Proposal to Provide School-Based Behavior Management Skills Development Services to Students of the Gadsden Independent School District Schools

TeamBuilders Counseling Services, Inc. is proposing to provide school-based Behavior Management Skills Development Services (BMS) in the Gadsden Independent School District Schools. TeamBuilders is a non-profit children's community mental health agency and currently provides BMS in 27 school districts in the State of New Mexico. The New Mexico Administrative Code (NMAC) defines BMS as:

> NMAC 7.20.11.7.N. BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES (BMS) means services provided on a staff-to-child ratio of at least 1:1. Behavior management skills development services are for children and adolescents with psychological, emotional, behavioral, neurobiological or substance abuse problems in the home, community or school when such problems are of such severity that highly supportive and structured therapeutic behavioral interventions are required. These services are designed to maintain the client in his/her home, community or school setting.

BMS is not a stand-alone behavioral health service. The goals and objectives of providing school-based BMS are individualized and directed by a comprehensive plan of care. BMS is an Enhanced EPSDT Service available as a benefit in the New Mexico Medicaid State Plan. Agencies with BMS programs are certified by the New Mexico CYFD Licensing and Certification Authority (LCA). A copy of relevant excerpts from NMAC regulations governing certification BMS and of children's mental health agencies in general is attached in this proposal. TeamBuilders is a CYFD certified provider of BMS and currently enjoys an Exemplary rating by the LCA.

Referrals for BMS can be made by any stakeholder in a child's life. These may include teachers, principals, counselors, coaches, clergy, parents, grandparents, law enforcement, CYFD Protective Services or Juvenile Probation and Parole, primary care physicians and behavioral health professionals.

Children qualifying for BMS are those Medicaid Managed Care, Exempt (also known as Medicaid Fee for Service) or State Coverage Insurance (SCI) eligible individuals under the age of twenty-one who are impacted by Serious Emotional Disturbance (SED) which manifests in severe problems with self-regulation of personal behavior. A psychosocial, psychological or psychiatric assessment is used to determine presence of an SED diagnosis. A copy of the qualifying SED diagnostic and functional impairment criteria is also attached.

A multi-disciplinary treatment team including parent/guardian, natural supports identified by the family, teachers or other designated school representative and TeamBuilders' staff is formed for the purposes of developing an individualized plan of care including long term goals, incremental objectives, targeted interventions and desired outcomes. The team meets monthly to discuss progress and need, and the plan of care is updated at least quarterly.

In addition to being a medically necessary service designed to help maintain children impacted by SED in the home, community and school settings, school-based BMS promotes learning through the reduction of student barriers to learning. This occurs for individuals served as well as the rest of students sharing the classroom with the student being served. School-based BMS enables teachers to spend more time teaching and students to spend more time learning, without barriers inhibiting the process. To quote one teacher "I can't teach, 90% of my attention goes to 10% of my students, and I am addressing behavioral problems in the classroom, not math problems."

BMS is provided by a trained paraprofessional over the age of twenty-one who has obtained a satisfactory background clearance from the New Mexico Children, Youth and Families Department. Guidelines regarding qualification of providers of BMS are evidenced in the NMAC regulations attached.

TeamBuilders' job description for a BMS Provider is also attached on page 3. A copy of a document titled BMS Do's and Don'ts which identifies some of the specific activities a BMS provider may and may not engage in when serving children in the school setting is attached on page 4. Provision of school-based BMS works to improve the health and well-being recipients and serves as a Classroom-Based Enabling Component, which can greatly enhance the educational experience of both students being served and those around them.

TeamBuilders respectfully requests the ability to assist the Gadsden Independent School District in meeting the behavioral health needs of its students who may be impacted by serious emotional disturbances while improving the ability of its teachers to promote and maintain the learning environment necessary to further the educational goals of its students. A Memorandum of Understanding allowing TeamBuilders to provide school-based BMS is attached.

TeamBuilders Counseling Services, Inc.

Job Description and Qualifications Positions: Behavior Management Specialist (BMS Provider)
Program: BMS
Classification: Non-Exempt
Status: Part-time Relief / Regular Part-time / Full-time
Type: Hourly

The **Behavior Management Specialist** is accountable to the BMS Program Coordinator. A Behavior Management Specialist provides a service offered to families with members with a neurological disorder (NBD) and/or serious emotional disturbance (SED). It is the responsibility of the Behavior Management Specialist to participate in development and maintenance as it relates to the care and treatment of client. This consists of client supervision, in the Specialist home, client home, community based, and/or in organized activities.

Duties and Responsibilities:

1 Provide supervision and monitor client behavior.
2 Implement interventions pertaining to the Treatment Plan.
3 Provide crisis intervention as needed or directed.
4 Plan, implement, and assess organized client activities.
5 Provide an appropriate and secure role model for and with client.
6 Attend supervision meetings (1 hour weekly), staff meetings (2 hours, second and fourth Friday monthly), and mandatory training sessions.
7 Document client's progression, behavior as related to Treatment Plan, and time per session in client file and hand in weekly (Monday).
8 Work with other staff to achieve program objectives.
9 Follow personnel and agency policies and procedures as they pertain to your individual program.
10 Uphold the standards of conduct of the Agency.
11 Other duties as directed or as assigned by the Program Coordinator.

Qualifications:

1 Must be over 21 years of age.
2 High School Diploma or GED.
3 Current First Aid and CPR certification
4 Current Non Violent Crisis Intervention certification.
5 Complete all pre-service and ongoing training requirements.
6 Criminal Records Clearance (local, state, and FBI).
7 Valid Driver's License and Current Car Insurance.
8 Possession of a values base consistent with the philosophy of the Agency.

Signed: _____ Date: _____

Printed Name: Location: _____

BMS DO'S AND DON'TS

While involved in the provision of school-based Behavior Management Skills Development Services,

TeamBuilders' BMS Provider CAN:

- Use logical and appropriate consequences and interventions
- Remove assigned client(s) from environment if behavior becomes a safety issue
- Intervene prior to the escalation of client(s)
- Enforce school rules with assigned client(s)
- Set expectations with client(s) prior to entering classroom setting
- Provide prudent information to school staff including medical, behavioral, and mental health history, when proper releases have been signed
- Be used as a "teacher's aide", provided that it doesn't interfere with the supervision of assigned clients
- Be asked to assist teacher in redirecting students exhibiting negative and/or disruptive behaviors
- Participate in client related teamings, IEP, or other scheduled meetings
- Travel with their assigned client(s) during special school events

TeamBuilders' BMS Provider CANNOT:

- Directly discipline other than assigned client(s)
- Provide supervision of students during class if teacher leaves the room
- Be used as crowd control before school, at lunch, after school, or at any special events
- Intervene with assigned client(s) prior to the teacher's attempt to correct the behavior (or prior to precipitants identified in any individualized program)
- Provide classroom "teaching" to their assigned clients or other students
- Leave assigned client(s) without prior approval from school administration, parents, and program coordinator
- Remove assigned client(s) from school grounds without prior approval from school administration, parents, and program coordinator
- Enforce school policy/discipline students other than assigned client(s)
- Violate any school rules
- Transport students other than assigned client(s)
- Interfere with the learning process

TITLE 8 SOCIAL SERVICES CHAPTER 322 ENHANCED EPSDT - COMMUNITY MENTAL HEALTH SERVICES PART 3 BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES

8.322.3.1 ISSUING AGENCY: New Mexico Human Services Department. [2/1/95; 8.322.3.1 NMAC -Rn, 8 NMAC 4.MAD.000.1, 11/1/05]

8.322.3.2 SCOPE: The rule applies to the general public. [2/1/95; 8.322.3.2 NMAC -Rn, 8 NMAC 4.MAD. 000.2, 11/1/05]

8.322.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See Sections 27-212 et seq. NMSA 1978 (Repl. Pamp. 1991). [2/1/95; 8.322.3.3 NMAC -Rn, 8 NMAC 4.MAD. 000.3, 11/1/05]

8.322.3.4 DURATION: Permanent [2/1/95; 8.322.3.4 NMAC -Rn, 8 NMAC 4.MAD. 000.4, 11/1/05]

8.322.3.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section. [2/1/95; 8.322.3.5 NMAC -Rn, 8 NMAC 4.MAD.000.5 & A, 11/1/05]

8.322.3.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement. [2/1/95; 8.322.3.6 NMAC -Rn, 8 NMAC 4.MAD.000.6, 11/1/05]

8.322.3.7 DEFINITIONS: [RESERVED]

8.322.3.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans. [2/1/95; 8.322.3.8 NMAC -Rn, 8 NMAC 4.MAD.002, 11/1/05]

8.322.3.9 BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients. To help recipients under twenty-one (21) years of age who are in need of behavior management intervention receive services, the New Mexico medical assistance division (MAD) pays for eligible providers to furnish these services as part of the early and periodic screening, diagnosis and treatment (EPSDT) program [42 CFR Section 441.57]. The need for behavior management services must be identified by an independent, qualified health care practitioner through an EPSDT examination or other diagnostic evaluation furnished through an EPSDT referral. Behavior management services assist in preventing inpatient hospitalizations or residential placement of recipients through use of teaching, training and coaching activities designed to assist individuals in acquiring, enhancing and maintaining the life, social and behavioral skills needed to function successfully within the home and community settings. Behavior management services are provided as part of a comprehensive approach to treatment and in conjunction with other services as indicated in a treatment plan. This part describes eligible providers, covered services, service limitations, and general reimbursement methodology. [2/1/95; 8.322.3.9 NMAC -Rn, 8 NMAC 4.MAD.745.2 & A, 11/1/05]

8.322.3.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider agreements by MAD, agencies that meet the following requirements are eligible to be reimbursed for providing behavior management services:

(1) certification as providers of behavior management skills development services by the children, youth and families department (CYFD); and

(2) employ or contract with behavior management specialists who work under the supervision of a licensed practitioner employed by a certified behavior management services agency.

B. Recipients have the right to receive services from the eligible provider of their choice.

C. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, certification standards and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD. [2/1/95; 8.322.3.10 NMAC - Rn, 8 NMAC 4.MAD.745.21 & A, 11/1/05]

8.322.3.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*. [2/1/95; 8.322.3.11 NMAC - Rn, 8 NMAC 4.MAD.745.22, 11/1/05]

8.322.3.12 ELIGIBLE RECIPIENTS:

A. Behavior management services can be furnished only to medicaid recipients under twenty-one (21) years of age who:

(1) are at-risk for out-of-home placement due to unmanageable behavior at home or within the community; or

(2) need behavior management intervention to avoid inpatient hospitalizations or residential treatment; or

(3) require behavior management support following institutional or other out-of-home placement as a transition to maintain the recipient in the home and community.

B. To receive services, recipients must meet the level of care for this service established by MAD or its designee. [2/1/95; 8.322.3.12 NMAC - Rn, 8 NMAC 4.MAD.745.23 & A, 11/1/05]

8.322.3.13 COVERED SERVICES: Medicaid covers services specified in individualized treatment plans which are designed to improve the recipient's performance in targeted behaviors, reduce emotional and behavioral excess, increase social skills and enhance behavioral skills through a regimen of positive intervention and reinforcement.

A. The following tasks must be identified in a behavior management plan, performed by behavior management specialists and included in the payment rate:

(1) implementation of the behavior management plan;

(2) assistance in achieving and/or maintaining appropriate behavior management skills through teaching, training and coaching activities;

(3) working with foster, adoptive or natural families to help recipients achieve and/or maintain appropriate behavior management skills; and

(4) maintaining case notes and documentation of tasks as required by the provider and the standards under which it operates.

B. An agency certified for behavioral management skills development services must:

(1) develop a behavior management plan, based on a relevant clinical assessment, as part of a comprehensive treatment plan covering an integrated program of therapeutic services as applicable;

identify all targeted behaviors that are to be addressed by the behavior management specialist;

assess the recipient's progress in behavioral management skills;

(4) ensure the service is part of a comprehensive treatment approach and is coordinated with other treatment modalities as appropriate; and

(5) offer twenty-four (24) hour availability of appropriate staff to respond to crisis situations.

[2/1/95; 8.322.3.13 NMAC - Rn, 8 NMAC 4.MAD.745.24 & A, 11/1/05]

8.322.3.14 NONCOVERED SERVICES: Behavior management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]. Medicaid does not cover the following specific services in conjunction with behavior management services:

A. formal educational or vocational services related to traditional academic subjects or vocational training;

B. activities which are not designed to accomplish the objectives delineated in covered services and which are not included in the behavioral management treatment plan; and

C. residential treatment care. [2/1/95; 8.322.3.14 NMAC - Rn, 8 NMAC 4.MAD.745.25 & A, 11/1/05]

8.322.3.15 BEHAVIOR MANAGEMENT PLAN: The behavior management plan must identify all targeted behaviors that are to be addressed by the behavior management specialist. The behavior management plan should include, when appropriate, a goal of working with the foster, adoptive or natural family of the individual in order to assist with the achievement and/or maintenance of behavior management skills. The behavior management plan must identify the use of a behavior management specialist, who is responsible for implementation of the behavior management plan through teaching, training and coaching skills.
[8.322.3.15 NMAC -N, 11/1/05]

8.322.3.16 TREATMENT PLAN: If the recipient is receiving other behavioral health services in addition to behavior management services, a treatment plan must be developed by a team of professionals in consultation with recipients, parents, legal guardians and physicians prior to service delivery or within fourteen (14) days of initiation of services.

A. The behavioral management plan must be included, when appropriate, in a comprehensive treatment plan which covers an integrated program of therapeutic services.

B. The team must review the treatment plan at least every thirty (30) days.

C. The following must be contained in the treatment plan or documents used in the development of the treatment plan. The treatment plan and all supporting documentation must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and the specific needs of the recipient;

(2) description of the functional level of the recipient, including the following:

(a) mental status assessment;

(b) intellectual function assessment;

(c) psychological assessment;

(d) educational assessment;

(e) vocational assessment;

(f) social assessment;

(g) medication assessment; and

(h) physical assessment.

(3) statement of the least restrictive conditions necessary to achieve the purposes of treatment;

description of intermediate and long-range goals, with the projected timetable for their attainment and the duration and scope of services;

statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provisions for the review and modification of the plan;

specification of responsibilities, description of staff involvement, orders for medication(s), treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the recipient; and

criteria for release to less restrictive settings for treatment, discharge plans, criteria for discharge and projected date of discharge. [2/1/95; 8.322.3.16 NMAC - Rn, 8 NMAC 4.MAD.745.26 & A, 11/1/05]

8.322.3.17 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Before any behavior management skills development services are furnished to medicaid recipients, prior authorization may be required from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953]. [2/1/95; 8.322.3.17 NMAC - Rn, 8 NMAC 4.MAD.745.27 & A, 11/1/05]

8.322.3.18 REIMBURSEMENT: Behavior management providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

A. Reimbursement to providers is made at the lesser of the following:
the provider's billed charge; or
the MAD fee schedule for the specific service or procedure.

B. The provider's billed charge must be its usual and customary charge for services.

C. "Usual and customary charge" refers to the amount which an individual provider charges the general public in the majority of cases for a specific procedure or service. [2/1/95; 8.322.3.18 NMAC - Rn, 8 NMAC 4.MAD.745.28, 11/1/05]

Excerpts from NMAC Title 7, Chapter 20, Part 11 (unedited regulations available here: http://www.nmcpr.state.nm.us/nmac/parts/title07/07.020.0011.htm.):

TITLE 7 HEALTH CHAPTER 20 MENTAL HEALTH PART 11 CERTIFICATION REQUIREMENTS FOR CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

7.20.11.1 ISSUING AGENCY: Children, Youth and Families Department
[7.20.11.1 NMAC - Rp 7 NMAC 20.11.1, 03/29/02]

7.20.11.2 SCOPE: This policy applies to all child and adolescent behavioral health programs described herein.
[7.20.11.2 NMAC - Rp 7 NMAC 20.11.2, 03/29/02]

7.20.11.3 STATUTORY AUTHORITY: 1978 NMSA Sections 32A-12.1.et seq.
[7.20.11.3 NMAC - Rp 7 NMAC 20.11.3, 03/29/02]

7.20.11.4 DURATION: Permanent
[7.20.11.4 NMAC - Rp 7 NMAC 20.11.4, 03/29/02]

7.20.11.5 EFFECTIVE DATE: March 29, 2002 unless a later date is cited at the end of section.
[7.20.11.5 NMAC - Rp 7 NMAC 20.11.5, 03/29/02]

7.20.11.6 OBJECTIVES:

A. to establish certification requirements for behavioral health services provided to children and adolescents of New Mexico through the medicaid program (Title XIX of the Social Security Act);

B. to provide for monitoring of agency compliance with these certification requirements to identify any factors that could affect the health, safety, and welfare of the clients or the staff;

C. to assure that the agency establishes and follows written policies and procedures that specify how these certification requirements are met; and

D. to assure that adequate supervision is provided at all times.

[7.20.11.6 NMAC - Rp 7 NMAC 20.11.6, 03/29/02]

7.20.11.7 DEFINITIONS:

K. BEHAVIORAL HEALTH ASSESSMENT means an assessment by an integrated series of procedures conducted with an individual to provide the basis for the development of an effective, comprehensive and individualized treatment plan.

L. BEHAVIORAL HEALTH SERVICES means services designed to meet behavioral and mental health and substance abuse needs of medicaid recipients in certified services.

M. BEHAVIOR MANAGEMENT means the use of basic techniques, such as reinforcement, redirection and voluntary time-outs to teach clients skills for managing and improving their own behavior; and the use of verbal de-escalation, therapeutic holds, personal restraint and seclusion in order to maintain a safe and therapeutic environment and to enhance the abilities of clients and care givers to manage client behavior.

N. BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES (BMS) means services provided on a staff-to-child ratio of at least 1:1. Behavior management skills development services are for children and adolescents with psychological, emotional, behavioral, neurobiological or substance abuse problems in the home, community or school when such problems are of such severity that highly supportive and structured therapeutic behavioral interventions are required. These services are designed to maintain the client in his/her home, community or school setting.

O. BEHAVIOR MANAGEMENT SERVICES PLAN means a service plan used in behavior management skills development services.

T. CERTIFICATION means an authorized status conferred by the department on a program that meets these certification requirements for providing service(s) to children and adolescents.

X. CHILD/ADOLESCENT means a person under the chronological age of 21 years.

Y. CLEARED STAFF MEMBER means an individual who has been approved by the department for employment in the immediate presence of children and adolescents by means of a state and federal criminal background clearance.

Z. CLIENT means any child or adolescent who receives treatment from a service certified by the department.

AB. CLINICAL STAFF means licensed mental health practitioners and treatment coordinators.

AC. CLINICAL SUPERVISOR means a staff member who is a licensed independent practitioner and who has responsibility and authority for supervising other clinical staff.

AD. COMMUNITY SUPPORTS means the coordination of resources to individuals/families necessary for them to implement strategies to promote recovery, rehabilitation and resilience.

AH. CORPORAL PUNISHMENT means a form of discipline or behavior control that involves forced exercise or touching a child's body with the intent to induce pain and includes, but is not limited to, shaking, spanking, hitting, hair pulling, and ear pulling.

AI. CRIMINAL RECORDS CHECK (CRC) means the process of submitting state and FBI approved fingerprint cards and any additional required background information to the department for the purpose of determining whether or not an individual has state or federal convictions on record that may disqualify the individual from direct unsupervised contact with children/adolescents and, when applicable, for the purpose of obtaining and reviewing a record of convictions.

AJ. CRIMINAL RECORDS CLEARANCE means a determination made by the department, based on the results of the criminal records check, that an individual may work directly and unsupervised with children and adolescents.

AN. CULTURALLY COMPETENT ASSESSMENT means the relevant cultural considerations in the assessment of the behavioral health needs of a client.

AX. DISCHARGE CRITERIA means specific clinically-based indicator(s) used to measure the client's degree of readiness for release from a given level of care stated in terms of achievement of treatment goals or reduction of symptoms; discharge criteria may also include indicators that a given level of care is inappropriate for a client due to such factors as dangerousness or non-responsiveness to treatment.

AY. DISCHARGE PLAN means a written section of a treatment plan/service plan and treatment plan/service plan reviews containing the following elements: behavioral and other clinical criteria that describe the conditions under which discharge will occur, identification of barriers to discharge; the level of care, specific services to be delivered, and the living situation into which discharge is projected to occur; the projected date of discharge, individuals responsible for implementing each action specified in the discharge plan, and, when indicated, revisions.

AZ. DISCIPLINE means non-abusive training that enables a client to develop self-control and orderly conduct in relationship to others.

CV. PERSONAL RESTRAINT means the application of physical force without the use of any device, for the purposes of restraining the free movement of a client's body. The term personal restraint is distinct from therapeutic hold and mechanical restraint as defined herein and does not include briefly holding a client, without undue force, in order to calm or comfort him or her, or holding a client's hand to safely escort a client from one area to another.

CW. PHYSICAL ESCORT means the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purposes of inducing a client who is exhibiting unsafe or potentially unsafe behavior to walk to a safe location.

CX. PHYSICAL HARM means physical injury that requires treatment beyond basic first aid; or that results in loss of functional use of a bodily member or organ or of a major life activity for a prolonged period of time; or results in loss of consciousness for any amount of time.

DI. PUNISHMENT means a penalty imposed on a child/adolescent by one in authority for wrongdoing.

DS. SECLUSION means a behavior management technique that involves locked isolation. Seclusion is distinct from therapeutic time-out.

EC. THERAPEUTIC HOLD means the brief physical holding of a client, without undue force, used as part of a behavioral plan by an individual trained and certified by a state recognized body in the use of therapeutic holds and personal restraints, in a manner consistent with written agency policy, for the purpose of providing emotional comfort or calming to the client, or physical safety to the client, other clients, staff member(s) or others. Therapeutic hold is distinct from personal restraint and mechanical restraint as defined above.

EE. THERAPEUTIC TIME-OUT means a technique involving individual isolation used as part of a written behavioral plan to prevent or decrease the potential for unsafe behavior and to give the client the opportunity to regain control.

EJ. TREATMENT PLAN means a written document formulated on an ongoing basis by a treatment team that guides and records for each client: individualized therapeutic goals and objectives; individualized therapeutic services provided; individualized discharge plans and aftercare plans.

EK. TREATMENT PLANNING means an ongoing process, based on assessment and regular reassessment of a client's needs, of documenting those needs, the interventions intended to address those needs, and the client's behavioral responses to interventions. Treatment planning includes initial treatment plans, comprehensive treatment plans, treatment plan reviews and discharge plans.

EL. TREATMENT TEAM means the group of individuals that assesses, plans, coordinates, implements, evaluates, reviews, and adjusts all aspects of a client's care over the course of treatment in a certified program. The treatment team includes the client, and as applicable, the client's family or legal guardian(s), therapist, direct service staff, treatment coordinators, treatment foster parents, the department's social worker or juvenile probation/parole officer, case manager, a representative from an educational agency, or other significant individuals in the client's life.

7.20.11.9 ISSUANCE OF CERTIFICATION:

A. Application for initial certification:

(1) Applications for the initial certification of a new program offering case management services, behavior management skills development services, day treatment services, group home services, all residential treatment services, or treatment foster care services are submitted to the LCA for review and approval. The application for initial certification of a program includes, but is not limited to, the following:

(a) a letter of intent naming the service for which the agency is requesting initial certification and describing how and where the proposed service will be delivered.

(b) policies and procedures showing that the agency complies with both the general provisions and the service-specific requirements of the program for which the agency is requesting initial certification; and an index that references each policy and procedure by the applicable certification requirement that the policy is designed to meet.

(c) job descriptions, required qualifications, resumes, current licenses, proof of credentials, and criminal records clearances for professional staff;

(d) job descriptions, required qualifications and criminal records clearances for direct service staff; and

(e) a complete set of the forms that will be used to document the services being provided.

(2) At the discretion of the LCA, the application process may include interviews with staff, administrators, or program directors.

(3) When applicant agencies have an established in-state or out-of-state history of providing mental health or substance abuse services for children and adolescents, whether or not the agency is currently providing such services, the agency's record with regulatory compliance will be considered during review of the new application;

(4) Applications will be reviewed by the LCA within 15 business days and a written response will be sent to the agency. The findings of the review will determine which of the following responses will be issued by the LCA:

(a) Complete applications that comply with all the requirements of these certification requirements will be issued an initial certification for a period of up to 120 days.

(b) Incomplete applications will be returned with a letter detailing what elements of the application are missing. initial certification will not be issued.

(c) When an application is complete, but fails to show that the agency has fully or substantially complied with all of these certification requirements, the LCA will issue a letter detailing the findings of the review, with a list of the changes required to show the new program to be in compliance with these certification requirements. An initial certification will not be issued.

(5) If, three months subsequent to the issuance of an LCA letter detailing missing or insufficient elements of an application, the agency has not responded with a completed application or has not achieved compliance with these certification requirements sufficient to warrant initial certification, the application will be

considered void. The agency may reapply for certification of the service, but will be required to begin a new application process.

(6) COA/CARF/JCAHO Accreditation does not confer state certification status on a program.

B. Types of certification:

(1) FULL CERTIFICATION: Full certification is granted to a program currently serving clients and found by the LCA to be in substantial compliance with these certification requirements. At the discretion of the LCA, the duration of full certification status is 12 to 24 months.

(2) EXEMPLARY STATUS is a type of full certification that may be granted to a program that has no history of temporary certification, sanctions or loss of certification in the previous two years and that, based on a determination made by the LCA, adheres to these certification requirements with only minor deficiencies, which pose no health and safety risks to clients. Exemplary status may be granted for up to 24 months.

(3) FULL CERTIFICATION: This certification is granted to a program currently serving clients and found to be in substantial compliance with these certification requirements, when only minor and few deficiencies, none of which compromise client health and safety, are identified in the LCA certification report. The program submits an action plan for the LCA's approval within the time frame specified by the LCA, detailing the measures that will be used to correct the deficiencies. At the discretion of the LCA, the program may also be required to implement a directed action(s) within specified time frames; or may be required to comply with monitoring as specified by the LCA during the period of certification. Based on a determination made by the LCA, the program produces proof of correction of deficiencies and/or compliance with directed action(s) and/or monitoring through submission of relevant documentation and/or by subsequent on-site review. The terms and the timeframes for monitoring are established in writing in the certification report.

(a) The LCA provides written notification indicating whether the program's action plan is approved. Action plans may be approved with amendments recommended and/or required within a time frame specified by the LCA. If an action plan is not approved, the LCA will specify items that require revision or supplementation in order to receive LCA approval.

(b) If another survey reveals additional deficiencies, the LCA may require amendment of the action plan, and/or issue new written directed actions, and/or implement a revised monitoring plan, and/or sanction the program based on new deficiencies identified.

(4) TEMPORARY CERTIFICATION: Temporary certification is granted to a program currently serving clients that is found by the LCA to be in partial compliance with the certification requirements, or to a program that has been on inactive status and is returning to active status.

(a) The LCA determines the duration of a temporary certification. Temporary certification may be granted for a period of up to 180 days. The LCA determines the duration of temporary certification based on factors that may include severity of deficiencies and the program's history of compliance with certification requirements.

(b) The program submits an action plan for the LCA's approval within 14 days of receipt of the LCA certification report detailing its findings of deficiencies, unless otherwise specified by the LCA. At the discretion of the LCA, the program may also be required to implement directed action(s) within specified time frames. The program may be required to comply with terms of monitoring specified by the LCA during the period of temporary certification, based on a determination made by the LCA.

(c) Items 9.B(3)(a) and (b) above are applicable for action plans that accompany temporary certification.

(d) For programs returning to active status, an action plan, directed action, and/or monitoring are not required unless specified by the LCA.

(e) If the program does not achieve substantial compliance with these certification requirements at the end of a temporary certification period, a sanction(s) may be imposed including non-renewal of certification.

(f) At the discretion of the LCA, a second consecutive temporary certificate may be issued for a period of up to 180 days, or certification may be allowed to expire without renewal.

(5) INITIAL CERTIFICATION: This certification is granted for a period of 120 days to a program that has met the minimum requirements to provide child and adolescent mental health or substance abuse services as determined by the application process described in certification requirement 9.A above. If the program has no clients at the end of 120 days, a second 120-day initial certification may be granted. If the program remains without clients beyond 240 days, the program's initial certificate expires and re-application for certification is required; or, at the discretion of the LCA, inactive status may be granted.

(6) INACTIVE STATUS: This certification is granted to a program not presently serving clients, but which has served clients within the current period of certification. A certificate of inactive status covers a period of time not to exceed 180 days from the date of issue. If the program continues without clients beyond 180 days, a second 180-Day certificate of inactive status may be granted upon request. If the program remains without clients beyond 365 days, the program's inactive status expires and re-application for initial certification is required.

(a) To return to active status from inactive status for a certified service, the program must notify the LCA in writing at least two weeks prior to its intended admission of clients. In addition to the written notice, the agency must submit the following to the LCA: information on any changes in personnel or agency policies and procedures during inactive status; proof of criminal records clearances, qualifications, and, as applicable, licensure for new supervisory and direct service staff of the certified program.
(b) Upon review of the submitted information, the LCA may grant temporary certification. The agency will not admit any client(s) until the LCA issues and the program receives temporary certification.
(7) AMENDED CERTIFICATE: This certification is granted to a program currently serving clients that has had a change of ownership or licensee, or that chooses to change its name. The agency submits a written request for an amended certificate to the LCA ten business days prior to the change.
(8) DEEMED CERTIFICATION: The LCA has discretion to grant deemed certification when a program is accredited by the council on accreditation (COA), the council on accreditation of rehabilitation facilities (CARF), or for residential treatment services, by the joint commission on accreditation of health care organizations (JCAHO), and the LCA determines that the standards of the accrediting body apply substantially to the program for which deemed certification is being considered. A certified program that is accredited by one of these organizations and wishes to request deemed certification must provide a copy of the accreditation report to the LCA within 30 days of receipt of the report, and must provide any other accreditation-related documentation to the LCA upon request. Upon receipt and review of the COA, CARF or JCAHO survey reports, the LCA, at its discretion, may issue deemed certification status effective for up to 24 months. For those intervening years that the above-mentioned accrediting bodies do not conduct on-site visits, the LCA may conduct annual or biennial certification on-site surveys.
(a) EXCEPTION: The deemed certification may not apply when COA, CARF or JCAHO identify any condition that the LCA, at its sole discretion, determines to be a significant violation of certification or accreditation standards, or that requires follow-up by the accrediting body; or when any condition reported to the LCA appears to pose a threat to health and/or safety; or when there is any other information indicating the existence of such a threat.
(b) All agencies and programs that receive deemed certification must comply with all applicable provisions of the Children's Health Act of 2000 and these certification requirements.
C. AUTOMATIC EXPIRATIONS OF A CERTIFICATION:
(1) A certificate automatically expires at midnight on the day a certified program discontinues or suspends operation or changes location.
(2) A certificate automatically expires at midnight on the tenth day after a certified program is sold, leased, or otherwise changes ownership and/or licensee, unless the agency has made a timely written request for amended certification. In such a case, the automatic expiration is stayed, and previous certification remains in effect if the agency has until the LCA acts on the application or takes other certification action.
D. WAIVERS AND/OR VARIANCES: Upon written request of the agency and at the discretion of the LCA, the LCA may issue a waiver and/or variance
E. CERTIFICATION REVIEWS: When possible, the LCA schedules on-site program reviews prior to expiration of certification. If the LCA does not perform a certification on-site review of a program prior to the expiration of its certification, and the program has not received a written report from the LCA recommending that the program's certification be allowed to expire, the certification continues in effect until the LCA performs a certification review.
F. The LCA, at its sole discretion, may extend any certification for a period of up to 12 months.
G. In the event that a program's certification is revoked, suspended, denied, or not renewed, the medicaid provider agreement terminates on the date of the revocation, suspension or denial.

[7.20.11.9 NMAC - Rp 7 NMAC 20.11.9, 03/29/02; A, 04/14/05]

7.20.11.15 CRIMINAL RECORDS CHECKS AND CLEARANCES:

A. Every program that provides child/adolescent mental health and/or substance abuse services pursuant to these certification requirements, operating in the state of New Mexico, must initiate and provide to the department two completed **s**tate-and FBI-approved fingerprint cards for each employee who will serve as direct services staff. The agency must have received the criminal records clearance from the prevention and intervention division of the department prior to the employee's direct, unsupervised contact with clients of the program. Noncompliance with this requirement may result in sanction up to loss of certification as referenced in NMSA 1978 32A-15-3.

B. All agencies must comply with 8.8.3 NMAC Regulations governing criminal records checks.

C. Student trainees in psychiatry, psychology, social work and/or nursing, or other related health, social or human-services disciplines who are enrolled in a clinical training program of a New Mexico state accredited institution of higher learning, and who are under the supervision of a cleared licensed independent practitioner, may be allowed to work with children without direct physical supervision during their enrolled student tenure if the trainee signs a sworn affidavit attesting that he or she has never been convicted of a crime that would disqualify him or her from providing direct services to children.

D. The certification requirements governing criminal records clearances remain in effect while a program is accredited by COA, CARF or JCAHO.

E. If a prospective employee has not lived in the United States continuously for the five years previous to hire, the equivalent of a criminal records clearance is required from any country in which he/she has lived within the last five years, for a period longer than one year.

F. If the agency receives reliable evidence that indicates that an employee or prospective employee poses a potential risk of child abuse, sexual abuse, exploitation, moral turpitude, cruelty, or indifference to children, the agency is in violation of these certification requirements and subject to sanction up to loss of certification if that individual is hired or retained.

G. Upon request by the LCA, the agency will provide a list of employees who are not required to have a criminal records clearance, and the reason why not.

H. Non-compliance with any certification requirement relating to criminal records checks and clearances may result in sanction or loss of certification. In addition to the foregoing, the following certification requirements relate to criminal records checks and clearances:

16.G.1(f) concerning prospective employee history verification and reference checks;

16.G.1(h) concerning letters of attestation for employees pending clearances;

16.G. 2 concerning disclosure of arrests/convictions;

16.H.1-5 concerning staff schedules.

[7.20.11.15 NMAC - Rp 7 NMAC 20.11.15, 03/29/02]

7.20.11.16 PERSONNEL:

A. The agency provides personnel who are trained, supervised and in all respects qualified to perform the functions for which they are responsible.

B. Each position, or group of like positions, is detailed in a written job description that clearly states qualifications, responsibilities and requirements.

C. Each agency employee meets all state registration, licensing and/or certification requirements applicable to his or her position and/or use of professional title(s) and the agency has copies of such licenses, etc. on file.

D. Orientation of personnel:

(1) The agency orients its personnel to the agency's goals, services, policies and procedures, and to the responsibilities of the staff member's position. Initial and ongoing orientation is documented in the personnel record.

(2) Orientation includes training on the establishment and maintenance of appropriate and responsive relationships and boundaries with clients.

E. Personnel training, development, responsibilities and supervision:

(1) The agency provides a training and development program to allow personnel to improve their knowledge, skills and abilities and to promote awareness and appreciation of the cultural background and need of persons served by the agency. This training will be documented in the personnel file.

(2) The agency provides staff development opportunities for personnel, including in-service training.

(3) Staff who require training to qualify for a position in which they are responsible for the care of children do not have sole responsibility for the care of children until after the successful completion of the training.

(4) Staff designated as direct service staff under service-specific certification requirements receive ongoing training related to the age and/or emotional development of the children for whom they are responsible.

(5) All certified services are provided under supervision of a clinical director who provides clinical oversight of the program, by way of documented supervision and consultation to all agency staff. Supervision may be direct, or may occur through a clinical supervisor who is directly supervised by the clinical director.

(6) All clinical supervision/consultation is documented and documentation includes the theme, date, length of time of supervision and signatures of those participating.

(7) In the event that the therapist and clinical supervisor are the same person, another properly credentialed clinician, either from within the agency or from outside the agency, provides supervision at least one time per month to the clinical supervisor.

(8) The responsibilities of the therapist include providing therapy and participating in the development of a treatment plan. These activities are documented.

(9) When the agency utilizes the services of professionals on a per interview, hourly, part-time, or independent contractor basis, the agency documents regular assessment of the quality of services provided.

F. Accountability:

(1) The agency ensures that the performance of all employees, consultants, contractors, and volunteers is consistent

with agency policy and these certification requirements.
(2) At least once a year, written performance reviews are conducted jointly between each staff member, including volunteers, and the person's supervisor.
G. Personnel records:
(1) A personnel record is maintained for each employee and volunteer. Each personnel record is readily accessible to the LCA at each site visit, and contains, at a minimum:
(a) documentation of all orientation and training, including dates, hours or credits, names of trainer and trainee, and written confirmation by trainer or training organization that the training has occurred;
(b) employee's name, current address, telephone number and emergency contact(s);
(c) job title and description;
(d) evidence of licensure for those employees required to be licensed;
(e) date first employed and dates of transfers or changes in position;
(f) documentation of a minimum of three employment reference checks within three weeks prior to employment (if this process yields fewer than three employment reference checks, additional professional and/or personal references are obtained to achieve the required minimum of three references);
(g) a copy of the employee's current CPR and first aid certificates;
(h) for cleared staff, the criminal records clearance letter, or for uncleared staff, a signed statement by the administrator, director, or operator attesting to direct supervision of the uncleared employee by a cleared employee until the clearance is received;
(i) application for employment or resume consistent with agency policy;
(j) performance reviews, as applicable.
(2) The agency's written policies and practices require that an applicant for employment disclose any prior criminal convictions, and employees report any arrests and/or convictions that occur while employed.
(3) The agency's written policies provide personnel with access to their records and a process to review the record and to make additions and corrections to the record.
H. Schedules of direct service staff in day treatment and residential facilities:
(1) Each facility or licensed unit maintains a written, legible schedule clearly identifying direct service staff responsible for care of clients.
(2) Each uncleared employee is identified on the staff schedule.
(3) The staff schedule is updated daily to reflect actual hours staff are present and changes in attendance as they occur.
(4) Original updated staff schedules are kept on file for at least 12 months.
(5) The updated schedule documents the client census for each unit of a residential treatment services center or group home service on a daily basis.

[7.20.11.16 NMAC - Rp 7 NMAC 20.11.16, 03/29/02; A, 10/29/04]

7.20.11.22 CLIENT PARTICIPATION, PROTECTION, AND CASE REVIEW:

A. The agency takes all reasonable action(s) to protect the health, safety, confidentiality, and rights of its clients. The agency informs the client of his or her rights and responsibilities and develops and implements policies and procedures that support and facilitate the client's full participation in treatment and related agency activities. The agency protects the confidentiality of client records through adherence to its own set of policies and procedures governing access to, and release of, confidential information.

B. Materials describing services offered, eligibility requirements and client rights and responsibilities are provided in a form understandable to the client and client's legal guardian(s) with consideration of the client's/guardian's primary language, and the mode of communication best understood by persons with visual or hearing impairments.

(1) If the client is unable to understand the materials for any reason, every effort is made to explain his or her rights and responsibilities in a manner understandable to the client. These efforts will be documented in the client's record.
(2) Materials are available or posted in the agency's reception area and/or handed to potential clients during their initial contact with the agency.
C. The agency explains to each client what his or her legal rights are in a manner consistent with the client's ability to understand and makes this information available to the client in writing, or in any other medium appropriate to the client's level of development. A written explanation of these rights is given to the parent/legal guardian upon admission.
(1) A client who receives residential treatment services has the rights enumerated in the New Mexico children's mental health and developmental disabilities Code, NMSA 1978, Sections 32A-6-1 et seq. (1995). Explanation of rights to the client and parents/legal guardian is documented in the client's record.
(2) The agency maintains and follows written policy affirming that clients may refuse any treatment or medication, unless the right to refuse treatment(s) has been limited by law or court order. The agency informs the individual of the risks of such refusal. Client refusal of treatment and advisement of risks of the refusal is documented in the client's record.
(3) The agency specifies in written policies and procedures the conditions under which it serves minors without parental/legal guardian consent, and when parental/legal guardian consent is not possible, designates who is authorized to give consent to treat the minor.
(a) The client record contains all applicable consents for treatment, including consent for emergency medical treatment and informed consent for prescription medication.
(b) Exception: Day treatment services, behavioral management skills development services and case management services programs are not required to file consents for prescription medications that are not taken during program hours unless the medications are prescribed by a program physician.
(c) Consent forms must contain the information identifying the specific treatment, prescription medication, information release, or event for which consent is being given prior to being signed by a client or guardian.
(4) Upon admission, each client receives an orientation to the agency's services that includes the basic expectations of the clients, the hours during which services are available, and any rules established by the agency regarding client conduct, with specific reference to behavior that could result in discontinuation of a service. Orientation of the client and parents/legal guardians is documented in the client's record.
(5) The agency maintains a written grievance/complaint procedure that is reviewed with the client and parent/legal guardian upon admission. The client's record contains documentation of the agency's explanation of the grievance procedure to the client and the parent/legal guardian.
(6) Financial arrangements are fully explained to the client and/or his or her parent/legal guardian upon admission, and at the time of any change in the financial arrangements.
(7) Procedures for protecting client assets: The agency establishes and follows written policies and procedures to identify how it manages, protects, and maintains accountability for client assets, including the segregation of client funds when an agency assumes fiduciary responsibility for a client's assets and/or disburses funds such as maintenance or allowance funds to clients.
(8) The agency establishes written procedures for providing client access to emergency medical services.
(9) Written agency policy specifies clinically appropriate and legally permissible methods of behavior management and discipline and provides training in their use to all direct service staff. The agency prohibits in policy and practice the following:
(a) degrading punishment;
(b) corporal or other physical punishment;
(c) group punishment for one individual's behavior;
(d) deprivation of an individual's rights and needs (e.g., food, phone contacts, etc.) when not based on documented clinical rationale;
(e) aversive stimuli used in behavior modification;
(f) punitive work assignments;
(g) isolation or seclusion, except as delineated in Section 24;
(h) harassment; and
(i) chemical or mechanical restraints, except as delineated in Section 24.I.
(10) The agency establishes and follows written policies and procedures for the use of therapeutic time-out in accordance with these certification requirements, including the following directives:
(a) therapeutic time-out can only be used for the length of time necessary for the client to resume self-control and/or to prevent harm to the client or others;
(b) therapeutic time-out is not used as a means of punishment;
(c) therapeutic time-out is not used for the convenience of staff; and
(d) therapeutic time-out is monitored closely and frequently to ensure the client's safety.
D. The agency prohibits the use or depiction of individuals (residents, clients, etc.), either personally or by name or likeness (e.g., photograph), in material (photographs, videotape or audiotape), presented in a context that is either commercial or public-service oriented in nature. An exception to this prohibition applies to children presented on the "Wednesday's child" television program, Los Ninos or other adoption exchange publications, in which case any participation and presentation is in accordance with the department's rules and regulations and with the knowledge, consent and active participation of the department.

E. Client information and case review: The agency maintains records and follows policies and procedures governing the access to, and release of, confidential information. The agency provides adequate facilities for the storage, processing and handling of clinical records, including suitably locked and secured rooms.

(1) The agency's written policies govern the retention, maintenance, and destruction of board administrative records, and records of former clients and personnel. These policies address:

(a) protection of the privacy of former clients and personnel; and

(b) legitimate future requests by former personnel or clients for information, particularly information that may not be available elsewhere.

(2) The agency has policies governing the disposition of records, security of records and timely access and retrieval of records in case of the agency's dissolution. The retention of records is required for the later of:

(a) four years after the client is released from treatment; or

(b) two years after the client reaches age 18; or

(c) two years after a client has been released from most recent legal guardianship, and is no longer under legal guardianship.

(3) The agency specifies in written policies and procedures how it releases information. Any release is in accordance with applicable state and federal laws. The agency does not request or use any information release form that has been signed by a client, parent, guardian or other party prior to pertinent information being completed on the form.

(4) In the event of a medical emergency that warrants immediate intervention in order to protect the life or safety of the client, access to information regarding the client's diagnoses and treatment plan/service plan may be provided to medical personnel.

F. Contents of the client record:

(1) Agency policy defines information to be contained in the client record. At the time of admission, the client's date of admission to each and any certified service is documented in a consistent location in the client record.

(2) Agency policy and practice provide that entries in the client record are made in an accurate, objective, factual, legible, timely, and clinically-based manner.

(a) Entries made in the client record pursuant to these certification requirements clearly identify the person completing the entry and his or her credentials.

(b) Late entries are identified as such; late entries include the actual date of the entry and the signature of the person completing the entry.

G. When prescribing medication or other treatments, the prescribing professional documents the indication for any medical procedures and/or prescription medications.

(1) When a client is seen by the prescribing professional, subsequent to a medical prescription or treatment, the professional documents the response to the prescription or treatment and any observed side effects.

(2) Medication, including non-prescription medication that is administered by a nurse or is self-administered, is documented by the agency staff with the date and time of administration, the name and dosage and any side effects observed.

H. A written discharge summary is placed in the client's record within 15 days of termination of services and includes:

clinical and safety status;

medications being taken at discharge*;*

documentation of notification to primary care physician;

specification of referrals/appointments made with specific names*;*

target behaviors addressed;

services provided;

progress attained, or lack thereof;

description of interventions to which the client did and did not respond, including medications;

recommendations for continued treatment and services.

I. Client review of case record:

(1) An individual may review his or her case record in the presence of a therapist or licensed independent practitioner of the agency on the agency's premises unless to do so would not be clinically indicated. The reasons why review is not clinically indicated are documented in the client's record. The confidentiality of other individuals is protected.

(2) The agency's policies and procedures allow the client to insert a statement into the record about his or her needs or about services he or she is receiving or may wish to receive. Any agency statements or responses are documented with evidence that the client was informed of insertion of such responses.

[7.20.11.22 NMAC - Rp 7 NMAC 20.11.22, 03/29/02; A, 04/14/05]

7.20.11.23 INTAKE, ASSESSMENT, TREATMENT PLANNING, DISCHARGE PLANNING, AND DISCHARGE:

A. The agency establishes criteria for admission, conducts ongoing clinical assessments, and develops, reviews, revises treatment plans and provides ongoing discharge planning with the full participation of the treatment team.

B. Clinical decisions are made only by qualified clinical personnel.

C. Intake and screening:

(1) The agency establishes and follows written criteria for admission to its program(s) and service(s), including exclusionary criteria.

(2) The agency establishes and follows written intake procedures to address clinical appropriateness for admission.

(3) The agency's eligibility criteria are consistent with EPSDT requirements and Licensing Requirements for Child and Adolescent Mental Health Facilities, 7.20.12 NMAC.

D. Assessments: The following applies to all certified services, except case management services. Each client is assessed at admission and reassessed at regularly specified times to evaluate his or her response to treatment, and specifically when significant changes occur in his or her condition or diagnosis. The assessment process is multidisciplinary, involves active participation of the family or guardian, whenever possible, and includes documented consideration of the client's and family's perceptions of treatment needs and priorities. Assessment processes include consideration of the client's physical, emotional, cognitive, educational, nutritional, and social development, as applicable. At a minimum, the following assessments are conducted and documented:

(1) An initial screening, conducted at admission, of physical, psychological, and social functioning, to determine the client's need for treatment, care, or services, and the need for further assessment; and assessment of risk of behavior that is life-threatening or otherwise dangerous to the client or others, including the need for special supervision or intervention.

(2) A full EPSDT screen (tot-to-teen health check) within 30 days of the initiation of services, unless such an examination has taken place and is documented within the 12 months prior to admission. The documented content of the history and physical examination must meet EPSDT requirements.

(3) The agency conducts a comprehensive assessment of each client's clinical needs. The comprehensive assessment is completed prior to writing the comprehensive treatment plan, and includes the following:

(a) Assessment of the client's personal, family, medical and social history, including:

(i) relevant previous records and collateral information;

(ii) relevant family and custodial history, including non-familial custody and guardianship;

(iii) client and family abuse of substances;

(iv) medical history, including medications;

(v) history, if available, as a victim of physical abuse, sexual abuse, neglect, or other trauma;

(vi) history as a perpetrator of physical or sexual abuse;

(vii) the individual's and family's perception of his or her current need for services;

(viii) identification of the individual's and family's strengths and resources; and

(ix) evaluation of current mental status.

(b) A psychosocial evaluation of the client's status and needs relevant to the following areas, as applicable:

(i) psychological functioning;

(ii) intellectual functioning;

(iii) educational/vocational functioning;

(iv) social functioning;

(v) developmental functioning;

(vi) substance abuse;

(vii) culture; and

(viii) leisure and recreation.

(c) Evaluation of high risk behaviors or potential for such;

(d) A summary of information gathered in the clinical assessment process, in a clinical formulation that includes identification of underlying dynamics that contribute to identified problems and service needs.

(4) If the comprehensive assessment is completed prior to admission, it is updated at the time of admission to each certified service.

(5) Assessment processes include the following:

(a) within 30 days of admission, an educational evaluation or current, age-appropriate individualized educational plan (IEP), or documented evidence that the client is performing satisfactorily at school;

(b) when indicated by clinical severity, a psychiatric evaluation;

(c) a psychological evaluation, when specialized psychological testing is indicated;

(d) monthly updates on mental status and current level of functioning, performed by a New Mexico licensed master's or doctoral level behavioral health practitioner.

(6) Assessment information is reviewed and updated as clinically indicated, and is documented in the client's record. For clients who have been in the service for one year or longer, an annual mental status exam and psychosocial assessment are conducted and documented in the client's record as an addendum to previous assessment(s). The agency makes every effort to obtain all significant collateral information and documents its efforts to do so. As collateral information becomes

available, the comprehensive assessment is amended.
E. Treatment planning and discharge planning: The treatment planning process is individualized and ongoing, and includes initial treatment planning, comprehensive treatment planning, discharge planning, and regular re-evaluation of treatment plans and discharge criteria.
(1) For certified services other than case management services and behavior management skills development services, an initial treatment plan is developed and documented within 72 hours of admission to each service. Based on information available at the time, the initial treatment plan contains the treatment planning elements identified above in 23.E (3) (a) through (j) below, with the exception that individualized treatment goals and objectives are targeted the first 14 days of treatment.
(2) For certified services other than case management and behavior management skills development services, a comprehensive treatment plan based on the comprehensive assessment is developed within 14 days of admission. The comprehensive treatment plan contains the treatment planning elements identified above in 23.E (3)
(a) through (j) below.
(3) Each initial and comprehensive treatment plans fulfill the following functions:
(a) involves the full participation of treatment team members, including the client and his or her parents/legal guardian, who are involved to the maximum extent possible; reasons for nonparticipation of client and/or family/legal guardian are documented in the client's record;
(b) is conducted in a language the client and/or family members can understand, or is explained to the client in language that invites full participation;
(c) is designed to improve the client's motivation and progress, and strengthen appropriate family relationships;
(d) is designed to improve the client's self-determination and personal responsibility;
(e) utilizes the client's strengths;
(f) is conducted under the direction of a person who has the authority to effect change and who possesses the experience and qualifications to enable him/her to conduct treatment planning; treatment plans meet the provisions of the Children's Code, NMSA 1978, Sections 32A-6-10, as amended, and are otherwise implemented in accordance with the provisions of Article 6 of the Children's Code;
(g) documents in measurable terms the specific behavioral changes targeted, including potential high-risk behaviors; corresponding time-limited intermediate and long-range treatment goals and objectives; frequency and duration of program-specific intervention(s) to be used, including medications, behavior management practices, and specific safety measures; the staff responsible for each intervention; projected timetables for the attainment of each treatment goal; a statement of the nature of the specific problem(s) and needs of the client; and a statement and rationale for the plan for achieving treatment goals;
(h) specifies and incorporates the client's permanency plan, for clients in the custody of the department;
(i) provides that clients with known or alleged history of sexually inappropriate behavior, sexual aggression or sexual perpetration are adequately supervised so as to ensure their safety and that of others; and
(j) documents a discharge plan that:
(i) requires that the client has achieved the objectives of the treatment plan;
(ii) requires that the discharge is safe and clinically appropriate for the client;
(iii) evaluates high risk behaviors or the potential for such;
(iv) explores options for alternative or additional services that may better meet the client's needs;
(v) establishes specific criteria for discharge to a less restrictive setting; and
(vi) establishes a projected discharge date, which is updated as clinically indicated.
(6) For behavior management skills development services, a service plan is developed within 14 days of initiation of services (see 28.C (1) (c).
F. The treatment plan is reviewed by the treatment team at intervals not to exceed 30 days and is revised as indicated by changes in the child's behavior or situation, the child's progress, or lack thereof.
(1) Each treatment plan review documents assessment of the following, in measurable terms:
(a) progress, or lack thereof, toward each treatment goal and objective;
(b) progress toward and/or identification of barriers to discharge;
(c) the client's response to all interventions, including specific behavioral interventions;
(d) the client's response to medications;
(e) consideration of significant events, incidents, and/or safety issues occurring in the period under review;
(f) revisions of goals, objectives, and interventions, if applicable;
(g) any change(s) or updates in diagnosis, mental status or level of functioning;
(h) the results of any referrals and/or the need for additional consultation;
(i) the effectiveness of behavior-management techniques used in the period under review.
(2) Some or all of the required elements of a treatment planning document may be recorded in a document other than the treatment plan/review, such as a clinical review form or format provided by, or to a payor, when the following conditions are met:
(a) all required elements are performed and documented in a timely manner by qualified clinical personnel;
(b) the client's record contains evidence of participation of treatment team members in each phase of the treatment planning process.
G. When aftercare is indicated at the time of non-emergency discharge, the agency involves the client, case manager (if applicable), the parent, legal guardian, or guardian ad litem, if applicable; and assists the client, family, or guardian in

arranging appointments, obtaining medication (if applicable), transportation and meeting other identified needs as documented in the treatment/discharge plan.

H. Prevention, planning, and processing of emergency discharge:

(1) The agency establishes policies and procedures for management of a child who is a danger to him/herself or others or presents a likelihood of serious harm to him/herself or others. The agency acts immediately to prevent such harm. At a minimum, the policies and procedures provide that the following be documented in the client's file:

(a) that the agency makes all appropriate efforts to manage the child's behavior prior to proposing emergency discharge;

(b) that the agency takes all appropriate action to protect the health and safety of other children and staff who are endangered.

(2) In the event of a proposed emergency discharge, the agency provides, at a minimum, procedural due process including written notice to the family/legal guardian, guardian ad litem and department, if applicable, and provision to stop the discharge action until the parent/legal guardian, guardian ad litem and/or the department exhausts any other legal remedy they wish to pursue. The agency documents the following in the client record:

(a) provision for participation of the parent/legal guardian, and guardian ad litem in the discharge process, whenever possible; and

(b) arrangement for a conference to be held including all interested persons or parties to discuss the proposed discharge, whenever possible.

(3) If the child's parent/legal guardian is unavailable to take custody of the child and immediate discharge of the child endangers the child, the agency does not discharge the child until a safe and orderly discharge is effected. If the child's family refuses to take physical custody of the child, the agency refers the case to the department.

I. Discharge: Non-emergency discharge occurs in accordance with the client's discharge plan, unless precipitated by a client's or guardian's refusal to consent to further treatment, or other unforeseen circumstances. Prior to discharge, the agency:

(1) evaluates the appropriateness of release of the client to the parent/legal guardian;

(2) provides that any discharge of the client occurs in a manner that provides for a safe and orderly transition; and

(3) provides for adequate pre-discharge notice, including specific reason for discharge.

[7.20.11.23 NMAC - Rp 7 NMAC 20.11.23, 03/29/02]

7.20.11.24 BEHAVIOR MANAGEMENT, PERSONAL RESTRAINT, AND SECLUSION PRACTICES: Certain provisions of this section are included to implement regulations of the federal centers for medicare and medicaid services (CMS) and may be amended when appropriate to reflect subsequent changes in the federal CMS regulations. These provisions are intended to implement, and to be consistent with the Child Health Act of 2000 and the CMS Interim Final Rule issued May 22, 2001, and are subject to further modifications as dictated by CMS.

A. The agency protects and promotes the rights of each client in the program, including the right to be free from physical or mental abuse, corporal punishment, and any personal restraint or seclusion imposed for purposes of discipline or convenience. The agency establishes and follows policies and procedures governing the use of behavior management practices including therapeutic hold, personal restraint and seclusion (when allowed as delineated below). This will include documentation of each therapeutic hold, personal restraint and seclusion in the client's record.

B. For those behavior management practices that are allowed for each type of program and are described above, the program supports their limited and justified use through:

(1) staff orientation and education that create a culture emphasizing prevention of the need for therapeutic hold, personal restraint and seclusion and their appropriate use;

assessment processes that identify and prevent potential behavioral risk factors; and

the development and promotion of preventive strategies and use of less restrictive alternatives.

C. Agency policy and procedures identify qualified staff authorized to approve the protocols and apply the criteria for use of therapeutic hold, personal restraint and seclusion.

D. Performance-improvement processes identify opportunities to reduce or eliminate the use of personal restraint or seclusion.

E. The agency establishes and follows policies and procedures for the safe, effective, limited, and least restrictive use of behavior management practices. The policies and procedures include measures to ensure that treatment planning includes regular review of the necessity for, type and frequency of behavior management practices used in individual cases.

F. When behavior management practices are used, the agency protects the safety, dignity, and privacy of clients to the maximum extent possible at all times during each procedure.

G. Treatment plans document the use of seclusion, personal restraint and therapeutic holds and include: consideration of the client's medical condition(s); the role of the client's history of trauma in his/her behavioral patterns; the treatment team's solicitation and consideration of specific suggestions from the client regarding prevention of future physical interventions.

H. Seclusion, personal restraint and therapeutic holds are implemented only by staff who have been trained and certified by a state recognized body in the prevention and use of therapeutic holds, personal restraint and seclusion. This training emphasizes de-escalation techniques and alternatives to physical contact with clients as a

means of managing behavior. Clients do not participate in the therapeutic holding, personal restraint or seclusion of other clients.

I. Mechanical and chemical restraints are prohibited in all programs except the program created under the Adolescent Treatment Hospital Act, which has been mandated by NMSA 1978 Sections 23-9-1 et.seq., to serve adolescents who are violent or have a history of violence, and which provides 24-hour on-site professional medical services in accordance with Section 3207 of the Children's Health Act of 2000.

J. Personal restraint and seclusion, as defined in these certification requirements, are used in JCAHO-accredited or non-JCAHO-accredited residential treatment centers and group homes; in emergency circumstances to ensure the immediate physical safety of the client, other clients, staff member(s) or others; and when less restrictive interventions have been determined to be ineffective. Personal restraint and seclusion are used in accordance with these provisions and with federal law, rule or regulation which may supersede state or accreditation regulations. Personal restraint and seclusion are imposed only by an individual trained and certified by a state-recognized body in the prevention and use of personal restraint and seclusion and in the curriculum that may be set forth in federal regulations to be promulgated under Title V of the Public Health Service Act (42 U.S.C. 290aa et seq. as amended by section 3208, Part I, section 595). When federal regulations are promulgated under Title V as described above, the curriculum set forth there shall be included in the training.

K. Physical escort is allowed as a safe means of moving a client to a safe location.

L. Personal restraint or seclusion are not to be used for staff convenience and/or as coercion, discipline, or retaliation by staff.

M. This sub-section (M) applies, for personal restraint, to facilities accredited by JCAHO, and to all residential treatment centers for seclusion. These entities require orders that are consistent with Department regulation, agency policy, and regulations of the centers for medicare and medicaid services (CMS) 42 CFR, Parts 441 and 483. These orders are issued by a restraint/seclusion clinician within one hour of initiation of personal restraint or seclusion, and include documented clinical justification for the use of personal restraint or seclusion.

(1) If the client has a treatment team physician and he or she is available, only he or she can order personal restraint or seclusion.

(2) If personal restraint or seclusion is ordered by someone other than the client's treatment team physician, the restraint/seclusion clinician will consult with the client's treatment team physician as soon as possible and inform him or her of the situation requiring the client to be restrained or placed in seclusion and document in the client's record the date and time the treatment team physician was consulted and the information imparted.

(3) The restraint/seclusion clinician must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the situation.

(4) If the order for personal restraint is verbal, the verbal order must be received by a restraint/seclusion clinician or a New Mexico licensed registered nurse (RN) or practical nurse (LPN). The restraint/seclusion clinician must verify the verbal order in a signed, written form placed in the client's record within 24 hours after the order is issued.

(5) A restraint/seclusion clinician's order must be obtained by a restraint/seclusion clinician or New Mexico licensed RN or LPN prior to or while the personal restraint or seclusion is being initiated by staff, or immediately after the situation ends.

(6) Each order for personal restraint or seclusion must be documented in the client's record and will include:

(a) the name of the restraint/seclusion clinician ordering the personal restraint or seclusion;

(b) the date and time the order was obtained;

(c) the emergency safety intervention ordered, including the length of time;

(d) the time the emergency safety intervention actually began and ended;

(e) the time and results of any one-hour assessment(s) required; and

(f) the emergency safety situation that required the client to be restrained or put in seclusion; and

(g) the name, title, and credentials of staff involved in the emergency safety intervention.

(7) Supervision and assessment of personal restraint or seclusion

(a) The restraint/seclusion clinician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(b) A New Mexico registered nurse or a restraint/seclusion clinician other than a doctoral level psychologist, must conduct a face-to-face assessment of the physical well being of the client within one hour of the initiation of the emergency safety intervention and immediately after the personal restraint is removed or the client is removed from seclusion. A restraint/seclusion clinician or a New Mexico registered nurse must conduct a face-toface assessment of the psychological well being of the client within one hour of the initiation of the emergency safety intervention and immediately after the personal restraint is removed or the client is removed from seclusion. When the personal restraint or seclusion is less than one hour in duration, and the restraint/seclusion clinician is not immediately available at the end of the period of restraint or seclusion, the restraint/seclusion clinician will evaluate the client's well-being as soon as possible after the conclusion of the restraint/seclusion, but in no case later than one hour after its initiation.

(c) If the situation requiring emergency safety intervention continues beyond the time limit of the order for the use of personal restraint or seclusion, the New Mexico RN or LPN must immediately contact the ordering restraint/seclusion clinician or the client's treatment team physician to receive further instructions. If clinical circumstances justify renewal of personal restraint or seclusion, then the renewal order must be obtained within the time frames outlined in 24.O (1) below.

N. This sub-section (N) applies to personal restraint in residential treatment services not accredited by JCAHO. In these residential treatment services, personal restraint requires the following, which is consistent with department regulation and agency policy.

(1) A New Mexico licensed independent practitioner, licensed professional mental health counselor (LPC), licensed master social worker (LMSW), or registered nurse must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(2) A New Mexico licensed independent practitioner, or a licensed professional mental health counselor (LPC), licensed master social worker (LMSW), in consultation with a licensed independent practitioner, or a registered nurse trained in the use of emergency safety interventions must conduct a face-to-face assessment of the well-being of the client within one hour of the initiation of the emergency safety intervention and immediately after the personal restraint is removed or the client is removed from seclusion. When the personal restraint or seclusion is less than one hour in duration, and the restraint/seclusion clinician is not immediately available at the end of the period of restraint or seclusion, the restraint/seclusion clinician will evaluate the client's well-being as soon as possible after the conclusion of the restraint/seclusion, bu in no case later than one hour after its initiation.

O. The following sub-section (O) applies to all residential treatment centers and group homes.

(1) The personal restraint or seclusion is limited to a maximum of two hours for clients age of 17 and one hour for clients under nine years of age.

(2) Post-intervention debriefings with the client will take place after each emergency safety intervention and the staff will document in the client's record that the debriefing sessions took place.

(3) The agency will have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the medicaid program that reasonably ensure that:

(a) A client will be transferred from the facility to the hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;

(b) Medical and other information needed for care of the client in light of such transfer will be exchanged between the organizations in accordance with state medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and

(c) Services will be available to each client 24 hours a day, seven days a week.

(4) The agency will document in the client's record all client injuries that occur as a result of an emergency safety intervention.

(5) All agencies will attest in writing that the facility is in compliance with CMS standards governing the use of personal restraint and seclusion. This attestation will be signed by the agency director.

(6) If the client is a minor, the agency will notify the parent(s) or legal guardian(s) that personal restraint or seclusion has been ordered as soon as possible after the initiation of each emergency safety intervention. This will be documented in the client's record, including the date and time of notification, the name of the staff person providing the notification, and who was notified.

(7) Agencies will provide for client health and safety by requiring direct service staff to demonstrate competencies related to the use of emergency safety interventions on a semiannual basis. Direct service staff will demonstrate, on an annual basis, their competency in the use of cardiopulmonary resuscitation. The agency will document in the staff personnel records that the training required was successfully completed.

(8) The agency must maintain an aggregate record of all situations requiring emergency safety intervention, the interventions used and their outcomes.

(9) Programs must report the death of any client to the CMS regional office by no later than close of business the next business day after the client's death. The report must include the name of the client and the name, street address and telephone number of the agency. The parent or legal guardian will also be notified. Staff must document in the client's record that the death was reported to the CMS regional office.

[7.20.11.24 NMAC -N, 03/29/02]

7.20.11.28 BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES:

A. Behavior management skill development services are delivered through an individualized behavior management skills development service plan designed to develop, restore, or maintain skills and behaviors that result in improved function or which prevent deterioration of function. Behavior management skills development services are delivered to clients up to age 21 who:

(1) are in need of behavior management skills development intervention to avoid inpatient hospitalization, residential treatment or separation from his/her family; or

(2) require continued intensive or supportive services following hospitalization or out-of-home placement as a transition to maintain the client in the least restrictive environment possible.

B. Personnel

(1) The behavior management skills development specialist meets the following criteria:

(a) is at least 21 years of age; and

(b) demonstrates the ability to independently implement and document the outcome of the goals, measurable objectives and interventions as defined in a behavioral management skills development service plan.

(2) The behavior management skills development specialist receives 20 hours of documented pre-service training, to include, but not limited to:

(a) crisis management/intervention;

(b) behavior management;

(c) emergency procedures, which include current CPR and first aid certificates.

(3) Within 90 days of hire, the behavior management skills development specialist receives an additional 20 documented hours of training, including but not limited to:

(a) etiology and symptoms of emotional disturbances and neurobiological disorders;

(b) family systems;

(c) basic communication and problem solving skills;

(d) child and adolescent development;

(e) issues related to ethnic and cultural interests of the clients served;

(f) action and potential side effects of medications.

(4) Behavior management skills development specialists receive supervision by a New Mexico licensed practitioner with a doctoral or master's degree from an accredited institution in a human service related field who has at least two years experience working with children, adolescents and families. Exception: If a supervisor with the above qualifications cannot be recruited, the supervisor must possess, at a minimum, a B.S.W., B.A., B.S., or B.U.S. in a human service related field plus four years experience working with seriously emotionally disturbed or neurobiological disordered children and adolescents.

(5) Supervision is provided for a minimum of two hours per month depending upon the complexity of the needs presented by clients and the supervisory needs of the behavior management skills development specialist. Supervision is documented with dates, times, and content of contacts.

C. Services:

(1) Behavior management skills development services focus on acquisition of skills and improvement of the client and/or family's performance related to targeted behaviors. The agency:

(a) conducts a clinical assessment, or acquires clinical information that guides the development of the behavior management skills development services plan;

(b) documents clinical review of information that enables the agency to complete the behavior management skills development service plan;

(c) develops a behavior management skills development service plan, including: client needs, measurable goals, interventions, discharge criteria, and a discharge plan, within 14 days of admission to the service;

(d) reviews the behavior management skills development service plan every 30 days and revises as necessary; and

(e) works in partnership with other agencies or individuals involved in the client's care to implement the discharge plan and link the client to aftercare, as indicated;

(f) provides services to one or more child(ren) from the same or different home(s), provided that a staff-to-client ratio of 1:1 is maintained at all times.

(2) The behavior management skills development specialist provides the following services:

(a) participation in the development, review and revision of the behavior management service plan;

(b) implementation of the behavior management skills development service plan to include teaching of behavior enhancing skills;

(c) documentation of each client contact, including date, time, duration, and the client's progress and/or response to the interventions each day service is provided, stated in terms of service plan goals and objectives; and

(d) coordinating with the family and school personnel, if appropriate, to assist the client to achieve and/or to maintain appropriate behavior management.

Severe Emotional Disturbance (SED)
CRITERIA CHECKLIST

SED determination is based on the age of the individual, diagnoses, functional impairment or symptoms, and duration of the disorder. The child/adolescent must meet all of the following criteria:

☐ 1. **Age:**

- ☐ be a person under the age of 18;

  OR

- ☐ be a person between the ages of 18 and 21, who received services prior to the 18th birthday, was diagnosed with a SED, and demonstrates a continued need for services

☐ 2. **Diagnoses:** The child/adolescent has an emotional and/or behavioral disability that has been diagnosed by a licensed psychiatrist, licensed psychologist, LISW, LMFT, or LPCC under the classification system in the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR). Please note: Although some Axis II and other disorders are excluded as primary diagnoses, all Axis II or other disorders should be documented and are likely to affect engagement and treatment planning. In addition, please note the following:

- Diagnoses that are included are only those providing a primary reason for receiving public system behavioral health services. Diagnoses describing a static deficit are not included, unless a qualifying Axis I disorder is also present;
- Most diagnoses marked NOS are excluded to ensure prompt and thorough assessment. The reasons for exceptions are noted where they appear.

Disorders usually first diagnosed in infancy, childhood, or adolescence

Axis II Disorders; i.e. Mental Retardation, as well as Learning Disorders, Motor Skills Disorder; Communication, and Pervasive Developmental Disorders are excluded. These disorders are primarily either static deficits or disorders for which mental health or substance use treatment is secondary to primary care or specialized non-behavioral health or developmental services.

- ☐ Attention-Deficit and Disruptive Behavior Disorders — All included (except NOS Disorder 312.9): 314.00 and 314.01, 314.9, 312.81, 314.82, 314.89, 313.81
- ☐ Feeding and Eating Disorders of Infancy or Early Childhood: 307.52, 307.53, 307.59
- ☐ Tic Disorders — All included (except NOS Disorder 307.20): 307.23, 307.22, 307.21
- ☐ Elimination Disorders: 787.6, 307.7, 307.6
- ☐ Other Disorders of Infancy, Childhood or Adolescence — All included (except NOS Disorder 313.9): 309.21, 313.23, 313.89, 307.3

Delirium, Dementia, and Amnestic and Other Cognitive Disorders and Mental Disorders Due to a General Medical Condition Not Elsewhere Classified (All excluded: Older age specific or, if chronic and disabling, treatment to be recommended is not behavioral health treatment or service.)

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☐ **Substance-Related Disorders**

All included (**except** the following NOS disorders: 291.9, 292.9):
303.90, 305.00, 303.00, 291.81, 291.0, 291.2, 291.1, 291.5, 292.3, 291.89, 304.40, 305.70, 292.89, 292.0, 292.81, 292.11, 292.12, 292.84, 305.90, 304.30, 305.20, 304.20, 205.60, 292.0, 304.50, 305.30, 304.60, 305.90, 305.1, 304.00, 305.50, 304.10, 305.40, 304.80, 304.90

Other Diagnostic Categories

☐ Schizophrenia and Other Psychotic Disorders (295.00 — all subtypes, 295.40, 295.70, 297.1, 298.8, 297.3, 293.81, 293.82, 298.9). Note that 298.9: Psychotic Disorder NOS is included as it indicates the presence of significant and severe symptoms, but precise diagnosis may not occur until further evaluation and treatment commences.

☐ Mood Disorders — All included: 296.0x, 296.2x, 296.3x, 300.4, 311, 296.40, 296.4x, 296.6x, 296.5x, 296.7, 296.89, 301.13, 296.80, 296.90

☐ Anxiety Disorders — All included: 300.0, 300.01, 300.21, 300.22, 300.29, 300.23, 300.3, 309.81, 308.3, 300.02, 293.84

☐ Somatoform Disorders — All included (except NOS Disorders 300.82): 300.11, 300.81, 300.82, 300.80, 300.89, 300.7, 300.82

☐ Factitious Disorders: 300.16 (NOS Disorder 300.19 is excluded)

☐ Dissociative Disorders — All included (except NOS Disorder 300.15): 300.12, 300.13, 200.14, 200.6

☐ Sexual and Gender Identity Disorders — Note that some codes not usually associated with children or adolescents may be indicators of abuse or trauma. Gender Identity codes are excluded and likely to be developmental rather than requiring behavioral health treatment. All other disorders in this category are included (except NOS Disorder 302.70): 302.72, 302.79, 302.73, 302.74, 302.75, 302.76, 306.51, 625.8, 208.89, 607.84, 625.0, 608.89, 625.8, 608.89, 302.4, 302.81, 302.89, 302.2, 302.83, 302.84, 302.3, 302.82, 302.9

☐ Eating Disorders — All included (except NOS Disorder 307.50): 307.1, 307.51

Sleep Disorders in children and adolescents are excluded and if chronic and disabling call for treatment that is not behavioral health treatment. Other primary diagnoses that do qualify for SED should be used if appropriate.

☐ Impulse-Control Disorders not elsewhere classified — All are included (except for NOS Disorder 312.30): 312.34, 312.32, 312.33, 312.31, 312.39

Personality Disorders — All are Axis II and **excluded**. An Axis I primary diagnosis must be included to qualify for SED. However, Axis II diagnoses should be documented and affect engagement and treatment planning.

Other Conditions That May Be a Focus of Clinical Attention are excluded and qualifying Axis I primary diagnosis is required.

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☐ 3. **Functional Impairment:**

The child/adolescent must have *either:*

- **a Functional Impairment in two of the listed capacities**
- **symptoms in one of the groups listed below.**

☐ *Functioning in self-care:*
Impairment in self-care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.

☐ *Functioning in community:*
Inability to maintain safety without assistance; a consistent lack of age-appropriate behavioral controls, decision-making, judgment and value systems which result in potential out-of-home placement.

☐ *Functioning in social relationships:*
Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults. Children and adolescents exhibit constrictions in their capacities for shared attention, engagement, initiation of two-way effective communication, and shared social problem solving.

☐ *Functioning in the family:*
Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents and/or caretakers (e.g., foster parents), disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable expectations that may result in removal from the family or its equivalent). Child-caregiver and family characteristics do not include developmentally based adaptive patterns that support social-emotional well-being. For early childhood functioning, major impairments undermine the fundamental foundation of healthy functioning exhibited by:

- rarely or minimally seeking comfort in distress
- limited positive affect and excessive levels of irritability, sadness or fear
- disruptions in feeding and sleeping patterns
- failure, even in unfamiliar settings, to check back with adult caregivers after venturing away
- willingness to go off with an unfamiliar adult with minimal or no hesitation
- regression of previously learned skills

☐ *Functioning at school/work:*
Impairment in school/work function is manifested by an inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others); identification by an IEP team as having an Emotional/Behavioral Disability; or inability to be consistently employed at a self-sustaining level (e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job).

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☐ 4. **Symptoms:**

Symptoms in one of the following groups:

☐ *Psychotic symptoms:*
Symptoms are characterized by defective or lost contact with reality, often with hallucinations or delusions.

☐ *Danger to self, others and property as a result of emotional disturbance:*
The individual is self-destructive, e.g., at risk for suicide, and/or at risk for causing injury to self, other persons, or significant damage to property.

☐ *Trauma symptoms:*
Children experiencing or witnessing serious unexpected events that threaten them or others. Children and adolescents who have been exposed to a known single event or series of discrete events experience a disruption in their age-expected range of emotional and social developmental capacities. Such children may experience:

- a disruption in a number of basic capacities such a sleep, eating, elimination, attention, impulse control, and mood patterns
- under-responsivity to sensations and become sensory seeking, physically very active, aggressive and/or antisocial
- under-responsivity to sensations but not sensory seeking and may shut down further and become lethargic or depressed and difficult to arouse
- over-responsivity to sensations and become hypervigilant or demonstrate fear and panic from being overwhelmed
- episodes of recurrent flashbacks or dissociation that present as staring or freezing

☐ 5. **Duration:**

☐ The disability must be expected to persist for six months or longer.

GADSDEN INDEPENDENT SCHOOL DISTRICT
FACILITIES USE AGREEMENT
WITH
TEAMBUILDERS COUNSELING SERVICES, INC.

The Board of Education for the Gadsden Independent School District ("Board" and "District") and TeamBuilders Counseling Services, ("Facilities User" and "TeamBuilders") agree to the provisions of this Facilities Use Agreement ("Agreement") and the covenants contained herein.

1. SCOPE OF USE.

a. Purpose. The Facilities User shall use District Facilities for the following purpose(s):

With the consent of the respective students and parents, to offer school-based behavioral health services ("Services") on the campuses of Gadsden School District to students and/or their families in individual and group settings. These Services may include intake and assessments; individual, family and group therapy; group counseling on topical issues as needed; Comprehensive Community Support Services; 1:1 Behavior Management Skills Development Services, and consultation with selected staff regarding student progress and behavior on District Property.

b. Facilities. The term "Facilities" shall mean any area, building or structure on District property. The following Facilities may be used by the Facilities User:

Any rooms/spaces on the campuses of Gadsden School District as designated and made available by the District. The District may change the specific rooms and spaces used by TeamBuilders at any time.

The Facilities User acknowledges that, in the event that a District-sponsored event is scheduled for any of the Facilities listed in subsection b., above, during the same dates and times listed in subsection c., below, the District shall have the primary right to use the Facilities listed in subsection b., above, notwithstanding any provision contained in this Agreement to the contrary. In the event that a conflict arises, and the parties cannot agree on the use of an alternative location by the Facilities User, this Agreement shall be null and void.

c. Dates and Times. The Facilities shall be used by the Facilities User during the following dates and times:

TeamBuilders may make its services available during and after school hours, as authorized in advance by the District. The District may change the dates and times TeamBuilders makes its services available to students at any time with appropriate notice on an "as needed" basis.

d. Term and Termination. This Agreement shall be effective as of **August 15, 2011.** This Agreement shall automatically terminate on **June 30, 2012** ("Termination Date"). This Agreement may be terminated by either party without cause prior to the Termination Date by providing thirty (30) days written notice to the other party.

e. Rental Fees. In lieu of monetary payment the Facilities User agrees that its services in the District's facilities shall be provided to students enrolled in the District and their families in support of the District's educational programs, to reduce truancy, drop-out rates and gang related behavior, to assist the District to address other disciplinary problems and to promote positive attitudes toward the completion of high school.

2. RESPONSIBILITIES AND LIABILITY RELEASE.

a. Responsibility for Care and Supervision. The Facilities User shall be responsible for the care and supervision of the Facilities and for payment of the Rental Fees, if any. The care and supervision of the Facilities may include, without limitation, responsibility for repairing any breakage, vandalism or other defacement of District property and responsibility for trash removal after each use of the Facilities.

b. Hold Harmless Agreement. The Facilities User does hereby covenant and agree that the District and its officers, employees, agents, members or representatives shall not be liable for any loss, damage, injury or liability of any kind to any person or property caused by or arising from any use of the Facilities, or any part thereof, or any building, structure or improvement thereon, or any equipment to be used therein, or because of any disrepair or arising from any act or omission of the District, nor shall the District be liable for any loss, damage or injury from any cause whatsoever to the property or persons entering upon or using the Facilities, or to any property stored or placed thereon as a result of the Facilities User's activities. Notwithstanding anything to the contrary contained herein and regardless of any insurance carried by the Facilities User, the Facilities User covenants to protect, indemnify the District and to hold the District harmless from any and all damages or liabilities arising out of or in connection with the Facilities User's activities pursuant to this Agreement.

c. Compliance with District Policies. The Facilities User is knowledgeable of the District's policies and procedures governing the use of Facilities for non-District related activities, and agrees to adhere to all applicable requirements. In addition, the Facilities User expressly agrees to provide adequate supervision and control of the activities to prevent injury to persons or loss of or damage to property; to repair or replace any loss of or damage to the District's property which results from the Facilities User's activities; and to prohibit the use or possession of drugs, alcohol, tobacco products, and/or weapons on District property.

3. Further Covenants by the Facilities User. TeamBuilders further covenants:

a. that only qualified personnel shall provide the services described in Paragraph 1, subsection a., above, and that all TeamBuilders staff delivering services at the Facilities will be insured and have had a criminal background clearance. All TeamBuilders staff will endorse ethical and legal standards and expectations of their licensure and their respective professional organizations;

b. to provide service assessments on each participant and maintain confidential client records. Information shared with the District will be limited to issues that might potentially influence a student's behavior or academic success in the school environment. All disclosures of information shall be subject to federal and state parental consent and confidentiality requirements;

c. to confer with school counselors regarding students needing/benefiting from behavioral health services that will be offered by TeamBuilders at specific sites;

d to participate in Student Assistance Team Meetings and/or staffing as needed with students who are/will be receiving services and will attend Student Services Meetings;

e. to share information regarding student progress contingent on parental consent and signed Release of Information; and

f. to provide the services pursuant to this Agreement without cost to the District.

GADSDEN SCHOOL DISTRICT:

By: _____ Date: _____

Print Name: _____

Title: _____

TEAMBUILDERS COUNSELING SERVICES, INC.:

By: _____ Date: _____

Print Name: Sun W. Vega

Title: Chief Operations Officer