Behavioral Health Agency Rulemaking Workshop – Notes
August 31, 2021

Agenda:

- Brief recap – see slides
- Review draft language – confirm certification categories and standards make sense
- ID any individual services that stick out as being inconsistent
- Nesting certifications

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(1) 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-XXXX; and

(b) Emergency service patrol in accordance with the individual service standards in WAC 246-341-XXXX.

JT - In respect to the language above, we thought about building in flex for new services to fit under this category. This would allow quickly adding the service without having to amend the WAC to list that service.

Michael T. *- Is the 988 system folks considered crisis telephone support?*
JT – this may still need to be determined. Telephone support services would make sense.
Wendy S. *– Seems like a good idea.*
JT – potential con is whether DOH is going to be asked to include things that we shouldn't be regulating?

Telephone support services:
JT - Two certifications for mental health and substance use disorder. We talked about combining to be behavioral health telephone support service so have combined those requirements from both. Does it make sense?
Wendy S. *– seems odd to call out the mh provider and SUD provider*
Karen H. *- It seems appropriate to include both.*
JT - (1)(c) –Does this make sense for SUD?
Wendy S. *– It makes sense for SUD.*
Joan B. *- I'm wondering if we have any actual crisis or telephone agencies in our meeting for feedback?*
Christopher D. *– yes Comprehensive HealthCare*
JT - (1)(d) Does this make sense for SUD?
Christopher D. *– this is appropriate for both SUD and Crisis.*
Joan B. *- I feel like I'm not qualified to provide feedback in this particular section since I have no experience in the area of BH or SUD*
JT - Documentation under subsection (2). Pulled this language from the mental health section. Any concerns with applying this to SUD?
Wendy S. *– looks good.*

Behavioral Health Support services:
JT - Note that the X's you see will need to be renumbered to reference the appropriate sections that will apply to the services that are included.

Clubhouses:
JT - Statute has a broad definition of Clubhouse that could include other types like a recovery café. Thinking of holding a separate meeting to discuss this topic. If you are interested, please type in your name and email in the Questions box so we can include you.

Case Management:
Kate R. - *WISe providers are using rehab case management for when clients are inpatient and we are coordinating with hospital and family for discharge planning, so wonder if there should be a specific definition in the WAC?*
JT - Case management could include rehabilitative case management. We will discuss in a future meeting including how and where we want to define these service terms.
Jessie E. *- We (at Compass Health) have never understood why Rehab Case Management is a seperate license - it is the same activity (care coordination, discharge planning, etc.) that we do under our other licenses, just in a different setting. It is a different SERI modality, but that doesn't seem to mean it needs it's own license type.*
Kate R. *– that makes sense.*
Wendy S. *– we have three docs (WAC, SERI, State Plan) – difficult administratively when we start using language differently. Building out the Clubhouse concept – we have to think about how the SERI is constructed as well as the state plan. Make sure we use language the same way through this process bc they are cross-referenced.*
JT – for this project, we will be aware about defining terms differently when there are common definitions. I met with HCA about the concept of this workshop for broadening and flexibility, and HCA was very receptive to that. We are working with them on conversations with the state Medicaid plan update. These standards are not driving HCA work but we are collaborating. We want to be careful that our rules are not too limiting. Excited to build flexibilities to allow other agencies to amend their language as well. It's an exciting time and a balancing act.
Note *that many other workshop attendees agree with Wendy S. about being careful with defining terms.*
Laura M. *- If the agency providing "club-house" services, yet they are not required to be staffed with credentialed or qualified professionals then what is the crisis plan for person's and behavioral outbursts at support service locations? It seems like this will create a heavy reliance on 911 ems and police services.*
JT – will take note and do some thinking and will get back an answer.
Christopher D. *– There is significant difference between rehabilitative case management. Which is hospital or injury based, occupational based versus case management services that occur in behavioral health. The descriptions need to clarify this definition.*
JT – State Medicaid Plan has a good description that we can use.
Kailey F. - Julie- I would be happy to help answer that question if you need additional information on Clubhouse.

Behavioral Health Support services subsection (2):
JT - Existing WAC -0640 – requirements for bio-psychosocial assessment and individual service plan (ISP) includes language for following a modified version. This clarifies that agencies would not follow -0640 but instead follow subsection (3) – just a clarification. Existing abbreviated requirements should stay the same. Copy of assessment – some agencies contract or have an agreement with another agency to do the ISP and assessment. If the agency is doing it in-house, they would need an additional certification.
Laura M. *- Section 3 - Why would non-credentialed staff have access to protected health information of people engaging in support services?*

JT – Staff providing services will have an Agency Affiliated Counselor (AAC) credential. The agency will have credentialed staff. The staffing requirements are in -0515. This may need to be clarified better regarding the agency requirement for assessment and ISP.
Melanie G. *- How recent does that assessment need to be??? I've been begging for more clarification on that for years.*
JT – current WAC doesn't say. Any recommendations to add a timeframe into the WAC?
Attendees with varying responses – 12 months; stay aligned with HCA; do not put that into WAC…..
JT – what does the SERI require?
Kelly T. – 12 months
Unknown *- MCOs will not pay for more than once a year.*
Jessie E. *- Are we talking about how the timing of the assessment compares to the intake with the support program? Someone might have a recent assessment when they come in but should not have to reassess in order to STAY in the supportive program.*
Kelly M. *- As an SUD provider, ASAM placement is how you make recommendations. ASAM placement criteria can change over a short time.*
Angela G. *- It would be helpful to see it in the WAC because MCOs sometimes ask for the assessment to be less than 2 weeks old but won't pay for it.*
JT – because of the variation in requirements, we should maybe not have a time frame.
Chris K. *- Under 3(d), would an agency be required to document the fact that a patient *declined* a referral to a more intensive level of care? My understanding is that we're currently required to document this at every encounter with a patient, even if they've resolutely said NO to that referral?*
Sarah B. *- For c, is that saying medication monitoring services, both psychiatric and non-psychiatric, does not need an ISP?*
JT – can clarify. The ISP had been removed for medication monitoring and management so added that the ISP is not required when providing medication monitoring services. This is consistent with the rule work done last summer.
Kailey F. *- Does this also comply with day support requirements? Can an agency outsource the assessment component but still provide day support? (not sure if this is the appropriate section to discuss this).*
JT – yes, which is why we left it in the day support services category and the intervention and treatment (partial hospitalization program).
Sarah B. *- For support services, are discharges no longer expected?*
JT – I will double check.
Melanie G. *- Just a reminder that not all agencies bill Medicaid so if something isn't called out in WAC and you are counting on it being called out in the state plan or MCO contracts, there may be some licensed agencies who only have to follow WAC and not those other things.*
Joan B. *- I would like to see language added about maximum time frame to accept MH and SUD assessments*
JT - Crisis support services (1)(a-d)… do any of these not apply to SUD crisis support services?
Joan B. *– Which providers do SUD crisis services?*
JT – It combines the certifications currently so am not able to tell you at this time.
Christopher D. *- Wouldn't (b) only be applicable during the crisis episode? Crisis Support would be following the crisis episode.*
JT – Good point!
Christopher D. *- Crisis covers both mental health and SUD.*
Joan B. *- fyi only-I've worked at a lot of the major SUD agencies in my area and none of those had crisis SUD services whereas all the MH providers normally provide.*

Kelli M. *- Is there concern that there are documentation standards/instructions in both the SERI and the WAC?*
JT – need it in both places – one is for reimbursement and our WAC is for regulatory purposes.
Wendy S. *- There is an SUD agency in Clallam County that provides SUD Crisis Services and this is consistent with their practice.*
Christopher D. - (b) implies that this is face to face and may be more applicable to phone services. Needs to be clarified...

Crisis support services:
JT – Subsection (5): "When services are provided in a private home or nonpublic setting…." Is this appropriate to have for SUD?
Sarah B. *– yes*
Wendy S. *– Absolutely*
Chris K. *- Yes, this is appropriate for SUD as well as mental health*

BH Intervention, assessment and treatment services:
JT – The ISP requirement had been removed but wanted to clarify that some agencies get the assessment from another agency or private provider (copy). Would psychiatric medication management fit here? Or further clarification needed?
Wendy S. *– Medication management is prescribing on an ongoing basis. You need a good evaluation to initiate that. Are you talking about people who have had that done at another agency and then they are carrying on? Seems questionable medical practice.*
JT – As part of the medical exam, they may be doing some psychiatric evaluation but I would need to check.
Wendy S. – concerning to have this outside of the individual and treatment services. You don't want to use the psychiatrist to manage the plan.
JT – The reason it belongs here is bc there needs to be a bio-psychosocial assessment done by the prescriber in-house at that agency.
Wendy S. *– our providers would never be comfortable doing it otherwise.*
JT – agree with carveout for the ISP?
Wendy S. *– yes for those who are just doing medication management.*
Holly B. *– following up to Wendy's statement. We would accept an assessment from another telecare provider.*
Chris D. *- Should be a current assessment with plan for review. Implies that client is stable... implies that services have been transferred to (or back to) primary care...*
Sarah B. *- It is for clients that have graduated from services but still need medication. The clients will not show for clinical services, but will appear for psychiatric services.*
Joan B*. - Some SUD and MH providers will do psych meds but not MAT so need to obtain MAT services elsewhere outside BHA*
Brooke E. *- From my vantage point, I also think this fits best in this section...needs to stay here - in Individual and Tx Services category. Strongly agree with current comment that it belongs here.*
Kelly T. *- I don't necessarily agree with not including medication management in the ISP if only receiving psychiatric medication management. MCOs and health care agencies have been pushing for integrated care, so keeping med management out of the ISP is further siloing our services.*
Jessie E. *- Agreed! There should be some kind of treatment plan. Maybe it doesn't need to meet all the requirements of a standard treatment plan.*

JT –Goal is to continue on their medications and also provide their treatment plan - would that work? But more may be required. Will look at this more.
April C. *- A prescriber will not necessarily create or maintain an ISP because if a client isn't seeing us for counseling or case management, there would be no ISP created.*
JT – that was the main argument being made.
Wendy S. *– The goal of integrated care…. A treatment plan is statement to prescribe xxx and follow up in xx number of days – treatment plan in a medical plan. The BHA treatment plan is much greater than that. As we align with the physical health care side, maybe it is around the medication management side. The ISP doesn't work with the EMR.*
JT – great perspective! Curious what others think about that?
Sydney S. *- Yes! Thank you Wendy*
Sarah B. *– Completely agree with Wendy.*
JT – There are many comments on this topic. I will capture all of the comments and come back to this.

Deferred prosecution:
JT - combined under level 2 SUD services. Pulled out language to make its own WAC section.
JT - ADIS added subsection (5) – court referred service. I wanted to keep with the other court-ordered services, however, if they're receiving ADIS they're not getting an ISP because they are not getting treatment or therapy. I'm curious about the assessment requirement. If a provider only provides ADIS, the assessment is being done and shows that they can just do ADIS services. The ADIS only agency would not be providing an assessment.
Tom D. *- That is the way it is done now.*
Linda G. *- I believe ADIS does not necessarily require an assessment. They are often just ordered by the judge.*
Joan B. *- Why does ADIS require copy of the assessment?*
Christopher D. *- ADIS Service is like an EAP or Behavioral Health Education program. May be documented in the same place but level of documentation ensures that curriculum is presented and not to the individualized level that other OP services would be documented.*
Joan B*. - Normally the client just gets verification that they completed the ADIS. Court orders the assessment, the assessment stays at the assessment agency and ADIS should NOT get a copy.*
Linda G*. - We offer ADIS and you pay and come in without seeing staff first.*
Joan B*. - Can we remove that language please to give ADIS agency a copy of someone's assessment. Too much info being shared about the client that is not necessary for a ADIS.*
JT - will modify the language regarding whether an assessment needs to be done.

Outpatient Crisis:
JT – list behavior crisis observation service. This would be provided in a community setting. If we list this service, do we need to create service standards?
Wendy S. *- I think the word observation is weird. Intervention would be better*
JT – we can work on the name
JT - SUD Crisis services subsection (3), does this make sense?
Sarah B. *- For d under SUD crisis, sounds like it should move up to the behavioral health items.*
JT – will make note
Wendy S. *- I'm not seeing any reference to Advanced Directives should be reviewed when available*
JT – will make note

Behavioral health crisis outreach service individual standards:
JT – included mention of SUD and included existing requirements – combined. (2) included certified peers because it's applicable to both.
Wendy S. – in conflict for DCRs in rural communities because they are the primary responder.
JT – good point. This is an existing conflict in our current rules. I will work on addressing this.
JT - DCR language. Do we need to keep this certification? Or would it fit under a different category? Is there someone who also looks at DCRs.
Wendy S. *– all are subcontracted through the ASO. They are looking at the RCWS and DCR protocols and are prescriptive about how that functions. It's a legal function as opposed as a clinical function. It is important to have it referenced.*
JT – stand alone certification.
Christopher D. *- BH-ASO and complaints are filed with the ombuds. Ombuds may or may not be a part of the ASO. Agree that DCR is more of a legal function.*

Residential and Inpatient Services:
JT - Separated into two different services. We have general standards (MH and SUD) all existing requirements from -1005. If we move the requirements under the IAT certification, they currently still apply to inpatient and residential facilities. This is what subsection(4) is doing.
JT - Individual Service Language for SUD from -1070. No changes to this and then same with the MH inpatient standards, so no changes there either. Hard to combine because they are both unique.
Wendy S. *- Residential Tx services can also be provided in DSHS licensed facilities.*
JT – enhanced services?
Wendy S. *– assisted living.*
JT – when provided in DSHS facilities they are not required to have a behavioral health license.
Wendy S. *– dually licensed. Residential service is regulated by DOH but the facility is licensed by DSHS.*
JT – maybe we should say, "state licensed facilities." Wendy, can you email me about that language?
Brennen J. - *Do these certification standards (all levels) take ASAM criteria into account?*
JT – there is a statement that applies to all BHAs. If you're providing SUD, ASAM criteria must be used…. General requirement.
Joan B. *- Given our new COVID-19 experience, should we take a look at the mandate for TB testing and broaden that particular requirement to include or change to something like other airborne disease testing?*
JT – will make note. For expanding testing requirements, do agencies get paid to do that? This can be a sticking point when adding requirements.

Medically supported withdrawal:
JT – we received comments that some do not fit into a specific model bc they don't have the right staff. Can we have a cert for medically supported withdrawal management. (c) is added language – if we add this, could this pull in the level 3.5 providers who are providing this service without the 24 hour nursing. Would this work?
Joan B. *- I feel strongly that this question needs to be submitted out to our WD management agencies or we will get ourselves in a mess.*
Tom D. *- Re your thoughts re Detox Services in 3.5, With the overwhelming effect that COVID is having on Hospitals and the fact that Detox Beds being full, I am wondering if there could be more flexibility with addressing Withdrawal Management needs by allowing some limited ability for ASAM 3.5 services to provide some care (with additional Medical Supports)? Clearly this would require some funds (Rates) to pay for the increased staff costs but, it might reduce the need for Hospital ED's to have to "Clear people" as stable for care in 3.5 (Or even in 3.3 PPW services) Levels of care?*

JT – great way to think about this! The funding and reimbursement is the biggest hang up to that concept. We could do it if agencies were appropriately staffed. It's probably acceptable now but the reimbursement is tricky. You may want to share that with HCA.

Before next meeting we will send:

- Draft language and notes in GovDelivery.
- ABA workshop announcement.

Next meeting:

- Cover involuntary services and go over a couple of Qs with the crisis and stabilization piece.
- Review and talk through the document showing nesting of certifications.
- Be thinking about whether there are certain services with inconsistent regulations? Ex supportive housing – HCA already has a lot of rules and we can refer to those.

Future meetings:

- Hot topics, such as telehealth.
- Final meeting on September 28th we will cover a mostly finalized draft that incorporates information from all of our discussions.

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

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

(2) 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.

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246-341-XXX2
Telephone support services- Individual service standards.

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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:

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(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.

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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.

(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;

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Commented [TJ(13]: Want to have additional discussion about this at a separate meeting.

Commented [TJ(14]: Currently rehabilitative case management in WAC with no individual service standards. Only description of service.

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(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-XXXX.
(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.

(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.

(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.

Commented [TJ(18]: Assessment definition: WAC 246-341-0640 (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 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.

Commented [TJ(19]: If agency chooses to conduct assessments this would bump them up to the IAT certification.

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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

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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.

Commented [TJ(23]: Copy and paste from 0730

(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.

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;

(b) 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) 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;

(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 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;

Commented [TJ(24]: Do crisis support services need to follow documentation requirements in the certification standards??

Commented [TJ(25]: From 0915

Commented [TJ(26]: In-person or videoconferencing allowed?

Commented [TJ(27]: From 0905. SUD?

Commented [TJ(28]: From 0900. SUD? Check applicability of below for support services?

Commented [TJ(29]: From 0900. SUD?

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(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;

(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 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);

Commented [TJ(35]: Several comments about this. Many believe it fits here. Currently fits in these requirements. Suggestion that ISP should not be required which would make it fit in the support services category or would need a specific carve out. Support category would allow the prescriber to rely on another agency/provider assessment rather than completing their own BPS assessment. Ex. many individuals have been on meds for a while and are not engaged or wanting to engage in counseling. BHAs want to be able to provide medication management to these individuals.

Commented [TJ(36]: Moved from 0640

(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 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:

Commented [TJ(37]: Removed ISP requirement last summer

(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.
(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:

Commented [TJ(38]: Copy and paste from 0800

(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

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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.

246-341-XX12

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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**.

246-341-XX13

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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 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.

Commented [TJ(42)]: Per stated current practice.

246-341-XX14

Commented [TJ(43)]: From 0805

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

Commented [TJ(44]: From 0815

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/drug information school.

246-341-XX16

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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 observation.

(3) 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;

Commented [TJ(46]: Inclusive of SUD? Language below reflects combo

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Commented [TJ(48]: Remove if combining under IAT

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(d) Transport or arrange for transport of an individual in a safe and timely manner, when necessary;
(e) Be available twenty-four hours a day, seven days a week; and
(f) 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;
(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.

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246-341-XX18

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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.

(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.

PDF **246-341-0810**

Commented [TJ(52]: Don't know where this fits, if it's needed, should be its own certification, etc.

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

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.

Commented [TJ(53]: Ended up separating rather than calling it BH residential and inpatient treatment due to the amount of requirements specific to MH vs SUD.

(2) Agencies certified for behavioral health residential and inpatient services must:

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(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;

(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) An agency providing residential or inpatient mental health or substance use disorder services must follow the certification standards in WAC 246-341-XX10 for intervention, assessment and treatment services.

(5) 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.

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Commented [TJ(56]: This is required if we move 0640 under IAT

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

(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:

(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:

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(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.

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:

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(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 (2) 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

(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.

Commented [TJ(59]: This is an attempt to incorporate the request for level 3.5 agencies that provide some nursing service, but not 24-hr nursing.

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Commented [TJ(61]: Would this make sense?

(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.

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(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.

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(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 certification standards for assessment, intervention, and treatment services in WAC 246-341-XX10 and 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.

(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(64]: 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;
(iv) The means to contact law enforcement immediately in the event of an elopement from the facility; and

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(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-XX19and the certification standards for intervention, assessment and treatment services in WAC 246-341-XX10.

(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.

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(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

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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.

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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.

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(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.

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