-four hours a day.

(3) An agency providing short-term involuntary services to youth, which are not contracted as a CLIP facility, may provide treatment for a child on a one hundred eighty-day inpatient involuntary commitment order only until the child is discharged from the order to the community, or until a bed is available for that child in a CLIP facility.

(4) An agency providing evaluation and treatment services must follow the individual service standards for inpatient and residential mental health services in WAC 246-341-XX21.

Commented [TJ(34]: From 1134

Commented [TJ(35]: From 1118

246-341-XX26

Secure withdrawal management and stabilization services- Individual service standards.

Secure withdrawal management and stabilization services are provided to an involuntary individual to assist in the process of withdrawal from psychoactive substances in a safe and effective manner, or medically stabilize an individual after acute intoxication, in accordance with chapters **71.05** and **71.34** RCW.

(1) An agency must meet the requirements for withdrawal management services in WAC **246-341-1100**.

Commented [TJ(36]: From 1104

(2) An agency providing secure withdrawal management and stabilization services must develop and implement policies and procedures to assure that a substance use disorder professional and licensed physician, physician assistant, or advanced registered nurse practitioner are available twenty-four hours a day, seven days a week for consultation and communication with the staff that provide direct care to individuals.

(3) An agency providing secure withdrawal management and stabilization services must document that each individual has received necessary screenings,

assessments, examinations, or evaluations to determine the nature of the disorder and the treatment necessary, including:

(a) A telephone screening reviewed by a nurse, as defined in chapter **18.79** RCW, or medical practitioner prior to admission that includes current level of intoxication, available medical history, and known medical risks; and

(b) An examination and evaluation in accordance with RCW **71.05.210** within twenty-four hours of admission to the facility.

(4) For individuals admitted to the secure withdrawal management and stabilization facility, the clinical record must contain:

(a) A statement of the circumstances under which the individual was brought to the unit;

(b) The admission date and time;

(c) The date and time when the involuntary detention period ends;

(d) A determination of whether to refer to a DCR to initiate civil commitment proceedings;

(e) If an individual is admitted voluntarily and appears to meet the criteria for initial detention, documentation that an evaluation was performed by a DCR within the time period required in RCW **71.05.050**, the results of the evaluation, and the disposition; and

(f) Review of the admission diagnosis and what information the determination was based upon.

(5) An agency certified to provide secure withdrawal management and stabilization services must ensure the treatment plan includes all of the following:

(a) A protocol for safe and effective withdrawal management, including medications as appropriate;

(b) Discharge assistance provided by substance use disorder professionals or persons with a co-occurring disorder specialist enhancement, including facilitating transitions to appropriate voluntary or involuntary inpatient services or to less restrictive alternatives as appropriate for the individual.

(6) An agency providing secure withdrawal management must meet the certification standards for medically supported withdrawal management in WAC 246-341-XX22.

Commented [TJ(37]: From 1104