

PART 819

CHEMICAL DEPENDENCE RESIDENTIAL SERVICES

[Statutory Authority: Mental Hygiene Law Sections 19.07(e), 19.09(b), 19.40, 32.01, 32.07(a)]

Notice: The following regulations are provided for informational purposes only. The Office of Alcoholism and Substance Abuse Services makes no assurance of reliability. For assured reliability, readers are referred to the *Official Compilation of Rules and Regulations*.

Sec.

- 819.1 Legal base**
- 819.2 Standards applicable to all residential service providers**
- 819.3 Admission procedures**
- 819.4 Post admission procedures**
- 819.5 Record keeping**
- 819.6 Quality improvement and utilization review**
- 819.7 General staffing**
- 819.8 Additional requirements for intensive residential rehabilitation**
- 819.9 Additional requirements for community residential services**
- 819.10 Additional requirements for supportive living services**
- 819.11 Severability**

819.1 Legal base.

(a) Section 19.07(e) of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt standards including necessary rules and regulations pertaining to chemical dependence services.

(b) Section 19.09(b) of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt regulations necessary and proper to implement any matter under his or her jurisdiction.

(c) Section 19.40 of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to issue operating certificates for the provision of chemical dependence services.

(d) Section 32.01 of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt any regulation reasonably necessary to implement and effectively exercise the powers and perform the duties conferred by Article 32 of the Mental Hygiene Law.

(e) Section 32.07(a) of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt regulations to effectuate the provisions and purposes of Article 32 of the Mental Hygiene Law

819.2 Standards applicable to all residential service providers.

(a) For purposes of this Part, Chemical dependence residential service or residential service means a chemical dependence residential service providing an array of services for persons suffering from chemical dependence. Such services may be provided directly or through cooperative relationships with other community service providers. This Part applies to any entity certified by the Office to provide a chemical dependence residential service and governs all residential program formerly certified by the Division of Alcoholism and Alcohol Abuse and/or the Office pursuant to Part 375 of this Title and all residential programs formerly licensed by the Division of Substance Abuse Services and/or the Office pursuant to Part 1030 of this Title. There are three levels of service that can be offered in a residential setting: intensive residential rehabilitation services, community residential services, and supportive living services. Each is distinguished by the complement of services available on site as well as the degree of dysfunction of the individual served in each setting. The three levels of residential services are defined as follows:

(1) Intensive residential rehabilitation services means residential services requiring twenty four hours a day, seven days per week treatment in a structured environment for individuals whose potential for independent living in recovery is contingent upon substantial social habilitation or rehabilitation. An integral part of this service is the case management of additional services from other providers that are needed by the resident. This level of residential service requires established written agreements with other appropriately certified providers to furnish psychiatric and health care services, in addition to

educational, social and vocational services. These services are appropriate for individuals who require chemical dependence services in a residential setting due to previous non-compliance, or relapse, in Outpatient service settings or their life skills deficits require sustained intensive rehabilitation.

(2) Community residential services means chemical dependence residential services providing supervised services to persons making the transition to abstinent living. Persons appropriate for this service Require the support of a drug and alcohol-free environment while receiving either outpatient services or educational and/or vocational services. These transitional residential services are for individuals who are completing or have completed a course of treatment, but who are not yet ready for independent living due to outstanding clinical issues or unmet needs for personal, social or vocational skills development. These services are appropriate for individuals who require ongoing clinical support.

(3) Supportive living services means chemical dependence treatment services which are designed to promote independent living in a supervised setting for individuals who have completed another course of treatment, are making the transition to independent living, and whose need for services does not require staffing on site on a twenty four hour a day basis. These treatment services are for individuals who either requires a long-term supportive environment following care in another type of residential service for an undetermined length of stay, or who are in need of a transitional living environment prior to establishing independent community living.

(b) The governing authority shall determine and establish written policies, procedures and methods governing the provision of services to residents which shall include a description of each service provided, including procedures for making appropriate referrals to and from other services, when necessary. These policies, procedures, and methods, which require review and approval by the governing authority, shall address, at a minimum, the following:

(1) admission, retention and discharge, including specific criteria relating thereto, as well as transfer procedures;

- (2) level of care determinations, comprehensive evaluations, treatment plans, and placement services;
- (3) staffing plans, including the use of volunteers;
- (4) screening and referral procedures for associated physical or psychiatric conditions;
- (5) the determination of fees for services rendered;
- (6) infection control;
- (7) public health education and screening with regard to tuberculosis, sexually transmitted diseases, hepatitis, AIDS and HIV prevention and harm reduction;
- (8) cooperative agreements with other chemical dependence service providers and other providers of services that the resident may need;
- (9) a requirement that if acupuncture is provided as an adjunct to the services provided by the service, it must be provided in accordance with Part 830 of this Title;
- (10) a requirement that when HIV and AIDS education, testing and counseling are provided, such services must be provided in accordance with Article 27-F of the Public Health Law and this Title;
- (11) the use of alcohol and other drug screening tests, such as breath testing, urine screening and/or blood tests;
- (12) procedures for the ordering, procuring, and disposing of medication, as well as the self-administration of medication;
- (13) quality improvement and utilization review;
- (14) clinical supervision and related procedures;
- (15) procedures for emergencies;
- (16) incident reporting and review in accordance with Part 836 of this Title;
- (17) record keeping procedures which ensure that documentation is accurate, timely, prepared by appropriate staff, and in conformance with the federal confidentiality regulations contained in 42 Code of Federal Regulations Part 2;

(18) personnel;

(19) procedures by which required educational services are provided for school age children who are in residence as either an individual who is receiving treatment or as part of a family unit; and

(20) procurement, storage, and preparation of food.

(c) A provider of residential services may provide residential services to an individual who is on methadone or other approved opiate maintenance, or is being detoxified from methadone. Opiate maintenance or detoxification services must be provided through a written agreement with an appropriately certified methadone/opiate provider in accordance with applicable federal and state requirements including, but not limited to, regulations of the federal Center for Substance Abuse Treatment, the United States Drug Enforcement Administration, the New York State Department of Health, and the Office, including but not limited to Part 828 of this Title.

(d) A chemical dependence residential service shall have as its goals:

(1) the promotion and maintenance of abstinence from alcohol and other mood-altering drugs and substances except those lawfully prescribed by a physician, physician's assistant, or nurse practitioner; however, if a residential service objects to a resident's continued use of such prescribed drugs or substances, the residential service shall document each of the following:

(i) obtain a signed consent form in accordance with the requirements of 42 Code of Federal Regulations Part 2 which authorizes the release of patient identifying information to the physician, physician's assistant, or nurse practitioner who prescribed the drug or substance to the resident ("the prescribing professional");

(ii) consult with the prescribing professional to ascertain their knowledge and awareness of the resident's history of chemical dependence, and if the prescribing professional is unaware of the resident's history of chemical dependence, inform the prescribing professional accordingly; and

(iii) after the required consultation in (ii) above, if the prescribing professional believes that the resident should be permitted to continue to use the drug or substance, the resident must be permitted to continue to use the drug or substance;

(2) the improvement of functioning and development of coping skills necessary to enable the resident to be safely, adequately and responsibly treated in the least intensive environment; and

(3) the utilization of individualized treatment/service plans to support the maintenance of recovery and the attainment of self-sufficiency, including, where appropriate, the ability to be functionally employed, and the improvement of the resident's quality of life.

(e) All residential services shall provide, either directly or through referral to appropriate agencies, habilitative and rehabilitative services consistent with identified needs and plans for services for individual residents. The following services shall be provided to residents as clinically indicated:

(1) Counseling. Each residential service shall make available to its residents individual, group and family counseling services as appropriate.

(i) A group therapy session shall contain no more than 15 persons.

(ii) Chemical dependence individual, group and family counseling must be provided by a clinical staff member.

(iii) Family counseling services include services to significant others.

(iv) Peer support may occur in a peer group setting where the group is facilitated by residents who have greater experience or seniority within the service. Such counseling must be directly supervised by a clinical staff member in attendance.

(2) Supportive services. Each service shall ensure that a comprehensive and appropriate range of support services are available to each resident. Such services shall include, as needed and as appropriate, legal, mental health, and social services, as well as vocational assessment and counseling.

(3) Educational and child care services. Each residential service which provides services to school-age children must make arrangements to ensure the availability of required educational and child care services.

(4) Structured activity and recreation. Residents shall be afforded the opportunity to participate in activities designed to develop skills to enable them to make effective use of leisure time as well as improve social skills, self esteem and responsibility.

(5) Orientation to community services. Each chemical dependence residential service shall provide orientation, advice and instruction in identifying and obtaining needed community services, including housing and other necessary case management services, to each resident.

(f) The certified bed capacity of each residential service may not be exceeded at any time except in cases of emergency and unexpected surges in demand where no alternative options are available, when the failure to temporarily accept individuals into the service would jeopardize their immediate health and safety, and where the excess of capacity would be time limited. Standards and procedures for such exceptions that are based upon the availability of adequate space, supplies and staff must be established with the prior approval of the Office.

(g) Food and nutrition.

(1) Intensive residential rehabilitation services shall ensure the availability of three meals each day to each resident and community residences shall ensure the availability of two meals each day to each resident. Such meals shall furnish sufficient nutrients and calories to meet normal needs as well as the special needs of persons in recovery. Supportive living services shall ensure the availability of adequate food to all participants.

(2) For intensive residential rehabilitation services and community residences, the facility shall have available snacks and beverages between meals. A qualified dietician, dietetic technician, nutritionist, or other appropriately qualified personnel shall provide menu planning services. Other suitable staff shall be responsible for the procurement of food supplies and the training and directing of food preparation and serving personnel. Copies of menus shall be kept on file for a period of one year.

819.3 Admission procedures.

(a) An individual who appears at the residential service seeking or having been referred for treatment or evaluation shall have an initial determination made and documented in a written record by a qualified health professional or other clinical staff under the supervision of a qualified health professional, which states the following:

(1) that the individual appears to be in need of chemical dependence services;

(2) that the individual appears to be free of serious communicable disease that can be transmitted through ordinary contact; and

(3) that the individual appears to be not in need of acute hospital care, acute psychiatric care, or other intensive services which cannot be provided in conjunction with residential care or would prevent him/her from participating in a chemical dependence service.

(b) The determinations made pursuant to the above shall be based upon service provider records, reports from other providers and/or through a face-to-face contact with the individual, all of which must be documented.

(c) Level of care determination. If an individual is determined to be appropriate for chemical dependence services, a level of care determination shall be made by a clinical staff member who shall be provided clinical oversight by a qualified health professional. The level of care determination shall be signed and dated by the clinical staff member. The level of care determination shall be made promptly and in no event not later than one day after the resident's first on site contact with the service.

(d) The level of care determination process must be in accord with the governing authority's policy and procedures and incorporate the use of the OASAS Level of Care for Alcohol and Drug Treatment Referral Protocol (LOCADTR) or another Office-approved protocol.

(e) Prohibition against discrimination. No individual shall be denied admission to the residential service based solely on the individual's:

(1) prior treatment history;

(2) referral source;

(3) maintenance on methadone or other medication prescribed and monitored by a physician, physician's assistant or nurse practitioner; however, if a residential service objects to an individual's continued use of such prescribed drugs or substances, the residential service shall document each of the following:

(i) obtain a signed consent form in accordance with the requirements of 42 Code of Federal Regulations Part 2 which authorizes the release of patient identifying information to the physician, physician's assistant, or nurse practitioner who prescribed the drug or substance to the individual ("the prescribing professional");

(ii) consult with the prescribing professional to ascertain their knowledge and awareness of the individual's history of chemical dependence, and if the prescribing professional is unaware of the individual's history of chemical dependence, inform the prescribing professional accordingly;

and

(iii) after the required consultation in (ii) above, if the prescribing professional believes that the individual should be permitted to continue to use the drug or substance, the individual must be permitted to continue to use the drug or substance;

(4) pregnancy;

(5) history of contact with the criminal justice system;

(6) HIV and AIDS status;

(7) physical or mental disability; or

(8) lack of cooperation by significant others in the treatment process.

(f) Admission criteria. To be admitted for residential services, the individual must be determined to be able to achieve or maintain abstinence and recovery goals with the application of residential services and:

(1) the individual must meet the admission criteria identified in Section 819.8 for intensive residential rehabilitation services; or

(2) the individual must meet the admission criteria identified in Section 819.9 for community residential services; or

(3) the individual must meet the admission criteria identified in Section 819.10 for supportive living services.

(g) If the individual is deemed inappropriate for residential services, unless the individual is already receiving chemical dependence services from another provider, a referral to a more appropriate service shall be made. The reasons for denial of any admission to the residential service must be provided to the individual and documented in a written record maintained by the residential service.

(h) If determined appropriate for the residential service, the individual shall be admitted. The decision to admit an individual shall be made by a staff member who is a qualified health professional authorized by the policy of the governing authority to admit individuals. The name of the qualified health professional who made the admission decision, along with the date of admission, must be documented in the case record.

(i) There must be a notation in the case record that the resident received a copy of the residential service's rules and regulations, including resident rights and a summary of federal confidentiality requirements, and a statement that notes that such rules were discussed with the resident, and that the resident indicated that he/she understood them.

(j) All residents shall be informed that admission is on a voluntary basis and that a resident shall be free to discharge him or herself from the service at any time. For residents under an external mandate, the potential consequences for premature discharge shall be explained, but this shall not alter the voluntary nature of admission and continued treatment. This provision shall not be construed to preclude or prohibit attempts to persuade a resident to remain in the service in his or her own best interest.

819.4 Post admission procedures.

(a) Comprehensive evaluation.

(1) The goal of the comprehensive evaluation shall be to obtain that information necessary to develop an individual treatment plan.

(2) The comprehensive evaluation shall obtain that information necessary to determine whether a diagnosis of alcohol related or psychoactive substance related use disorder in accordance with the International Classification of Diseases, Ninth Revision or another Office-approved protocol is indicated.

(3) Each comprehensive evaluation shall be based, in part, on clinical interviews with the resident, and may also include interviews with significant others, if possible and appropriate.

(4) No later than fourteen days after admission, staff shall complete the resident's comprehensive evaluation which shall include a written report of findings and conclusions addressing, at a minimum, the resident's:

(i) chemical use, abuse and dependence history;

(ii) history of previous attempts to abstain from chemicals and previous treatment experiences;

(iii) comprehensive psychosocial history, including, but not limited to, the following:

(A) legal involvements;

(B) HIV and AIDS, tuberculosis, hepatitis or other communicable disease risk assessment;

(C) relationships with, history of the use of chemicals by, and the impact of the use of chemicals on, significant others;

(D) an assessment of the resident's individual, social and educational strengths and weaknesses, including, but not limited to, the resident's literacy level, daily living skills and use of leisure time;

(E) the resident's medical history, mental health history, current status, and the resident's lethality (danger to himself/herself or to others) assessment; and

(F) a specific diagnosis of alcohol related or psychoactive substance related use disorder in accordance with the International Classification of Diseases, Ninth Revision or another Office-approved protocol.

(5) The comprehensive evaluation shall bear the names of the staff members who participated in evaluating the individual and must be signed by the qualified health professional responsible for the evaluation.

(b) Medical history.

(1) For those residents who do not have available a medical history and no physical examination has been performed within 12 months, within forty-five days after admission the resident's medical history shall be recorded and placed in the resident's case record and the resident shall receive a physical examination by a physician, physician's assistant, or a nurse practitioner. The physical examination may include but shall not be limited to the investigation of, and if appropriate, screenings for infectious diseases; pulmonary, cardiac or liver abnormalities; and physical and/or mental limitations or disabilities

which may require special services or attention during treatment. The physical examination shall also include the following laboratory tests:

- (a) complete blood count and differential;
- (b) routine and microscopic urinalysis;
- (c) if medically or clinically indicated, urine screening for drugs;
- (d) intradermal PPD, given and interpreted by the medical staff unless the resident is known to be PPD positive;
- (e) or any other tests the examining physician or other medical staff member deems to be necessary, including, but not limited to, an EKG, a chest X-ray, or a pregnancy test.

(2) If the patient has a medical history available and has had a physical examination performed within 12 months prior to admission, or if the resident is being admitted directly to the residential service from another chemical dependence service authorized by the Office, the existing medical history and physical examination documentation may be used to comply with the requirements of this Part, provided that such documentation has been reviewed and determined to be current and accurate.

(3) Resident records shall include a summary of the results of the physical examination and shall also demonstrate that appropriate medical care is recommended to any resident whose health status indicates the need for such care.

(c) After the comprehensive evaluation is completed, a resident shall be retained in such treatment only if the resident:

- (1) has a diagnosis of alcohol related or psychoactive substance related use disorder in accordance with the International Classification of Diseases, Ninth Revision or another Office-approved protocol;
- (2) continues to meet the admission criteria in this Part;
- (3) is free of serious communicable diseases that can be transmitted through ordinary contact with other residents;

(4) has no medical or surgical condition or mental disability requiring acute care in a general or psychiatric hospital;

(5) is not in need of medically managed detoxification; and

(6) can benefit from continued treatment in a residential service.

(d) If the comprehensive evaluation indicates that the individual needs services beyond the capacity of the residential service to provide either alone or in conjunction with another program, referral to appropriate services shall be made. Identification of such referrals and the results of those referrals to identified program(s) shall be documented in the resident record.

(e) If a resident is referred directly to the residential service from another service certified by the Office, or is readmitted to the same service within sixty days of discharge, the existing level of care determination and comprehensive evaluation may be used, provided that documentation is maintained demonstrating a review and update.

(f) An initial treatment/service plan addressing the resident's individual needs must be developed within three days of admission, or readmission, to the chemical dependence residential service and shall be prepared in consultation with the resident, as documented by the resident's signature on the treatment/service plan. This initial treatment/service plan must contain a statement which documents that the individual is appropriate for this level of care, identifies the assignment of a named clinical staff member with the responsibility to provide orientation to the individual, and includes a preliminary schedule of activities, therapies and interventions.

(g) A comprehensive treatment/service plan ("treatment/service plan"), based on the admitting evaluation, shall be prepared within thirty days of development of the initial treatment/service plan to meet the identified needs of the resident, and shall take into account cultural and social factors as well as the particular characteristics, conditions and circumstances of each resident. For individuals moving directly from one chemical dependence service to another, an updated treatment/service plan shall be acceptable if it is in conformance with the requirements of this Section.

(h) The treatment/service plan shall:

- (1) be developed in collaboration with the resident as evidenced by the resident's signature thereon;
- (2) be based on the admitting evaluations specified above and any additional evaluation(s) determined to be required;
- (3) specify goals for each problem identified;
- (4) specify the objectives to be achieved while the resident is receiving services which shall be used to measure progress toward attainment of goals;
- (5) include schedules for the provision of all services prescribed;
- (6) identify the single member of the clinical staff responsible for coordinating and managing the resident's care ("the responsible clinical staff member");
- (7) include the diagnosis for which the resident is being treated; and
- (8) be signed by the responsible clinical staff member and approved and signed by the clinical staff member's supervisor or another supervising qualified health professional within seven days.

(i) Where a service is to be provided by any other service or facility off site, the treatment/service plan must contain a description of the nature of the service, a record that referral for such service has been made, the results of the referral, and procedures for ongoing coordination of care.

(j) Treatment according to the treatment/service plan. The clinical staff member shall ensure that the treatment/service plan is included in the resident record and that all treatment is provided in accordance with the treatment/service plan.

(k) The case of any resident who is not responding to treatment, is not meeting goals defined in the comprehensive treatment/service plan, including educational and vocational goals, or who is disruptive to the service must be discussed at a case conference, or by the clinical supervisor and the clinical staff member in a supportive living service, and the treatment/service plan revised accordingly.

(l) Documentation of service

(1) Progress notes shall be written, signed and dated by the responsible clinical staff member no less often than once every two weeks. All treatment plan life areas that are addressed in the two-week period must be documented in the applicable progress note.

(2) Progress notes shall provide a chronology of the resident's progress related to the goals established in the treatment/service plan and be sufficient to delineate the course and results of treatment/services. The progress notes shall indicate the resident's participation in all significant services that are provided.

(m) Discharge planning. Discharge planning shall begin as soon as the resident is admitted, be considered as part of the treatment/service planning process, and be provided by the responsible clinical staff member. The discharge plan shall be developed in collaboration with the resident and any significant other(s) the resident chooses to involve. If the resident is a minor, the discharge plan must also be developed in consultation with his or her parent or guardian, unless the minor is being treated without parental consent as authorized by Section 22.11 of the Mental Hygiene Law.

(1) The discharge plan shall be based on the individual's self-reported confidence in maintaining abstinence and following an individualized relapse prevention plan, an assessment of the resident's home environment, suitability of housing, vocational/educational/employment status, and relationships with significant others to establish the level of social resources available to the resident and the need for services to significant others. The discharge plan shall include but not be limited to:

- (i) identification of continuing chemical dependence services and any other treatment, rehabilitation, self-help and vocational, educational and employment services the resident will need after discharge;
- (ii) identification of specific providers of these needed services; and
- (iii) specific referrals and initial appointments for these needed services.

(n) No resident shall be discharged without a discharge plan which has been reviewed by the clinical supervisor or designee prior to the discharge of the resident. This does not apply to residents who leave the service without permission or otherwise fail to cooperate in the discharge planning process. A portion of the discharge plan which includes referrals for continuing care shall be given to the resident upon discharge.

(o) Discharge criteria. A resident shall be appropriate for discharge from the residential service and shall be discharged when he or she meets one or more of the following criteria:

- (1) the resident has accomplished the goals and objectives which were identified in the comprehensive treatment/service plan;
- (2) the resident refuses further care;
- (3) the resident has been referred to other appropriate treatment which cannot be provided in conjunction with the residential service;
- (4) the resident has been removed from the service by the criminal justice system or other legal process;
- (5) the resident has received maximum benefit from the service; and/or
- (6) the resident is disruptive to the service and/or fails to comply with the reasonably applied written behavioral standards of the facility.

(p) A summary which includes the course and results of care must be prepared and included in each resident's record within thirty days of discharge.

819.5 Record keeping.

(a) Chemical dependence residential services must maintain individual case records for each resident served.

These records must, at a minimum, include the information required in this Part, as well as the source of referral, documentation of any case conferences or case reviews, reports of other evaluations and case consultations, medical orders, if applicable, and consent forms.

(b) Resident records maintained by chemical dependence residential services are confidential and may only be disclosed in conformity with federal regulations relating to the confidentiality of records as set forth in 42 Code of Federal Regulations Part 2 and other applicable law.

(c) Any medical procedures required, including use of any medication, shall be maintained in accord with the requirements of federal and state law and approved policies and procedures.

(d) All medical services provided must be provided pursuant to physicians, physician assistants, or nurse practitioner's order.

(e) In the event that more than one chemical dependence service is offered by a facility, the resident record shall identify the service in which the resident is currently participating.

(f) Statistical information shall be reported to the Office as required and on the prescribed forms therefore.

819.6 Quality improvement and utilization review.

(a) Each chemical dependence residential service shall establish and implement a quality improvement plan and utilization review plan in accordance with this section. The utilization review requirement may be met by the following:

(1) the service may perform its utilization review process internally; or

(2) the service may enter into an agreement with another organization, competent to perform utilization review, to complete its utilization review process.

(b) The utilization review plan shall include procedures for ensuring that admissions are appropriate, that retention and discharge criteria are met, and that services are appropriate. The utilization review plan shall consider each resident's need for continued treatment, the extent of the resident's chemical dependence problem, and the continued effectiveness of, and progress in, treatment.

(c) Each residential service shall establish a written quality improvement plan in accordance with this section.

(1) The quality improvement plan shall identify clinically relevant quality indicators that are based upon professionally recognized standards of care. This process shall include but not be limited to:

(i) no less than quarterly self-evaluations which may include an independent peer review process as discussed below, to ensure compliance with applicable regulations and performance standards;

(ii) findings of other management activities, including but not limited to; utilization reviews, incident reviews, and reviews of staff training, development and supervision needs;

(iii) surveys of resident satisfaction; and

(iv) analysis of treatment outcome data.

(2) The residential service shall prepare an annual report and submit it to the governing authority. This report shall document the effectiveness and efficiency of the service in relation to its goals and indicate any recommendations for improvement in its services to residents, as well as recommended changes in its policies and procedures.

(3) The purpose of independent peer review is to review the quality and appropriateness of residential services. The review is to focus on such services and the chemical dependence service system rather than on the individual practitioners. The intent of the independent peer review process is to continuously improve the residential services to chemically dependent individuals.

819.7 General staffing.

(a) Staff may be either specifically assigned to the chemical dependence residential service or may be part of the staff of the facility within which the chemical dependence residential service is located. However, if these staff members is part of the general facility staff, they must have specific training and experience in the treatment of chemical use, abuse and dependence specific to the services provided. The percentage of time that each shared staff is assigned to the chemical dependence residential service must be documented.

(b) Each residential program must provide clinical supervision and ensure and document that all clinical staff have a training plan based on individual employee needs. Such training may be provided directly or through outside arrangements and must be provided at least every three years. Training must be ongoing and documented in each employee's personnel record. Training may include, but is not limited to, the following areas:

- (1) chemical dependence;
- (2) individual, group and family counseling;
- (3) child abuse and domestic violence;
- (4) therapies and other activities supportive of recovery;
- (5) co-occurring disorders;
- (6) communicable diseases such as tuberculosis, sexually transmitted diseases, hepatitis, HIV/AIDS;
- (7) infection control procedures;
- (8) clinical supervision;
- (9) quality improvement;
- (10) vocational rehabilitation and employment preparation services;
- (11) cultural diversity and cultural competence;
- (12) tobacco dependence;
- (13) problem gambling; and
- (14) community based recovery supports and services.

(c) All chemical dependence residential services shall identify a clinical supervisor who shall be responsible for the day-to-day clinical operation of each residence and provide routine supervision for the staff. The clinical supervisor shall be a qualified health professional with at least three years of administrative and clinical experience in chemical dependence residential services.

(d) All chemical dependence residential services shall have sufficient clinical staff that have received training in, and are designated by the clinical supervisor to perform, the following tasks:

(1) evaluation of resident needs, development and implementation of individualized treatment/service plans for each resident, including individual, group and family counseling;

(2) participation with staff and, as necessary, other services and agencies to assure the development, management and implementation of comprehensive services for each resident, reflecting both chemical dependence issues and other habilitation or rehabilitation needs; and

(3) preparation and maintenance of case records for each individual resident.

(e) At least twenty-five per cent of all clinical staff members shall be qualified health professionals. For three years following the effective date of this Part, when determining the number of qualified health professionals pursuant to the foregoing, a residential service may count all of the qualified health professionals that are employed by, or at the direction of, the residential service at all of the residential service's facilities located within the State of New York, including Public Health Law Article 28 facilities. Individuals who have completed a minimum of 350 education and training clock hours in the areas required by Part 853 of this Title governing Credentialed Alcoholism and Substance Abuse Counselors, as well as individuals who have completed a minimum of 4000 hours of appropriate work experience and a minimum of 85 clock hours of education and training related to knowledge of alcoholism and substance abuse as required by Part 853 of this Title governing Credentialed Alcoholism and Substance Abuse Counselors, may be counted towards satisfying the twenty-five percent requirement provided that such individuals, also known as CASAC Trainees, may not be considered qualified health professionals for any purpose under this Part.

Notwithstanding the foregoing, during the three year period following the effective date of this Part, each residential service shall have sufficient qualified health professional staffing levels to meet the requirements of this Part which mandate that certain duties be performed by, under the supervision of, or at the direction of, a qualified health professional.

(f) Each residential service shall have a qualified individual designated as the Health Coordinator who will ensure the provision of education, risk reduction, counseling and referral services to all residents\regarding HIV and AIDS, tuberculosis, hepatitis, sexually transmitted diseases and other communicable diseases.

(g) There shall be sufficient staff available to ensure that the space and equipment of the service is clean and maintained in working order to minimize the need for treatment staff to perform non-treatment functions and to optimize operational efficiency.

(h) Clinical staff members who are not qualified health professionals shall have qualifications appropriate to their assigned responsibilities as set forth in the service's personnel policies and shall be subject to appropriate professional staff supervision and continuing education and training.

(i) In addition to staffing requirements of this Part, a residential service may utilize volunteers, students or trainees, on a salaried or non-salaried basis if such volunteers, students or trainees are provided close professional staff supervision and necessary didactic education from both internal and external sources.

819.8 Additional requirements for intensive residential rehabilitation.

(a) Admission criteria. In addition to the admission criteria applicable to residential services generally, an individual admitted to intensive residential rehabilitation services must meet the following criteria:

(1) The individual must have demonstrated an inability to participate in or comply with treatment outside of a twenty-four hour setting as indicated by one or more of the following:

(i) recent unsuccessful attempts at abstinence; or

(ii) a history of prior treatment episodes, including a demonstrated inability to complete outpatient treatment; or

(iii) substantial deficits in functional skills evidencing the need for extensive habilitation or rehabilitation in order to achieve lasting recovery in an independent setting.

(b) Clinical services. Intensive residential services are required to provide a minimum of forty hours per week within a structured therapeutic environment, consisting of the services identified in Section 819.4 of this Part and include the following:

(1) Rehabilitation and/or habilitation services.

(i) Each service shall ensure that a comprehensive and appropriate range of rehabilitative services are available to each resident. Such services include, but are not limited to:

(A) vocational services such as vocational assessment, job skills training, and employment readiness training;

(B) educational remediation services; and

(C) life, parenting and social skills training.

(ii) These services may be provided directly by the service or by referral.

(iii) These services shall be reflected in the resident's comprehensive treatment/service plan and the resident's progress shall be documented.

(2) Personal, social, and community skills training and development. Residents shall receive training in community living skills, personal hygiene and personal care skills as needed by each individual. Such skill development shall include, but is not limited to, social interaction and leisure activity

(c) Comprehensive treatment plan update.

(1) Each comprehensive plan, once established, must be reviewed and revised at least every three months thereafter by the responsible clinical staff member in consultation with the resident and reviewed and signed by the supervisor.

(2) A summary of the resident's progress in each of the specified goals shall be prepared and documented in the resident's record as part of the plan update.

(d) Staffing.

(1) Each residential facility shall have a full-time manager on site whose duties shall include overseeing the day-to-day operations of the service.

(2) There shall be sufficient staff available to all residents at all times. During late evening and night shifts, there shall be at least one responsible staff person awake and on duty.

(3) In addition to the twenty four hour per day, seven day per week coverage, all intensive residential rehabilitation services shall have sufficient staff to insure that counseling and rehabilitation services are available and responsive to the needs of each individual. An intensive residential rehabilitation service will have no less than one clinical staff member for every fifteen residents.

(4) For those residential rehabilitation services that serve children, at least one clinical staff member with training and experience in child care shall be available.

819.9 Additional requirements for community residential services.

(a) Admission criteria. In addition to the admission criteria applicable to residential services generally, an individual admitted to community residential services must meet the following criteria:

- (1) The individual must be homeless or must have a living environment not conducive to recovery.
- (2) The individual must be determined to need outpatient treatment services and/or other support services such as vocational or educational services, in addition to the residential services provided by the community residence.

(b) Clinical services.

(1) In addition to the service elements required of all residential services, community residential services are specifically required to provide a structured therapeutic environment designed to facilitate the individual's progress toward recovery from chemical dependence or abuse.

(2) The service shall maintain a focus on the development and improvement of the skills necessary for recovery.

(3) Specific services to be provided shall include the following:

(i) Each community residential service shall ensure that its residents have access to individual, group and family counseling services as needed and appropriate.

(ii) Each community residence shall have written referral agreements with one or more chemical dependence outpatient services to provide outpatient treatment services, as necessary.

(iii) The community residence shall ensure that such services are integrated with the activities and services provided by the residence and incorporated in the individual's service plan.

(iv) Each community residence shall ensure that a comprehensive and appropriate range of rehabilitative procedures are available to each resident. Such services include but are not limited to:

(A) vocational services such as vocational assessment;

(B) job skills training, and employment readiness training;

(C) educational remediation; and

(D) life, parenting and social skills training.

(4) Rehabilitation services may be provided directly by the service or by referral.

(5) Rehabilitation services shall be identified in the resident's comprehensive service plan.

(6) Personal, social, and community skills training and development. Residents shall receive training in community living skills, personal hygiene and personal care skills as needed by each resident. Such skill development shall include, but is not limited to, a program of social interaction and leisure activities.

(c) Service plan review.

(1) Each service plan, once established, must be completely reviewed and revised at least every three months thereafter by the responsible clinical staff member in consultation with the resident and reviewed and signed by the supervisor.

(2) Any resident who is not responding to treatment, is not meeting goals defined in the comprehensive service plan, including educational and vocational goals, or who is disruptive to the service, shall have the same noted in the case file and the circumstances addressed at a case conference, and the service plan revised accordingly.

(d) Staffing.

(1) Each community residence shall have a full time manager responsible for the day-to-day operation of the service.

(2) There shall be staff on site twenty-four hours per day, seven days per week.

(3) All community residential services shall have sufficient staff to insure that supportive and rehabilitation services are available and responsive to the needs of each resident. In addition to the twenty-four-a-day coverage, community residential services will have at least one clinical staff member for every fifteen residents.

819.10 Additional requirements for supportive living services.

(a) Admission criteria. In addition to the admission criteria applicable to residential services generally, an individual admitted to a supportive living service must meet the following criteria:

- (1) the individual requires support of a residence that provides an alcohol- and drug-free environment;
- (2) the individual requires the peer support of fellow residents to maintain abstinence;
- (3) the individual does not require twenty four hour a day on-site supervision by clinical staff; and
- (4) the individual exhibits the skills and strengths necessary to maintain abstinence and readapt to independent living in the community while receiving the minimal clinical and peer support provided by this residential environment.

(b) Clinical services. There shall be scheduled clinical interaction at least one time per week designed to support residents in their efforts to maintain abstinence and reduce the probability of relapse.

(c) Service plan review. Each service plan, once established, must be reviewed at least every six months thereafter, at which time the progress toward accomplishing the goals and objectives is reviewed. The case of any resident who is not making progress toward accomplishing goals or who is disruptive to the service must be discussed and the service plan revised accordingly. The service plan must be signed by the resident and the clinical staff member.

(d) Staffing. Supportive living services shall be staffed as follows:

- (1) there shall be at least one full time equivalent clinical staff member for each fifteen residents; and
- (2) there shall be sufficient clinical staff members to ensure at least one visit to each supportive living service once per week, in order to assure the proper maintenance of the living site and that residents are maintaining an environment and schedule appropriate to and supportive of each individual's abstinent, independent living; and

(3) there shall be sufficient clinical staff members to ensure that each resident is contacted personally at least once a week by staff to assure safety, adherence to the established service plan and support for daily independent living, through guidance, training, and assistance, as necessary.

819.11 Severability.

If any provision of this Part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this Part which can be given effect without the invalid provisions or applications, and to this end the provisions of this Part are declared to be severable.