



DEPARTMENT OF HUMAN SERVICES

Behavioral Health

BEHAVIORAL HEALTH

2 CCR 502-1

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

Statement of Basis and Purpose, Fiscal Impact/Regulatory Analysis and Specific Statutory Authority

Rules regarding the Care and Treatment of the Mentally Ill were originally adopted on 3/21/1977, and subsequently amended through April 20, 1993 (effective May 30, 1993), by the Department of Institutions.

The purpose of the 1991 revision of these rules is to make the regulations easier to locate within the document, easier to read and to understand; to incorporate policy statement formerly contained in the Division of Mental Health's Procedures Manual; and to add several changes recommended to the Department of Institutions by the Mental Health Advisory Board for Service Standards and Regulations.

These rules were proposed pursuant to Notice of Public Hearing published on November 10, 1991, and after proper notice, a public hearing was conducted on Thursday, December 5, 1991. Written and oral testimony presented to the Department of Institutions was considered in the determination to adopt these rules. The record of the rule-making proceeding demonstrates the need for these regulations; the regulations have been clearly and simply stated; and the regulations do not conflict with other provisions of law. The effective date for these rules is March 1, 1992.

Sections 103.2.A.2 and 103.2.A.3, which were adopted after January 1, 1992 and before January 1, 1993, were not extended by H.B. 93-1131 and therefore expired effective June 1, 1993.

The entire re-write of these rules were adopted following publication at the 4/2/2004 State Board of Human Services meeting, with an effective date of 6/1/2004 (Rule-making #03-5-14-1). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Performance Improvement, Boards and Commissions Division, State Board Administration.

Addition of rules concerning Acute Treatment Units, Sections 19.500 through 19.568.2 were adopted following publication at the 9/7/2007 State Board of Human Services meeting, with an effective date of 11/1/2007 (Rule-making #07-3-22-2). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Performance Improvement, Boards and Commissions Division, State Board Administration.

Revision of Section 19.421.3 was adopted following publication at the 7/12/2013 State Board of Human Services meeting, with an effective date of 9/1/2013 (Rule-making# 13-5-14-1). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Enterprise Partnerships, Division of Boards and Commissions, State Board Administration.

Rules regarding care and treatment of the mentally ill, as originally found in 2 CCR 502-1 (Rule Vol. 19), are repealed in their entirety and rewritten as a consolidation of Behavioral Health rules in 2 CCR 502-1 (Rule Vol. 21) as adopted following publication at the 9/6/2013 State Board of Human Services meeting, with an effective date of 11/1/2013 (Rule-making# 13-3-4-1). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Enterprise Partnerships, Division of Boards and Commissions, State Board Administration.

Revisions to Sections 21.900 through 21.950 were adopted on an emergency basis at the 11/6/2015 State Board of Human Services meeting, with an effective date of 11/6/2015 (Rule-making# 15-10-20-1). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Strategic Communications and Legislative Relations, State Board Administration.

Revisions to Sections 21.900 through 21.950 were adopted as final (permanent) at the 12/4/2015 State Board of Human Services meeting, with an effective date of 2/1/2016 (Rule-making# 15-10-20-1). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Strategic Communications and Legislative Relations, State Board Administration.

Revisions to Sections 21.000 through 21.330 were adopted at the 3/4/2016 State Board of Human Services meeting, with an effective date of 5/1/2016 (Rule-making# 15-08-26-1). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Strategic Communications and Legislative Relations, State Board Administration.

Revisions to Sections 21.120.3 and 21.120.31 were adopted at the 9/9/2016 State Board of Human Services meeting, with an effective date of 11/1/2016 (Rule-making# 16-5-11-1). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Strategic Communications and Legislative Relation, State Board Administrator.

Addition of rules concerning the Behavioral Health Crisis Response System, Sections 21.400 through 21.400.6 were adopted at the 9/9/2016 State Board of Human Services meeting, with an effective date of 11/1/2016 (Rule-making# 16-5-11-1). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these additions were incorporated by reference into rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Strategic Communications and Legislative Relation, State Board Administrator.

The following Chapters 1 - 11 apply to all agencies that apply for, receive, or renew a Behavioral Health Entity license or 27-65 designation on or after January 1, 2024.

Chapter 1: General Statutory Authority and Definitions

1.1 Authority and Applicability

- A. The statutory authority for the promulgation of these regulations is set forth in Sections 27-50-106, C.R.S., 27-50-107 (3), C.R.S., 27-50-301(5), C.R.S., 27-50-502, C.R.S., 27-65-118, C.R.S. and 27-65-128, C.R.S. This regulation is intended to be consistent with the requirements of the State Administrative Procedures Act (the "APA"), Section 24-4-101 through -109, C.R.S.
- B. Chapters 1-10 of these rules may be applicable to holders of the following license types or designation following approval of an application for a Behavioral Health Entity license or renewal of a designation:
 - 1. Behavioral Health Entity license by the Colorado Department of Public Health and Environment;
 - 2. Approval or designation by the Office of Behavioral Health, as it existed before the effective date of Section 27-60-203(5), C.R.S., or the BHA pursuant to Article 50 of Title 27, C.R.S. or Article 65 and 66 of Title 27 C.R.S.
- C. On an annual basis, the BHA will review the effectiveness of these rules and produce a written report of the results of this review to the State Board of Human Services. This review will include engagement with stakeholders and may include, but is not limited to, analysis of grievance data and trends in enforcement actions taken by the BHA. The BHA will provide this report annually to State Board of Human Services (SBHS) by September 1 starting September 1, 2024. The BHA will present information in the report to SBHS at the board's next session following submission of the written report unless the board and the BHA agree that presentation of the report occur at a different session of the board. If it is determined based on this review that changes to these rules are advised, the BHA shall propose these changes to the State Board of Human Services for promulgation in accordance with Section 26-1-107, C.R.S.

1.2 General Definitions

"27-65 Designated Facility" means an agency that has applied for and been approved by the Behavioral Health Administration (BHA) under these rules to provide mental health services governed by Article 65 of Title 27, C.R.S.

"42 C.F.R. Part 2" means the federal regulations issued by the United States Secretary of Health and Human Services found at 42 C.F.R. Part 2 (Jan. 2023), which are hereby incorporated by reference. No later editions or amendments are incorporated. These regulations are available at no cost from the U.S. Department of Health & Human Services, Substance Abuse & Mental Health Services Administration, Office of Communications, 5600 Fishers Lane, Rockville, MD 20857 or at <https://www.ecfr.gov/current/Title-42>. These regulations are also available for public inspection and copying at the Behavioral Health Administration, 710 S. Ash Street, Unit C140, Denver, CO 80246, during regular business hours.

“42 C.F.R. Part 441” means the federal regulations issued by the United States Secretary of Health and Human Services found at 42 C.F.R. Part 441.151 (Feb.2023), which are hereby incorporated by reference. No later editions or amendments are incorporated. These regulations are available at no cost from the U.S. Department of Health & Human Services, Substance Abuse & Mental Health Services Administration, Office of Communications, 5600 Fishers Lane, Rockville, MD20857 or at <https://www.ecfr.gov/current/Title-42>. These regulations are also available for public inspection and copying at the Behavioral Health Administration, 710 S. Ash Street, Unit C140, Denver, CO 80246, during regular business hours.

“72-hour Emergency Rule” means the regulation issued by the Drug Enforcement Administration (DEA) found at 21 C.F.R. § 1306.07 (Apr.2022), which is hereby incorporated by reference. No later editions or amendments are incorporated. This regulation is available at no cost from the DEA at 8701 Morrisette Drive Springfield, VA 22152 or at <https://www.ecfr.gov/current/Title-21>. This regulation is also available for public inspection and copying at the Behavioral Health Administration (BHA), 710 S. Ash Street, Unit C140, Denver, CO 80246, during regular business hours.

“988” means the National Suicide Prevention Lifeline (The Lifeline).

“Activities of Daily Living (ADLs)” means activities that are oriented toward taking care of one’s own body, such as bathing, showering, bowel and bladder management, dressing, eating, feeding, functional mobility, personal device care, personal hygiene and grooming, sexual activity, sleep, rest, and toilet hygiene.

“Acute Treatment Unit” (ATU) means an agency or a distinct part of an agency, with an endorsement as outlined in Chapter 6 for short-term psychiatric care, which may include treatment for substance use disorders, that provides a twenty-four-hour, therapeutically planned and professionally staffed environment for individuals who do not require inpatient hospitalization but need more intense and individualized services than are available on an outpatient basis, such as crisis management and stabilization services.

“ADDs” means the “Alcohol and Drug Driving Safety” program, established under Section 42-4-1301.3, C.R.S., the Judicial Department administers an alcohol and drug driving safety program in each judicial district that provides pre-sentence and post-sentence alcohol and drug evaluations on individuals convicted of DUI, DUI per se, or DWAI.

“Administration” means (a) assisting a person in the ingestion, application, inhalation, or, using universal precautions, rectal or vaginal insertion of medication, including prescription drugs, (b) doing so in accordance with the legibly written or printed directions of the attending physician or other authorized practitioner or as written on the prescription label and (c) making a written record thereof with regard to each medication administered, including the time and the amount taken, but “administration” does not include judgment, evaluation, or assessments. Nor does it include the injection of medication, the monitoring of medication, or the self-administration of medication, including prescription drugs and including the self-injection of medication by a person.

“Admission” means that point in an individual’s relationship with an organized treatment service when the intake process has been completed and the individual is eligible to receive the services.

“Admission Summary” means a brief review of assessments and other relevant intake data, including screenings, which summarizes an individual’s current status and provides a basis for individualized service planning.

“Adverse Childhood Experiences (ACES)” means traumatic events that occur before the age of eighteen (18) years old. Aces can include but are not limited to:

A. Abuse, which can be emotional, verbal, physical or sexual;

- B. Neglect, either physical or emotional;
- C. Witnessing or experiencing domestic violence;
- D. Substance misuse by a member of the household;
- E. Divorce or separation of parents and/or caregivers or parental abandonment;
- F. Mental illness of a member of the household;
- G. Loss of a member of the household;
- H. Attempted, or death by, suicide of a member of the household; and,
- I. Incarceration of a member of the household.

“Affidavit of Enrollment” means the document approved by the Department of Revenue, Division of Motor Vehicles pursuant to Section 42-2-132(2)(II)(c), C.R.S. indicating proof of an individual’s current enrollment in a Level II Alcohol and Drug Education and Treatment program.

“Agency” means a behavioral health provider licensed, designated, or approved by the BHA.

“Aggrieved” means having suffered actual loss or injury or being exposed to potential loss or injury to legitimate interests as defined in Section 24-4-102(3.5), C.R.S.

“Alcohol and Drug Evaluation Specialists” or “ADES,” means persons within the Judicial Department, qualified to conduct pre- and post-sentence evaluations on, and provide supervision for, individuals convicted of DUI/DWAI.

“Americans with Disabilities Act”, or “ADA,” means the Federal Americans with Disabilities Act of 1990, pub. L. No. 101-336 (1990), codified at 42 U.S.C. § 12101 et seq. (Jan 2017).

“ASAM Criteria” means the publication from the American Society of Addiction Medicine by Mee-lee, D., Shulman, G.D., Fishman, M.J., Gastfriend, D.R., Miller, M.M., eds Titled the ASAM Criteria: Treatment Criteria for Addictive, Substance-related, and Co-occurring Conditions, 3rd ed. Carson City, NV: The Change Companies®; 2013, which is hereby incorporated by reference. No later editions or amendments are incorporated. The ASAM Criteria is available for a reasonable charge at www.asam.org. It is also available for public inspection at the Behavioral Health Administration, 710 S. Ash Street, Unit C140, Denver, CO 80246, during regular business hours.

“Assent” means to agree or approve of something (such as an idea or suggestion) especially after thoughtful consideration.

“Assessment” means a formal and continuous process of collecting and evaluating information about an individual for service planning, treatment, and referral. Assessments establish justification for services.

“Auxiliary Aids or Services” means an aid or service that is used to provide information to an individual with a cognitive, developmental, intellectual, neurological, or physical disability, and is available in a format or manner that allows the individual to better understand the information.

“Behavioral Health” has the same meaning as provided in Section 27-50-101(1), C.R.S.

“Behavioral Health Administration” or “BHA” has the same meaning as provided in 27-50-101(2), C.R.S.

"Behavioral Health Administration DUI/DWAI legal supplement", or "legal supplement," means the document available to BHEs providing DUI/DWAI programming, incorporating information about recent legal updates to legislation impacting DUI/DWAI-involved individuals (2023 version), which is incorporated by reference. No later editions or amendments are incorporated. The legal supplement is available for inspection on the BHA website at <https://bha.Colorado.gov/behavioral-health/DUI-services> and at the Behavioral Health Administration headquarters, 710 South Ash Street, Unit C140, Denver, CO 80246, during regular business hours.

"Behavioral Health Crisis" means a significant disruption in a person's mental or emotional stability or functioning resulting in an urgent need for immediate assessment and treatment to prevent a serious deterioration in the person's mental or physical health.

"Behavioral Health Disorder" has the same meaning as provided in Section 27-50-101(3), C.R.S.

"Behavioral Health Entity" has the same meaning as provided in Section 27-50-101(4), C.R.S.

"Behavioral Health Provider" has the same meaning as provided in Section 27-50-101(6), C.R.S.

"Behavioral Health Safety Net Provider" has the same meaning as provided in Section 27-50-101(7), C.R.S.

"Best Practices" are professional procedures, interventions, techniques, and treatment approaches that have some quantitative data showing positive treatment outcomes over a period of time but may not have enough research or replication to be considered an evidence-based approach.

"Breath or Blood Testing" has the same meaning as provided in Section 42-4-1301.1(2)(a)(I), C.R.S.

"Brief Therapeutic Interventions" means interactions that are intended to induce a change in a behavioral health-related behavior(s).

"Care Coordination" means services that support individuals and families and initiate care and navigating crisis supports, mental health and substance use disorder assistance, and services that address the social determinants of health, and preventive care services.

"Certificate of Compliance" means an official document issued by the Department of Public Safety, Division of Fire Prevention and Control for a building or structure as evidence that materials and products meet specified codes and standards, that work has been performed in compliance with approved construction documents, and that the provisions of applicable fire and life safety codes and standards continue to be appropriately maintained.

"Chemical Restraint" has the same meaning as provided in 26-20-102(2), C.R.S.

"Child/Children" means a person under eighteen (18) years of age.

"Clearance Practice" means the process of identifying specific health needs and conditions that may require specialty management in a higher level of care, such as a crisis stabilization unit or an inpatient psychiatric hospital. Accepting agencies may have varying requirements prior to accepting a referral.

"Clinically Managed" means services that are directed by clinical personnel, which may include but are not required to be, medical personnel. These services involve on-site behavioral health support to address problems related to emotional, behavioral, or cognitive concerns, readiness to change, relapse, or recovery environment.

“Clinically Monitored” means that behavioral health services are accessed in the community, and not provided directly on-site by the agency. The agency is responsible for monitoring of the individual’s engagement in services and coordinating care, as needed.

“Colorado Crisis Services” means the statewide behavioral health crisis response system offering individuals mental health, substance use, or emotional crisis help, information and referrals.

“Commissioner” has the same meaning as provided in Section 27-50-101(9), C.R.S.

“Community-Based” has the same meaning as provided in Section 27-50-101(10), C.R.S.

“Community-Based Respite Care Services” means services of a temporary or short-term nature provided to an individual to temporarily relieve the family or other home providers from the care and maintenance of such individual.

“Comorbid” means the simultaneous presence of two or more diseases or medical conditions in an individual.

“Competent to Proceed” has the same meaning as provided in Section 16-8.5-101(5), C.R.S.

“Comprehensive Community Behavioral Health Provider” has the same meaning as provided in Section 27-50-101(11), C.R.S.

“Continuum of Care” or “Behavioral Health Continuum of Care” is a model of care that guides and tracks patient outcomes through a comprehensive array of health services that include strategies for prevention, early intervention, treatment, and recovery from mental health problems and disorders with the goal of supporting the individual’s ability to live productively in the community.

“Controlled Substance” has the same meaning as provided in Section 18-18-102(5), C.R.S.

“Co-occurring” disorders may include any combination of two or more substance use disorders and mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR).

“Crisis Assessment” means a standardized assessment form created by the Behavioral Health Administration, available on the BHA website.

“Crisis Stabilization Services” means services provided in a crisis stabilization unit (CSU).

“Crisis Stabilization Unit” (CSU) means an agency, endorsed for behavioral health crisis and emergency services per Chapter 6 and that provides short-term, bed-based crisis stabilization services in a twenty-four-hour environment for individuals who cannot be served in a less restrictive environment.

“Critical Incident” means a significant event or condition, which may be of public concern, which jeopardizes the health, safety, and/or welfare of personnel and/or individuals.

“Culturally and Linguistically Appropriate Services (CLAS)” means services that are respectful of and responsive to individual cultural health beliefs, practices, preferred languages, health literacy levels and communication needs.

“Danger to the Person’s Self or Others” means:

- A. A person poses a substantial risk of physical harm to the person’s self as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm to the person’s self; or

- B. A person poses a substantial risk of physical harm to another person or persons, as manifested by evidence of recent homicidal or other violent behavior by the person in question, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt, or threat to do serious physical harm by the person in question.

“Deficiency” means a failure to fully comply with any statutory and/or regulatory requirements applicable to an agency.

“Designated Representative” means a designated representative of an individual or service provider who is a person so authorized in writing or by court order to act on behalf of the individual or service provider. In the case of a deceased individual, the personal representative, as defined at Section 15-10-201(39), C.R.S., or, if none has been appointed, heirs shall be deemed to be designated representatives of the individual.

“Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision,” or “DSM-5-TR,” is published by the American Psychiatric Association (2022), which is hereby incorporated by reference. No later editions or amendments are incorporated. A copy may be purchased directly from the American Psychiatric Association at <https://www.psychiatry.org> and/or inspected at the American Psychiatric Association, 1000 Wilson boulevard, Arlington, VA 22209-3901. A copy may also be inspected at the Behavioral Health Administration, 710 S. Ash Street, Unit C140, Denver, CO 80246, during regular business hours.

“Disaster” means the occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property resulting from any natural cause or cause of human origin, including but not limited to fire, flood, earthquake, wind, storm, wave action, hazardous substance incident, oil spill or other water contamination requiring emergency action to avert danger or damage, volcanic activity, epidemic, air pollution, blight, drought, infestation, explosion, civil disturbance, hostile military or paramilitary action, or a condition of riot, insurrection, or invasion existing in the state or in any county, city, town, or district in the state as defined in Section 24-33.5-703(3), C.R.S.

“Discharge” means the termination of treatment obligations and/or services between an individual and the agency. For agencies that provide concurrent behavioral health services to an individual, “discharge” is specific to the discontinued treatment obligation or service and does not impact or apply to an individual’s concurrent, active behavioral health service(s).

“Dispense” means to interpret, evaluate, and implement a prescription drug order or chart order, including the preparation of a drug for an individual in a suitable container appropriately labeled for subsequent administration or use by an individual.

“Dispute” means a verbal or written expression of dissatisfaction to a BHE about the care or services received or not received by an individual, that cannot be resolved to the satisfaction of the person expressing the dispute at the time of submission to BHE personnel. Disputes may be submitted by the individual or a personal representative on behalf of the individual.

“Divert Status” means the period of time in which an agency is unable to accommodate new admissions for timely services. This status may be necessary for reasons including but not limited to, the maximum number of individuals the agency is able to serve is exhausted, unexpected personnel concerns, and safety or environmental concerns.

“DUI/DWAI” for purposes of this Chapter 10, includes the following impaired offenses:

- A. “driving under the influence” as defined in Section 42-4-1301(1)(f), C.R.S.;
- B. “driving while ability impaired” as defined in Section 42-4-1301(1)(g), C.R.S.;

- C. “DUI per se” as defined in Section 42-4-1301(2)(a), C.R.S.;
- D. Operating an aircraft under the influence as defined in Section 41-2-102, C.R.S.;
- E. Operating a vessel while under the influence as defined in Section 33-13-108.1, C.R.S.; and
- F. Underage Drinking and Driving (UDD) as defined in Sections 42-1-102(109.7) C.R.S. and 42-4-1301, C.R.S.
 - 1. For the purpose of this section, UDD applies to individuals that are under twenty-one (21) years of age.
 - 2. Agencies providing UDD services to individuals under eighteen (18) years of age shall comply with Chapter 8 of these rules.

“DUI/DWAI Reporting System” or “DRS” is the official document generated from data entered by endorsed DUI/DWAI programs into the Treatment Management System (TMS). This document reflects at minimum an individual’s education and treatment enrollment, attendance, compliance, and discharge status.

“Early Intervention Services” means:

- A. Services provided to an individual who is at risk of developing a mental health, substance use, or co-occurring disorder which may include screening, brief intervention, referral(s) to treatment (SBIRT), and/or education-only services;
- B. Services provided to an individual who is currently diagnosed with a mental health, substance use, or co-occurring disorder and is undergoing screening, brief intervention, referral(s) to treatment (SBIRT), and/or education-only services.

“Egress Alert Device” means a device that is affixed to a structure or worn by an individual that triggers a visual or auditory alarm when an individual leaves the building or grounds. An egress alert device is considered restrictive when the device is used to prevent the elopement of an individual.

“Emergency” means an unexpected event that places life or property in danger and requires an immediate response through the use of state and community resources and procedures per Section 24-33.5-703(3.5), C.R.S.

“Emergency Services” means the public organizations that respond to emergencies when they occur. This includes, but is not limited to, police, ambulance, and firefighting services. It may also include emergency behavioral health services accessed during times of crisis, such as Colorado Crisis Services.

“Endorsement” means approval for an agency approved, licensed, or designated by the BHA to provide a specific service.

“Essential Behavioral Health Safety Net Provider” has the same meaning as defined in Section 27-50-101(13), C.R.S.

“Evidence-Based” means practices, principles, and programming that uses interventions, techniques, and treatment methods that have been tested using scientific methodology and proven to be effective in improving outcomes for a specific population.

“External Services” means personal services and protective oversight services provided to an individual by family members, or health care professionals who are not personnel of the agency. External service providers include, but are not limited to, home health providers, hospice, private pay caregivers, friends, and family members.

“Facility,” as used in the definition of BHE set forth above in part 1.2 of these rules, means a Behavioral Health Entity licensed by the Department of Public Health and Environment; a public or private “treatment facility” required to meet the approval standards established under Section 27-81-106, C.R.S.; an entity providing emergency or crisis behavioral health services; an entity providing behavioral health residential services; or an entity providing withdrawal management services.

“Family Member” means a spouse, partner in a civil union, as defined in Section 14-15-103 (5), C.R.S., parent, adult child, or adult sibling of a person with a mental health disorder.

“Federally Qualified Health Center” has the same meaning as defined in the federal “Social Security Act”, 42 U.S.C. Sec. 1395x(aa)(4)(2022).

“Fentanyl Education” means the fentanyl education program developed by the BHA pursuant to Section 27-80-1287, C.R.S. This program is accessible publicly and will be required for those individuals that have a court order to complete the program as a condition of probation or parole.

“Follow-Up Services” means services that may include interactions after the initial early intervention session and are intended to reassess an individual’s behavioral health status and progress, promote, or sustain reduction in symptomology and risk factors for a behavioral health disorder, as defined by the DSM-5-TR, and assess an individual’s need for additional referral(s) to services.

“Full Time Equivalent” (FTE) means the scheduled working hours for personnel divided by the number of hours in a full-time workweek for the entity. For example, if the entity considers forty hours to be a full-time workweek, then personnel working twenty hours per week would have an FTE of 0.5.

“Gender Identity” means a person’s innate sense of the person’s own gender, which may or may not correspond with the person’s sex assigned at birth. Gender identity does not include sexual orientation or gender non-conforming expressions.

“Good Standing” means that a license, certification, registration, or enrollment has not been revoked or suspended and against which there are no outstanding disciplinary or adverse actions.

“Governing Body” means the board of trustees, directors, or other governing body in whom the ultimate authority and responsibility for the conduct of the agency is vested.

“Grievance” means an expression of dissatisfaction made to the BHA about the care or services received or not received by an individual, that could not be resolved to the satisfaction of the person expressing the grievance at the time of submission to BHE personnel. Grievances may be submitted by an individual or entity, including but not limited to, recipients of service, family members of recipients of service, authorized representatives of recipients of service, licensed facilities, state departments and members of the general public.

“Harm Reduction” means an approach that emphasizes engaging directly with individuals whose actions or behaviors place them at risk for a variety of adverse mental health, substance use disorder or physical health outcomes. Harm reduction is a set of practical strategies and ideas aimed at reducing potential negative consequences associated with a variety of actions or behaviors. These strategies and approaches may include but are not limited to safer drug use, overdose prevention, safer sex, medication adherence, managed drug use, abstinence, and addressing environmental conditions along with the actions or behaviors themselves.

"Health-Related Social Needs (HRSN)" means an individual's unmet, adverse social conditions (e.g., housing instability, homelessness, nutrition insecurity) that contribute to poor health and are a result of underlying social determinants of health.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996), codified at 42 U.S.C. § 300gg (2012) and 29 U.S.C. § 1181 et seq. (2012) and 42 U.S.C. § 1320d et seq. (2012) and the federal regulations issued by the U.S. Department of Health & Human Services found at 45 C.F.R. part 160 (2017); 45 C.F.R. part 162 (2017); and, 45 C.F.R. part 164 (2017), which are hereby incorporated by reference. No later editions or amendments are incorporated. These regulations are available at no cost from the U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Room 509f, HHH building, Washington, D.C. 20201 or at <https://www.ecfr.gov/>. These regulations are also available for public inspection and copying at the Behavioral Health Administration, 710 S. Ash Street, Unit C140, Denver, CO 80246 during regular business hours.

"Hospitalization" means twenty-four (24) hour out-of-home placement for treatment in a facility for a person with a mental health disorder.

"Incompetent to Proceed" has the same meaning as defined in Section 16-8.5-101(12), C.R.S. for adults and in Section 19-2.5-102(25), C.R.S. for youth.

"Individual" means a person seeking or receiving behavioral health services and includes a respondent, as defined by Section 27-65-102(29), C.R.S.

"Informed Consent" means an informed assent that is freely given. It is always preceded by the following:

- A. An explanation of the nature and purpose of the recommended treatment or procedure in layman's terms and in a form of communication understood by the individual or the individual's designated representative;
- B. An explanation of the risks and benefits of a treatment or procedure, the probability of success, mortality risks, and serious side effects;
- C. An explanation of the alternatives with the risks and benefits of these alternatives;
- D. An explanation of the risks and benefits if no treatment is pursued;
- E. An explanation of the recuperative period which includes a discussion of anticipated problems; and
- F. An explanation that the individual, or the individual's designated representative, is free to withdraw consent and to discontinue participation in the treatment regimen at any time.

"Initial License" means the licensing of a facility or provider organization by the BHA that is not currently licensed by the BHA, as well as a licensure change from one type to another.

"Inpatient" refers to inpatient hospitalization as well as twenty-four (24) hour residential levels of care.

"In-Person" means services provided in the same physical location as the individual and agency personnel. This may include on-scene crisis responses.

"Inspection" means a process of review to ensure licensed, approved, or designated entities are operating in substantial conformity with applicable licensing, approval, and/or designation rules.

“Integrated Care Model” means the systematic coordination of mental health, substance use, and primary care services.

“Intensive Case Management” means community-based services provided to individuals with serious behavioral health disorders who are at risk of needing a more intensive 24-hour placement and is designed to provide extra support for living in the community. These services include assessment, care plan development, multi-system referrals, assistance with wraparound and supportive living services, monitoring and follow-up.

“Intensive Outpatient Program” or “IOP” means a service provided for individuals that require a more structured outpatient treatment experience than can be received in standard outpatient services. Program may be treatment for mental health, substance-related, and co-occurring disorders.

“Interlock Enhancement Counseling”, or “IEC,” means the evidence-based intervention curriculum which combines cognitive behavioral treatment with motivational interviewing/motivational enhancement as a treatment intervention. IEC was developed by Timken, Nandi, and Marques, for DUI/DWAI individuals who have alcohol ignition interlock devices installed in their vehicles (July 2012), which is incorporated by reference. No later editions or amendments are incorporated. This curriculum is available to providers of DUI/DWAI services at no cost through the BHA. A copy of the curriculum is available for inspection at the Behavioral Health Administration headquarters, 710 S. Ash Street, Unit C140, Denver, CO 80246, during regular business hours.

“Legal Guardian” is an individual appointed by the court, or by will, to make decisions concerning an incapacitated individual's or minor's care, health, and welfare.

“Legal Representative” means one of the following acting within the scope of their authority:

- A. The guardian of the individual, as defined in Section 15-14-102, C.R.S., where proof is offered that such guardian has been duly appointed by a court of law, acting within the scope of such guardianship;
- B. An individual named as the agent in a power of attorney (POA), as defined in Section 15-14-500.5, C.R.S., that authorizes the individual to act on the individual's behalf, as enumerated in the POA;
- C. An individual selected as a proxy decision-maker pursuant to Section 15-18.5-101 through -105, C.R.S., to make medical treatment decisions. For the purposes of these rules, the proxy decision-maker serves as the individual's legal representative for the purposes of medical treatment decisions only; or
- D. A conservator, where proof is offered that such conservator has been duly appointed by a court of law, acting within the scope of such conservatorship.

“Lethal Means Restriction” means an approach to suicide prevention that reduces access to a fatal method of suicide (e.g., firearms, medications, sharps), thus preventing or reducing the lethality of an attempt.

“Letter of Intent” means the notification provided to the BHA related to an application for an initial BHE license or safety net approval.

“Level I and Level II Alcohol and Drug Education or Treatment” means a BHA endorsed ADDS education or treatment program as defined in Section 42-4-1301.3(3)(c)(IV) C.R.S.

“Level II Four Plus”, also referred to as “Track F” treatment, is an ADDS program, intended for an individual who has four (4) or more alcohol and/or drug impaired driving offenses, as noted in Section 42-4-1301.3(3)(c)(IV), C.R.S. This includes vehicular homicide and vehicular assault where alcohol or other drugs were involved. Only programs endorsed to provide Level II Four Plus treatment may accept referrals for this level of service.

“Level II Four Plus: competencies and phases” means the BHA-approved document available to Level II Four Plus programs, providing additional guidance regarding competency and phase completion. It is available on the BHA website.

“Level 3-Withdrawal Management” or “Level 3-WM” means the on-site service offered twenty-four (24) hours per day to individuals who are intoxicated and actively withdrawing from the use of one (1) or more substances. It includes both Level 3.2-WM and Level 3.7-WM, as defined in part 1.2 of these rules.

“Living Space Assignment” means the assigned bathroom and sleeping quarters of individuals served by the agency.

“Managed Care Entity” has the same meaning as provided in Section 25.5-5-403(4), C.R.S.

“Medically Managed” means services that are directly provided and/or managed by licensed medical personnel.

“Mechanical Restraint” means a physical device used to involuntarily restrict the movement of an individual or the movement or normal function of a portion of an individual’s body.

“Medically Monitored” means services that are provided by an interdisciplinary team of personnel including nurses, behavioral health professionals, other health care professionals and technical personnel, under the direction of a licensed physician. Medical monitoring is provided through a mix of direct individual contact, review of records, team meetings, twenty-four (24) hour coverage by a physician, and quality assurance programs.

“Medication/Psychiatric - Only Services” means services dedicated solely to the management of medications prescribed to an individual for the management of mental health, substance use, and/or co-occurring behavioral health disorders.

“Medication-Assisted Treatment,” or “MAT” services, means the use of medications, in combination with or without counseling and behavioral therapies, to provide a whole-person approach to the treatment of substance use disorders. Medications used in MAT are approved by the United States Food and Drug administration (FDA) and MAT programs are clinically driven and tailored to meet each individual’s needs. MAT services may include Medications for Opioid Use Disorder (MOUD) services for the specialized treatment of Opioid Use Disorder (OUD).

“Medication Diversion” means the transfer of any controlled substance from a licit to an illicit channel of distribution or use.

“Medication Formulary” means the *Required Formulary Psychotropic Medications: 2018*, which is available at no cost from the Colorado Department of Human Services at <https://bha.colorado.gov/behavioral-health/medication-consistency>. The medication formulary is a list of minimum medications, established pursuant to Section 27-70-103, C.R.S., that may be used by service providers to increase the likelihood that a broad spectrum of effective medications are available to individuals to treat behavioral health disorders, regardless of the setting or service provider. The medication formulary may not contain a complete list of medications, and providers may prescribe and/or carry any additional medications they deem necessary.

“Member” means a person or entity with an ownership interest in the limited liability company.

"Mental Health Disorder" has the same meaning as provided in Section 27-50-101(15), C.R.S.

"Mental Health Transitional Living Home" means a community-based residential agency providing residential support to individuals who require ongoing support with daily living due to their behavioral health diagnosis but whose needs do not rise to the level of hospitalization. There are two levels of mental health transition living homes:

- A. "Level One Mental Health Transitional Living Homes" provide clinically monitored services as defined in part 1.2 of these rules.
- B. "Level Two Mental Health Transitional Living Homes" provide clinically managed services as defined in part 1.2 of these rules.

"Mental Status Examination " means a structured assessment of the individual's behavioral and cognitive functioning. The specific cognitive functions of alertness, language, memory, constructional ability, and abstract reasoning are the most clinically relevant. The mental status examination can include but is not limited to:

- A. The individual's appearance and general behavior;
- B. Level of consciousness and attentiveness;
- C. Motor and speech activity;
- D. Mood and affect;
- E. Thought and perception;
- F. Attitude and insight; and
- G. Higher cognitive abilities.

"Milieu" means the shared living space of the agency and includes the living space assignments for individuals served.

"Minor in Possession" (MIP) is an offense committed by an individuals aged twenty-one (21) and younger for possession or consumption of ethyl alcohol or possession of two ounces or less or consumption of marijuana or possession of marijuana paraphernalia. MIP may result in fines, court-ordered public service, a substance use disorder assessment, and/or substance abuse education program per Section 18-13-122, C.R.S.

"Monitoring" means the observation, review, and documentation of results when tracking an individual's progress over a period of time related to an event. This may include, but is not limited to, monitoring of medication compliance and administration, and monitoring of vital signs while actively withdrawing from substances.

"Motivational Enhancement" means the counseling approach to initiate behavior change by helping an individual resolve ambivalence about engaging in treatment services and reducing engagement in harmful behavior and activities. This approach employs strategies to evoke rapid and internally motivated change in the individual rather than guiding the individual stepwise through the recovery process.

"Multidisciplinary Team" or "MDT" means a group of personnel, acting within their professional role(s) and respective scope(s) of practice, who are members of different professions, working together to provide services to individuals.

“Natural Supports” means the relationships that occur in everyday life. Natural supports typically involve family members, friends, co-workers, neighbors, and acquaintances and are self-defined by the individual in crisis.

“No Refusal Requirements” means the requirements found in 27-50-301(4), C.R.S. that establish the conditions under which a behavioral health safety net provider cannot refuse to treat an individual.

“On-Site” means at the location that is licensed, designated, or approved by the BHA for the provision of behavioral health services.

“Opioid Antagonist” has the same meaning provided in Section 17-1-113.4(4)(b), C.R.S.

“Outreach, Education, and Engagement Services” means services by an agency that have identified priority target populations and service needs in the area the agency serves that require higher levels of active engagement by the agency to produce positive behavioral health outcomes.

“Outpatient Competency Restoration” means a community-based program that allows adults and juveniles in the criminal justice or juvenile justice system, who are found incompetent to proceed by the court, to receive psychoeducation services, case management, and referrals to community-based services and supports throughout all of Colorado with the goal of restoring competency.

“Outpatient Treatment” means behavioral health services provided to an individual in accordance with their service plan on a regular basis in a non-overnight setting, which may include, but not be limited to, individual, group, or family counseling, peer support professional services, case management, or medication management.

“OWNPATH” is an online directory operated by the Colorado Behavioral Health Administration that allows individuals to find behavioral health providers licensed, designated, or approved by the BHA in order to access specific services or resources that best meet the individual’s behavioral health needs.

“Paired Mobile Response” means a mobile crisis response in which two personnel respond, one person on scene and the other person on scene or via telehealth. Both members of the paired response should be crisis professionals.

“Partial Hospitalization Program” or “PHP” means a service provided for individuals that require regularly scheduled monitoring or management while providing clinical structure in an outpatient setting to treat mental health, substance use, or co-occurring needs in addition to providing direct access to medical, psychiatric, and laboratory services.

“Pass” means written permission by an agency for an individual to leave campus grounds.

“Peer Respite Home” means an agency staffed by peer support professionals that provides temporary accommodations to prevent behavioral health-related hospitalizations.

“Peer Support” means recovery-oriented services provided by peer support professionals that promote self-management of psychiatric symptoms, relapse prevention, treatment choices, mutual support, enrichment, and rights protection. Peer support also provides social supports and a lifeline for individuals who have difficulties developing and maintaining relationships.

“Persistent Drunk Driver”, or “PDD,” has the same meaning as provided in Section 42-1-102(68.5)(a), C.R.S.

“Personal Services” means those services that an agency and its personnel provide for each individual including, but not limited to:

- A. An environment that is sanitary and safe from physical harm;
- B. Individualized social supervision;
- C. Assistance with transportation; and
- D. Assistance with activities of daily living.

“Person-Centered Care” means individuals participate in the development of treatment goals and services provided to the greatest extent possible. Person-centered service planning is strength-based and focuses on individual capacities, preferences, and goals. Individuals are core participants in the development of the plans and goals of treatment.

“Pharmacotherapy” means the treatment by an authorized practitioner of an individual’s behavioral health condition(s) through medicinal use of pharmaceutical products.

“Physical Management” means the physical action of placing one’s hands on an individual to gain physical control to protect the individual or others from physical harm after all attempts to verbally direct or de-escalate the individual have failed. Any attempts at physical management of a child is considered restraint.

“Physical Restraint” means the use of bodily, physical force to involuntarily limit a person’s freedom of movement, except that “physical restraint” does not include the holding of a child or youth by one adult for the purpose of calming or comforting the child.

“Plan of Action” is a description of how an agency plans to bring into compliance any standards identified as out of compliance within a specified time period.

“Postpartum” means the period of time following the end of a pregnancy or birth of a child up to one year.

“Primary Complaint” or “Presenting Problem” means the reason, concern, or motivation which prompts an individual to seek services or that which the individual’s referral source identifies as the issue which requires intervention, usually in the individual’s own words.

“Priority Populations” has the same meaning as provided in Section 27-50-101(17), C.R.S.

“Protective Oversight” means guidance of an individual as required by the needs of the individual or legal representative or as reasonably requested by the individual including the following:

- A. Being aware of an individual’s general whereabouts, although the individual may travel independently in the facility; and
- B. Monitoring the activities of the individual on the premises to ensure the individual’s health, safety, and well-being, including monitoring the individual’s needs and ensuring that they receive the services and care necessary to protect health, safety, and well-being.

“Prosocial” means relating to or denoting behavior which is positive (e.g., friendly, expresses empathy to or about others, and respects rules as well as the boundaries of others), helpful, and intended to promote social acceptance and friendship which is positive, helpful, and intended to promote social acceptance and friendship.

“Protective Factor” means the characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor’s impact. Protective factors are seen as positive countering events. Protective factors may include factors such as positive self-image, self-control, or social competence.

“Provider Organization,” as used in the definition of BHE set forth above, means a corporation, partnership, limited liability company, business trust, association, or organized group of persons, which is in the business of behavioral health care delivery or management and that (a) includes ten (10) or more full time equivalent (FTE) fully licensed or certified professionals providing diagnostic, therapeutic, or psychological services for behavioral health conditions under the providers’ Professional Practice Act.

“Psychiatric Advance Directive (PAD)” means a written instruction, created pursuant to Section 15-18.7-202, C.R.S. concerning behavioral health treatment, medication, and alternative treatment decisions, preferences, and history to be made on behalf of the adult who provided the instruction.

“Psychotherapy” or “psychotherapy services” has the same meaning as defined in Section 12-245-202(14), C.R.S.

“Readiness to Change” means an individual’s emotional and cognitive awareness of and interest in the need to change, coupled with a commitment to change.

“Real-Time” documentation means that the personnel providing a monitoring activity enters the result in the individual’s record at the time of the monitoring activity, allowing necessary information to transition seamlessly between shift change. If this process involves delayed entry of results into an electronic health record or other tracking system, the documentation reflecting real-time communication must be included in the individual’s record.

“Recovery” means a process of change through which individuals improve their health and wellness and ability to live a self-directed life and strive to reach their full potential.

“Recovery Support Services Organization” (RSSO) has the same meaning as in 27-60-108(2)(c).

“Residential Child Care Facility (RCCF)” has the same meaning as described in Section 26-6-903(29), C.R.S.

“Residential Services” means the on-site service for individuals whose mental health and/or substance use issues and symptoms are severe enough to require a twenty-four (24)-hour per day structured program and oversight, but that do not require hospitalization. It includes mental health transitional living homes, but does not include residential child care facilities.

“Restraint” has the same meaning as described in Section 26-20-102(6), C.R.S.

“Risk Factors” mean the characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes. Risk factors on an individual level may include an individual’s genetic predisposition to addiction or exposure to alcohol or other potentially harmful substance(s) prenatally.

“Risk, Need, Responsivity,” or “RNR,” means the model of evaluating how to best engage an individual involved in the criminal justice system. It incorporates the following principles:

- A. Criminogenic risk: the likelihood that an individual will engage in future illegal behavior in the form of a new crime or failure to comply with conditions of probation or parole.
- B. Criminogenic need: dynamic risk factors that increase an individual’s likelihood to engage in future illegal behavior in the form of a new crime or failure to comply with conditions of probation or parole. This includes, but is not limited to, factors such as lack of employment or livable wages, or the presence of a substance use disorder. These factors are malleable and responsive to intervention.

- C. Responsivity: maximizing the potential success of treatment intervention by tailoring the intervention to the learning style, secondary needs, motivation, and strengths of the individual.

“SAMHSA” means the Substance Abuse and Mental Health Services Administration overseen by the United States Department of Health and Human Services.

“Screening” means a brief process used to identify current behavioral health or health needs and is typically documented through the use of a standardized instrument. Screening is used to determine the need for further assessment, referral, or immediate intervention services.

“Seclusion” has the same meaning as described in Section 26-20-102(7), C.R.S.

“Self-Administration” means the ability of a person to take medication independently without assistance by administration from another person.

“Sequential Intercept Model (SIM)” means the model of how individuals with behavioral health disorders come into contact with and move through the criminal justice system.

“Service Plan” means a written description of the services to be provided by the agency to meet an individual's treatment needs.

“Session” means a face-to-face, telehealth, or audio-only interaction of the individual and personnel. Session may include but is not limited to individual therapy, group therapy, medication-assisted treatment education and/or monitoring, family therapy, peer professional services, educational/occupational groups, recreational therapy, intake, discharge, service planning, and other therapies.

“Social Determinants of Health” refers to the conditions in which individuals are born, grow, live, work and age. They include factors such as socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care.

“Stock Medication” means medication that is not labeled for, or intended for, use by a specific individual when it leaves the pharmacy but is intended to be stored and ultimately administered by a licensed health care professional in accordance with applicable laws and regulations.

“Sub-Endorsement” means a secondary endorsement for a specific type of service within the broader category of an endorsement.

“Substance Use Disorder” has the same meaning as provided in Section 27-50-101(20), C.R.S.

“Supervising Entity” means the official employed by probation, parole, or other representative of the criminal justice system who is responsible for oversight and supervision of the individual. Other representatives may include, but are not limited to, direct employees or contractors of the Department of Corrections, the Division of Criminal Justice, The Judicial Department, or the Department of Human Services. The supervising entity is often responsible for referring individuals into specific education and/or treatment services and reporting compliance with terms of supervision to the courts.

“Supervision” for the purposes of Chapter 6 only means weekly clinical guidance from a licensee or authorized practitioner.

“Telehealth” means delivery of services through telecommunications systems that are compliant with all federal and state protections of individual privacy, to facilitate individual assessment, diagnosis, consultation, treatment, and/or service planning/case management when the individual and the person providing services are not in the same physical location. Telecommunications systems used to provide telehealth include information, electronic, and communication technologies. Telehealth may include audio-only methods in accordance with state and federal regulation unless noted otherwise.

“Tiered Inspection” means an on-site re-licensure survey that has a reduced scope and reviews fewer items for compliance with applicable state regulations than a full re-licensure survey.

“Transfer” means being able to move from one body position to another. This includes, but is not limited to, moving from a bed to a chair or standing up from a chair to grasp adaptive equipment.

“Trauma-Informed” means an approach to care that realizes the widespread impact of trauma, understands potential paths for recovery, recognizes the signs and symptoms of trauma in individuals, families, personnel, and others involved in the system, and responds by fully integrating knowledge about trauma into policies, procedures, and practices, seeking to actively resist re-traumatization. The six key principles of a trauma-informed approach include:

- A. Safety, trustworthiness and transparency;
- B. Peer support, collaboration and mutuality;
- C. Empowerment, voice and choice;
- D. Cultural issues;
- E. Historical issues; and
- F. Gender issues.

“Treatment Management System,” or “TMS” means the database utilized by endorsed DUI/DWAI programs to electronically track and report an individual’s enrollment and status in required DUI/DWAI services through the completion of the “DUI/DWAI reporting system,” or “DRS” record.

“Treatment Type” means the focus of behavioral health services that the agency provides. It may include services focused on mental health disorders, substance use disorders, or both, also referred to as “co-occurring” disorders.

“Triage” means a dynamic process of evaluating and prioritizing urgent needs and intervention options based on the nature and severity of the individuals’ presenting situation.

“Two (2) Generational Approach” means focusing on both children and parents’ and/or legal guardians’ needs at the same time. This approach focuses on breaking down barriers by strengthening education, economic supports, social capital, and health and well-being. The core principles of the Two Generational Approach are:

- A. Measure and account for outcomes for both children and their parents and/or legal guardians;
- B. Engage and listen to the voices of families;
- C. Foster innovation and evidence together;
- D. Align and link systems and funding streams; and
- E. Ensure access.

“Underinsured” means an individual’s insurance plan does not cover the cost of necessary care, either medical or behavioral, leaving the individual with out-of-pocket costs they are unable to pay.

“Understanding the ADDS Evaluation Training” means the mutually developed, webinar-based training offered by the BHA and State Court Administrator’s Office.

“Undue Hardship” means a situation where compliance with a rule creates a substantial, unnecessary burden on the applicant or agency’s business operation or the families or community it serves, and which reasonable means cannot remedy. An undue hardship does not include the normal cost of operating the business.

“Walk-In Crisis Services” means immediate and confidential, in-person crisis support, information, and referrals to any individual in need including to anyone experiencing a self-defined crisis.

“Warm Handoff” means an approach to care transitions in which a behavioral health care provider uses face-to-face or telehealth contact to directly link individuals being treated to other providers or services.

“Warm Line/Support Line” means a telephonic service where individuals can “opt in” from the statewide crisis line to receive individualized screening and resources by peer support professionals.

“Whole Person Health” means physical, mental, and social wellness which is achieved through integrated care and adequately addressing social determinants of health.

“Withdrawal Management” or “WM” means the services required to assist an individual experiencing withdrawal from the use of one (1) or more substances, as identified by the individual’s acute intoxication and/or withdrawal potential, also known as the dimension 1 rating, from the ASAM Criteria. Withdrawal management is divided into the following levels:

- A. “Level 1-WM” means ambulatory withdrawal management without extended on-site monitoring services. This is an outpatient service that involves medically supervised evaluation, withdrawal management, and referral services that are delivered on a regular schedule.
- B. “Level 2-WM” means ambulatory withdrawal management with extended on-site monitoring. This is an outpatient service that involves regularly scheduled sessions of physician approved monitoring of withdrawal management protocols.
- C. “Level 3.2-WM” means clinically managed residential withdrawal management. This is an organized service delivered in a setting that provides twenty-four (24) hour supervision, observation, and support to individuals who are intoxicated and/or experiencing withdrawal. This service is characterized by its emphasis on peer and social support rather than medical and/or nursing care.
- D. “Level 3.7-WM” means medically monitored inpatient withdrawal management. This is an organized service delivered by medical and nursing professionals, which provides for twenty-four (24) hour evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols.

“Women’s and Maternal Behavioral Health Treatment” means creating an environment and service continuum that reflects an understanding of and is grounded in the unique biological, developmental, historical, relational, economic and social experiences that shape women’s lives, and thus responds through factors which include, but are not limited to, site selection; personnel selection and training; program development; content; and wrap-around supports that address gender-specific issues in the course of prevention, intervention, treatment and recovery services. This was previously known as gender-responsive treatment.

“Youth” means an individual who is under twenty-one (21) years of age.

1.3 Personnel Definitions

“Administrator” means a person implementing policies and procedures on an agency-wide, endorsement, service, or physical location-specific basis, who is responsible for the day-to-day operation of such endorsement, service, or location.

“Advanced Practice Registered Nurse” or “APRN” has the same meaning as provided in Section 12-255-104, C.R.S.

“Approved Restoration Provider” means a comprehensive community behavioral health provider who appears on the approved provider list as passing all contract application requirements with the outpatient competency restoration services program department within the Office of Civil and Forensic Mental Health (OCFMH).

“Authorized Practitioner” means the person (a) authorized by law to prescribe treatment, medication, or medical devices, (b) who holds a current unrestricted license to practice, and (c) is acting within the scope of such authority. This includes persons registered with the Drug Enforcement Administration (DEA) to prescribe controlled substances. This includes, but is not limited to:

- A. A physician, psychiatrist, medical doctor, or doctor of osteopathy licensed pursuant to Article 240 of Title 12, C.R.S.,
- B. A physician assistant licensed pursuant to part 113 of Article 240 of Title 12, C.R.S., and
- C. An advanced practice registered nurse (APRN), licensed pursuant to part 255 of Title 12, C.R.S.

“Candidate” means a person receiving clinical supervision, acting within their scope of practice, and seeking licensure through DORA. It includes the following:

- A. Psychologist candidates, pursuant to Section 12-245-3, C.R.S.;
- B. Clinical social work candidates, pursuant to Section 12-245-4, C.R.S.;
- C. Marriage and family therapist candidates, pursuant to Section 12-245-5, C.R.S.;
- D. Licensed professional counselor candidates, pursuant to Section 12-245-6, C.R.S.; and
- E. Licensed addiction counselor candidates, pursuant to Section 12-245-8, C.R.S.

“Certified Addiction Specialist” or “CAS,” means a person who possesses a valid, unsuspended, and unrevoked addiction counseling certificate issued by DORA, authorizing them to practice addiction counseling commensurate with their certification level and scope of practice, per Section 12-245-8, C.R.S.

“Certified Addiction Technician” or “CAT” means a person who possesses a valid, unsuspended, and unrevoked addiction counseling certificate issued by DORA, authorizing them to practice addiction counseling commensurate with their certification level and scope of practice, per Section 12-245-8, C.R.S.

“Clinical Director” means a person responsible for overseeing individual treatment services, including, but not limited to ensuring appropriate training and supervision for clinical personnel.

“Clinical Supervision” means the following:

- A. Supervision that is received to meet the standard qualifications for clinical supervision as defined by a professional practice board and standards in the Colorado Mental Health Practice Act, pursuant to Article 245 of Title 12, C.R.S. the delivery, frequency, and specific requirements may vary depending upon the credential and the respective skills of the two (2) professionals involved, and the population and/or the specific individual being served.
- B. Supervision provided to personnel who are not seeking or not eligible for professional licensure but are otherwise qualified to provide services to individuals based on education, training, or other credentials implies that the supervisor accepts oversight and responsibility for the services provided by this personnel. The supervisor must follow standards in the Colorado Mental Health Practice Act, pursuant to Article 245 of Title 12, C.R.S. The nature of the supervisory relationship depends on the respective skills of the two professionals involved, the individual population and/or the specific individual being served. It is usually ongoing, required, and hierarchical in nature.

“Counselor-In-Training” means a person currently in the process of obtaining a professional credential pursuant to Article 245 of Title 12, C.R.S. “Counselor-In-Training” does not include candidates as defined in this part 1.3.

“Colorado Department of Regulatory Agencies,” or “DORA” means the division of professions and occupations within this state department as created in Section 24-1-122, C.R.S.

“Crisis Professional” means any person who is receiving or has received crisis professional curriculum training approved by the BHA specific to crisis assessment, management, de-escalation, safety planning and all relevant laws and provisions such that training is complete, and the person can lead a crisis response.

“Group Living Worker” means a person without a behavioral health credential or license that is adequately trained and supervised to recognize and respond to behavioral health concerns. This person may assist in twenty-four (24) hour management and oversight of the milieu and, in certain facilities, may also serve a correctional or supervision-focused role. This does not include peer support professionals.

“Intern” means personnel completing a clinical degree program of study performing duties under the direct clinical supervision of degree-corresponding licensed personnel.

“Licensed Addiction Counselor” or “LAC” means a person who possesses a valid, unsuspended, and unrevoked addiction counseling license issued by DORA, authorizing them to practice addiction counseling commensurate with their licensure level and scope of practice, per Section 12-245-801 through -806, C.R.S.

“Licensed Social Worker” means a person who:

- A. Is a licensed social worker or licensed clinical social worker; and
- B. Possesses a valid, unsuspended, and unrevoked license issued pursuant to Section 12-245-404, C.R.S.

“Licensed Professional Counselor” or “LPC” means a person who is a professional counselor licensed pursuant to Section 12-245-601 through -607, C.R.S.

“Licensee” means a psychologist, social worker, clinical social worker, marriage and family therapist, licensed professional counselor, or addiction counselor licensed as defined in 12-245-202(8), C.R.S.

“Manager” means a person involved in and/or responsible for decisions made on behalf of an agency regarding clinical and/or operational policies, procedures, and actions for a physical location, endorsement, service type, and/or the agency. This may include administrators or clinical directors, depending on the structure and operation of the agency. An agency may have a single manager, or multiple managers, as appropriate for the combination of endorsements, services, and locations included in the agency license.

“Marriage and Family Therapist” or “LMFT” means a person who possesses a valid, unsuspended, and unrevoked license as a marriage and family therapist pursuant to Section 12-245-504, C.R.S.

“Nurse” means a person who holds a current unrestricted license to practice pursuant to 12-255-110, C.R.S., and is acting within the scope of such authority.

“Peer Support Professional” means the following persons who meet the qualifications as described in Section 27-60-108(3)(a)(III), C.R.S.:

- A. A peer support specialist;
- B. A recovery coach;
- C. A peer and family recovery support specialist;
- D. A peer mentor;
- E. A family advocate; or
- F. A family systems navigator.

“Personnel” means persons employed by and/or providing services under the direction of an agency, including, but not limited to managers, administrators, clinical directors, employees, contractors, students, interns, volunteers, or treatment-involved mentors.

“Professional Person” has the same meaning as described in Section 27-65-102(27), C.R.S.

“Psychologist” means a person who possesses a valid, unsuspended, and unrevoked license as a psychologist licensed pursuant to Section 12-245-304, C.R.S.

“Qualified Medication Administration Person” or “QMAP” means a person who passed a competency evaluation administered by the Department of Public Health and Environment before July 1, 2017, or passed a competency evaluation administered by an approved training entity on or after July 1, 2017, and whose name appears on the Department of Public Health and Environment’s list of persons who have passed the requisite competency evaluation.

“Qualified Practitioner” means a physician or other person licensed, registered, or otherwise permitted to distribute, dispense, or to administer a controlled substance in the course of professional practice.

“Supervision” for the purposes of Chapter 6 only means weekly clinical guidance from a licensee or authorized practitioner.

Chapter 2: General Behavioral Health Entity Licensing Standards

2.1 Authority and Applicability

- A. Chapter 2 establishes the conditions that an agency must meet in order to be licensed as a Behavioral Health Entity (BHE), and the minimum standards for the operation of a BHE. The statutory authority for the promulgation of these regulations is set forth in Sections 27-50-107(3)(b), C.R.S. and 27-50-502(1), C.R.S.
- B. As of January 1, 2024, it is unlawful for any person, partnership, association, or corporation, not already possessing a valid license to operate a BHE or substance use disorder facility, to conduct or maintain a BHE, without having obtained a license from the Behavioral Health Administration (BHA) per Section 27-50-501, C.R.S.
- C. Pursuant to Section 27-50-502(1)(g), C.R.S., these rules shall include a timeline for compliance with BHE standards that exceed the standards under which a BHE was previously licensed or approved. BHEs shall be subject to the following rule compliance timeline:
 - 1. Upon these rules going into effect, the BHA shall take immediate action on rule violations that impact the health, safety, and welfare of individuals receiving services provided by a BHE.
 - 2. All BHEs, licensed by the BHA, shall be in full compliance of these rules, and any rules that apply to any endorsements an entity has elected to obtain, by July 1, 2024.

2.2 License Requirement

- A. Any entity seeking initial licensure as a BHE shall apply for a license from the (BHA) if the entity would previously have been licensed or subject to any of the following:
 - 1. BHE licensure by the Colorado Department of Public Health and Environment;
 - 2. Approval or designation by the Office of Behavioral Health, as it existed before the effective date of this part, or the BHA pursuant to Article 50 of Title 27, C.R.S. or Article 66 of Title 27 C.R.S.; or
 - 3. Approval by the Office of Behavioral Health, as it existed before the effective date of this part, or the BHA pursuant to Section 27-81-106, C.R.S. as an approved treatment program for substance use disorders. This includes agencies that:
 - a. Are required by statute to be licensed by the BHA;
 - b. Receive public funds to provide substance use disorder treatment or substance use disorder education;
 - c. Provide such treatment to individual populations whose referral sources require them to be treated in agencies licensed by the BHA; or
 - d. Are acquiring existing agencies or sites licensed by the BHA.
- B. Entities previously licensed as described in part 2.2.A of this Chapter shall seek an initial BHE license at least sixty (60) calendar days prior to the expiration of their existing license.
- C. Any entity that meets the definition of a BHE, as defined in these rules, shall be licensed pursuant to this Chapter 2.

- D. Hospitals are exempt from BHE licensure as they do not meet the definition of providing community-based services.

2.3 General Licensing Requirements

- A. The BHE shall ensure compliance with the following:
1. The BHE may only provide services for which it holds an endorsement as part of its license.
 2. If a BHE has not provided behavioral health services specific to its endorsement for one (1) year, the BHA will review the endorsement and may remove the endorsement from the BHE's license.
 3. The following endorsements are considered outpatient service endorsements:
 - a. Behavioral Health Outpatient services as described in Chapter 4 of these rules;
 - b. Behavioral Health High-Intensity Outpatient services as described in Chapter 4 of these rules;
 - c. Walk-In Crisis services as described in Chapter 6 of these rules;
 - d. Mobile Crisis services as described in Chapter 6 of these rules;
 - e. Ambulatory Withdrawal Management without Extended On-Site Monitoring (Level 1-WM) as described in Chapter 4 of these rules; and
 - f. Ambulatory Withdrawal Management with Extended On-Site Monitoring (Level 2-WM) as described in Chapter 4 of these rules.
 4. The following endorsements are considered residential/overnight endorsements:
 - a. Residential services as described in Chapter 5 of these rules;
 - b. Crisis Stabilization Unit services as described in Chapter 6 of these rules;
 - c. Acute Treatment Unit services as described in Chapter 6 of these rules;
 - d. Residential Respite services as described in Chapter 6 of these rules;
 - e. Clinically Managed Residential Withdrawal Management (Level 3.2-WM) as described in Chapter 5 of these rules; and
 - f. Medically Monitored Inpatient Withdrawal Management (Level 3.7-WM) as described in Chapter 5 of these rules.
 5. The BHE shall ensure all of its operations, locations, and services, including contracted services or personnel, comply with laws, regulations, and standards as applicable and required by Chapter 2 of these rules, in addition to Chapters specific to any endorsements held by the BHE.
 6. The BHE shall meet the requirements in Chapter 2 of these rules, regardless of endorsements included as part of its BHE license.

7. The BHE shall meet endorsement-specific requirements, as applicable to the endorsements included as part of the BHE's license.
 8. The BHE shall have at least one endorsement and shall provide at least one type of service for each endorsement held. Endorsement standards are detailed in Chapters 3 through 10 of these rules.
- B. A BHE may only provide services for which it holds an endorsement, and at locations authorized by its license.
- C. A BHE will be issued a single entity-wide license which identifies all physical locations included in the license and endorsements for services the BHE is licensed to provide by location. The BHE shall display the license, or a copy thereof, in a manner readily visible to individuals at each physical location included in the license.
- D. Each physical location of the BHE must meet the standards adopted by the director of the Division of Fire Prevention and Control (DFPC), as applicable to the services provided in that location.
- E. BHEs are prohibited from engaging in the following actions:
1. Making a false statement of material fact about individuals served by the BHE, its personnel, capacity, or other operational components verbally to a BHA representative or agent or in any public document or in relation to a matter under investigation by the BHA or another governmental entity;
 2. Preventing, interfering with, or attempting to impede in any way the work of a representative or agent of the BHA in investigating or enforcing the applicable statutes or regulations;
 3. Falsely advertising or in any way misrepresenting the BHE's ability to provide services for the individuals served based on its license type or status;
 4. Failing to provide reports and documents required by regulation or statute in a timely and complete fashion;
 5. Failing to comply with or complete a plan of action in the time or manner specified;
 6. Falsifying records or documents;
 7. Knowingly using or disseminating misleading, deceptive, or false information;
 8. Accepting commissions, rebates, or other forms of remuneration for referrals or other treatment decisions; or
 9. Exercising undue influence or coercion over an individual to obtain certain decisions or actions or for financial or personal gain. A relationship other than a professional relationship, including but not limited to a relationship of a sexual nature, between an owner, director, manager, administrator, or other personnel and an individual, shall be considered exercise of undue influence or coercion.

2.4 Governance

- A. The BHE shall have a governing body consisting of members who singularly or collectively have professional or lived experience sufficient to oversee the types of endorsements, services, and number of physical locations included in the BHE's license.
- B. The governing body shall meet at regularly stated intervals at least four (4) times per calendar year and maintain records of the meetings.
- C. The governing body shall be responsible for high-level strategy, oversight, and accountability. If the BHE has a board of directors as its governing body, the board of directors may delegate operations and management responsibilities to an executive hired by the board who shall at the executive's discretion delegate specific operations and management responsibilities including those in this part 2.4.C to an executive leadership team. These responsibilities include:
 - 1. Ensuring the planning and organization of day-to-day operations.
 - 2. Defining, in writing, the scope of services provided by the BHE, including services provided through arrangements with, or referrals to, other health care service providers.
 - 3. Ensuring the provision of facilities, personnel, and services in compliance with applicable endorsement-specific standards found in Chapters 3 through 10 of these rules.
 - 4. Establishing organizational structures that clearly delineate personnel positions, lines of authority, and supervision.
 - 5. Ensuring all services and locations operate in compliance with applicable federal, state, and local laws and regulations, including but not limited to the rehabilitation act of 1973, 29 U.S.C. § 794, and the Americans with Disabilities Act, 42 U.S.C. § 12101, et seq.
 - 6. Ensuring professionally ethical conduct on the part of all personnel providing services, whether paid, contracted, or volunteer, and ensuring a system is in place to implement corrective measures when needed and monitor such system.
 - 7. Developing and implementing a quality management program in compliance with the requirements of part 2.17 of this Chapter, taking into account each endorsement's services and any significant differences in individual populations served.
 - 8. Ensuring emergency preparedness for the BHE, in accordance with part 2.4.F of this Chapter.
 - 9. Establishing and maintaining a system of financial management and accountability for the BHE.
 - 10. Developing, implementing, and reviewing policies at a minimum once every three years or as needed in accordance with part 2.4.D of this Chapter.
 - 11. Maintaining relationships and agreements with treatment facilities, organizations, and services to provide individual transfers, referrals, and transitions of care.
 - 12. Ensuring all marketing, advertising, or promotional information published or otherwise distributed by the BHE is accurate, including, the services the BHE provides.
 - 13. Considering and documenting the use of individual input in decision-making processes in accordance with part 2.4.D.3.i of this Chapter.

- D. The governing body or executive leadership team if so, delegated as described in part 2.4.C shall be responsible for ensuring the development and implementation of these policies and procedures and must review any changes to policies and procedures for the BHE. The governing body or executive leadership must ensure compliance with the policy requirements in this subpart and as found elsewhere in this Chapter. Every three (3) years, the governing body or executive leadership shall review all policies and procedures.
1. The BHE must have policies regarding administrative and/or clinical oversight of the BHE's endorsements, services, and/or physical locations that meet oversight requirements. Requirements included in part 2.5.A of this Chapter, and shall include, but not be limited to:
 - a. Oversight positions within the BHE, such as an administrator or clinical director, and whether each position is for the endorsement, specific services, specific locations, or a combination thereof.
 - b. The authority and responsibilities for each oversight position.
 - c. The model or framework for clinical supervision. Such model or framework may differ by endorsement, service, or setting.
 - d. The procedure for accessing oversight personnel or their delegate when the oversight personnel are not on-site, including, but not limited to, methods of contact, on-call or other procedures, and required response times.
 2. At a minimum, the BHE shall have policies and procedures that address the following items:
 - a. Critical incident and occurrence reporting in accordance with part 2.16 of this Chapter.
 - b. Individual rights in accordance with part 2.7 of this Chapter.
 - c. Individual grievances, including dispute resolution procedures, in accordance with part 2.8 of this Chapter.
 - d. Infection prevention and control in accordance with part 2.4.E of this Chapter.
 - e. Personnel, including a code of ethics for all personnel. This also includes those policies and procedures required by part 2.5 of this Chapter, and as required by the endorsements of the BHE license. This code of ethics must be made available to individuals upon request.
 - f. As applicable, screening, admission, assessment/discharge, service plan, and care policies as required by parts 2.10, 2.12, and 2.13 of this Chapter.
 - g. As applicable, medication administration in accordance with part 2.15 of this Chapter.
 - h. Defining and preventing conflicts of interest and dual relationships, and where such conflicts exist, developing and implementing controls to minimize such conflict and ensure decisions are made for the best interest of the individual.
 - i. The use of individual input and feedback in governing body decisions, including, but not limited to:

- (1) The formal or informal processes, appropriate for the individuals served and the size and complexity of services offered, to be used for collection of individual input and feedback.
 - (2) How the governing body will document individual input and how that feedback has been considered.
 - j. Individual records, including but not limited to confidentiality, access, and disposal/destruction of records as required by part 2.11 of this Chapter.
 - k. Building safety and security
 - (1) Such policies may be for the agency, an endorsement, or physical location.
 - (2) Policies must address the needs of the individual population being served and/or the services being provided.
 - (3) policies may include, but are not limited to, electronic surveillance, delayed egress, and/or locked settings as appropriate.
- E. The BHE shall have infection prevention and control policies and procedures that reflect the scope and complexity of the services provided across the BHE, including but not limited to:
 - 1. Maintenance of a sanitary environment.
 - 2. Mitigation of risks associated with infections and the prevention of the spread of communicable disease, including, but not limited to, hand hygiene, bloodborne and airborne pathogens, and respiratory hygiene and cough etiquette for individuals and BHE personnel.
 - 3. Coordination with other federal, state, and local agencies, including but not limited to a process for when and how to seek assistance from a medical professional and/or the local health department.
 - 4. For BHEs that administer medications or injections on-site, as well as all agencies providing overnight or residential services, a requirement that at least one person trained in infection control be employed by or regularly available to the BHE.
- F. The BHE shall be responsible for emergency preparedness policies and procedures, including the following:
 - 1. Completing a risk assessment of potential hazards and preparedness measures to address natural and human-caused crises including, but not limited to, fire, gas leaks/explosions, power outages, tornados, flooding, threatened or actual acts of violence, and bioterror, pandemic, or disease outbreak events. The governing body shall review such risk assessments annually and whenever BHE operations are modified through the addition or discontinuation of a physical location, service, or endorsement.
 - 2. Developing and implementing a written emergency management plan addressing the hazards identified in part 2.4.F.1, above, and meeting, at a minimum, the following requirements:

- a. The plan must differentiate between endorsements, physical locations, and individual populations served and meet the requirements applicable to any endorsements held by the BHE.
 - b. The plan must be updated based on changes in the risk assessment conducted in accordance with part 2.4.F.1 of these rules, above.
 - c. The plan must address interruptions in the normal supply of essentials, including, but not limited to water, food, pharmaceuticals, and personal protective equipment (PPE), if these are regularly provided or used by BHE personnel or individuals.
 - d. The plan must ensure continuation of necessary care to all individuals immediately following any emergency.
 - e. The plan must address the protection and transfer of individual information, as needed.
 - f. The plan must address the methods and frequency of holding routine drills to ensure BHE personnel's familiarity with emergency procedures, in compliance with requirements established by the Department of Public Safety, Division of Fire Prevention and Control in 8 CCR 1507-31 (December 15, 2021), which is hereby incorporated by reference. No later editions or amendments are incorporated. These regulations are available at no cost at <https://www.coloradosos.gov/CCR/DisplayRule.do?action=ruleinfo&ruleId=3177&deptID=17&agencyID=43&deptName=Department%20of%20Public%20Safety&agencyName=Division%20of%20Fire%20Prevention%20and%20Control&seriesNum=8%20CCR%20150>. These regulations are also available for public inspection and copying at the BHA, 710 S. Ash Street, Unit C140, Denver, CO 80246, during regular business hours.
3. If the BHE has an automated external defibrillator (AED), personnel must be trained in its use, and it must be maintained in accordance with the manufacturer's specifications.

2.5 Personnel and Contracted Services

- A. The BHE shall ensure administrative and/or clinical oversight of endorsement(s), service(s), and physical location(s), in accordance with policies and procedures adopted by the governing body under part 2.4.D of these rules, including, as required by those policies:
 1. An administrator responsible for implementing endorsement and service policies and procedures adopted by the governing body, as well as the day-to-day operation of the endorsement, services, or location, including, but not limited to:
 - a. Management of business and financial operations.
 - b. Ensuring standards in part 2 of this Chapter are met in the endorsement, services, and location, including, but not limited to the standards in part 2.15 of these rules, medication administration.
 - c. Ensuring buildings are properly maintained and building safety/security needs are met.
 - d. Implementing infection control and emergency preparedness policies and procedures, in accordance with governing body policies.

- e. Establishing and maintaining relationships with agencies, services, and behavioral health resources within the community.
 - f. Identifying personnel to whom administrator responsibilities are delegated during periods when the administrator is neither on-site nor available through interactive means within thirty (30) minutes.
 - g. A BHE may have a single administrator, or multiple administrators for the combination of endorsements, services, and locations included in the BHE license.
 - 2. For BHEs providing clinical services, a clinical director, responsible for the overall clinical services provided to individuals, including, but not limited to:
 - a. Ensuring training and continuing education for all BHE personnel, relevant to the services provided by the personnel.
 - b. Ensuring supervision and clinical oversight of BHE personnel in accordance with part 2.5.1 of these rules.
 - c. Including a method to provide clinical supervision and oversight during periods when the clinical director is unable to fulfill their duties within thirty (30) minutes.
 - d. Ensuring services provided are appropriate as indicated in screenings and assessments.
 - 3. A BHE may have a single clinical director, or multiple clinical directors, as appropriate for the combination of endorsements, services, and locations included in the BHE license.
 - 4. The minimum qualifications for the administrator and clinical director are set by the BHE's policies and procedures.
 - 5. An administrator or clinical director may be specific to a physical location or may be shared among locations, as appropriate for the services, size, and geographic dispersion of the services.
 - 6. A single person may serve as both the administrator and the clinical director, if that person meets qualifications for both, and it is consistent with policies adopted by the governing body.
- B. The BHE shall maintain a sufficient number of qualified personnel for each endorsement and at each physical location to provide the endorsed services, meet the clinical needs of the individuals, and comply with state and federal requirements. The BHE shall ensure personnel are only assigned duties they are competent to perform adequately and safely.
- C. All personnel assigned to direct individual care must be qualified through either professional credentials, education, training, and/or experience in the principles, policies, procedures, and appropriate techniques for providing individual services.
- 1. Personnel providing individual services must be legally authorized to provide the service in accordance with applicable federal, state, and local laws.
 - 2. Licensed, certified, and/or registered personnel must have an active license, certification, or registration in the state of Colorado and may only provide services within their scope of practice.

3. The BHE shall verify the license, certification, or registration, and check for any disciplinary action against personnel providing individual services, through the Colorado department of regulatory agencies or other state or federal agency not more than thirty (30) days before official hire date prior to hire.
 4. The BHE shall create policies and procedures regarding supervision of all personnel pursuant to part 2.5.1 of this Chapter.
- D. The BHE shall obtain, prior to hire or contract of new personnel or acceptance of persons for volunteer service if that volunteer service involves unsupervised direct contact with individuals receiving services, a name-based criminal history record check for each prospective personnel or volunteer.
1. If the prospective personnel has lived in Colorado for more than three (3) years at the time of application, the BHE shall obtain a name-based criminal history report conducted by the Colorado Bureau of Investigation (CBI).
 2. If the prospective personnel has lived in Colorado for three (3) years or less at the time of application, the BHE shall obtain a name-based criminal history report for each state in which the prospective personnel has lived during the past three (3) years, conducted by the respective states' bureaus of investigation or equivalent state-level law enforcement agency, or a national criminal history report conducted by the federal bureau of investigation.
 3. The BHE shall bear the cost of obtaining such information.
 4. If a BHE contracts with a staffing agency for the provision of services, it shall require that the staffing agency meet the requirements of this part 2.5.D.
 5. When determining whether a prospective personnel is eligible for hire or contract, if the criminal history record check reveals the person has a conviction or plea of guilty, active deferred judgment, or nolo contendere, the BHE shall follow its policy developed in accordance with part 2.5.E.3.a of this Chapter.
- E. The BHE shall have written personnel policies developed in accordance with part 2.5.C of this Chapter, including, but not limited to:
1. Line of authority/management hierarchy of personnel.
 2. Job descriptions/responsibilities.
 3. Written criteria and procedures for evaluating which convictions or complaints make prospective personnel unacceptable for hire, or for existing personnel unacceptable for retention, including:
 - a. Factors to be considered when determining whether prospective personnel are eligible for hire when their criminal history record check reveals a conviction or plea of guilty, active deferred judgment, or nolo contendere, including, but not limited to:
 - (1) The nature and seriousness of the offense;

- (2) The nature of the position and how the offense relates to or may impact the duties of the position. Experience in the criminal justice system is not necessarily a disqualifier and, in certain circumstances, a BHE may determine that some lived experiences would benefit a particular position;
 - (3) The length of time since the conviction or plea;
 - (4) Whether such conviction is isolated or part of a pattern; and
 - (5) Whether there are mitigating or aggravating circumstances involved.
 - 4. Conditions of employment, including but not limited to:
 - a. That personnel refrain from sexual or romantic relationships between supervisors and supervisees and sexual or romantic relationships with individuals served.
 - 5. Position qualifications and required credentials.
 - 6. Orientation, training, and continuing education requirements, for the populations served and services provided.
 - 7. Routine monitoring of personnel credentials and disciplinary actions.
 - 8. Requirements for self-reporting of new or current investigations, criminal charges, indictments, or convictions that may affect the personnel's ability to carry out their duties or functions of the job.
 - 9. Policies requiring all personnel to be free of communicable disease that can be readily transmitted in the BHE.
 - a. All personnel that have direct contact with individuals must be required to have a tuberculin skin test prior to direct contact with individuals. In the event of a positive reaction to the skin test, evidence of a chest x-ray and other appropriate follow-up may be required in accordance with community standards of practice.
- F. The BHE shall ensure that all personnel have access to and know about the BHE's policies, procedures, and state and federal laws and regulations relevant to their respective duties.
- G. The BHE must maintain records on all personnel, including, but not limited to:
 - 1. Date of hire;
 - 2. Job description;
 - 3. Results of criminal history record checks;
 - 4. Documentation of professional credentials, education, and training;
 - 5. Documentation of any disciplinary action taken against the person by a credentialing body;
 - 6. Documentation of orientation and training;

7. Evidence of review of the BHE's policies, procedures, and state and federal laws and regulations relevant to their respective duties; and
 8. Documentation of tuberculosis testing and results, for personnel who have direct contact with individuals.
- H. The BHE must ensure that all personnel complete an initial orientation on basic infection prevention and control, safety, and emergency preparedness procedures.
- I. The BHE must ensure that all personnel receive the following training prior to working independently with individuals, and on a periodic basis consistent with policies developed in accordance with part 2.5.E of this Chapter, above
1. Training specific to the particular needs of the populations served, including the provision of person-centered, trauma-informed, harm reduction-focused, physically and programmatically accessible, and culturally and linguistically responsive services;
 2. Infection control;
 3. Emergency preparedness, including de-escalation of potentially dangerous situations, including but not limited to threats of violence, acts of violence, and abuse/mistreatment of an individual;
 4. Critical incident reporting;
 5. Suicide prevention;
 6. Individual rights of the population served;
 7. Confidentiality, including individual privacy and records privacy and security;
 8. BHE policies and procedures;
 9. Mandatory reporting requirements for suspected abuse or neglect in accordance with part 2.8.A.9.a of this Chapter; and
 10. Understanding of basic pharmacology and medications that are relevant to the treatment type and population served by the agency, including but not limited to medication-assisted treatment (MAT) services and medications for opioid use disorders (MOUD).
 - a. This training requirement may not be used as reason to hold unqualified personnel out as experts in pharmacology. BHEs must not encourage personnel to hold themselves out as able to make recommendations that are outside of their scope of practice to individuals receiving services. Rather, this training requirement is meant to ensure that personnel receive a base knowledge for the behavioral health community they service and allow for meaningful, timely, and supportive recovery-focused interactions with individuals receiving services.

2.5.1 Clinical Supervision

- A. The BHE must ensure that all personnel providing behavioral health services, with the exception of peer support professionals, receive clinical supervision, as defined in part 1.3 of these rules.
- B. The BHE will develop policies and procedures for supervision that address the following:

1. Supervisee's mandatory disclosure statement that clearly states they are under supervision and by whom;
 2. Requirements for regular evaluation of the supervisee's progress with a rubric that is tied to the responsibilities assigned;
 3. Documentation and frequency of supervisor reviews and feedback provided;
 4. Maximum number of supervisees a supervisor oversees; and
 5. How supervision/consultation is covered by personnel with comparable credentials when the usual supervisor is not available.
- C. Clinical supervisors must at minimum:
1. Meet the standard qualifications for clinical supervision as defined by the supervisor's professional practice board.
 2. Deliver clinical supervision within the supervisor's professional practice license and ethical standards for:
 - a. Those that are licensed or seeking professional licensure; or
 - b. When supervising personnel that are not seeking or not eligible for professional licensure, such as group living workers, the supervisor must follow standards in the Colorado Mental Health Practice Act, as defined in Article 245 of Title 12, C.R.S.
 3. Dedicate time between the supervisor and supervisee to instruct, model, and encourage self-reflection regarding acquisition of clinical and administrative skills by the supervisees. Clinical supervisor will determine skills through observation, evaluation, feedback, and mutual problem-solving.
 4. Address ethics and ethical dilemmas as aligned with the appropriate professional practice board.
 5. Provide professional direction based on experience, expertise, and/or for ethical or safety concerns.
 6. Ensure that safety and crisis management plans are followed and that clinical supervisors are available to personnel for assistance in crisis situations and processing of the crisis event afterwards.
 7. Document the date, duration, and the content of supervision session for their supervisee(s), which may include a professional development plan. All documents pertaining to clinical supervision must be provided to the supervisee and the BHA upon request.
- D. Personnel-specific clinical supervision requirements
1. Licensees and authorized practitioners will be provided with clinical supervision and/or consultation at minimum upon request by the licensee or authorized practitioner or during times of individual emergency.

2. Candidates will be provided with clinical supervision at a rate that will meet their licensing requirements for the license they are pursuing or at a minimum of one (1) hour every two (2) weeks, whichever provides a higher level of clinical supervision.
3. All clinical documentation completed by a counselor-in-training and/or intern still in pursuit of their clinical degree must be reviewed and co-signed by a clinical supervisor able to supervise pursuant to their scope of practice.
4. Personnel not seeking or not eligible for licensure, but that are providing clinical services, will be provided clinical supervision at a frequency that ensures treatment to individuals is appropriate, safe, and in line with assessment treatment needs and the individual's treatment goals.

2.6 General Building and Fire Safety Provisions

- A. Each BHE shall be in compliance with all applicable local zoning, housing, fire, and sanitary codes and ordinances of the city, city and county, or county where it is situated.
- B. All physical locations of a BHE must be constructed in conformity with the standards adopted by the director of the DFPC at the Colorado Department of Public Safety, as applicable.
- C. A BHE that is subject to fire prevention and life safety code requirements, may not provide services in areas subject to plan review, except as approved by DFPC.
- D. The BHE shall provide an interior environment that is clean and sanitary, maintained and in good repair, and free of hazards to health and safety.
- E. The BHE shall ensure the prominent posting of evacuation routes and exits in each physical location.
- F. The BHE shall prominently post the hours of operation at the entrance of each physical location, and on the BHE's website.

2.7 Individual Rights

- A. The BHE shall develop and implement a policy regarding individual rights. The policy must ensure that each individual or, when applicable, the individual's designated representative, has the right to:
 1. Participate in all decisions involving the individual's care or treatment.
 2. Be informed about whether the BHE is participating in teaching programs, and to provide informed consent prior to being included in any clinical trials relating to the individual's care.
 3. Refuse any drug, test, procedure, service, or treatment and to be informed of risks and benefits of this action.
 4. Receive care and treatment, in compliance with state statute, that is free from discrimination on the basis of physical or mental disability, race, ethnicity, socio-economic status, religion, gender expression, gender identity, sex, sexuality, culture, and/or languages spoken; and that recognizes an individual's dignity, cultural values and religious beliefs; as well as provides for personal privacy to the extent possible during the course of treatment.

5. Be informed of, at a minimum, the first names and credentials of the personnel that are providing services to the individual. Full names and qualifications of the service providers must be provided upon request to the individual or the individual's designated representative or when required by the department of regulatory agencies.
6. Receive, upon request:
 - a. Prior to initiation of non-emergent care or treatment, the estimated average charge to the individual. This information must be presented to the individual in a manner that is consistent with all state and federal laws and regulations.
 - b. The BHE's general billing procedures.
 - c. An itemized bill that identifies treatment and services by date. The itemized bill must enable individuals or their legal representatives to validate the charges for items and services provided and must include contact information, including a telephone number, for billing inquiries. The itemized bill must be made available either within ten (10) business days of the request, thirty (30) days after discharge, or thirty (30) days after the service is rendered – whichever is later.
7. Give informed consent for all treatment and services. The personnel must obtain informed consent for treatment they provide to the individual. Informed consent includes:
 - a. A written agreement executed between the BHE and the individual or the individual's legal representative at the time of admission. The parties may amend the agreement if there is written consent of both parties. No agreement will be construed to relieve the BHE of any requirement or obligation imposed by law or regulation.
 - b. Individual consents must include consent to treatment. If the individual is refusing treatment or an aspect of treatment, the BHE must have the individual sign a form to confirm their refusal.
 - c. If the governor or local government declares an emergency or disaster, a BHE may obtain documented oral agreements or consents in place of written agreements or consents. Documented oral agreements and consents may only be used as necessary because of circumstances related to the emergency or disaster. The BHE shall send a hard copy or electronic copy of the documented agreement or consent to the individual within two (2) business days of the oral agreement or consent.
8. Register disputes with the BHE and grievances with the BHA and to be informed of the procedures for registering complaints and grievances including contact information.
9. Be free of abuse and neglect.

- a. The BHE must develop and implement policies and procedures that prevent, detect, investigate, and respond to incidents of abuse or neglect. This includes suspected physical, sexual, or psychological abuse; exploitation and/or caretaker neglect; as well as child abuse, neglect and/or child safety issues, which must include definitions of abuse and neglect under the Colorado Children's Code (Section 19-1-103, C.R.S.), and that are consistent with the reporting of child abuse allowed under federal law. Policies and procedures must also be consistent with definitions and mandated reporting requirements for mistreatment, abuse, neglect, and exploitation of at-risk adults under the Colorado Human Services and Criminal Codes (Sections 26-3.1-101, 26-3.1-102, 18-6.5-108, C.R.S.).
 - (1) Prevention includes, but is not limited to, adequate staffing to meet the needs of the individuals, screening personnel for records of abuse and neglect, and protecting individuals from abuse during investigation of allegations.
 - (2) Detection includes, but is not limited to, establishing a reporting system and training personnel regarding identifying, reporting, and intervening in incidences of abuse and neglect.
 - b. The BHE shall investigate all allegations of abuse or neglect against BHE personnel, or made against an individual, when the allegation occurs during service provision or on BHE premises. The BHE shall implement corrective actions in accordance with such investigations.
- 10. Be free from the improper application of restraints or seclusion. Restraints or seclusion may only be used in a manner consistent with part 2.14 of this Chapter.
- 11. Expect that the BHE in which the individual is admitted can meet the identified and reasonably anticipated care, treatment, and service needs of the individual.
- 12. Receive care from the BHE in accordance with the individual's needs.
- 13. Have the confidentiality of their individual records maintained.
 - a. A BHE must comply with all applicable state and federal laws and regulations for release of information including but not limited to 42 C.F.R. Part 2, Section 27-65-123, C.R.S. and HIPAA.
 - b. When obtaining informed consent or an authorization for release of information, the signed release must state, at a minimum:
 - (1) Persons who may receive the information in the records;
 - (2) The purpose for obtaining this information;
 - (3) The information to be released;
 - (4) That the release may be revoked by the individual, or legal representative at any time; and
 - (5) That the release of information is only valid for a time period specified but such time cannot exceed two (2) years from the date of signature.

14. Receive care in a safe setting.
15. Be notified if referrals to other providers are to entities in which the BHE has a direct or indirect financial benefit, including a benefit that has financial value, but is not a direct monetary payment.
16. Formulate medical and psychiatric advance directives and have the BHE comply with such directives, as applicable, and in compliance with applicable state statute.
 - a. When the BHE is aware that an individual has developed advance directives, the BHE shall make good faith efforts to obtain the directives and the directives must become part of the individual's record.
 - b. The BHE shall disclose the policy regarding individual rights to the individual or the individual's designated representative prior to treatment or upon admission, where possible. For any services requiring multiple individual encounters, disclosure provided at the beginning of such care or treatment course must meet the intent of the regulations.

2.8 Dispute and Grievance Resolution

- A. Each BHE shall post a clear and unambiguous notice of dispute and grievance procedures in each physical location in an area that is open to the public and on the BHE's website. The notice must also be provided in writing and/or electronically upon admission to services.
 1. The BHE shall establish a uniform procedure for prompt management of disputes brought by individuals accessing, receiving, or being evaluated for services and their family members. The BHE shall develop policies and procedures for handling disputes.
 2. The BHE shall provide a fair dispute resolution process that allows options for submitting both verbal and/or written disputes. The process must provide the individual with a response no later than thirty (30) business days from submission of the dispute. If the dispute is received verbally, the representative shall create a written documentation of the dispute.
- B. As part of the BHE's resolution process, the BHE must inform persons who have submitted a dispute verbally or in writing that they may also submit a grievance to the BHA. The BHE must provide information about how to submit a grievance to the BHA.
 1. The BHE shall designate a representative, who must be available to assist individuals in resolving disputes.
 2. The BHE shall educate individuals and their representatives about the mechanisms in place for filing disputes. This education must include an explanation of the individual's rights; the dispute process and procedures; and the name, contact information, and responsibilities of the designated representative within the BHE. Appropriate contacts for external appeal must also be provided, which may include, but are not limited to, the following: the Colorado Department of Regulatory Agencies; the Colorado Department of Public Health and Environment; the Colorado Department of Health care policy and financing; or the governor's designated protection and advocacy system for individuals with mental illness. Documentation in the records must include the dated signature of the individual receiving the information.

3. The BHE must post a notice of rights, dispute procedure, and the designated representative's name, office location, responsibilities, and telephone number in prominent locations where persons access, receive or are evaluated for services. The notice shall be translated into languages commonly used by the populations in the service area.
4. The BHE must maintain a record of submitted disputes, separate from the individual records that include the date, the type of dispute, and the outcome of investigation. These dispute records must be provided annually to the BHA.
5. Upon request, the BHE must provide an individual and any interested person with contact information for registering complaints with any other state departments.

2.9 Individual Services

- A. The BHE must ensure individuals are provided services in the least restrictive setting that meets the individual's needs.
- B. The BHE may use telehealth methods for the provision of services under these regulations except for services that specifically require in-person contact. If a service is allowable via telehealth according to state and federal regulations, appropriate methods will be noted within the applicable endorsement Chapter. If an individual prefers to receive services in-person and the BHE does not offer the appropriate service in-person, the BHE shall refer the individual to another entity that offers the service in-person.
 1. If the BHE uses telehealth methods, it must develop and implement policies and procedures regarding telehealth services, including:
 - a. Collection of required signatures;
 - b. Training for personnel specific to the modality or manner for determining competence with the modality;
 - c. Procedure for personnel response if an individual experiences an emergency while receiving services via telehealth, including collection of information about the individual's remote location for each session;
 - d. Confidentiality protocols designed to protect the individual's privacy in accordance with state and federal law; and
 - e. Specification as to whether policies apply to the BHE as a whole, a physical location, or a specific endorsement, as appropriate.
 2. Services provided via telehealth methods must be documented in the individual's record, consistent with documentation requirements for in-person services.
 3. Services may be provided through synchronous audio-visual methods but must not include text-only methods such as text message or email. Some services may be provided through audio-only methods according to state and federal regulations. If audio-only methods are used, the following must be noted in the individual record:
 - a. The reason that audio-visual methods were not utilized.
 - b. The clinical determination of appropriateness for service delivery method.

- C. If the BHE uses public community settings for the provision of services, it shall develop and implement policies and procedures regarding the delivery of such services, including:
1. Collection of required signatures when necessary;
 2. Selection and utilization of public spaces that are safe and accessible to the individuals being served;
 3. Procedures for how the BHE will ensure individual privacy and confidentiality in the public setting according to state and federal regulations;
 4. Procedure for personnel response if an individual experiences an emergency while receiving services in the public setting;
 5. Procedure to promote and monitor personnel safety while providing services in this setting; and
 6. Such policies may apply to the BHE as a whole, a physical location, or a specific endorsement, as applicable.
- D. The BHE shall develop and implement policies and procedures regarding behavioral health emergency services and methods for addressing individuals or individuals with unexpected high acuity and/or urgent behavioral health needs. Such policies and procedures may apply to the BHE as a whole, a specific endorsement, or a physical location, as appropriate, and must include, but not be limited to:
1. The behavioral health emergency services provided by the BHE, if any, and the hours during which such behavioral health emergency services are available.
 2. How the BHE ensures access to behavioral health emergency services when not provided directly by the BHE, including, but not limited to:
 - a. Criteria used in determining when behavioral health emergency services are needed;
 - b. Internal protocols for personnel and supervisors in response to behavioral health emergency;
 - c. Protocols for facilitating transfers to other agencies; and
 - d. Methods of providing information to individuals to ensure understanding of how to access behavioral health emergency services.
 3. The methods for identifying and responding to and/or mitigating sudden or unpredictable high-acuity or increased needs in existing individuals within twenty-four (24) hours of notification of increased need
- E. The BHE must develop and implement policies and procedures regarding access to emergency medical services. Such policies and procedures may be for the BHE as a whole, a specific endorsement, or a physical location, as appropriate, and must include, but are not limited to:
1. The medical emergency services provided by the BHE, if any, and the hours during which such medical emergency services are available.

2. How the BHE ensures access to medical emergency services when not provided directly by the BHE, including, but not limited to:
 - a. Criteria used in determining when medical emergency services are needed;
 - b. Internal protocols for personnel in response to a medical emergency; and
 - c. Protocols for facilitating transfers of individuals to emergency medical providers or facilities.
 3. Methods of providing information to individuals to ensure the individual's understanding of how to access medical emergency services.
- F. The BHE shall inform individuals how to access medical and behavioral health crisis or emergency services twenty-four (24) hours per day, seven (7) days per week.
- G. The BHE shall provide care coordination to individuals consistent with the following requirements:
1. Care coordination must be carried out in keeping with the individual's needs for care and, to the extent possible, in accordance with the individual's expressed preferences. Care coordination may involve the individual's family, parent, legal guardian, caregiver, and other supports identified by the individual.
 2. Care coordination services may include the following, as appropriate for the needs of the individual:
 - a. Screenings to identify the individual's priorities, goals, strengths, and the barriers faced, including those related to health-related social needs.
 - b. Supporting the individual in accessing care and services within the health care and social service systems and equipping the individual with information to navigate and manage their care.
 - (1) This shall include providing accessible and culturally and linguistically meaningful resources and information, including resource directories such as OWNPATH.
 - c. Conducting application assistance, referrals, and warm hand-offs to access appropriate resources and care.
 3. Information sharing
 - a. The BHE shall prioritize information sharing with other providers delivering services to the individual for the purpose of care coordination.
 - b. Information sharing must occur as clinically indicated, and as approved by the individual, throughout an individual's episode of care.
 - c. Information sharing must include obtaining or demonstrated efforts to obtain records from previous or existing behavioral health, physical health, and other social needs service providers, during the assessment period, and on an ongoing basis.

- d. The BHE shall ensure individuals' preferences for shared information are adequately documented in individual records, consistent with the principles of person and family-centered care.
- e. The BHE shall obtain authorization for release of information from individuals or their legal representative for all care coordination relationships. If the BHE is unable, after reasonable attempts, to obtain authorization for any care coordination activity as required by this Chapter, the attempts must be documented in the individual's record and revisited periodically, such as during transitions of care or when the individual receives a new diagnoses or has a change in condition.
 - (1) Information sharing that is permissible under HIPAA without authorization from the individual or legal representative is not subject to this requirement.
- f. The BHE must maintain the necessary documentation to satisfy the requirements of all applicable federal and state privacy laws, including individual privacy requirements specific to the care of children.
- g. A referral must include, in accordance with individual consent and as clinically necessary and applicable, information regarding:
 - (1) Health status;
 - (2) Active diagnoses;
 - (3) Known allergies;
 - (4) Test results;
 - (5) Lab results;
 - (6) Medications list;
 - (7) Treatment course, time and detail of modalities used, and response to treatment or other recovery supports (status of changes);
 - (8) Existing scheduled appointments to include physical health, behavioral health and other recovery and supportive services that may be part of the care plan;
 - (9) Recent history or risks for urgent/acute care (e.g., recent emergency department visit, hospitalization, etc.); and
 - (10) Reasonable accommodations.
- h. All information sharing must occur in compliance with applicable federal and state laws, including but not limited to HIPAA and 42 C.F.R. Part 2.

H. Medication consistency

- 1. The BHE shall ensure all clinical staff are aware of and have access to the medication formulary.

2. The BHE shall ensure personnel have access to the medications on the medication formulary when prescribing medications to treat behavioral health disorders for an individual who is or was involved with the criminal or juvenile justice system.

2.10 Admission and Discharge Criteria

- A. For applicable services, the BHE shall develop and implement admission and discharge policies. Such policies may be for the BHE as a whole, a particular endorsement, and/or a specific physical location, as appropriate, and must include, at a minimum:
 1. Criteria to ensure the BHE, endorsement, and/or location only treats individuals for whom it can provide immediate assessment and treatment based on the individual's needs.
 2. Admission criteria to ensure treatment in the least restrictive setting based on the individual's level of care needs. The following must not be the sole reason for treatment ineligibility:
 - a. Relapse;
 - b. Leaving previous treatment against advice or lack of engagement in previous treatment;
 - c. Pregnancy;
 - d. Drug use;
 - e. Involuntary commitment;
 - f. Current utilization of any medication-assisted treatment (MAT) or interest in beginning MAT services;
 - g. Previous or pending disputes, grievances, or appeals; or
 - h. Place of residence.
 3. Procedures for transferring an individual from a level of care to a different level of care within the BHE.
 4. Procedures for referring an individual to other service providers when the individual cannot be admitted to the BHE.
 5. Criteria and procedures for an individual's discharge from treatment, including, but not limited to:
 - a. When an individual is being transferred from the BHE to another provider.
 - b. Timely discharge of an individual receiving voluntary services upon the individual's request, once appropriate screening and assessment is complete.
 - c. Discharge and transfer procedures for an individual receiving services on an involuntary basis, if applicable.
 - d. Subparts 2.10.A.5.a, 2.10.A.5.b and 2.10.A.5.c of this Chapter must comply with the following requirements:

- (1) At the time of discharge, the BHE must, unless the individual refuses, provide support to facilitate a smooth transition to alternate services to address any existing service needs.
 - (2) If an individual declines support in connecting with additional services at the time of discharge, the reason given by the individual shall be documented within the record.
 - (3) When the individual agrees to BHE support in transitioning providers, the BHE must obtain a release of information to communicate with and share records with the new provider. The BHE shall ensure that the discharge summary meets the requirements set forth in part 2.10.A.6 of this Chapter and is provided to the receiving provider no later than fifteen (15) days from the date of discharge. The BHE shall make every effort to complete and send the discharge summary prior to the individual's initial appointment with the receiving provider.
 - (4) When the BHE facilitates the transition of care to a new behavioral health provider or alternative resource at the time of discharge, the BHE shall inform the individual of the date, time, and location of the scheduled visit and/or any other information necessary to access the service or resource to which the individual is referred. The BHE shall consider barriers to care for the individual and support the individual in connecting with necessary resources to promote access to care. If this cannot be completed, the BHE shall document the reason within the record as well as any attempts made.
 - e. Information and documentation to be provided to the individual upon discharge, unless clinically contraindicated, including, but not limited to:
 - (1) Medication information, including medication name, dosage, instructions for follow-up, and whether the individual was provided with medication upon discharge.
 - (a) The BHE may provide individuals with unused, prescribed medications as part of the discharge process, unless it has been determined that doing so would pose a risk to the health and safety of the individual.
 - (2) Detailed information on transitioning care to other providers, including referral information, when providing referrals.
 - (3) Documentation that the discharge is being made against the advice of the provider, as applicable.
 - (4) Documentation required when the above information in this subpart 2.10.A.5.e is not provided to the individual at discharge.
 - (5) Written notification of discharge with reason for discharge.
 - (6) Written notification of BHE and BHA dispute resolution and grievance procedures.
6. Requirements for a discharge summary to facilitate continuity of individual care, including, but not limited to:

- a. The timeframe for discharge summary completion, which may not be more than fifteen (15) calendar days after discharge.
- b. Information to be included in the discharge summary to inform future providers of treatment history, including, but not limited to:
 - (1) Demographic information, including, but not limited to, name, date of birth, gender identity, emergency contact information, insurance information, preferred language, and any cultural factors to consider in treatment;
 - (2) A brief summary of the episode of care, including, but not limited to, the presenting issue, services received, diagnosis assigned or modified, and any outstanding needs identified;
 - (3) Information on the individual's status within the judicial system, including any type of behavioral health certification or hold;
 - (4) A summary of medications prescribed during treatment, including the individual's responses to medications;
 - (5) Medications recommended and prescribed at discharge; and
 - (6) Documentation of referrals and recommendations for follow-up care.
- c. This discharge information may be in narrative or abbreviated format and must be written in a manner that can be readily understood by a receiving provider to allow for prompt resumption of services.

2.11 Individual Records

- A. A confidential individual record must be maintained for each individual receiving services from the BHE. This record must not contain protected health information pertaining to other individuals receiving services.
- B. Each individual record must include at a minimum:
 - 1. Demographic and medical information, including, but not limited to, individual name, address, telephone number, emergency contact information, physician or health provider information, and current diagnosis;
 - 2. Screenings, assessments and reassessments, service plans, documentation of informed consent including consent to treatment, releases of information, physician or practitioner orders, documentation of services, treatment progress notes and medication, admission summary, discharge summary, and any endorsement or service-specific requirements, as set by this Chapter;
 - 3. Medical and psychiatric advance directives when such directives are furnished by the individual;
 - 4. The individual's medication administration record;
 - 5. The out-of-state offender questionnaire, if providing substance use disorder (SUD) services;

6. Personal belonging inventories;
 7. Court documents, when such documents are relevant to the individual's treatment;
 8. Records of required communication with referral sources such as court, probation, child welfare, and parole; and
 9. Drug and alcohol testing and monitoring results.
- C. Individual records must be available to an individual or their designated representative through the BHE or their designated representative at reasonable times and upon reasonable notice in accordance with all applicable state and federal laws, including but not limited to HIPAA and 42 C.F.R. Part 2.
1. If the service provider is deceased or unavailable, the current custodian of the record shall designate a substitute service provider for purposes of compliance with these regulations.
- D. A statement of the BHE's procedures for obtaining records, and the right to appeal grievances regarding access to records to the BHA must be posted in conspicuous public places on the premises and made available to each individual upon admission to the BHE.
- E. An individual, whether currently receiving services or discharged from a BHE, may inspect, or obtain a copy of their own record. The BHE must act on the request to review the individual's record within a reasonable time, which must not exceed thirty (30) days except when an extension is allowable in accordance with 45 C.F.R. 164.524(b)(2).
- F. BHEs must not charge the individual or designated representative for inspection of the individual record.
- G. Records must be kept in accordance with all applicable state and federal laws and regulations.
- H. Access to medical records contained within the individual's records must be accessed in a manner that is consistent with all applicable state and federal laws, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- I. If there are changes/corrections, deletions, or other modifications to any portion of an individual record, the person who is making the changes must note in the record the date, time, nature, reason, correction, deletion, or other modification, and their name, to the change, correction, deletion, or other modification.
- J. Records must be retained as follows:
1. Adult outpatient endorsements as defined in 2.3.A.3 of this Chapter must be retained for seven (7) years from the date of discharge from the BHE.
 - a. Records for individuals who are less than eighteen (18) years old when admitted to the BHE must be retained until the individual is twenty-five (25) years old.
 2. Adult residential/overnight endorsements as defined in part 2.3.A.4 of this Chapter must be retained for ten (10) years from the date of discharge from the BHE.
 - a. Records for individuals who are less than eighteen (18) years old when admitted to the BHE must be retained until the individual is twenty-eight (28) years old.

3. The confidentiality of the individual record, including all medical, behavioral health, psychological, and demographic information must be protected in accordance with all applicable federal and state laws and regulations, including during record use, storage, transportation, transmission, and disposal.
 4. When a BHE closes a physical location and/or discontinues any endorsement, it must maintain records of individuals served in accordance with the requirements of this part 2.11.J.
 5. A BHE that ceases operation must comply with the provisions of part 2.24 of this Chapter regarding individual records.
- K. Effect of this part 2.11 on similar rights of an individual
1. Nothing in this part 2.11 may be construed to limit the right of an individual or the individual's designated representative to inspect individual records, including the individual's medical or psychological data pursuant to Section 27-65-123, C.R.S.
 2. Nothing in this part 2.11 may be construed to require a person responsible for the diagnosis or treatment of a child for substance use disorder or use of drugs, pursuant to Sections 25-4-409 and 13-22-102, C.R.S. to release records of such diagnosis or treatment to a parent, guardian, or person other than the minor or their designated representative.
 3. Nothing in this part 2.11 may be construed to waive the responsibility of a custodian of medical records in the BHE to maintain confidentiality of those records in its possession.
 4. Nothing in this part 2.11 may limit the right of an individual, the individual's personal representative, or a person who requests the medical records upon submission of a federal law compliant authorization, a valid subpoena, or a court order to inspect the individual's records.

2.12 Screening, Initial Assessment, and Comprehensive Assessment

2.12.1 Screening

- A. Personnel meeting qualifications under part 2.5.C of this Chapter shall complete a screening and triage process to determine urgency of the individual's needs, including the need for emergency or urgent medical or psychiatric services, and whether the BHE can provide the appropriate care in light of the individual's needs.
- B. Screening tools/approaches must be culturally and linguistically appropriate and trauma-informed and should accommodate an individual's disability/disabilities (hearing disability, cognitive limitations, visual impairment, etc.) as required.
- C. Screenings must collect at least the following information from an individual seeking services:
 1. Identifying information;
 2. Primary complaint/reason for seeking services;
 3. Current behavioral health symptoms, including severity, duration, mental status, and changes or impairments in functioning due to symptoms;
 4. Medical concerns/chronic health issues, including pregnancy and postpartum status; and

5. Evaluation of imminent risk, including:
 - a. Suicide risk;
 - b. Danger to self or others;
 - c. Urgent or critical medical conditions, including withdrawal or overdose risk; or
 - d. Other immediate risks, including threats from another person;
 - (1) If, at any point in the course of treatment, a screening of imminent risk is completed to assess the need for a mental health hold (M1 hold), all personnel conducting the screening shall use the BHA-designated M1 screening form notwithstanding any 27-65 designation.
 6. Preliminary determination of level of care needed.
- D. Screenings that identify an imminent risk must be reviewed by a licensee, licensed addiction counselor (LAC), a certified addiction specialist (CAS), authorized practitioner, or a licensure candidate performing within the scope of their practice.
- E. Screenings should be conducted in-person unless contraindicated. If contraindicated, screenings may be conducted via audio-visual or audio only telehealth. Clinical rationale must be documented in the case of a telehealth screening.
- F. To avoid redundant screening, supporting documentation that a screening tool was administered within the past six (6) months may be incorporated into an individual's record in place of similar screening requirements, with the exception of screenings for imminent risk as described in part 2.12.1.C.5 of this Chapter. Screenings for imminent risk as described in 2.12.1.C.5 of this Chapter must be completed any time an individual is screened for treatment by a BHE notwithstanding any other recent screenings.
- G. Any BHE providing substance use disorder (SUD) services for any level of care shall:
1. Screen and register adults with out-of-state offenses in accordance with Section 17-27.1-101, C.R.S.
 - a. This does not apply to crisis services found in Chapter 6 of these rules or withdrawal management services found in Chapters 4 and 5 of these rules.

2.12.2 Initial Assessment

- A. An initial assessment must be completed and signed and/or approved by a licensee, licensed addiction counselor (LAC), a certified addiction specialist (CAS), authorized practitioner, or a licensure candidate performing within the scope of their practice. BHEs must meet timeline requirements set forth in applicable endorsement Chapters. See endorsement Chapters 4 through 10 of these rules for additional initial assessment requirements.
- B. The initial assessment, including information gathered as part of the preliminary screening and risk assessment, includes, at a minimum:
1. Provisional diagnoses;
 2. The source of referral;

3. The reason for seeking care, as stated by the individual or other referral source(s);
 4. Identification of the individual's immediate clinical care needs related to the diagnosis for mental and substance use disorders;
 5. A list of current prescriptions and prescribing physicians, over-the-counter medications, and any other substances the individual may be taking, including doses and frequency;
 6. An assessment of whether the individual is a risk to self or to others, including suicide risk factors;
 7. An assessment of whether the individual has other concerns for their safety;
 8. Assessment of need for medical care (with referral and follow-up as required);
 9. A determination of whether the individual presently is or ever has been a member of the U.S. Armed Services;
 10. Current health care providers; and
 11. Screening all individuals for current pregnancy status and desire to become pregnant within the next year. If not pregnant or desirous of pregnancy in the next twelve (12) months, individuals must be asked if they want access to contraceptive/family planning care, and the individual must be appropriately referred.
 - a. Individuals shall be screened and appropriately referred, for past and present risk factors associated with behavioral health disorders and that are associated with:
 - (1) Pregnancy complications, including risks to the health of the pregnant individual and fetus;
 - (2) Acquiring and transmitting Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), Tuberculosis (TB), Hepatitis A, B, or C, and other infectious diseases; and,
 - (3) If clinically indicated by the presence of continuing risk factors, screening must be conducted at a minimum on a quarterly basis.
- C. As needed, releases of information must be obtained.

2.12.3 Comprehensive Assessment

- A. The BHE must complete a comprehensive best practices assessment that focuses on person-centered care, which is signed and/or approved by a licensee, licensed addiction counselor (LAC), a certified addiction specialist (CAS), an authorized practitioner, or a licensure candidate performing within the scope of their practice. BHEs must meet timeline requirements set forth in applicable endorsement Chapters. See endorsement Chapters 4 through 10 of these rules for additional requirements.
- B. Information gathered as part of screening and/or the initial assessment may be incorporated into the comprehensive assessment.
- C. For BHEs that have or are seeking a SUD sub-endorsement for any level of care, assessments must:

1. Use the ASAM Criteria as a guide for assessing and placing individuals in the appropriate level of care;
 2. Document information gathered on the six (6) dimensions outlined in the ASAM Criteria for assessments; and
 3. Utilize the decisional flow process as outlined in the ASAM Criteria to determine and document the assessed level of care.
- D. The BHE must conduct assessments throughout the course of treatment, review previous assessments and update those assessments whenever there is a change in the person's level of care or functioning. The assessments must occur, at minimum, every six (6) months, unless otherwise indicated in an endorsement Chapter.
- E. All methods and procedures used to assess and evaluate an individual must be developmentally and age appropriate, culturally and linguistically appropriate and trauma informed. All methods and procedures used to assess and evaluate an individual must be able to be provided in the preferred language and/or communication method of frequently encountered Limited English Proficiency (LEP) groups of the BHE.
- F. The assessment must be documented in the individual's record and, at minimum, include the following information, if available and applicable:
1. Identification and demographic data;
 2. Primary complaint/reason for seeking services, including onset of symptoms and severity of symptoms;
 3. Mental health history, including but not limited to:
 - a. Suicidal risk and ideation, and
 - b. Homicidal ideation.
 4. Substance use and substance use withdrawal history;
 5. Physical and dental health status, including but not limited to human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), tuberculosis (TB), hepatitis A, B, or C, and other infectious diseases status and risk evaluation;
 6. A diagnosis with sufficient supporting criteria, as well as any subsequent changes in diagnosis;
 7. A mental status examination(s) for individuals who receive a diagnosis. When completing a mental status exam, personnel must consider other diagnoses or disabilities that may impact motor and speech activity;
 8. History of involuntary treatment;
 9. Advance directives, including medical and psychiatric;
 10. Capacity for self-sufficiency and daily functioning;

11. Cultural factors that may impact treatment, including age, ethnicity, linguistic/communication needs, gender, gender identity, sexual orientation, relational roles, spiritual beliefs, socio-economic status, personal values, level of acculturation and/or assimilation, and coping skills;
 12. Education, vocational training, and military service;
 13. Family and/or social relationships;
 14. Trauma and trauma history;
 15. Physical and/or sexual abuse or perpetration and current risk;
 16. Legal issues that may impact behavioral health outcomes;
 17. Issues specific to older adults such as hearing loss, vision loss, strength; mobility and other aging issues;
 18. Issues specific to children such as growth and development, daily activities, legal guardians and need for family involvement and engagement in the child's treatment;
 19. Strengths, abilities, skills, and interests; and
 20. Barriers to treatment.
- G. Assessments must apprise individuals, as applicable, of risk factors associated with acquiring and transmitting HIV/AIDS, Tuberculosis (TB), Hepatitis A, B, or C, and other infectious diseases. Appropriate testing and pre and post-test counseling must be offered on-site or through referral.
- H. Additional assessment requirements may be required for specific endorsements. See endorsement Chapters 4 through 10 of these rules for additional requirements.

2.13 Service Planning

2.13.1 Service plan

- A. If providing clinical services, the BHE shall ensure the development and review of a written service plan for each individual as follows:
1. The service plan must be developed as soon as practicable after admission, but no later than the timeframes identified in the endorsement-specific Chapters of these rules (i.e., Chapters 4 through 10).
 2. The service plan must be reviewed and revised in writing when there is a change in the individual's level of functioning or service needs, and no later than applicable endorsement-specific timeframes. Such revision must include documentation of progress made in relation to planned treatment outcomes, changes in treatment focus, and length of stay adjustments, as applicable.
 3. The service plan must:
 - a. Meet the developmental and cultural needs of the individual;
 - b. Specify goals based on the initial and/or comprehensive assessment in a manner understandable to the individual;

- c. Identify the type, frequency, and duration of services;
 - d. Be individually directed, including the individual's strengths and identities; and
 - e. Include involvement of other identified family and/or supportive individuals, when appropriate.
- 4. The service plan may include tasks or activities to be performed by the individual, such as an individual doing their own laundry or preparing their own meals/snacks, only when such tasks are therapeutic. Tasks must not be included in the service plan solely for the convenience of the BHE.
- 5. The service plan must be signed by all parties involved in the development of the plan, including the individual, or the individual's parent or legal guardian in cases where the individual is a child, or the individual has a court-appointed legal guardian and has not consented to services without the involvement of the legal guardian. Signatures must include at least one of the following: a licensee, licensed addiction counselor (LAC), a certified addiction specialist (CAS), authorized practitioner, or a licensure candidate performing within the scope of their practice.
 - a. A copy of the service plan must be offered to the individual, or to the individual's parent or legal guardian, as appropriate.
 - b. The BHE must include documentation in the individual record in cases where the plan is not signed by the individual or the individual's parent or legal guardian if involved in the development of the plan, and in cases where offering the service plan to a parent or legal guardian is contraindicated.

2.13.2 Treatment Progress Documentation Requirements

- A. The individual record must include progress notes, documenting a chronological record of treatment, date and type of service, session activity, and progress toward individual-specific treatment goals.
- B. The minimum frequency of progress note completion may vary by endorsement. See specific endorsement requirements in Chapters 4 through 10 of these rules for details.
- C. Progress notes must include any noted change in physical, behavioral, cognitive, and functional condition and action taken by personnel to address the individual's changing needs.
- D. Progress notes must be signed and dated or electronically approved by personnel, practicing within the scope of their practice, at the time they are written, with at least first initial, last name, and degree and/or professional credentials.
- E. Verbal orders must be recorded at the time they are given and authenticated as soon as practical.

2.14 Protection of Individuals from Involuntary Restraint or Seclusion

2.14.1 General Provisions

- A. The following rules covering seclusion, restraint, and physical management apply to all agencies that use seclusion, restraint, and/or physical management. If a BHE has decided to use seclusion, restraint, and/or physical management, the BHE shall use seclusion, restraint, and/or physical management only in accordance with the rules in this part 2.14.

- B. These rules do not supersede any requirements under Sections 26-20-101 through -111, C.R.S.
- C. If any provision of this part 2.14 conflicts with any provision concerning the use of seclusion, restraint, and/or physical management on an individual with an intellectual or developmental disability as stated in Article 10.5 of Title 27, C.R.S., Article 10 of Title 25.5, C.R.S. or any rule adopted pursuant to those Articles, the provisions of those Articles or rules prevail.
- D. Individuals being detained under Sections 27-65-106 through -110, C.R.S., may be secluded or restrained involuntarily under the conditions in this part; otherwise, there must be a signed informed consent for such an intervention as subject to part 2.11 of this Chapter.
- E. A BHE may only use seclusion, restraint, and/or physical management:
 - 1. In cases of emergency, as defined at Section 26-20-102(3), C.R.S., to be a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to affect such bodily harm; and
 - 2. After the failure of less restrictive alternatives, including but not limited to after all attempts to verbally direct or de-escalate the individual have failed; or
 - 3. After a determination that such alternatives would be inappropriate or ineffective under the circumstances.
- F. A BHE that uses seclusion, restraint, and/or physical management pursuant to the provisions of part 2.14.1.E, may only use such seclusion, restraint, and/or physical management:
 - 1. For the purpose of preventing the continuation or renewal of an emergency;
 - 2. For the period of time necessary to accomplish its purpose; and
 - 3. In the case of physical restraint, with no more force than is necessary to limit the individual's freedom of movement.
- G. Seclusion, restraint, and/or physical management must never be used:
 - 1. As a punishment or disciplinary sanction;
 - 2. As a means of coercion;
 - 3. As part of an involuntary service plan or behavior modification plan;
 - 4. For convenience;
 - 5. For the purpose of retaliation; or
 - 6. For the purpose of protection, unless:
 - a. The restraint or seclusion is ordered by a court; or
 - b. In an emergency, as provided for in this part 2.14.1.F.1 above.
- H. Physical management for individuals under the age of eighteen (18) must always be considered as restraint and follow the restraint order rules pursuant to part 2.14.13 of this Chapter.

2.14.2 Policies and Procedures Regarding Seclusion, Restraint, and Physical Management

- A. The BHE shall have and shall implement written policies and procedures that describe the situations in which the use of seclusion, restraint, and/or physical management are considered appropriate and the personnel who can order their use. The policies and procedures must include the requirements in this part 2.14 and Section 26-20-101 through -111, C.R.S. these policies and procedures must also include:
1. For a BHE that does not authorize the use of seclusion, restraint, and/or physical management of any type, a policy statement noting the prohibition against the use of seclusion, restraint, and/or physical management and the procedures that personnel will utilize in lieu of seclusion, restraint, and/or physical management.
 2. For a BHE that utilizes seclusion, restraint, and/or physical management, a policy statement regarding the review process for the use of seclusion, restraint, and/or physical management. The review process must include a provision for terminating the seclusion, restraint, and/or physical management episode when the reviewer does not concur with the order for continuation.
 - a. If the reviewer is not an authorized practitioner, then the order must be discontinued by an authorized practitioner.
 3. Personnel shall ensure that no individual endures harm or harassment when secluded and/or restrained.
 4. A policy statement that a BHE shall ensure that the care and treatment are skillfully and humanely administered with full respect for the individual's dignity, pursuant to Section 27-65-101(1)(a), C.R.S.
 5. Protocols for when the use of restraint, seclusion, and/or physical management is appropriate, which include restrictions on the use of these techniques. A BHE may impose more, but not fewer, restrictions on the use of these techniques than is required by this Chapter.
 6. Details on the type of physical management interventions that personnel are approved to use.
 7. Details on how seclusion, restraint, and/or physical management will be altered to include any necessary accommodations the individual may need, including but not limited to changing emergency interventions to not restrain hands and ability to communicate for those individuals that speak sign language.
 8. If a BHE does not have a 27-65 designation with the BHA and is using seclusion and/or restraint interventions, that BHE's policies and procedures must include details on transferring an individual to a 27-65 designated facility if after one (1) hour of seclusion and/or restraint interventions have been used and the individual is assessed as continued risk, meeting criteria for an emergency hold under 27-65-106, C.R.S., and needing further intervention(s).

2.14.3 Personnel Training

- A. The BHE shall ensure that all personnel involved in utilizing seclusion, restraint, and/or physical management are trained in the use of seclusion, restraint, and/or physical management as described in this part 2.14.

- B. The BHE shall ensure that personnel are trained to explain, where possible, the use of seclusion, restraint, and/or physical management to the individual who is to be secluded, restrained, or physically managed and to the individual's designated representative, if appropriate.
- C. Training must be standardized and evaluated every three (3) years to ensure incorporation of evidence-based best practices for seclusion, restraint, and/or physical management.
- D. Training must be provided to personnel within the first month of their orientation period and annually thereafter unless training is needed sooner.
- E. Personnel shall obtain certification in cardiopulmonary resuscitation (CPR), including periodic recertification as needed to maintain certification.
- F. Training must include at minimum, but is not limited to:
 - 1. The safe use of seclusion, restraint, and/or physical management including content related to the risks of positional asphyxia, aspiration, traumatization, and recognize and respond to signs of physical distress of an individual who is secluded, restrained, and/or physically managed;
 - 2. Address concepts related to prevention and non-physical interventions such as de-escalation and mediation;
 - 3. Educate personnel of how their culture, language, biases, values, and perceptions influence their response and escalation of person involved; and
 - 4. Understanding and recognizing underlying behavioral health and physical health conditions, medications, and their potential effects as well as how age, developmental level, cultural background, language, history of physical or sexual abuse, and prior experience with seclusion, restraint, and/or physical management will influence an individual's responses to seclusion, restraint, and physical management.
- G. Personnel must demonstrate knowledge and application of seclusion, restraint, and physical management training on an annual basis when working with persons over the age of twenty-one (21), and on a semi-annual basis when working with youth twenty (20) years old and younger.

2.14.4 Standards of Care Upon Admission

- A. At admission, the BHE shall inform both the individual and the individual's legal representative, as applicable, of the BHE's policy regarding the use of seclusion, restraint, and physical management during an emergency behavioral health episode for individuals in a treatment program. This must, as is reasonable under the circumstances, be communicated in a language and modality accessible to the individual.
- B. Upon an individual's admission, personnel shall collaborate with the individual and the individual's legal representative, when applicable, to formulate strategies that may minimize the potential for a behavioral health emergency event that requires interventions of seclusion, restraint, and/or physical management.
- C. A BHE electing to utilize seclusion, restraint, and/or physical management shall assess each individual upon admission regarding:
 - 1. Assault and trauma history;
 - 2. Seclusion, restraint, and/or physical management history;

3. Individual's risk factors for a behavioral emergency, and individually identified strategies to avoid seclusion, restraint, and/or physical management; and
4. The BHE shall ascertain any applicable behavioral health advance directives.

2.14.5 Use of Physical Management

- A. Physical management for individuals under the age of eighteen (18) must always be considered as restraint and follow the restraint order rules pursuant to this part 2.14.13.
- B. Physical management shall only be used on an emergency basis for a maximum of one (1) minute, when the situation places the individual or others at imminent risk of serious physical harm after all attempts to verbally direct or de-escalate the person have failed.
 1. If physical management is used for longer than one (1) minute, the intervention is restraint, pursuant to Section 26-20-102(6), C.R.S., and personnel must follow the restraint order rules pursuant to part 2.14.7 of this Chapter.
- C. To ensure the safety of each individual and personnel, each BHE shall designate emergency physical management techniques to be utilized during emergency situations.
- D. The term "physical management" does not include briefly holding an individual in order to comfort them.
- E. The physical management continuum may include:
 1. Utilizing transitional measures;
 2. Placing one's hands on an individual to physically guide and/or physically control the individual;
 3. Use of an approved restraint method specified in the BHE's policies and procedures to maintain safety of the individual;
 4. Placing an individual into an approved prolonged restraint method specified in the BHE's policies and procedures;
 5. Physical management may be used to move or escort an individual into seclusion.
 - a. Seclusion, in itself, is not a form of physical management.
- F. Physical management must be documented in the clinical record to include the following:
 1. Documentation of the behavioral necessity for physical management and any de-escalation techniques attempted prior to utilizing physical management.
 2. Documentation of the approved physical management method utilized.

2.14.6 Use of Seclusion

- A. If an order for seclusion is verbal, the verbal order must be received by a registered nurse or other trained licensed personnel, such as a licensed practical nurse, while the emergency safety intervention is being initiated by personnel or immediately after the emergency safety situation begins.

1. The physician or other authorized practitioner permitted to order seclusion must verify the verbal order in a signed written form in the individual's record. Signatures must be entered into the record no more than twenty-four (24) hours after the event.
 2. The physician or other authorized practitioner to order seclusion must be available to personnel for consultation, at least by telephone, throughout the period of the emergency safety intervention.
- B. Within one (1) hour of the initiation of the original order of seclusion an authorized practitioner, such as a registered nurse or physician assistant, trained in the use of emergency safety interventions and permitted to assess the physical and psychological well-being of the individual, shall conduct a face-to-face assessment of the physical and psychological well-being of the individual including but not limited to:
1. The individual's physical and psychological status;
 2. The individual's behavior;
 3. The appropriateness of the intervention measures; and
 4. Any complications resulting from the intervention.
- C. When the one (1) hour assessment described in this part 2.14.6.B is conducted by a registered nurse or a physician assistant, that personnel must consult with the attending physician when the assessment is completed.
- D. Results of the one (1) hour assessment must determine if continued emergency interventions need to be re-ordered by the authorized practitioner.
1. Assessment results and continuation order, if applicable, must be contained in the clinical record.
- E. Seclusion occurs any time an individual is placed alone in a room and not allowed to leave.
- F. Seclusion must be used only when other less restrictive methods have failed.
1. Documentation of less restrictive methods and the outcome must be contained in the clinical record.
- G. Seclusion must not be used for punishment, for the convenience of personnel, or as a substitute for a program of care and treatment.
- H. Seclusion rooms must be lighted, clean, safe, and have a window for personnel to observe.
- I. Seclusion rooms must be a minimum of 100 square feet.
- J. Relief periods from seclusion must be offered for reasonable access to toilet facilities.

2.14.7 Use of Restraint

- A. If an order for restraint is verbal, the verbal order must be received by a registered nurse or other trained licensed personnel, such as a licensed practical nurse, while the emergency safety intervention is being initiated by personnel or immediately after the emergency safety situation begins.

1. The physician or other authorized practitioner permitted to order restraint must verify the verbal order in a signed written form in the individual's record. Signatures must be entered into the record no more than twenty-four (24) hours after the event.
 2. The physician or other authorized practitioner to order restraint must be available to personnel for consultation throughout the period of the emergency safety intervention.
- B. An individual in physical restraint must be released from such restraint within fifteen (15) minutes after the initiation of physical restraint, except when precluded for safety reasons pursuant to part 2.14.1 of this section.
- C. Within one (1) hour of the initiation of the original order for the emergency safety intervention, an authorized practitioner, such as a registered nurse or physician assistant, trained in the use of emergency safety interventions and permitted to assess the physical and psychological well-being of the individual, shall conduct a face-to-face assessment of the physical and psychological well-being of the individual including but not limited to:
1. The individual's physical and psychological status;
 2. The individual's behavior;
 3. The appropriateness of the intervention measures; and
 4. Any complications resulting from the intervention.
- D. When the one (1) hour assessment described in this part 2.14.7.C is conducted by a registered nurse or a physician assistant, that personnel must consult with the attending physician when the assessment is completed.
- E. Results of the one (1) hour assessment must determine if continued emergency interventions need to be reordered by the authorized practitioner.
1. Assessment results and continuation order, if applicable, must be contained in the clinical record.
- F. The decision to restrain must be based on a current clinical assessment and may also be based on other reliable information including information that was used to support the decision to take the individual into custody for treatment and evaluation. The fact that an individual is being evaluated or treated under Sections 27-65-106 through 27-65-111 [effective July 1, 2024], C.R.S., must not be the sole justification for the use of restraint.
- G. Restraint includes chemical restraint, mechanical restraint, and physical restraint.
- H. Mechanical restraints may be used only for the purpose of preventing such bodily movement that is likely to result in imminent injury to self or others. Mechanical restraint must not be used solely to prevent unauthorized departure.
- I. Restraint of an individual by a chemical spray is not permissible.
- J. The type of restraint must be appropriate to the type of behavior to be controlled, the physical condition of the individual, the age of the individual and the type of effect restraint may have upon the individual.

- K. Restraint must be applied only if alternative interventions have failed. Justification for immediate use of restraint without first attempting alternative interventions must be documented in the clinical record; however, alternative techniques are not required if the alternatives would be ineffective or unsafe when the individual's behavior could cause harm to self or others.
- L. The term "restraint" as used in this section, does not include restraints used while the BHE is engaged in transporting an individual from one location to another location when it is within the scope of that BHE's powers and authority to conduct such transportation pursuant to Section 26-20-101 through -111, C.R.S.
- M. No physical or mechanical restraint of an individual may place excess pressure on the chest or back of that individual, cover the individual's face, or inhibit or impede the individual's ability to breathe.

2.14.8 Chemical Restraint

- A. If an order for chemical restraint is verbal, the verbal order must be received by a registered nurse or other trained licensed personnel, such as a licensed practical nurse, while the emergency safety intervention is being initiated by personnel or immediately after the emergency safety situation begins.
 - 1. The physician or other authorized practitioner permitted to order chemical restraint must verify the verbal order in a signed written form in the individual's record. Signatures must be entered into the record no more than twenty-four (24) hours after the event.
 - 2. The physician or other authorized practitioner to order chemical restraint must be available to personnel for consultation, throughout the period of the emergency safety intervention.
- B. An order for a chemical restraint, along with the reasons for its issuance, must be recorded in writing at the time of its issuance;
- C. An order for a chemical restraint must be signed at the time of its issuance by such authorized practitioner, who is present at the time of the emergency;
- D. An order for a chemical restraint, if authorized by telephone, must be transcribed, and signed at the time of its issuance by personnel with the authority to accept telephone medication orders who is present at the time of the emergency.
- E. Personnel trained in the administration of medication shall make notations in the record of the individual as to the effect of the chemical restraint and the individual's response to the chemical restraint.

2.14.9 Explanation to Individual in Seclusion/Restraint

- A. In any situation in which seclusion/restraint is utilized, information must be given to the secluded/restrained individual, and the individual's legal representative when applicable, as soon as possible after they have been secluded or restrained. The individual must be given a clear explanation of:
 - 1. The reasons for use of such intervention;
 - 2. The observation procedure, the desired effect; and
 - 3. The circumstances under which the procedure will be terminated.

- B. That the explanation has been given to the individual and the individual's legal representative, when applicable, must be documented in the clinical record.
- C. As soon as possible, upon termination of seclusion and/or restraint, personnel shall debrief with the individual and assess for any traumatic stress that may have been triggered as a result of seclusion/restraint.

2.14.10 Observation & Care of Individuals in Seclusion and/or Restraint

- A. An individual who is in seclusion/restraint must be observed in-person by trained BHE personnel at no more than ten (10) feet physical distance from the individual.
 - 1. Such observation, along with the behavior of the individual, must be documented every fifteen (15) minutes.
- B. Unless contraindicated by the individual's condition, such observation must include consistent efforts to interact personally with the individual throughout the episode.
- C. Ongoing provisions must be made for nursing care, hygiene, diet, and motion of any restrained limbs throughout the episode.
- D. BHE personnel must maintain a continuous line-of sight throughout the episode with the individual held in mechanical restraints.
- E. For individuals held in mechanical restraints, BHE personnel must observe the individual at least every fifteen (15) minutes to ensure that:
 - 1. The individual is properly positioned;
 - 2. The individual's blood circulation is not restricted;
 - 3. The individual's airway is not obstructed; and
 - 4. The individual's other physical needs are met, pursuant to this part 2.14.10.
- F. For individuals held in mechanical restraints, the BHE shall offer relief periods of at least ten (10) minutes as often as every two (2) hours, so long as relief from the mechanical restraint is determined by personnel to be safe pursuant to part 2.14.1 of this section.
- G. Personnel must document relief periods both offered and granted.
- H. The individual must have access to food at least every four (4) hours.
- I. The individual must have access to fluids and toileting upon request or during offered relief periods but must at minimum be offered every two (2) hours.
 - 1. During such relief periods, personnel shall ensure proper positioning of the individual and provide movement of limbs, as necessary.
- J. Personnel must provide assistance for use of necessary toileting methods.
 - 1. Appropriate toileting does not include the use of adult diapers if not typically used by the individual when not restrained or secluded.
 - 2. If the individual typically uses adult diapers, they are to be changed immediately if soiled.

- K. Personnel shall maintain the individual's dignity and safety during relief periods.
- L. Cameras and other electronic monitoring devices must not replace face-to-face observations.
- M. To the extent that the duties specified in Section 26-20-101 through -111, C.R.S. are more protective of individual rights or are in conflict with the provisions in this part 2.14, the provisions of Section 26-20-101 through -111, C.R.S. shall apply.

2.14.11 Continued Use of Seclusion and/or Restraint

- A. Personnel must document efforts to assure that the use of seclusion/restraint is as brief as possible.
- B. The original order of seclusion/restraint of an individual must not exceed one (1) hour without an order for continued seclusion/restraint from an authorized practitioner. A verbal order, including telephone or other electronic orders, may be used if followed by a written order from the authorized practitioner.
- C. Seclusion/restraint must not be ordered on an "as needed" basis.
- D. A new written order is required every four (4) hours and shall include a documented examination by an authorized practitioner.
- E. Continued seclusion/restraint in excess of twenty-four (24) hours shall require an administrative review.
 - 1. The administrative reviewer shall be a different authorized practitioner with the authority and knowledge necessary to review clinical information and reach a determination that the extension of a seclusion and/or restraint episode beyond twenty- four (24) hours is clinically necessary.
 - 2. If the administrative reviewer does not concur with the order for continuation of seclusion/restraint, the order shall be discontinued and the authorized practitioner in charge of treatment shall be notified of such discontinuation.
- F. An administrative review must be initiated at the conclusion of each twenty-four (24) hour period of continuous use of seclusion/restraint.

2.14.12 Documentation Requirements

- A. Each BHE must ensure that an appropriate notation of the use of seclusion, restraint and/or physical management is documented in the record of the individual who was secluded, restrained, and/or physically managed and must be completed before the end of the shift of the personnel involved in the seclusion, restraint and/or physical management episode(s). Each BHE shall document the following in the individual's record:
 - 1. Specifics of the episode including identified triggers, precipitating events, the individual's specific behavior(s) and the nature of the danger;
 - 2. Type of restraint, if utilized;
 - 3. Specific date and times of initiation and discontinuation of seclusion, restraint and/or physical management and total length of time individual is secluded, restrained, and/or physically managed;

4. A description of specific non-physical and least restrictive interventions that were attempted prior and the individual's response;
 5. Identification of personnel involved in the initiation and application of the seclusion, restraint and/or physical management;
 6. Notification to an authorized practitioner within one (1) hour of the seclusion/restraint intervention;
 7. Care provided while individual was secluded, restrained, and/or physically managed, including:
 - a. Observations conducted;
 - b. Assessments of position, respiration, circulation, and range of motion;
 - c. Documentation of ongoing 15-minute observation and care checks, as subject to applicable rules, along with relief periods both offered and granted for food, fluid, and/or toileting;
 - d. Interventions provided to promote comfort and safety as well as expedite release;
 - e. The individual's response to these interventions; and
 - f. The effect of the restraint or seclusion on the individual;
 8. Documentation that the individual, and the individual's legal representative if applicable, was given a clear explanation of the reasons for use of such intervention, the observation procedure, the desired effect, and the circumstances under which the intervention will be terminated including criteria for release and individual understanding of that criteria; and,
 9. Documentation that personnel debriefed the incident with the individual and assessed for trauma, processed the traumatic event, and identified triggers.
- B. Any administrative reviewer shall document the clinical justification for the continued use of seclusion/restraint in the individual's chart. The justification must include:
1. Documentation that the authorized practitioner ordering the continuous use of seclusion/restraint in excess of four (4) hours has conducted a face-to-face evaluation of the individual within the previous four (4) hours;
 2. Documentation of the ongoing behaviors or findings that warrant the continued use of seclusion/restraint and other assessment information as appropriate;
 3. Documentation of a plan for ongoing efforts to actively address the behaviors that resulted in the use of seclusion/restraint;
 4. A determination of the clinical appropriateness of the continuation of seclusion/restraint; and
 5. A summary of the information considered by the reviewer and the result of the administrative review with the date, time and signature of the individual completing the review.

- C. Information regarding use of seclusion/restraint must be readily accessible to authorized individuals for review. The BHE shall have the ability to gather data as follows:
 - 1. Each seclusion/restraint episode including date and time the episode started and ended, specific to each individual over the period of one complete calendar year from January 1 through December 31.

2.14.13 Additional Procedures and Requirements for Seclusion/Restraint of a Youth

- A. Procedures for youth must include the following in addition to the requirements found in part 2.14 of this Chapter, unless otherwise required in this part 2.14.13.
- B. This part 2.14.13 does not apply to adult individuals over the age of 21.
- C. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the youth's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).
 - 1. Physical management is always considered restraint for an individual under age eighteen (18) and must follow the restraint order rules pursuant to this part 2.14 of this Chapter.
- D. Orders for seclusion/restraint must be by an authorized practitioner in the BHE to order seclusion/restraint and trained in the use of emergency safety interventions. Federal regulations at 42 C.F.R. Part 441, specifically 441.151 require that inpatient psychiatric services for individuals under age twenty-one (21) be provided under the direction of a physician.
 - 1. If the individual's treatment team assigned physician is available, only they can order seclusion/restraint. If they are not available, then another team physician may make the order.
- E. A physician or other authorized practitioner must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with personnel.
- F. If the order for seclusion/restraint is verbal, the order must be received by a registered nurse or other trained licensed personnel, such as a licensed practical nurse, while the emergency safety intervention is being initiated by personnel or immediately after the emergency safety situation begins.
 - 1. The physician or other authorized practitioner permitted to order restraint or seclusion must verify the verbal order in a signed written form in the minor's record. Signatures must be entered into the record no more than twenty-four (24) hours after the event.
 - 2. The physician or other authorized practitioner to order restraint or seclusion must be available to personnel for consultation, at least by telephone, throughout the period of the emergency safety intervention.
- G. Each order for seclusion/restraint must be limited to no longer than the duration of the emergency safety situation.
- H. Under no circumstances may the total order time exceed:
 - 1. Four (4) hours for persons ages eighteen (18) to twenty-one (21);

2. Two (2) hours for persons ages nine (9) to seventeen (17); or
 3. One (1) hour for persons under the age of nine (9).
- I. Within one (1) hour of the initiation of the order of the emergency safety intervention, a physician, or other authorized practitioner trained in the use of emergency safety interventions and permitted to assess the physical and psychological well-being of the youth, must conduct a face - to - face assessment of the physical and psychological well-being of the individual including but not limited to:
1. The youth's physical and psychological status;
 2. The youth's behavior;
 3. The appropriateness of the intervention measures; and
 4. Any complications resulting from the intervention.
- J. Results of the one (1) hour assessment must be documented in the individual's record.
- K. Notification of parent(s) and/or legal guardian(s), when applicable:
1. The BHE must notify the parent(s) and/or legal guardian(s) of the individual who has been in seclusion or restraint as soon as possible after the initiation of each emergency safety intervention.
 2. The BHE shall document in the individual's record that the parent(s) or legal guardian(s) have been notified of the emergency safety intervention, including date and time of the notification and the name of personnel providing the notification.

2.15 Medication Administration

- A. The BHE shall ensure that medications are administered only by licensed or certified personnel allowed to administer medications under their own scopes of practice, or unlicensed personnel who are qualified medication administration persons (QMAPs) acting within their own scope of practice.
- B. When using QMAPs to administer medication, the BHE shall ensure compliance with 6 CCR 1011-1, Chapter 24 (July 19, 2017), which is hereby incorporated by reference. No later editions or amendments are incorporated. This Colorado Department of Public Health and Environment rule is available at no cost at <https://www.sos.state.co.us/CCR/welcome.do>. Individuals may inspect or obtain a copy of the rule at the BHA, 710 S. Ash Street, Unit C140, Denver, CO 80246, during regular business hours.

2.16 Critical Incident Reporting

- A. A critical incident includes but is not limited to the following:
1. Breach of confidentiality: any unauthorized disclosure of protected health information as described in HIPAA, 42 C.F.R. Part 2, and/or Section 27-65-101 through -131, C.R.S.
 2. Death: including the death of an individual inside of or outside of the BHE's physical location while an individual is receiving services or where an individual has attempted to receive services from the BHE within the past thirty (30) calendar days.

3. Elopement: absconding from a mental health hold, certification, emergency/involuntary commitment, or a secure facility where an individual is being held as a result of a court order. This includes any unauthorized absence of a child, when a child cannot be accounted for or when there is reasonable suspicion to believe the child has absconded.
4. Any instance when an individual cannot be located following a search of the BHE, the BHE grounds, and the area surrounding the BHE, and:
 - a. There are circumstances that place the individual's health, safety, or welfare at risk; or
 - b. The individual has been missing for eight (8) hours.
5. Medication diversion: any medication diversion as defined in part 1.2 of these rules if the diverted drugs are injectable, the BHE shall also report the full name and date of birth of any individual who diverted the injectable drugs, if known.
6. Medication error: medication error that resulted or could have resulted in harm to the individual.
7. Medical emergency: any suicide attempt/self-injury, other form of serious injury, health emergency, overdose or serious illness which occurred on BHE premises or in the presence of BHE personnel.
8. Any instance involving physical, sexual, or verbal abuse of an individual, as described in Sections 18-3-202, 18-3-203, 18-3-204, 18-3-206, 18-3-402, 18-3-404, 18-3-405, 18-3-405.3, 18-3-405.5, and 18-9-111 (exempting however, the phrase "intended to harass"), C.R.S. by another individual, personnel, or a visitor to the BHE.
9. Any instance that results in any of the following serious injuries to an individual:
 - a. Brain or spinal cord injuries;
 - b. Life-threatening complications of anesthesia or life-threatening transfusion errors or reactions; or,
 - c. Second- or third-degree burns involving twenty percent (20%) or more of the body surface area of an adult or more than fifteen percent (15%) of the body surface area of a child.
10. Any instance involving caretaker neglect of an individual, as defined in 26-3.1-101(2.3), C.R.S. or child abuse or neglect as defined in 19-1-103(1), C.R.S.
11. Any instance involving misappropriation of an individual's property, meaning patterns of loss or single incidences of deliberately misplacing, exploiting, or wrongfully using, either temporarily or permanently, an individual's belongings or money without the individual's consent.
12. Any occurrence involving the malfunction or intentional or accidental misuse of care equipment that occurs during treatment or diagnosis of an individual and that significantly or adversely affects or, if not averted, would have significantly adversely affected an individual.

- B. Critical incidents must be reported to the BHA within one (1) business day after the incident. Critical incidents must also be reported to the BHA within one (1) business day of when the BHE determines that a reportable incident has occurred and the BHA requests such reporting.
- C. The BHA may conduct scheduled or unscheduled site reviews for specific monitoring purposes and investigation of critical incidents reports in accordance with:
 - 1. BHA policies and procedures,
 - 2. Regulations that protect the confidentiality and individual rights in accordance with Sections 27-65-101 through -131, C.R.S.; HIPAA; and 42 C.F.R. Part 2,
 - 3. Controlled Substance Licensing; Section 27-81-113, C.R.S.; Section 27-80-212, C.R.S., and Section 18-18-503, C.R.S.
- D. The BHA shall have access to relevant documentation required to determine compliance with these rules.
- E. The BHE must:
 - 1. Establish written policies and procedures for reporting and reviewing all critical incidents occurring at the BHE;
 - 2. Submit critical incidents reports to the BHA using state prescribed forms that can be obtained from the BHA's website at <https://bha.colorado.gov/for-providers>. This is not in lieu of other reporting mandated by state statute or federal guidelines;
 - 3. Make available a report with the investigation findings for review by the BHA, upon request; and,
 - 4. Maintain critical incidents reports for a minimum of three (3) years following the incident unless it would violate any other federal or state law.
- F. Nothing in this part shall be construed to limit or modify any statutory or common law right, privilege, confidentiality, or immunity.

2.17 Quality Management Program

- A. Every BHE must have a quality management program (QMP) designed to improve individual safety and well-being. The individual safety component of the program must implement improvements in response to patterns and trends associated with service delivery errors and potential for error. The individual well-being component of the QMP must implement improvements that are not necessarily tied to errors or potential for error but instead to the continuous quality improvement principle that opportunities always exist to enhance service delivery.
- B. The BHE must implement the QMP in accordance with a quality management plan that is reviewed and approved annually by the governing body. The plan must have the following elements:
 - 1. Identification of quality management programs
 - a. For the individual safety component of the QMP, the plan must identify:

- (1) The types of service delivery errors and potential for error that will be monitored, which must be based, at minimum, on a review of negative individual outcomes that are unanticipated, individual disputes, critical incidents, deficiencies cited by regulatory agencies, occurrences and/or errors, and potential for errors reported by personnel.
 - (2) A process for personnel to report service delivery error and potential for error within a prescribed period of time and a plan for how personnel will be trained regarding such reporting.
 - (3) The methods used to collect and analyze data to find patterns and trends. The plan must also include how the governing body, if applicable, and the administrator will be informed of such patterns and trends.
 - (4) The method(s) used to select quality management projects.
 - (5) The method(s) for selecting the service delivery practice(s) that will be reviewed.
2. Implementation of the individual well-being component
 - a. The plan must include development of improvement strategies. This may include identifying the personnel that will be involved in designing the intervention, opportunities for individual input, and the administrative approvals needed to finalize the intervention design.
 - b. The plan must document each improvement strategy including:
 - (1) A description of the intervention design. For individual safety improvements, this must include how information about patterns and trends will be shared with personnel and how the underlying systemic problem(s) that led to the pattern or trend will be addressed.
 - (2) How personnel will be allocated and/or trained to implement the strategy.
 - (3) How the strategy will be evaluated for effectiveness.
 - (4) Timelines for implementation and evaluation of the strategy and how the BHE is tracking the meeting of these milestones.
- C. The BHA may audit a BHE's QMP to determine compliance with part 2.17 of this Chapter.
 1. If the BHA determines that an investigation of any incident or outcome is necessary, it may, unless otherwise prohibited by law, investigate and review documents related to the incident or outcome to determine actions taken by the BHE.

2.18 Initial Application Procedure

- A. Any person or business entity seeking a license to operate a BHE shall initially notify the BHA by submitting a letter of intent. Upon receipt of a letter of intent, the BHA will open a license application file.

- B. The applicant must provide the BHA with a complete application including all information and attachments specified in the application form, which is available to access on the BHA's website, and any additional information requested by the BHA. The appropriate non-refundable fee(s) for the license category requested must be submitted with the application. Applications must be submitted at least ninety (90) calendar days before the anticipated start-up date.
 - 1. A license application may be considered abandoned if the applicant fails to complete the application within twelve (12) months. The BHA may administratively close the application process.
 - 2. After an administrative closure, the applicant may file a new license application along with the corresponding initial license fee.
- C. With the submission of an application for a license to operate a BHE, or within ten (10) days after a change in ownership or management of a BHE, each owner and manager shall submit a complete set of the owner's and manager's fingerprints to the Colorado Bureau of Investigation (CBI) for the purpose of conducting a fingerprint-based criminal history record check. The CBI shall forward the fingerprints to the Federal Bureau of Investigation (FBI) for the purpose of conducting fingerprint-based criminal history record checks. Each owner and each manager shall pay the CBI the costs associated with the fingerprint-based criminal history record check. Upon completion of the criminal history record check, the CBI shall forward the results to the BHA. The BHA may acquire a name-based criminal history record check for an applicant who has twice submitted to a fingerprint-based criminal history record check and whose fingerprints are unclassifiable.
- D. Each applicant must provide the following information:
 - 1. The legal name of the applicant and all other names used by it to provide services. The BHE has a continuing duty to submit notification to the BHA for all name changes at least thirty (30) calendar days prior to the effective date of the change.
 - a. Applicants for initial licensure must submit a distinctive license name that does not need to include the services to be provided, but it may not mislead or confuse the public regarding the license or type of services to be provided.
 - b. Duplication of an existing name is prohibited except between agencies that are affiliated through ownership or controlling interest.
 - c. Each BHE shall be identified by this distinctive name on stationery, billing materials, and exterior signage that clearly identifies the licensed entity. Exterior signage must conform to the applicable local zoning requirements.
 - d. If the BHE has a "doing business as" name, it must hold itself out to the public using such name, as it appears on the license.
 - 2. Contact information for the BHE must include a mailing address, telephone number, and e-mail addresses. If applicable, the BHE's website and facsimile number must be provided.
 - 3. The identity, address, and telephone number of all persons and business entities with a controlling interest in the BHE, including but not limited to:
 - a. A non-profit corporation shall list the governing body and officers.

- b. A for-profit corporation shall list the names of the officers and stockholders who directly or indirectly own or control five percent or more of the shares of the corporation.
 - c. A sole proprietor shall include proof of lawful presence in the United States.
 - d. A partnership shall list the names of all partners.
 - e. The chief executive officer of the BHE.
 - f. If the addresses and telephone numbers provided above are the same as the contact information for the BHE itself, the BHE shall also provide an alternate address and telephone number for at least one person for use in the event of an emergency or closure of the BHE.
- 4. Proof of professional liability insurance. BHEs must maintain such coverage for the duration of the license term and must notify the BHA of any change in the amount, type, or provider of professional liability insurance coverage during the license term.
- 5. Articles of incorporation, Articles of organization, partnership agreement, or other organizing documents required by the secretary of state to conduct business in Colorado; and by-laws or equivalent documents that govern the rights, duties, and capital contributions of the business entity.
- 6. The address(es) of the physical location(s) where services are delivered, as well as, if different, where records are stored for BHA review.
- 7. A map for each floor of the BHE's buildings indicating room layout, services to be provided in each of the rooms, the proposed physical extent of the license within each building, and all occupancies contiguous to the BHE regardless if services are being delivered under the terms of the license.
 - a. If services are delivered in multiple buildings located on a campus, a street map of the campus must be submitted that indicates which buildings and floors are occupied as part of the license.
 - b. Maps must be submitted to the BHA.
- 8. A copy of any management agreement pertaining to operation of the entity that sets forth the financial and administrative responsibilities of each party.
- 9. If an applicant leases one or more building(s) to operate under the license, a copy of the lease or leases must be filed with the license application and show clearly in its context which party to the agreement is to be held responsible for the physical condition of the property.
- 10. A statement, on the applicant's letterhead, if available, signed and dated, submitted with the application stating whether any of the actions listed in this part 2.17.D.10.a.(2) of these rules have occurred, regardless of whether the action has been stayed in a judicial appeal or otherwise settled between the parties. The actions are to be reported if they occurred within ten (10) years preceding the date of the application. For initial licensure, the BHA may, based upon information received in the statement, request additional information from the applicant beyond the ten-year time frame.

- a. For initial licensure of the BHE, whether one or more individuals or entities identified in the response to part 2.18.D.3 of this Chapter has a controlling or ownership interest in the BHE and has been the subject or party to any of the following:
 - (1) A civil judgment or criminal conviction resulting from conduct or an offense in the operation, management or ownership of a BHE or other entity related to substandard care or health care fraud. A guilty verdict, a plea of guilty, or a plea of nolo contendere (no contest) accepted by the court is considered a conviction.
 - (2) A disciplinary action imposed upon the BHE by a governmental entity in another state that registers or licenses agencies including but not limited to, a sanction, probation, civil penalty, or a denial, suspension, revocation, or modification of a license or registration.
 - (3) Limitation, denial, revocation, or suspension by any federal, state, or local authorities of any health care related license.
 - (4) The refusal to grant or renew a license for operation of a BHE, or contract for participation or certification for Medicaid, Medicare, or other public health or social services payment program.
 - b. For a change of ownership of a BHE, whether any of the new owners have been the subject of, or a party to, one of more of the following events:
 - (1) A civil judgment or a criminal conviction in a case brought by the federal, state, or local authorities that resulted from the operation, management, or ownership of a BHE or other entity related to substandard care or health care fraud.
 - (2) Limitation, denial, revocation, or suspension of a state license or federal certification by another jurisdiction.
11. Any statement regarding the information requested in 2.18.D.10 of this Chapter must include the following, as applicable:
- a. If the event is an action by a governmental agency, as described in part 2.18.D.10.b: the name of the agency, its jurisdiction, the case name, and the docket proceeding or case number by which the event is designated, and a copy of the consent decree, order, or decision.
 - b. If the event is a felony conviction or misdemeanor involving moral turpitude: the court, its jurisdiction, the case name, the case number, a description of the matter or a copy of the indictment or charges, and any plea or verdict entered by the court. For the purposes of this rule, “crimes of moral turpitude” include the following felony, misdemeanors, or municipal offenses:
 - (1) Any of the offenses against the person set forth in Title 18, Article 3 of the Colorado Revised Statutes. Examples of such offenses include, but are not limited to, any assault, menacing, or unlawful sexual behavior;
 - (2) Any of the offenses against property set forth in Title 18, Article 4 of the Colorado Revised Statutes. Examples of such offenses include, but are not limited to, any arson, theft, trespass, or criminal mischief;

- (3) Any of the offenses involving fraud set forth in Title 18, Article 5 of the Colorado Revised Statutes;
 - (4) Computer crime as set forth in Title 18, Article 5.5 of the Colorado Revised Statutes;
 - (5) Any of the offenses involving the family relations set forth in Title 18, Article 6, Part 4 (wrongs to children), when committed intentionally and knowingly or recklessly; Part 6 (harboring a minor); or Part 8 (domestic violence), of the Colorado Revised Statutes;
 - (6) Any of the offenses constituting wrongs to at-risk adults set forth in Title 18, Article 6.5 of the Colorado Revised Statutes;
 - (7) Any of the offenses relating to morals set forth in Title 18, Article 7 of the Colorado Revised Statutes. Examples of such offenses include, but are not limited to, prostitution, indecent exposure, and criminal invasion of privacy;
 - (8) Any other offense in any jurisdiction whatsoever that is committed intentionally, knowingly, or recklessly, and involves violence, coercion, threats, cruelty, fraud, deception, or deprivation of legally recognized rights; and,
 - (9) Any conspiracy, solicitation, or criminal attempt to commit any of the above offenses, or participation as an accessory to any of the above offenses.
 - c. If the event is a civil action or arbitration proceeding: the court or arbiter, the jurisdiction, the case name, the case number, a description of the matter or a copy of the complaint, and a copy of the verdict of the court or arbitration decision.
- E. The BHA will not issue or renew a BHE license unless it has received a certificate of compliance as defined in Chapter 1 of these rules for each physical location where services are provided
- F. Each application must be signed under penalty of perjury by an authorized corporate officer, general partner, member, or sole proprietor of the BHE as appropriate.
- G. The BHA shall conduct a preliminary assessment of the application and notify the applicant of any application defects.
 1. The applicant shall respond within fourteen (14) calendar days to written notice of any application defect.
- H. License fees must be submitted to the BHA as specified below:
 1. An applicant for an initial license as a BHE shall submit the following nonrefundable fee(s) with the application for licensure, as applicable:
 - a. A base fee of \$500, regardless of endorsements or physical locations included as part of the application for initial licensure. The base fee includes one physical location in which services are to be provided under an outpatient endorsement as defined in part 2.3.A.3 of this Chapter.

- b. A fee of \$300 for each additional physical location in which services are to be provided under an outpatient endorsement as defined in part 2.3.A.3 of this Chapter included as part of the application for initial licensure, to be paid only by applicants that are seeking licensure that includes endorsement for outpatient services.
 - c. A fee of \$600 for each physical location in which services are to be provided under a residential/overnight endorsement as defined in part 2.3.A.4 of this Chapter, to be paid only by applicants seeking such endorsement.
 - d. Endorsements for services not listed in parts 2.3.A.3 or 2.3.A.4 shall not require a fee.
- 2. A BHE may apply to add an endorsement to its license at any time with the submission of fees outlined in part 2.20.H.1.b and part 2.20.H.1.c.
- I. The duration of the initial license will be one (1) year from the date of issuance.
- J. The BHA will provide written notice to the applicant within thirty (30) calendar days of receipt of a complete application.
- K. The BHA will act on an application within thirty (30) calendar days of receipt of the completed application.

2.19 Provisional Licenses

- A. Where an applicant for an initial license fails to fully conform to the applicable statutes and regulations but the BHA determines the applicant is in substantial compliance with these rules and regulations and is temporarily unable to conform to all the minimum standards, a provisional license may be granted. No provisional license may be issued to an applicant if the operations may adversely affect the health, safety, or welfare of individuals, personnel, or other persons. A provisional license will only be issued upon payment of the non-refundable provisional license fee.
 - 1. A provisional license will be valid for ninety (90) days.
 - 2. A second provisional license may be issued if the BHA determines that it is likely compliance can be achieved by the date of expiration of the second provisional license.
 - 3. The second provisional license may be issued for the same duration as the first upon payment of a second non-refundable provisional license fee. The BHA will not issue a third or subsequent provisional license to the applicant.
 - 4. During the term of the provisional license, the BHA shall conduct any review it deems necessary to determine if the applicant meets the requirements for a regular license.
 - 5. If the BHA determines, prior to expiration of the provisional license, that the applicant is in compliance with all applicable rules, it may issue a regular license upon payment of the applicable initial license fee. The regular license will be valid for one (1) year from the date of issuance of the regular license, unless otherwise acted upon pursuant to part 2.24 of this Chapter.

2.20 License Renewal

- A. A BHE seeking renewal must provide the BHA with a license application, signed under penalty of perjury by an authorized corporate officer, general partner, member, or sole proprietor of the BHE as appropriate, and the appropriate fee at least sixty (60) calendar days prior to the expiration of the existing license. Renewal applications shall contain the information required in part 2.18.D of this Chapter unless the information has been previously submitted and no changes have been made to the information currently held by the BHA.
- B. Failure to submit a completed renewal application to the BHA thirty (30) calendar days prior to expiration of the existing license will result in assessment of a late fee in an amount equal to the renewal fee.
- C. Failure of the BHE to accurately answer or report any of the information requested by the BHA will be considered good cause to deny the license renewal application.
- D. The BHA shall conduct a preliminary assessment of the renewal application and notify the BHE of any application defects.
 - 1. The BHE shall respond within fourteen (14) calendar days to written notice of any application defect.
- E. A BHE submitting a renewal application shall submit the following nonrefundable fees, as applicable:
 - 1. A base fee of \$500, regardless of endorsements or physical locations included as part of the application for licensure renewal. The base fee includes one physical location in which services are to be provided under an outpatient endorsement as defined in part 2.3.A.3 of this Chapter.
 - 2. A fee of \$300 for each additional physical location in which services are to be provided under an outpatient endorsement as defined in part 2.3.A.3 of this Chapter included as part of the application for licensure renewal, to be paid only by applicants that are seeking licensure that includes endorsement for outpatient services.
 - 3. A fee of \$600 for each physical location in which services are to be provided under a residential/overnight endorsement as defined in part 2.3.A.4 of this Chapter, to be paid only by applicants seeking such endorsement.
 - 4. Endorsements for services not listed in parts 2.3.A.3 or 2.3.A.4 shall not require a fee.
- F. The duration of the renewal license will be one (1) year from issuance.

2.21 Change of Ownership/Management

- A. If a BHE undergoes a change in ownership without following the procedures outlined in this part 2.21, their existing license may be terminated. Termination of the license may not occur until after a hearing and in compliance with the provisions and procedures specified in 24-4-101 through -109, C.R.S.

- B. When a BHE initiates a change of ownership, the BHE must submit notification to the BHA within the specified time frame, and the prospective new BHE shall submit an application and supporting documentation for change of ownership along with the requisite fees in part 2.21.G of this Chapter within the same time frame. The time frame for submission of the notification and the application and supporting documentation shall be at least thirty (30) calendar days before a change of ownership involving any BHE.
- C. The BHA will consider the following criteria in determining whether there is a change of ownership of a BHE that requires a new license. The transfer of fifty percent (50%) of the ownership interest referred to in this part 2.21 may occur during the course of one transaction or during a series of transactions occurring over a five-year period.
 - 1. Sole proprietors:
 - a. The transfer of at least fifty percent (50%) of the ownership interest in a BHE from a sole proprietor to another individual, whether or not the transaction affects the Title to real property, shall be considered a change of ownership.
 - b. Change of ownership does not include forming a corporation from the sole proprietorship with the proprietor as the sole shareholder or forming a limited liability company from sole proprietorship with the proprietor as the sole member.
 - 2. Partnerships:
 - a. Dissolution of the partnership and conversion into any other legal structure shall be considered a change of ownership if the conversion also includes a transfer of at least fifty percent (50%) of the ownership to one or more new owners.
 - b. Change of ownership does not include dissolution of the partnership to form a corporation with the same persons retaining ownership in the new corporation.
 - 3. Corporations:
 - a. Merger of two or more corporations resulting in the creation of a new corporate entity will be considered a change of ownership if the consolidation includes a transfer of at least fifty percent (50%) of the ownership to one or more new owners.
 - b. Formation of a corporation from a partnership, a sole proprietorship, or a limited liability company will be considered a change of ownership if the change includes a transfer of at least fifty percent (50%) of the ownership to one or more new owners.
 - c. The transfer, purchase, or sale of shares in the corporation such that at least fifty percent (50%) of the ownership of the corporation is shifted to one or more new owners will be considered a change of ownership.
 - 4. Limited liability companies:
 - a. The transfer of at least fifty percent (50%) of the ownership interest in the company will be considered a change of ownership.

- b. The termination or dissolution of the company and the conversion thereof into any other entity will be considered a change of ownership if the conversion also includes a transfer of at least fifty percent (50%) of the ownership to one or more new owners.
 - c. Change of ownership does not include transfers of ownership interest between existing members if the transaction does not involve the acquisition of ownership interest by a new member.
 - 5. Non-profits:
 - a. The transfer of at least fifty percent (50%) of the controlling interest in the nonprofit is considered a change of ownership.
 - 6. Management contracts, leases, or other operational arrangements:
 - a. If the BHE enters into a lease arrangement or management agreement whereby the owner retains no authority or responsibility for the operation and management of the BHE, the action will be considered a change of ownership that requires a new license.
 - 7. Legal structures:
 - a. The conversion of a BHE's legal structure, or the legal structure of a business entity that has an ownership interest in the BHE is a change of ownership if the conversion also includes a transfer of at least fifty percent (50%) of the BHE's ownership interest to one or more new owners.
- D. Each BHE undergoing a change of ownership shall submit an application as prescribed in 2.18.B through 2.18.F of this Chapter.
- E. The existing BHE is responsible for correcting all rule violations and deficiencies in any current plan of action before the change of ownership becomes effective. In the event that such corrective actions cannot be accomplished in the time frame specified, the prospective BHE shall be responsible for all uncorrected rule violations and deficiencies including any current plan of action submitted by the previous BHE unless the prospective BHE submits a revised plan of action, approved by the BHA, before the change of ownership becomes effective.
- F. When the BHA issues a license to the new owner, the previous owner must return its license to the BHA within five (5) calendar days of the new owner's receipt of its license.
- G. For a change of ownership, a BHE must submit the following nonrefundable fee(s) with the application for licensure, as applicable:
 - 1. A base fee of \$500, regardless of endorsements or physical locations included as part of the application for licensure. The base fee includes one physical location in which services are to be provided under an outpatient endorsement as defined in part 2.3.A.3 of this Chapter.
 - 2. A fee of \$300 for each additional physical location in which services are to be provided under an outpatient endorsement as defined in part 2.3.A.3 of this Chapter included as part of the application for licensure, to be paid only by applicants that are seeking licensure that includes endorsement for outpatient services.

3. A fee of \$600 for each physical location in which services are to be provided under a residential/overnight endorsement as defined in part 2.3.A.4 of this Chapter, to be paid only by applicants seeking such endorsement.
4. Endorsements for services not listed in parts 2.3.A.3 or 2.3.A.4 shall not require a fee.

2.22 Rule Waivers

- A. This part establishes procedures with respect to waiver of regulations relating to BHE licensing.
- B. Any BHE or applicant that has applied for or been issued a license to operate a BHE has the right to apply for a waiver of any rule or standard set forth in these rules which, in their opinion, poses an undue hardship on the applicant, BHE, or community.
- C. Nothing contained in these provisions abrogates the BHE's obligation to meet minimum requirements under local safety, fire, electrical, building, zoning, and similar codes.
- D. Nothing herein authorizes a waiver of any statutory requirement under state or federal law, except to the extent permitted therein.
- E. Upon application to the BHA, a waiver may be granted in accordance with this part 2.22. Absent the existence of a current waiver issued pursuant to this part, BHEs are expected to comply at all times with all applicable regulations except in instances where they are granted a provisional license in accordance with part 2.19 of this Chapter. BHEs must comply with all regulations in this part as well as all regulations in the endorsement parts of these rules (i.e., Chapters 3 through 10) that apply to a BHE unless and until a waiver is granted.
- F. Waiver applications must be submitted to the BHA in writing.
 1. The BHA will only consider one regulation per waiver.
 2. The waiver application must provide the BHA information related to:
 - a. The regulation the BHE or applicant is requesting to waive;
 - b. The reason why the waiver is being requested;
 - c. A proposed alternate compliance plan;
 - d. Any other information relevant to the waiver request that would inform the BHA's decision in either granting or denying the waiver.
 3. The waiver application must be signed by an authorized representative of the BHE or applicant, who is the primary contact person and the person responsible for ensuring that accurate and complete information is provided to the BHA.
- G. In making its determination, the BHA may consider any information it deems relevant, including but not limited to:
 1. Critical incident and complaint investigation reports, licensure or certification survey reports, anticipated impact of the waiver on individual safety and quality of care if any, and findings of these reports related to the BHE and/or the operator or owner thereof.

2. When determining whether a waiver should be granted, the BHA shall prioritize consideration of the impact of the waiver on the health, safety, and welfare of individuals over any alleged undue hardship.
- H. The BHA shall act on a waiver application within ninety (90) calendar days of receipt of the completed application. An application will not be deemed complete until the BHE has provided all information and documentation requested by the BHA.
- I. The BHA may specify terms and conditions under which any waiver is granted, including which terms and conditions must be met in order for the waiver to remain effective. The term for which each waiver granted will remain effective must be specified at the time of issuance but may not exceed the term of the current license.
 1. At any time, upon reasonable cause, the BHA may inspect a BHE with an active waiver to ensure that the terms and conditions of the waiver are being observed, and/or that the continued existence of the waiver is otherwise appropriate.
 2. Within thirty (30) calendar days of the termination, expiration, or revocation of a waiver, the BHE shall submit to the BHA an attestation of compliance with the regulation to which the waiver pertained.
- J. A waiver will automatically terminate upon a change of ownership of the BHE, as defined in part 2.21 of this Chapter. However, to prevent such automatic termination, the prospective new owner may submit a waiver application to the BHA prior to the effective date of the change of ownership. Provided the BHA receives the new application by this date, the waiver will be deemed to remain effective until such time as the BHA acts on the application.
 1. Except as otherwise provided in this part 2.22, a waiver may not be granted for a term that exceeds the current license term.
 2. If a BHE wishes to maintain a waiver beyond the stated term, it must submit a new waiver application to the BHA not less than ninety (90) calendar days prior to the expiration of the current term of the waiver or with a license renewal.
- K. Notwithstanding anything in this part 2.22 to the contrary, the BHA may revoke a waiver if it determines that:
 1. The waiver's continuation jeopardizes the health, safety, or welfare of individuals served by the BHE;
 2. The waiver application contained false or misleading information;
 3. The terms and conditions of the waiver have not been complied with;
 4. The conditions under which a waiver was granted no longer exist or have changed materially; or,
 5. A change in a federal or state statute or regulation prohibits, or is inconsistent with, the continuation of the waiver.
- L. Notice of the revocation of a waiver must be provided to the BHE in accordance with the Colorado administrative procedures act, Section 24-4-101 through -109, C.R.S.
- M. A BHE may appeal the decision of the BHA regarding a waiver application or revocation, as provided in the Colorado administrative procedures act, Section 24-4-101 through -109, C.R.S.

2.23 Continuing Obligations and BHA Oversight

- A. Each BHE must have and maintain electronic business communication tools, including but not limited to, internet access and a valid e-mail address. The BHE must use these tools to receive and submit information.
- B. The license is only valid while in the possession of the BHE to whom it is issued and may not be subject to sale, assignment, or other transfer, voluntary or involuntary, nor is a license valid for any premises other than those for which it was originally issued.
- C. The BHE must provide accurate and truthful information to the BHA during inspections, investigations, and licensing activities.
- D. When a BHE is subject to inspection, certification, or review by other agencies, accrediting organizations, or inspecting companies, the BHE shall provide and/or release to the BHA, upon request, any correspondence, reports, or recommendations concerning the BHE that were prepared by such organizations.
- E. Each BHE must submit notification to the BHA of any change in the information required by part 2.18.D of this Chapter from what was contained in the last submitted license application.
 - 1. Changes to the operation of the BHE may not be implemented without prior approval from the BHA. A BHE shall, at least thirty (30) calendar days in advance, submit notification to the BHA regarding any of the following proposed changes.
 - a. Change in license category or classification.
 - b. Change in the scope of services, including the addition or removal of an endorsement, a service, or a physical location.
 - c. Change in legal name of the BHE and all other names used by it to provide services.
- F. The BHA and any duly authorized representatives thereof have the right to enter upon and into the premises of any licensed BHE or applicant for a BHE license in order to determine the state of compliance with the statutes and regulations and must initially identify themselves to the person in charge of the BHE at the time.
- G. Licensure surveys and tiered inspections
 - 1. For each BHE that is eligible, the BHA will either extend the standard licensure survey cycle up to three (3) years or utilize a tiered licensure inspection system.
 - 2. To be eligible, the BHE must meet all the following criteria:
 - a. Licensed for at least three (3) years;
 - b. No conditions imposed on the license within three (3) years prior to the date of the survey;
 - c. No patterns of rule violations, which occurs when a BHE commits the same class of rule violation three or more times in consecutive inspections, as documented in the inspection and survey reports issued by the BHA within the three (3) years prior to the date of the inspection; and,

- d. No substantiated complaint resulting in the discovery of significant deficiencies that may negatively affect the life, health, or safety of individuals served by the BHE within the three (3) years prior to the date of the survey.
 - 3. The BHA may expand the scope of a tiered inspection to an extended or full survey if the BHA finds rule violations during the tiered inspection process.
- H. The BHA may use the following measures to ensure a BHE's full compliance with the applicable statutory and regulatory criteria.
- 1. The BHA may conduct an unscheduled or unannounced review of a current BHE based upon, but not limited to, the following criteria:
 - a. Routine compliance inspection;
 - b. Reason exists to question the BHE's continued fitness to conduct or maintain licensed operations;
 - c. A complaint alleging non-compliance with license requirements;
 - d. Discovery of previously undisclosed information regarding a BHE or any of its owners, officers, managers, or other personnel if such information affects or has the potential to affect the BHE's provision of services; or
 - e. The omission of relevant information from documents requested by the BHA or indication of false information submitted to the BHA.
 - 2. Plan of action
 - a. If after review or pursuant to a complaint, it is determined that a BHE is not in compliance with these rules, the BHE shall be notified in writing, within thirty (30) business days of the specific deficiency/deficiencies.
 - b. After any review, the BHA may request a plan of action from a BHE or require a BHE's compliance with a BHA directed plan of action.
 - c. If the BHE does not agree with any or all the findings regarding non-compliance, the BHE has fourteen (14) business days from the receipt of non-compliance notice to dispute the findings by submitting evidence to the BHA.
 - d. The BHE shall receive a written response within thirty (30) business days of the review of submitted evidence.
 - e. If the submitted information is sufficient, the BHE shall be determined in compliance with these rules.
 - f. If the BHE continues to be found out of compliance with these rules, the BHE shall have thirty (30) business days from the date of receipt of the review findings to submit a plan of action.
 - g. The plan of action must be in the format prescribed by the BHA and included, but not be limited to, the following:
 - (1) A description of how the BHE will correct each identified deficiency.

- (a) If deficient practice was cited for specific personnel, the description shall include the measures that will be put in place or systemic changes made to ensure that the deficient practice will not reoccur for the affected individuals(s) and/or other individuals having the potential to be affected.
 - (2) A description of how the BHE will monitor the corrective action to ensure each deficiency is remedied and will not reoccur, and
 - (3) A completion date that is no later than ninety (90) calendar days from the issuance of the deficiency list, unless otherwise required or approved by the BHA. The completion date is the date that the entity deems it can achieve compliance.
- h. A completed plan of action must be:
 - (1) Signed by the BHE's director, administrator, or manager, and
 - (2) Submitted to the BHA within thirty (30) calendar days after the date of the BHA's written notice of deficiencies.
 - (a) If an extension of time is needed to complete the plan of action, the BHE shall request an extension in writing from the BHA prior to the plan of action due date. The BHA may grant an extension of time.
- i. The BHA has discretion to approve, impose, modify, or reject a plan of action.
 - (1) If the plan of action is accepted, the BHA shall notify the BHE by issuing a written notice of acceptance.
 - (2) If the plan of action is unacceptable, the BHA shall notify the BHE in writing, and the BHE shall re-submit the changes within the time frame prescribed by the BHA.
 - (3) If the BHE fails to comply with the requirements or deadlines for submission of a plan or fails to submit requested changes to the plan, the BHA may reject the plan of action and impose disciplinary sanctions as set forth in part 2.24 of this Chapter.
 - (4) If the BHE fails to implement the actions agreed to by the action date in the approved plan of action, the BHA may impose enforcement sanctions as set forth below.
- I. The BHE must provide, upon request, access to or copies of the following to the BHA for the performance of its regulatory oversight responsibilities:
 - 1. Individual records.
 - 2. Reports and information including but not limited to, staffing reports, census data, statistical information, and other records, as determined by the BHA.
- J. Oversight and enforcement activities may include review of endorsements and/or separate physical locations as necessary for the BHA to ensure the health, safety, and welfare of individuals.

2.24 Enforcement and Adverse Actions

2.24.1 License, Designation, or Endorsement Denials

- A. The BHA may deny an application for an initial or renewal license, or an application for endorsement(s) for reasons including but not limited to, the following:
1. The BHE has not fully complied with all local, state, and federal laws and regulations applicable to that license category, endorsement, or classification;
 2. The application or accompanying documents contain a false statement of material fact;
 3. The BHE fails to respond to BHA requests for additional information in the time frame indicated in the request;
 4. The BHE refuses any part of an inspection;
 5. The BHE fails to comply with or successfully complete an acceptable plan of action;
 6. The results of the background check reveal a felony or misdemeanor conviction of a crime of moral turpitude as described in part 2.18.D.11.b of this Chapter;
 7. The BHE has failed to cooperate with the investigation of any local, state, or federal regulatory body or law enforcement agency; or
 8. The BHE is not in compliance with regulatory requirements or has a documented pattern of non-compliance that has harmed or has the potential to harm the health or safety of the individual(s) served.
- B. If BHA denies an application for an initial or renewal license, it shall provide the BHE with a written notice by mail to the applicant at the address shown on the application. The notice must explain the basis for the denial and afford the BHE the opportunity to respond.
- C. Appeals of licensure denials must be conducted in accordance with the State Administrative Procedure Act, Section 24-4-101 through -109, C.R.S. and 26-1-106, C.R.S.

2.24.2 Revocation or Suspension of a License, Designation, or Endorsement

- A. The BHA may limit, revoke, or suspend an existing license or endorsement if a BHE fails or refuses to comply with the statutory and/or regulatory requirements applicable to its license and endorsements associated with its license. The BHA may limit the overall BHE license, any endorsements or physical locations, or any combination thereof for failure or refusal to comply. Failures to comply include, but are not limited to:
1. Making a false statement of material fact about individuals served by the BHE, its personnel, capacity, or other operational components verbally or in any public document or in a matter under investigation by the BHA or another governmental entity,
 2. Preventing, interfering with, or attempting to impede in any way the work of a representative or agent of the BHA in investigating or enforcing the applicable statutes or regulations,
 3. Falsely advertising or in any way misrepresenting the BHE's ability to provide services for the individuals served based on its license type or status,

4. Failing to provide reports and documents required by regulation or statute in a timely and complete fashion,
 5. Failing to comply with or complete a plan of action in the time or manner specified,
 6. Falsifying records or documents,
 7. Knowingly using or disseminating misleading, deceptive, or false information,
 8. Accepting commissions, rebates, or other forms of remuneration for referrals or other treatment decisions, or
 9. Exercising undue influence or coercion over an individual to obtain certain decisions or actions or for financial or personal gain. A relationship other than a professional relationship, including but not limited to a relationship of a sexual nature, between an owner, director, manager, administrator, or other personnel and an individual.
 10. Noncompliance with the requirements of Sections 27-50-501 through 27-50-509, C.R.S. and any applicable regulations promulgated pursuant to those statutes.
- B. The BHA may revoke or suspend an existing license if one or more individuals or entities identified in the response to part 2.18.D.3 of this Chapter has a controlling or ownership interest in the BHE and:
1. Has been the subject or party to any of the actions described in part 2.18.D.10.a:
 2. Has a felony or misdemeanor conviction of a crime of moral turpitude as described in part 2.18.D.11.b of this Chapter.
- C. Except in the case of a summary suspension in accordance with 24-4-104(4)(a), C.R.S., suspension or revocation must not occur until after a hearing and in compliance with the provisions and procedures specified in Section 24-4-101 through Section -109, C.R.S. and Section 27-50-505, C.R.S.

2.24.3 Conditional Licenses

- A. If a BHE is found to be out of compliance with applicable BHA, state, or federal law or regulations, the BHA may impose conditions upon a license prior to issuing an initial or renewal license or during an existing license term. If the BHA imposes conditions on a license, the BHE shall immediately comply with all conditions until and unless said conditions are overturned or stayed on appeal.
1. Imposition of conditions on a license does not constitute a modification to the license if the BHE agrees to the conditions. If an agreement is not reached, the BHE may appeal in accordance with part 2.24.5 of this Chapter, Section 24-4-101 through -109, and Section 27-50-505, C.R.S.
- B. If conditions are imposed at the same time as an initial or renewal license, the BHE shall pay the applicable initial or renewal license fee plus the conditional fee equal to the amount of their initial or renewal license fee.
- C. If conditions are imposed during the license term, the BHE shall pay the conditional fee and the conditions must run concurrently with the existing license term.

- D. If the conditions are renewed in whole or in part for the next license term, the BHE shall pay the applicable renewal fee along with the conditional fee in effect at the time of renewal.
- E. If the BHA imposes conditions of continuing duration that require only minimal administrative oversight, it may waive the conditional fee after the BHE has complied with the conditions for a full license term.
- F. If a BHE holds a conditional license, it shall post a clearly legible copy of the license conditions in a conspicuous public place in the BHE.

2.24.4 Intermediate Restrictions

- A. The BHA may impose the following intermediate restrictions or conditions on a BHE in accordance with Section 27-50-505 (3), C.R.S.:
 - 1. Retaining a consultant to address corrective measures including deficient practice resulting from systemic failure;
 - 2. Monitoring by the BHA for a specific period;
 - 3. Providing additional training to employees, owners, or operators of the BHE;
 - 4. Complying with a directed written plan to correct the violation; or
 - 5. Paying a civil fine not to exceed two thousand dollars (\$2,000) in a calendar year. The assessment of these fines shall follow the procedures set forth in Section 26.5.-5-323, C.R.S.
- B. The BHE may appeal any intermediate restriction or condition to the BHA in accordance with the Colorado Administrative Procedures Act Section 24-4-101 through -109, C.R.S.

2.24.5 Right to Appeal

- A. Any BHE adversely affected or aggrieved by the BHA's decisions in regard to implementation of these rules, has the right to appeal to the Colorado Department of Personnel and Administration, Office of Administrative Courts, and may subsequently seek judicial review of the BHA's action in accordance with Section 24-4-101 through -109, C.R.S.
- B. The following actions may be submitted to an administrative law judge for an evidentiary hearing: denial of a license, designation, or endorsement; denial of a renewal; provisional license; conditional license; revocation; denial of a waiver; limitation of a license, denial of a modification; and imposition of an intermediate restriction or condition.
- C. After written notification from the BHA of intended action, the BHE has twenty-one (21) calendar days to submit a written appeal. The appeal must be received by the BHA within twenty-one (21) days from the date the written notification of action letter was sent by the BHA.
- D. In all cases except waiver denials, the BHA will file a notice of charges with the office of administrative courts to begin the administrative process. In waiver denials, if the applicant for the waiver requests an appeal, the request for appeal must be forwarded to the office of administrative courts. Once the appellant's request is forwarded to the office of administrative courts, the BHA may file a notice of charges.

- E. Subsequent to an evidentiary hearing at the office of the administrative courts and the issuance of a final agency decision, a party may seek to appeal the final agency decision through judicial review in accordance with Section 24-4-106, C.R.S.

2.25 BHE Closure

- A. Each license issued by the BHA will become invalid if the BHE fails to timely renew the license, ceases operation, or there is final BHA action suspending or revoking the license. The license must be returned to the BHA within ten (10) calendar days of the event that invalidated it.

2.25.1 Emergency Closures

- A. In the event of an emergency affecting the physical space of the BHE that necessitates the removal of individuals and personnel from the BHE, a BHE shall provide the BHA with verbal notice of the event at the time of removal and a written report within fourteen (14) calendar days after the removal explaining the emergent situation and the actions taken by the BHE to provide services that meet the health and safety needs of the individuals. Based on the extenuating circumstances, the BHA may approve the continuation of the license during the time period that it takes to make the physical space appropriate for individuals and personnel to return.

2.25.2 Permanent Closures

- A. Each BHE that surrenders its license shall accomplish the following with regard to any individual records that the entity is legally obligated to maintain:
 - 1. Within ten (10) calendar days prior to closure, inform the BHA in writing of the specific plan for storage and retrieval of individual records;
 - 2. Unless noted otherwise within an endorsement Chapter, within ten (10) calendar days of closure, inform all individuals or designated representatives thereof, in writing, how and where to obtain their individual records; and
 - 3. Provide secure storage for any remaining individual records.
- B. In the event of a BHE closure, the BHE shall be responsible for appropriate continuity of care for each individual served by the BHE.

2.26 Residential and Overnight Standards

- A. A BHE providing residential and/or overnight services as defined in part 2.3.A.4 of this Chapter shall meet the standards in this part 2.26.
- B. Each physical location in which residential and/or overnight services are provided must meet the following personnel requirements:
 - 1. Each physical location must have appropriate oversight personnel, such as an administrator and/or clinical director, or personnel delegated those same responsibilities, available twenty-four (24) hours per day, seven (7) days per week.
 - a. Oversight personnel when the administrator and/or clinical director are not physically on-site must be in accordance with policies as required at part 2.2.4.A.6 of this Chapter.

2. Each physical location must have at least one person trained in cardio-pulmonary resuscitation (CPR) and first aid on-site and on-duty at all times when individuals are present.
- C. Personnel providing services under the residential/overnight endorsement shall be trained in the following:
1. The recognition and response to common side effects of medications used for behavioral health disorders, and response to emergency drug reactions;
 2. Behavior management and de-escalation techniques, including incidents involving harm to self or others, and elopement; and,
 3. Behavioral health and medical emergency response training, consistent with emergency services policies required in parts 2.9.D and 2.9.E of this Chapter.
 4. Personnel preparing or serving food shall complete food safety training. At a minimum, this must include that personnel overseeing dietary services shall have knowledge of foodborne disease prevention, including, but not limited to, hygienic practices and food safety techniques pertaining to preparation, food storage, and dishwashing.
- D. The BHE shall have policies and procedures specific to the residential/overnight endorsement, services, or physical location, as applicable, including, but not limited to:
1. Policies and procedures to be followed in the event of serious illness, injury, or death of an individual during their stay, including, but not limited to:
 - a. Criteria for when an individual's injury or illness warrants medical treatment or an in-person medical evaluation.
 - b. Requirements for notifying the individual's emergency contact, including immediate notification in the case of an emergency room visit or unscheduled hospitalization.
 - c. Reporting procedures within the BHE.
 2. BHEs that provide overnight/residential services shall maintain enough food and water on hand to provide all individuals with three (3) nutritionally balanced meals for four (4) days.
 3. Written policies and procedures for the management of individuals' personal funds and property, including, but not limited to:
 - a. An inventory of all the individual's personal belongings must be conducted upon admission, and documented by at least two (2) individuals, one of which must be the individual when the individual is capable and willing to document the inventory. Such inventory must be maintained in the individual record.
 - b. All inventoried property must be returned to the individual upon discharge, and such return must be documented by at least two (2) individuals, one of which must be the individual when the individual is capable and willing to document the inventory. Such documentation must be included in the individual record.
 4. Infection control policies to address risks associated with housekeeping, dietary services, and linen and laundry services, in addition to the requirements at part 2.4.E of this Chapter.

- a. Policies for linen and laundry services must include:
 - (1) Procedures for preventing contamination between soiled linen and clean linen through either the use of gloves or hand washing.
 - (2) Procedures for soiled linen to be stored separately from clean linen, in separate enclosed areas.
 - b. Dietary services must be provided using methods that conform to state or local food safety standards, including, at a minimum:
 - (1) Food must be prepared, handled, and stored in a sanitary manner, so that it is free from spoilage and/or contamination, and must be safe for human consumption.
 - (2) Reusable equipment, dishes, cutlery, and other wares used for the preparation, serving, or storage of food must be washed in a safe and sanitary manner, and, in the case of dishwashing machines, in accordance with manufacturer's instructions.
5. The provision of linen and laundry services, including, but not limited to:
- a. Individuals must have access to laundry services for personal clothing, which may be provided through the use of personal laundry facilities, a centralized laundry service, or may be contracted for with an outside provider.
 - b. A requirement to maintain a sufficient supply of clean linen, including sheets and towels.
6. The provision of dietary services, including but not limited to:
- a. The BHE must ensure enough food and water on hand to provide all individuals with three (3) nutritionally balanced meals for four (4) days.
 - b. A BHE responsible for providing meals to individuals must:
 - (1) Provide at least three meals daily, at regular times comparable to normal mealtimes in the community, or in accordance with individual needs, preferences, and plans of care.
 - (a) Nourishing meal substitutes and between-meal snacks must be provided, in accordance with plans of care, to individuals who want to eat at non-traditional times or outside of scheduled meal service times.
 - (b) Meals must include a variety of foods, be nutritionally balanced, and sufficient in amount to satisfy appetites of individuals.
 - (c) Appealing substitutes of similar nutritive value must be available for individuals who choose not to eat food that is initially served or who request an alternative meal.
 - (2) Offer drinks, including water and other liquids, to individuals with every meal and between meals throughout the day.

- (3) Ensure that individuals have independent access to water at all times.
- 7. If the population served includes individuals assessed to be at risk of imminent harm to self or others, the BHE shall require safety checks be conducted at least every fifteen (15) minutes and at every shift change to identify and remedy hazards and shall maintain documentation of such checks.
- 8. The type of first aid equipment maintained by the BHE, including a requirement that such equipment be maintained in a readily accessible location, at each physical location providing services under the residential and/or overnight endorsement. First aid equipment must include, but not be limited to, an automated external defibrillator (AED).
 - a. First aid supplies and equipment must be kept unexpired and in a reliable condition.
- 9. Smoking policies applicable to individuals, including, but not limited to any prohibitions on smoking, designated areas for smoking, and methods/substances allowed under any smoking policy, such as tobacco, electronic cigarettes, vaporizers, etc.
- E. The BHE must ensure there is a minimum of one (1) full bathroom for every six (6) individuals, including a toilet, sink, toilet paper dispenser, mirror, tub and/or shower, and towel rack.
- F. Bathrooms must be equipped with soap dispensers, or the BHE shall have a procedure in place that prevents individuals from sharing soap.
- G. The BHE shall ensure that individuals have access to basic hygiene supplies.
- H. In addition to the requirements of part 2.4 of this Chapter, each BHE's emergency policies must address:
 - 1. When to evacuate the premises, when to shelter in place, and the procedures for doing so;
 - 2. A predetermined means of communicating with individuals, families, staff and other providers;
 - 3. A plan that ensures the availability of, or access to, emergency power for essential functions and all individual required medical devices or auxiliary aids or services;
 - 4. Storage and preservation of medications; and
 - 5. In the event relocation of individuals becomes necessary, written agreements with other health facilities and/or community agencies.
- I. The BHE shall have readily available a roster of current individuals, their room assignments and emergency contact information, along with a facility diagram showing room locations.
- J. Hot water must not measure more than 120 degrees Fahrenheit at taps which are accessible by individuals.
- K. A BHE serving both adults and children must ensure management of the living space assignments includes physical barriers and personnel oversight of activities to ensure safety. This management must include, but is not limited to:
 - 1. Physical barriers, such as doors or walls;

2. Personnel stations that separate living space assignments;
3. Other practical arrangements that support the safe management of the individuals receiving services.

2.27 Fentanyl and Other Opioid Use Disorder Education and Treatment

2.27.1 Statutory Authority and Applicability

- A. Authority to approve BHEs to provide treatment of substance use disorders, including fentanyl and other opioid use disorders, is provided by Section 18-1.3-401 and 18-1.3-501, C.R.S.
- B. BHEs providing services for the treatment of substance use disorders including fentanyl and other opioid use disorders must exist across all endorsed service types. For this reason, all BHEs shall comply with this part 2.27. In addition to this part 2.27, BHEs shall comply with provisions of the applicable endorsed services, as noted below:
 1. BHEs providing outpatient and high-intensity outpatient services shall comply with parts 4.3, 4.6, and/or 4.7 of these rules.
 2. BHEs providing residential services shall comply with parts 5.1 through 5.4 of these rules and the applicable sub-endorsement(s) of residential services (parts 5.6, 5.8, 5.10, and 5.11 of these rules).
 3. BHEs providing withdrawal management services shall comply with parts 4.5, 4.8, 5.1, 5.2, 5.3, 5.7, and 5.12 of these rules.

2.27.2 Placement in Services

- A. Individuals receiving fentanyl and other opioid use disorder treatment must be assessed and referred into education and/or treatment by a supervising entity as a condition of probation or parole. The BHE is expected to evaluate whether the supervising entity's recommendation matches the individual's assessed clinical need(s). The BHE is expected to address any differences identified with the supervising entity directly and document results in the individual's record.
- B. BHEs shall include a copy of the referral paperwork, demonstrating placement in the fentanyl or other opioid-specific treatment services as required by the supervising entity, in the individual's record.
- C. If a BHE is unable to obtain a copy of the court order and/or written documentation of supervising entity's recommendation for education and/or treatment, there must be documentation of attempt(s) to obtain the paperwork from the referral source.
- D. Individuals receiving fentanyl and other opioid use disorder treatment are expected to complete the required fentanyl education program as part of that process. The BHE must verify that the individual completes this requirement when it is clinically appropriate for the individual, prior to discharging from services. Documentation of this must be kept in the individual's record.

2.27.3 Support Systems

- A. The BHE shall be capable of delivering all necessary medication for opioid use disorder (MOUD) services that are clinically indicated for the individual under applicable law. These services may be provided through direct service provision or active collaboration with other agencies that are able to provide MOUD services.

- B. Opioid antagonists
 - 1. Opioid antagonists must:
 - a. Be discussed and provided upon individual request at the initial assessment.
 - b. Documentation shall be reflected in the individual record response from individual and if dosages were provided for the individual to keep on their person.
 - 2. BHEs shall:
 - a. Ensure that opioid antagonists are available on-site at all times,
 - b. Ensure that opioid antagonists are made available to all individuals being served to keep on their person. This may be achieved through providing access to the opioid antagonist directly, or through coordination with another resource;
 - c. Make reasonable documented attempts and to ensure that all individuals receiving treatment know how to administer the opioid antagonist in case of emergency, and,
 - d. Promote or directly provide information to the individual's referred support system to allow for the administration of opioid antagonists.

2.27.4 Personnel Training and Competencies

- A. All personnel interacting with individuals receiving fentanyl and other opioid-specific services shall be trained in the following:
 - 1. Proper use of opioid antagonists, and
 - 2. Recognition and response to signs and symptoms of drug overdose.
- B. Additionally, all personnel providing treatment and peer support professionals interacting with individuals receiving fentanyl and other opioid-specific services shall be trained and demonstrate competency in the following topics:
 - 1. Substances of misuse and dependence including, but not limited to alcohol, tobacco, and other drugs, and polysubstance abuse;
 - 2. Pharmacology of the medications for opioid use disorder (MOUD), including but not limited to loss of tolerance to opioids, dangerous drug or alcohol interactions with the MOUD, and purpose of the medication's use;
 - 3. Culturally and linguistically appropriate services, awareness, and responsiveness to current misuse trends for opioid-involved individuals; and
 - 4. Harm-reduction and trauma-informed practices in the treatment of opioid use disorder.

2.27.5 Collaboration and Termination of Court-Ordered Services

- A. With written permission from individuals who are required to attend services as a condition of probation, agencies shall communicate regular updates to the referring supervising entity for the portion of the treatment episode in which fentanyl and other opioid-specific services are determined to be clinically necessary. This determination of clinical necessity must be made by:
 - 1. A licensee;
 - 2. A candidate;
 - 3. An authorized practitioner; or
 - 4. A certified addiction specialist (CAS).
- B. Individuals that no longer meet clinical necessity for fentanyl or other opioid-specific treatment as a condition of probation, pursuant to Section 18-1.3-510(3)(a), C.R.S., but may benefit from aftercare or continued services to address other relevant behavioral health needs may remain in treatment. The BHE is not required to communicate further progress updates to the referring supervising entity unless the individual requests and consents to this communication.

Chapter 3: Behavioral Health Recovery Supports

3.1 Authority and Applicability

- A. Chapter 3 establishes the standards that BHEs must follow when electing to provide mental health and substance use recovery supports as part of a recovery supports endorsement. The authority to promulgate these service-specific requirements that apply to BHEs electing to provide this service comes from Sections 27-50-107(3) and 27-50-502(1), C.R.S.
- B. All agencies providing recovery support services rendered by peer support professionals shall meet the standards in this Chapter. If the agency requires a BHE license, the agency must comply with Chapter 2.
- C. This Chapter does not apply to licensed recovery support services organizations. Regulations for licensed recovery support services organizations are found in Section 21.600.

3.2 Service Provision

- A. Recovery support services include a variety of recovery-focused services and supports for individuals with a behavioral health disorder and/or who are in recovery from a behavioral health disorder. These services are rendered by peer support professionals. These services must include engaging individuals in peer-to-peer relationships that support healing, personal growth, life skills development, self-care, and crisis strategy development to help achieve recovery, wellness, and life goals. These services include:
 - 1. Peer support professional-run drop in centers;
 - 2. Recovery and wellness centers;
 - 3. Employment services;
 - 4. Prevention and early intervention activities;
 - 5. Peer support professional mentoring for children and youth;
 - 6. Warm lines, as defined in Chapter 1 of these rules;

7. Advocacy services;
 8. Recovery coaching;
 9. Peer support professional-led support groups;
 10. Navigating services (resources);
 11. Recovery planning services; and
 12. Other activities supporting the recovery experience of an individual.
- B. A peer support professional may provide services in a variety of settings, if permitted access, that may include but are not limited to:
1. Court-affiliated settings, such as the Department of Corrections, county jails, or community correctional placements;
 2. Physical health settings, such as primary care physician offices;
 3. Emergency departments;
 4. Audio-visual or audio-only telehealth;
 5. Agencies serving homeless communities;
 6. Peer respite homes;
 7. School-based health centers;
 8. Home and community-based settings, including salons and other gathering places; and
 9. Brick and mortar recovery community organizations, including faith based organizations.
- C. Agencies endorsed pursuant to this Chapter 3 must ensure peer support professionals are not required to provide services that compromise the dynamic of a peer-to-peer relationship or that are outside the scope of providing recovery-focused services. Activities that are outside of the scope of a peer support professional include, but are not limited to:
1. Performing clinical/diagnostic assessments, service planning, or treatment; and
 2. Drug and/or alcohol testing, monitoring, and/or collection of toxicology samples.
- D. Agencies endorsed pursuant to this Chapter 3 must submit job descriptions of all peer support professional positions in accordance with part 2.6.E of these rules.
- E. Peer support professionals must provide individuals with a written disclosure at the time of first contact that includes
1. Their full name;
 2. Their contact information;
 3. Their qualifications;

4. Their role in work with the individual;
5. Their supervisor's name;
6. Their supervisor's contact information; and
7. The name of the agency that employs the peer support professional.

3.3 Personnel Qualifications and Training

- A. Peer support professionals providing peer recovery support services must hold a professional peer support certification credential or have successfully completed formal training that covers all content areas outlined in “core competencies for peer workers in behavioral health services - 2018” (December 13, 2018), established by United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), which is incorporated herein by reference and does not include any later amendments or editions. These standards are available at no cost at <https://www.samhsa.gov/> and are also available for public inspection and copying at the Behavioral Health Administration, 710 S. Ash Street, Unit C140, Denver, CO 80246, during regular business hours.
- B. Training or proof of certification must be documented in personnel files.
- C. For peer support professionals with a certification credential, the certification credential must include the following requirements:
 1. At least sixty (60) hours of training, including training covering all content areas in “core competencies for peer workers in behavioral health services – 2018” established by United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), incorporated by reference in subsection A, above;
 2. At least 200 hours of experience as a peer support professional; and
 3. Passing a certification exam.
- D. Peer support professionals with a certification credential must be in good standing with their certifying body, including compliance with the certifying body's code of ethics.

3.4 Supervision

- A. Peer support professionals must be supervised on at least a monthly basis for at least an hour by a licensee or authorized practitioner in good standing with their credentialing body and/or an experienced peer support professional who meets the criteria set forth in Section 3.3 of this Chapter. Supervisors shall document supervision date, time, duration, and topics discussed.
- B. Supervisors of peer support professionals must demonstrate to the BHA that they have received training in
 1. The provision of peer support services;
 2. The supervision of peer support professionals; and
 3. The role of peer support professionals.

- C. Supervision of a peer support professional may include co-reflective supervision strategies in which supervisors and supervisees engage in a relationship of mutual learning.

3.5 Documentation Requirements

- A. Agencies endorsed to provide recovery supports must maintain records of the services provided to individuals by peer support professionals. These records shall include at a minimum the date, time, and duration of the service.

Chapter 4: Behavioral Health Outpatient and High Intensity Outpatient Services

4.1 Authority and Applicability

- A. Chapter 4 establishes the standards for and applies to agencies electing to provide mental health and substance use outpatient services and high-intensity outpatient services. The authority to promulgate these service-specific requirements that apply to BHEs electing to provide this service comes from Sections 27-50-502(1), 27-50-106, 27-50-301(5), and 27-50-107(3)(b), C.R.S.
- B. These rules apply to and are established to create standards for agencies seeking sub-endorsements to provide behavioral health outpatient services, which includes early intervention, outpatient, intensive outpatient, partial hospitalization, and ambulatory withdrawal management services. Agencies may also choose to provide optional sub-endorsements of minor in possession services, in conjunction with the correlated sub-endorsements in this Chapter.

4.2 Early Intervention Services Standards

- A. These rules are established to create standards for agencies seeking sub-endorsements to provide early intervention, which includes ASAM Criteria Level 0.5 type services.
- B. Agencies providing early intervention services must meet the standards in part 4.2 of these rules.

4.2.1 Service Delivery and Setting

- A. Early intervention services are generally intended for individuals who are not appropriate for more intensive levels of care, are sufficiently stabilized to complete early intervention services prior to moving to a different level of care, are attending education-only services, or are being screened in a stabilization setting and are provided referrals for appropriate level of care once stabilized.
- B. Early intervention services are appropriate for individuals with mental health, substance use, and co-occurring disorders that are of low severity, or are of moderate to high severity, as defined by the DSM-5-TR, but have been stabilized and are awaiting entry into a higher level of care.
- C. All services provided must be adapted to the individual's developmental stage, physical, cultural, and comprehensive needs.
- D. Early intervention services may be delivered via telehealth in accordance with the standards set in part 2.9 of these rules.
- E. If early intervention services are related to court-ordered DUI/DWAI requirements, services must comply with parts 10.1 through 10.9 of these rules, including telehealth provisions.
- F. Treatment groups must not exceed twelve (12) individuals receiving services.

4.2.2 Personnel

- A. The agency must ensure early intervention services are provided by personnel meeting the qualifications in parts 1.3 and 2.5 of these rules.
- B. Agencies providing early intervention services must ensure treatment personnel have supervisor consultation within twenty-four (24) hours via in-person or telephone to discuss, at minimum, psychiatric or medical concerns of individuals receiving services as necessary.
 - 1. Personnel must have supervisor consultation available within one (1) hour via in-person or by telehealth to discuss, when warranted crisis and/or emergency situations.

4.2.3 Service Provisions

- A. Duration of early intervention services may vary dependent upon individual needs.
- B. Early intervention services must be provided in accordance with individual screening information as defined in part 2.12.1 of these rules, or the court ordered education requirements for education-only individuals.
 - 1. Continued screening will be conducted when symptomology and risk factors for a diagnosis of mental health, substance use, and/or co-occurring disorder(s), as defined by the DSM-5-TR, are identified by personnel. Referral(s) to match screened treatment needs will be provided to the individual and documented pursuant to part 4.2.4 of these rules.
 - 2. Referral(s) will be provided in collaboration with the individual.
- C. Early intervention services may include brief therapeutic interventions of individual, group, or family counseling, peer support services, medication/psychiatric-only services, follow-up services, and/or regulated education groups mandated to the individual by a supervising entity.
 - 1. An individual is classified as receiving medication/psychiatric - only services when the agency provides a maximum of three (3) services, in addition to services related to medications, within a six (6) month period of time.

4.2.4 Documentation and Timeliness

- A. Early intervention agencies must complete appropriate screening in accordance with screening guidelines in part 2.12.1 of these rules upon intake of individual into services.
 - 1. Other screening may be used in addition for program and/or individual specific needs.
- B. Agencies must complete the screening requirements within two (2) calendar days.
- C. Early intervention level services are exempt from assessment and service plan expectations of parts 2.12.2, 2.12.3 and 2.13.1 of these rules, unless the individual attending services is moved to a higher level of care within the same agency.
- D. Progress notes must be completed for each early intervention session. Progress notes must be completed to standards identified in part 2.13.2 of these rules, and at a minimum frequency of one (1) note per session.
- E. Referrals to other services must be documented in the individual's file including:
 - 1. Recommendations of care;

2. Reason for discharge;
 3. Recommended programs for individual to enroll in; and
 4. Follow-up plan including care coordination and documentation needs.
- F. If providing medication/psychiatric-only services, a licensee or authorized practitioner shall complete and document in the individual record at least annually:
1. Clinical rationale supporting a medication/psychiatric-only service status;
 2. An updated assessment; and
 3. An updated service plan.

4.3 Outpatient Services Standards

- A. These rules are established to create standards for agencies seeking a sub-endorsement to provide outpatient services, which includes ASAM Criteria Level 1.0 type services.
- B. All agencies providing behavioral health outpatient treatment services must meet the standards in this part 4.3.

4.3.1 Service delivery and setting

- A. Outpatient services are generally intended for individuals who are assessed as not appropriate for more intensive levels of care. Outpatient services may also be a step-down from a higher level of care or offered when an individual is in early stages of change and declines participation in the higher level of care indicated by the assessment.
- B. Outpatient services are appropriate for individuals diagnosed with mental health, substance-related, and co-occurring disorders if the mental health disorders are of moderate severity, or are of high severity, as defined by the DSM-5-TR, but have been stabilized.
- C. All services provided must be adapted to the individual's developmental stage, physical, cultural, and comprehensive needs.
- D. Outpatient services may be delivered via in-person, audio-visual telehealth, or audio-only telehealth format in accordance with part 2.9 of these rules.
- E. Treatment groups must not exceed twelve (12) individuals receiving services.

4.3.2 Personnel

- A. Treatment personnel, for the purpose of outpatient services, unless otherwise noted, means the following behavioral health professionals trained in mental health and/or substance use disorder identification and treatment and acting within their scope of practice:
1. Authorized practitioners;
 2. Licensees;
 3. Certified addiction specialists (CAS);
 4. Candidates;

5. Certified addiction technicians (CAT); and
 - a. If utilizing certified addiction technicians (CAT), the agency must ensure that CATs do not comprise more than twenty-five (25%) of the agency's personnel.
6. Counselors-in-training and/or interns.
 - a. If utilizing counselors-in-training and/or interns, the agency must ensure that all clinical documentation is reviewed and co-signed by a clinical agency supervisor able to supervise pursuant to their scope of practice. Counselor-in-training and/or intern personnel must not comprise more than twenty-five percent (25%) of the agency's personnel.
- B. Outpatient services may include recovery support services rendered by peer support professionals in accordance with Chapter 3 of these rules.
- C. Agencies providing outpatient services must ensure treatment personnel have supervisor consultation available within twenty-four (24) hours via in-person or by telehealth to discuss, when warranted, psychiatric or medical concerns of individuals receiving services.
 1. Personnel must have supervisor consultation available within one (1) hour via in-person or telehealth to discuss, when warranted crisis and/or emergency situations.

4.3.3 Service Provisions

- A. Outpatient services must be conducted in regularly scheduled sessions of no more than eight (8) treatment contact hours per week for adults, and no more than five (5) treatment contact hours per week for children.
 1. Treatment contact hours does not include pro-social activities.
 2. Treatment contact hours may include medication/psychiatric-only services pursuant to this part 4.3.3.
- B. Outpatient treatment services must be provided in accordance with the individual's service plan.
- C. When referral(s) are needed to best meet the individual assessed needs, referral(s) must be provided in collaboration with the individual and their choice(s) for referred services.
- D. Medication/psychiatric-only services may be provided when:
 1. An individual is classified as receiving medication/psychiatric - only services when the agency provides a maximum of three (3) services, in addition to services related to medications, within a six (6) month period of time.

4.3.4 Documentation and Timeliness

- A. Outpatient service documentation must follow the provisions set forth in parts 2.10, 2.11, 2.12, and 2.13 of these rules.
- B. Upon intake into services, preliminary screening and risk assessment must be completed in compliance with part 2.12.1 of these rules.

- C. As soon as is practicable upon admission, but no later than ten (10) calendar days from the date of preliminary screening and risk assessment, the agency must complete an initial assessment in accordance with part 2.12.2 of these rules.
 - 1. If the screening and risk assessment identifies an urgent clinical need, clinical services must be provided, and the initial assessment must be completed within one (1) calendar day of preliminary screening.
- D. As soon as is practicable upon admission, but no later than sixty (60) calendar days from the first date of services, the agency must complete a comprehensive assessment in accordance with part 2.12.3 of these rules. Completion of the comprehensive assessment does not preclude the initiation of services.
- E. The individual service plan must be created, in accordance with part 2.13.1 of these rules, within fourteen (14) calendar days after the initial assessment. The service plan must be updated to reflect information from the comprehensive assessment. The agency must update the service plan throughout the course of treatment, review previous goals, and update those goals whenever there is a change in the individual's level of care or functioning, and must occur, at minimum, every six (6) months.
- F. Outpatient treatment services must be documented in the individual's record in accordance with part 2.13.2 of these rules, and at a minimum frequency of one (1) note per session.
- G. If providing medication/psychiatric-only services, a licensee or authorized practitioner shall complete and document in the individual record at least every six (6) months:
 - 1. Clinical rationale supporting a medication/psychiatric-only service status;
 - 2. An updated assessment; and
 - 3. An updated service plan.

4.4 Minor in Possession (MIP): Education and Treatment Services Standards

4.4.1 MIP General Provisions

- A. Agencies providing Minor in Possession education and treatment must comply with this part 4.4.
- B. If providing MIP treatment to individuals under eighteen (18) years of age, agencies must receive the Children and Family endorsement and follow the standards of care in Chapter 8 of these rules.
- C. Agencies must not place an individual with a MIP citation in DUI/DWAI education or therapy groups unless the youth also has a DUI/DWAI offense.
- D. All agency education and treatment personnel must have documented training, supervision and experience in youth development and prevention, intervention, and treatment approaches.
- E. Individuals that are sixteen (16) years of age and under must be treated in separate groups than those treating individuals seventeen (17) to twenty (20) years old.
- F. Agencies must conduct ongoing assessment of progress in education and/or treatment level of care to determine if individuals are in the appropriate service level.

4.4.2 MIP: First Offense Education and Early Intervention

- A. MIP education is for individuals who have received their first MIP citation and must be conducted in an outpatient setting and comply with early intervention procedures in part 4.2 of these rules.
- B. MIP education must be at least eight (8) hours, completed over no less than a two (2) day period with no more than four (4) hours of education per day.
- C. Education topics must include:
 - 1. Current legal consequences for additional MIP citations;
 - 2. Resources or referrals for treatment level services, when indicated;
 - 3. Developmental impact of early onset substance use and subsequent impact on the developing brain;
 - 4. Physiological effect of alcohol and other drug use;
 - 5. Refusal skills; and
 - 6. Avoidance of high-risk situations.
- D. For children, agencies must include and document a minimum of two (2) hours of parental or legal guardian involvement, unless contraindicated, and document the determination to not include parental or guardian involvement and reasoning for this determination.

4.4.3 MIP: Second and Subsequent Offense Outpatient Treatment

- A. In addition to the provisions outlined in this part 4.4.3, agencies providing MIP outpatient treatment must also comply with part 4.3.
- B. Second offense MIP therapy must be conducted in an outpatient setting, must be a minimum of twelve (12) hours in duration over eight (8) weeks, and must not exceed ninety (90) minute sessions, excluding breaks and administrative procedures.
- C. Agencies must complete an individualized service plan, with each individual in accordance with parts 2.13.1 and 8.5 of these rules.
- D. For children, agencies must include and document a minimum of four (4) hours of parental or legal guardian involvement, unless contraindicated, and document the determination to not include parental or guardian involvement and reasoning for this determination.
- E. For third and subsequent minor in possession offenses, agencies shall conduct a comprehensive assessment to determine substance use disorder treatment needs of the individual.
- F. Third and subsequent MIP outpatient treatment must be conducted at a minimum of twenty (20) hours of substance use disorder treatment over a minimum thirteen (13) week period, as determined by the assessment. Groups must not exceed ninety (90) minutes in duration.
- G. Additional assessed service offerings and referral(s) must be offered to meet the needs of the individual and family members, when determined by the assessment.

4.5 Level 1-Withdrawal Management (Level 1-WM): Ambulatory Withdrawal Management Without Extended On-Site Monitoring Standards

- A. This part 4.5 is established to create standards for agencies seeking a sub-endorsement to provide outpatient Level 1-Withdrawal Management (Level 1-WM) services in accordance with Chapter 6 of the ASAM Criteria.
- B. Agencies providing Level 1-WM services must meet the standards in this part 4.5. Agencies providing Level 1-WM services may:
 - 1. Also engage in outpatient behavioral health treatment services by meeting the standards for the outpatient sub-endorsement(s) selected by the agency, or
 - 2. Provide only Level 1-WM services and coordinate with other providers for ongoing and concurrent outpatient behavioral health treatment services.

4.5.1 Service delivery and setting

- A. Level 1-WM is an outpatient withdrawal management service that complements individualized behavioral health treatment services.
- B. Individuals may participate in Level 1-WM for a period of time in which it is determined to be medically appropriate. Admission to Level 1-WM services must not hinder the individual's ability to participate in concurrent behavioral health services. This includes the potential process of admitting to, and discharging from, such withdrawal management services one (1) or more times by the individual.
- C. Level 1-WM services are generally provided in a clinical or addiction-focused treatment office, medical health care facility, or home health care-type agency.
- D. Level 1-WM services offered by agencies that do not provide behavioral health services within their agency structure must be affiliated with agencies or other behavioral health providers as needed to ensure the treatment needs of all individuals served can be met. Documentation of this affiliation must be presented to the BHA, upon request. Referral(s) will be provided in collaboration with the individual and their choice(s) for referred services.
- E. Support systems
 - 1. Agencies must:
 - a. Have the ability to obtain a comprehensive medical history and physical examination at the time of admission to Level 1-WM services;
 - b. Have twenty-four (24)-hour access to emergency medical consultation services, should services become indicated;
 - c. Have the ability to provide or assist in accessing transportation services for individuals who lack safe transportation; and
 - d. Have the ability to coordinate services with behavioral health personnel, within the agency or through referral.
- F. Diagnostic criteria

1. Individuals participating in Level 1-WM services typically exhibit a mild to moderate withdrawal severity rating on standardized withdrawal severity scales as well as mild/stable psychiatric symptoms for emotional, behavioral, and cognitive conditions.
 2. Individuals may also present with a higher withdrawal severity rating on standardized withdrawal severity scales, with protective factors and other support system(s) in place to safely participate in this level of outpatient care.
 3. Due to the safety concerns inherent with withdrawal, the following may not be appropriate for Level 1-WM services:
 - a. Individuals who are experiencing withdrawal from more than one class of substance.
 - b. Individuals with recent complicated withdrawal symptoms as identified by ASAM Criteria.
 - c. If the medical personnel determines that an individual meeting one or both of the above criteria can be safely and effectively served in a Level 1-WM setting, the rationale and plan for safe management and services must be documented in the individual's record.
- G. Individuals may be more advanced in their readiness to change and need minimal assistance with transportation and other engagement barriers.
- H. Individuals may participate in Level 1-WM services without a formal substance use disorder diagnosis if collateral information indicates a high probability of such diagnosis. The agency must ensure further evaluation of this probable diagnosis, either completed within the agency or through referral to a behavioral health provider.
- I. Agencies must:
1. Provide safe management and documentation of signs and symptoms of intoxication and withdrawal; and
 2. Ensure that discharge planning begins at the time of admission to Level 1-WM services, to allow for necessary care coordination and transition into ongoing or concurrent treatment services to occur successfully based on screening or assessment of needs.

4.5.2 Personnel

- A. Level 1-WM services are primarily provided by medical professionals who are acting within the scope of their practice and are trained in assessing and managing intoxication and states of withdrawal. This may include, but is not limited to, authorized practitioners.

4.5.3 Service Provisions

- A. Agencies must develop policies and procedures to address service delivery expectations. These policies and procedures must address, but are not limited to the following:
1. Consultation with specialized clinical and medical professionals for individualized Level 1-WM care;

2. Coordinating an individual's transition into other levels of care, determined to be appropriate through triage, screening, evaluation, and/or assessment processes completed during their Level 1-WM services. This may include collaboration with emergency behavioral health services, such as Colorado Crisis Services, as appropriate;
 3. Conducting or arranging for laboratory and/or toxicology tests to be completed;
 4. Responding to individuals who are assessed as being a current threat to themselves or others, including the appropriate use of law enforcement;
 5. Communication with intoxicated individuals leaving Level 1-WM services against personnel recommendations, including the use of emergency commitments; and
 6. Circumstances under which individuals may be discharged from Level 1-WM services, other than completing withdrawal management or leaving against personnel recommendations.
- B. Admission procedures for Level 1-WM services must include at a minimum:
1. Collecting of information regarding the degree of alcohol and/or other drug intoxication as evidenced by breathalyzer, urinalysis, self-report, observation or other evidence-based or best practices;
 2. A pregnancy screening for pregnancy-capable individuals;
 3. Taking of vital signs; and
 4. Administration of a validated clinical withdrawal assessment tool.
- C. Therapies offered by the agency must include a range of treatment approaches and support services based on the screening or assessment of the individual's treatment needs. Treatment services may include but are not limited to:
1. Screening;
 2. Assessment;
 3. Group and individual counseling;
 4. Motivational enhancement;
 5. Family therapy;
 6. Educational groups;
 7. Occupational and recreational therapy;
 8. Addiction pharmacology;
 9. Mental health and physical health pharmacology, as needed;
 10. Medication management;
 11. Peer, social and recovery support;

12. Care coordination; and
 13. Support for the development of life skills.
- D. If the agency does not provide a treatment approach or support service necessary to meet the individual's treatment needs, the agency must ensure that care coordination occurs.
- E. Agencies must provide additional service planning for managing individuals with medical conditions, suicidal ideation, pregnancy, psychiatric conditions, and other conditions which place individuals at additional risk during withdrawal management.
- F. Agencies must provide assessments of individual readiness for treatment and services based on the service plan and the assessments and interventions shall be documented in the individual's record.
- G. Medication-assisted treatment (MAT) for withdrawal management
1. Agencies must continue individuals on their medication-assisted treatment regimen and will only remove individuals from medications treating opioid use disorders at the individual's request or if it is deemed medically appropriate by an authorized practitioner.
 2. Agencies must inform individuals receiving services about access to medication-assisted treatment. Upon the individual's consent, the agency must provide medication-assisted treatment directly.
 3. Agencies must obtain a controlled substance license pursuant to section 21.300 of 2 CCR 502-1 from the BHA if they plan to dispense, compound, or administer a controlled substance from stock medication in order to treat a substance use disorder or to treat the withdrawal symptoms of a substance use disorder.
 - a. A controlled substance license is not required if the agency intends to provide medication-assisted treatment (MAT) services through prescription writing only, under an independent prescriber's license.

4.5.4 Documentation and Timeliness

- A. Upon admission to Level 1-WM services, the agency must complete the following requirements, keeping documentation of timely completion in the individual's record:
1. Conduct a physical examination of the individual. This may be conducted by an authorized practitioner;
 2. Conduct an addiction-focused history of the individual. This may be conducted by an authorized practitioner; and
 3. Utilize screening tools in the process of gathering sufficient biopsychosocial and ASAM dimensional criteria as outlined in Chapter 6 of the ASAM Criteria, to inform an individualized, withdrawal management-focused service plan.
- B. Implementation of the service plan, including any amendments to the service plan and the individual's clinical response to the services provided, must be maintained in the individual's record during the time they remain engaged in Level 1-WM services. This may include withdrawal rating scales or flow sheets that are used, as needed.

- C. The service plan and progression tracking may be indicated in progress notes that align with the existing medical model for documentation.
- D. Individuals may engage in a pattern of admitting to, and discharging from, Level 1-WM services in a repeated and fluid manner throughout a concurrent behavioral health episode of care. Documentation specific to these engagement milestones for Level 1-WM services may be reflected in the existing medical model documentation and does not require a formal discharge summary as detailed in part 2.10.A.5 of these rules.
- E. Considerations for discharge from Level 1-WM services include, but are not limited to:
 - 1. Resolution of withdrawal symptoms;
 - 2. Symptoms that have not improved or have intensified after engaging in Level 1-WM services and the individual requires a higher service, such as Level 2-withdrawal management (Level 2-WM); or
 - 3. The individual is unable to participate in Level 1-WM and may require a different support system or delivery mechanism.
- F. If a higher level of care is required, the Level 1-WM agency must initiate a referral to the appropriate level of care.

4.6 Intensive Outpatient Program (IOP) Services Standards

- A. These rules are established to create standards for agencies seeking a sub-endorsement to provide intensive outpatient program (IOP) services, which includes ASAM Criteria Level 2.1 type services.
- B. Agencies providing intensive outpatient program services must meet the standards in this part 4.6.

4.6.1 Service Delivery and Setting

- A. Individuals receiving this level of service meet diagnostic criteria of acute state moderate severity mental illness, substance use, or co-occurring disorder criteria, as defined in the DSM-5-TR. Individuals may also meet high severity, as defined in the DSM-5-TR, but are stabilized and/or receiving medication-assisted treatment, as defined in part 1.2 of these rules, or pharmacotherapy, as defined in part 1.2 of these rules.
- B. IOP services are intended for individuals who require a higher level of intervention than can be provided in standard outpatient services.
- C. All services must be adapted to the individual's developmental stage and physical and comprehensive needs.
- D. Services may be delivered via in-person, audio-visual telehealth, or audio-only telehealth format in accordance with telehealth regulations found in part 2.9 of these rules.
- E. Treatment groups must not exceed twelve (12) individuals receiving services.
- F. IOP support systems

1. Agencies providing IOP services must have direct affiliation or close coordination through referral to more and less intensive levels of care. Agencies must also have a documented consultation and/or referral process through internal staff or other affiliation in place for medical, psychiatric, and medication-assisted treatment needs.
 - a. Referral(s) will be provided in collaboration with the individual and their choice(s) for referred services.

4.6.2 Personnel

- A. Treatment personnel, for the purpose of this Chapter, unless otherwise noted, means the following behavioral health professionals trained in mental health, substance use, and/or co-occurring disorder identification and treatment and acting within their scope of practice:
 1. Authorized practitioners;
 2. Licensees;
 3. Certified addiction specialists (CAS);
 4. Candidates;
 5. Certified addiction technicians (CAT);
 - a. If utilizing certified addiction technicians (CAT), the agency must ensure that CATs do not comprise more than twenty-five (25%) of the agency's personnel.
 6. Counselors-in-training and/or interns.
 - a. If utilizing counselors-in-training and/or interns, the agency must ensure that all clinical documentation is reviewed and co-signed by a clinical agency supervisor able to supervise pursuant to their scope of practice. Counselor-in-training and/or intern personnel must not comprise more than twenty-five percent (25%) of the agency's personnel.
- B. Agencies providing IOP must ensure treatment personnel have supervisor consultation available within eight (8) hours via in-person or by telehealth to discuss, when warranted, at minimum, psychiatric or medical concerns of individuals receiving services.
- C. Personnel must have supervisor consultation available within one (1) hour via in-person or telehealth to discuss, when warranted crisis/emergency situations.
- D. Services may include recovery support services rendered by peer support professionals in accordance with Chapter 3 of these rules.
- E. Agencies providing IOP services must provide training appropriate to the treatment-type focus and best practice standards.
 1. Training must include that treatment personnel understand the signs and symptoms of mental health, substance use, and co-occurring disorders and the basics of psychopharmacology.

4.6.3 Service Provisions

- A. Services must be conducted in regularly scheduled sessions that follow a planned format of treatment services of nine (9) to nineteen (19) contact hours per week for adults and six (6) to nineteen (19) contact hours per week for children under the age of eighteen (18).
- B. Services may include individual therapy, group therapy, medication-assisted treatment (MAT) monitoring and/or education, psychiatric medication education and/or monitoring, family therapy, peer professional services, educational/occupational groups, recreational therapy, and other therapies as deemed appropriate by assessment of the individual receiving services.

4.6.4 Documentation and Timeliness

- A. Agencies providing IOP services must document services pursuant to the standards set in parts 2.10, 2.11, 2.12, and 2.13 of these rules.
- B. Upon initiation of services to an individual, preliminary screening and risk assessment must be completed in compliance with part 2.12.1 of these rules.
- C. As soon as is practicable upon admission, but no later than ten (10) calendar days from the date of preliminary screening and risk assessment, the agency must complete an initial assessment in accordance with part 2.12.2 of these rules.
 - 1. If the screening and risk assessment identifies an urgent clinical need for treatment of the individual, clinical services must be provided immediately, and the initial assessment must be completed within one (1) calendar day of preliminary screening.
- D. As soon as is practicable upon admission, but no later than sixty (60) calendar days from the first date of services, the agency must complete a comprehensive assessment in accordance with part 2.12.3 of these rules. The requirement that the comprehensive assessment be completed within sixty (60) days does not preclude the initiation or completion of the comprehensive assessment or the provision of treatment during the intervening sixty (60) day period.
- E. Individual service plans must be created, in accordance with part 2.13.1 of these rules, within fourteen (14) calendar days after initial assessment. The service plan must be updated to reflect information from the completed comprehensive assessment. The agency must update the service plan throughout the course of treatment, review previous goals, and update those goals whenever there is a change in the person's level of care or functioning, and must occur, at minimum, every six (6) months.
- F. IOP services must be documented in the individual's record in accordance with part 2.11 and 2.13.2 of these rules and at a minimum frequency of one (1) progress note per session.

4.7 Partial Hospitalization Program (PHP) Services Standards

- A. These rules are established to create standards for agencies seeking a sub-endorsement to provide partial hospitalization program (PHP) services, which includes ASAM Criteria Level 2.5 type services.
- B. Agencies providing partial hospitalization program services must meet the standards in this part 4.7.

4.7.1 Service Delivery and Setting

- A. PHP services must generally be intended for individuals who require daily monitoring or management to treat mental health, substance use, and co-occurring disorders, as defined by the DSM-5-TR, that can be provided in a structured outpatient setting. Services include direct access to medical, psychiatric, and laboratory services.
- B. PHP service sites for children must include access to educational services and coordination with a school system, as appropriate.
- C. PHP services are appropriate for individuals with co-occurring mental health and substance use disorders if the disorders are diagnosed as moderate severity or are of higher severity, as defined by the DSM-5-TR, but have been stabilized.
- D. All services provided must be adapted to individual's developmental stage and physical and comprehensive needs.
- E. Services may be delivered via in-person, audio-visual telehealth, or audio-only telehealth format in accordance with telehealth regulations found in part 2.9 of these rules.
- F. PHP agencies must meet the facility requirements set forth in part 2.6 of these rules or requirements in accordance with facility mandates under other regulatory state and federal entities for licensure in cases such as a medical facility, school, or other.
- G. Treatment groups must not exceed twelve (12) individuals receiving services.
- H. PHP support systems
 - 1. Agencies providing PHP services must inform individuals receiving treatment how to access emergency services by telephone twenty-four (24) hours per day, seven (7) days per week when the program is not in session. At minimum, agencies must provide emergency services information that includes contact information for services provided by the behavioral health crisis response system created pursuant to Section 27-60-103, C.R.S.
 - 2. Agencies providing PHP services must have direct affiliation or close coordination through referral to more and less intensive levels of care. Agencies providing PHP services must also have a documented consultation and/or referral process through internal staff or other affiliation for medical, psychiatric, and medication-assisted treatment needs.
 - a. Referral(s) will be provided in collaboration with the individual and their choice(s) for referred services.

4.7.2 Personnel

- A. Treatment personnel, for the purpose of PHP services, unless otherwise noted, means the following behavioral health professionals trained in mental health and/or substance use disorder identification and treatment and acting within their scope of practice:
 - 1. Authorized practitioners;
 - 2. Licensees;
 - 3. Certified addiction specialists (CAS);
 - 4. Candidates;

5. Certified addiction technicians (CAT);
 - a. If utilizing certified addiction technicians (CAT), the agency must ensure that CATs do not comprise more than twenty-five (25%) of the agency's personnel.
6. Counselors-in-training and/or interns.
 - a. If utilizing counselors-in-training and/or interns, the agency must ensure that all clinical documentation is reviewed and co-signed by a clinical agency supervisor able to supervise pursuant to their scope of practice. Counselor-in-training and/or intern personnel must not comprise more than twenty-five percent (25%) of the agency's personnel.
- B. Services may include recovery support services rendered by peer support professionals in accordance with Chapter 3 of these rules.
- C. Agencies providing PHP services must ensure treatment personnel have supervisor consultation available within eight (8) hours via in-person or by telehealth and within two (2) calendar days in-person or by telehealth, when warranted, at minimum, to discuss at minimum psychiatric or medical concerns of individuals receiving services.
- D. Personnel must have supervisor consultation available within one (1) hour via in-person or telehealth to discuss, when warranted crisis and/or emergency situations.
- E. In addition to trainings required as a BHE in part 2.5 of these rules, PHP endorsed agencies must provide training appropriate to their treatment-type focus, as well as best practice standards.
 1. Training for PHP endorsed agencies must include training that treatment personnel understand the signs and symptoms of mental health, substance use, and co-occurring disorders and the basics of psychopharmacology.
 2. PHP endorsed agencies must ensure that all personnel providing medical services at the PHP have completed and maintained any training required by the personnel's applicable government licensing entity in order to work within behavioral health focused services.

4.7.3 Service Provisions

- A. Mental health - only service provisions
 1. Individuals for this level of treatment meet diagnosed acute state severe and persistent mental illness criteria, as defined in the DSM-5-TR, and are not at current risk of harming themselves or others.
 2. Services must be provided at a minimum of twenty (20) or more hours a week including a minimum of three (3) hours per day and a minimum of four (4) calendar days per week. Service frequency and intensity must be modified to meet assessment and service plan objectives.
 3. Services may include medical services, individual therapy, group therapy, medication management, educational/occupational groups, peer professional services, recreational therapy, and other therapies as deemed appropriate by assessment of the individual receiving services.
- B. Substance use disorder and co-occurring service provisions (including ASAM Criteria Level 2.5)

1. Individuals for this level of treatment meet diagnostic criteria for a substance use related disorder as defined in the DSM-5-TR and are at low risk of withdrawal or have minimal remaining withdrawal symptoms.
2. Services must be conducted with a minimum frequency of twenty (20) regularly scheduled treatment contact hours per week.
3. Services may include medical services, individual therapy, group therapy, medication management, medication-assisted treatment monitoring/education, educational/occupational groups, recreational therapy, peer professional services, and other therapies as deemed appropriate by assessment of individual receiving services.

4.7.4 Documentation and Timeliness

- A. All PHP service documentation requirements must follow the requirements set forth in parts 2.10, 2.11, 2.12, and 2.13 of these rules.
- B. Upon entrance into service, preliminary screening and risk assessment must be completed in compliance with part 2.12.1 of these rules.
- C. As soon as practicable upon admission, but no later than ten (10) calendar days from the date of preliminary screening and risk assessment, the agency must complete an initial assessment in accordance with part 2.12.2 of these rules
 1. If the screening identifies an urgent need, clinical services are provided, and the initial assessment must be completed within one (1) calendar day of preliminary screening.
- D. As soon as practicable upon admission, but no later than sixty (60) calendar days from the first date of services, the agency must complete a comprehensive assessment in accordance with part 2.12.3 of these rules. The requirement that the comprehensive assessment be completed within sixty (60) days does not preclude the initiation or completion of the comprehensive assessment or the provision of treatment during the intervening sixty (60) day period.
- E. The individual service plan must be created, in accordance with part 2.13.1 of these rules, within fourteen (14) calendar days after initial assessment. The service plan must be updated to reflect information from the completed comprehensive assessment. The agency must update the service plan throughout the course of treatment, review previous goals and update those goals whenever there is a change in the person's level of care or functioning, and must occur, at minimum, every fourteen (14) calendar days.
- F. PHP services must be documented in the individual's record in accordance with part 2.11 and 2.13.2 of these rules and at a minimum frequency of one (1) progress note per session and one (1) progress note per week.

4.8 Level 2-Withdrawal Management (Level 2-WM): Ambulatory Withdrawal Management with Extended On-Site Monitoring Services Standards

- A. This part 4.8 is established to create standards for agencies seeking a sub-endorsement to provide outpatient Level 2-Withdrawal Management (Level 2-WM) services in accordance with Chapter 6 of the ASAM Criteria.
- B. Agencies providing Level 2-WM services must meet the standards in this part 4.8. Agencies providing Level 2-WM services may:

1. Also engage in outpatient behavioral health services by meeting the standards for the outpatient sub-endorsement(s) selected by the agency; or
2. Provide only Level 2-WM services and coordinate with other providers for ongoing and concurrent outpatient behavioral health treatment services.

4.8.1 Service Delivery and Setting

- A. Level 2-WM is an outpatient withdrawal management service that complements individualized behavioral health treatment services.
- B. Individuals may participate in Level 2-WM for a period of time in which it is determined to be medically appropriate. Admission to Level 2-WM services must not hinder the individual's ability to participate in concurrent behavioral health services. This includes the potential process of admitting to, and discharging from, such withdrawal management services one (1) or more times by the individual.
- C. Level 2-WM services are generally provided in a day hospital-type setting, general health care facility, or an agency providing substance use disorder or mental health treatment.
- D. Level 2-WM services offered by agencies that do not provide behavioral health services within their agency structure must be affiliated with BHEs or other necessary providers to ensure the treatment needs of all individuals served can be met. Documentation of this affiliation must be presented to the BHA, upon request. Referral(s) will be provided in collaboration with the individual and their choice(s) for referred services.
- E. Support systems
 1. Agencies must:
 - a. Have the ability to obtain a comprehensive medical history and physical examination at the time of admission to Level 2-WM services;
 - b. Have twenty-four (24)-hour access to emergency medical consultation services, should emergency services become indicated;
 - c. Have the ability to provide or assist in accessing transportation services for individuals who lack safe transportation; and
 - d. Have the ability to coordinate services with behavioral health personnel, within the agency or through referral.
- F. Diagnostic criteria
 1. Individuals participating in Level 2-WM services typically exhibit a moderate withdrawal severity rating on standardized withdrawal severity scales as well as mild/stable psychiatric symptoms for emotional, behavioral, and cognitive conditions.
 2. Individuals may also present with a higher withdrawal severity rating on standardized withdrawal severity scales or with higher psychiatric symptom requirements, with sufficient protective factors and other support system(s) in place to safely participate in Level 2-WM services.
 3. Due to the safety concerns inherent with withdrawal, individuals with complicated withdrawal severity ratings may not be appropriate for Level 2-WM services.

- a. If the medical personnel determines that an individual meeting the above criteria can be safely and effectively served in a Level 2-WM setting, the rationale and plan for safe management and services must be documented in the individual's record.
 - 4. Individuals may be more advanced in their readiness to change and may require assistance with transportation or other engagement barriers.
 - 5. Individuals may participate in Level 2-WM services without a formal substance use disorder diagnosis if collateral information indicates a high probability of such diagnosis. The agency must ensure further evaluation of this probable diagnosis, either completed within the agency or through referral to a behavioral health provider.
- G. Agencies must:
- 1. Provide safe management and documentation of signs and symptoms of intoxication and withdrawal; and
 - 2. Ensure that discharge planning begins at the time of admission to Level 2-WM services, to allow for necessary care coordination and transition into ongoing or concurrent treatment services to occur successfully based on screening or assessment of needs.

4.8.2 Personnel

- A. Level 2-WM services are primarily provided by medical professionals who are acting within the scope of their practice and are trained in assessing and managing intoxication and states of withdrawal. This may include, but is not limited to:
- 1. Authorized practitioners; and
 - 2. Nurses.
- B. Level 2-WM is an outpatient service that requires daily monitoring of withdrawal symptoms and assessments of progress. This requires medical personnel to be readily accessible and able to evaluate an individual's needs and safe placement in Level 2-WM.

4.8.3 Service Provisions

- A. Agencies must develop policies and procedures to address service delivery expectations. These policies and procedures must address, but are not limited to the following:
- 1. Consultation with specialized clinical and medical professionals for individualized Level 2-WM care;
 - 2. Coordinating an individual's transition into other Levels of care determined to be appropriate through triage, screening, evaluation, and/or assessment processes completed during their Level 2-WM services. This may include collaboration with emergency behavioral health services, such as Colorado Crisis Services, as appropriate;
 - 3. Conducting or arranging for laboratory and/or toxicology tests to be completed;
 - 4. Responding to individuals who are assessed as being a current threat to themselves or others, including the appropriate use of law enforcement;

5. Communication with intoxicated individuals leaving Level 2-WM services against personnel recommendations, including the use of emergency commitments; and
 6. Circumstances under which individuals may be discharged from Level 2-WM services, other than completing withdrawal management or leaving against personnel recommendations.
- B. Admission procedures for Level 2-WM services must include at a minimum:
1. Collection of information regarding the degree of alcohol and/or other drug intoxication as evidenced by breathalyzer, urinalysis, self-report, observation, or other evidence-based or best practices;
 2. A pregnancy screening for pregnancy-capable individuals;
 3. Taking of vital signs; and
 4. Administration of a validated clinical withdrawal assessment tool.
- C. Therapies offered by the agency must include a range of treatment approaches and support services based on the screening or assessment of the individual's treatment needs. Treatment services may include but are not limited to:
1. Screening;
 2. Assessment;
 3. Group and individual counseling;
 4. Motivational enhancement;
 5. Family therapy;
 6. Educational groups;
 7. Occupational and recreational therapy;
 8. Addiction pharmacology;
 9. Mental health and physical health pharmacology, as needed;
 10. Medication management;
 11. Peer, social and recovery support;
 12. Care coordination; and
 13. Support for the development of life skills.
- D. If the agency does not provide a treatment approach or support service necessary to meet the individual's treatment needs, the agency must ensure that care coordination occurs.
- E. Agencies must provide additional service planning for managing individuals with medical conditions, suicidal ideation, pregnancy, psychiatric conditions, and other conditions which place individuals at additional risk during withdrawal management.

- F. Agencies must provide assessments of individual readiness for treatment and services based on the service plan and the assessments and interventions shall be documented in the individual's record.
- G. Medication-assisted treatment (MAT) for withdrawal management
 - 1. Agencies must continue individuals on their medication-assisted treatment regimen and will only remove individuals from medications treating opioid use disorders at the individual's request or if it is deemed medically appropriate by an authorized practitioner.
 - 2. Agencies must inform individuals receiving services about access to medication-assisted treatment. Upon the individual's consent, the agency must provide medication-assisted treatment directly.
 - 3. Agencies must obtain a controlled substance license pursuant to section 21.300 of 2 CCR 502-1 from the BHA if they plan to dispense, compound, or administer a controlled substance from stock medication in order to treat a substance use disorder or to treat the withdrawal symptoms of a substance use disorder.
 - a. A controlled substance license is not required if the agency intends to provide medication-assisted treatment (MAT) services through prescription writing only, under an independent prescriber's license.

4.8.4 Documentation and Timeliness

- A. Upon admission to Level 2-WM services, the agency must complete the following requirements, keeping documentation of timely completion in the individual's record:
 - 1. Conduct a physical examination of the individual. This may be conducted by an authorized practitioner;
 - 2. Conduct an addiction-focused history of the individual. This may be conducted by an authorized practitioner; and
 - 3. Utilize screening tools in the process of gathering sufficient biopsychosocial and ASAM dimensional criteria as outlined in Chapter 6 of the ASAM Criteria, to inform an individualized, withdrawal management-focused service plan.
- B. Implementation of the service plan, including any amendments to the service plan and the individual's clinical response to the services provided, must be maintained in the individual's record during the time they remain engaged in Level 2-WM services. This may include serial medical assessments, withdrawal rating scales and/or flow sheets that are conducted, as needed.
- C. The service plan and progression tracking may be indicated in progress notes that align with the existing medical model for documentation.
- D. Individuals may engage in a pattern of admitting to, and discharging from, Level 2-WM services in a repeated and fluid manner throughout a concurrent behavioral health episode of care. Documentation specific to these engagement milestones for Level 2-WM services may be reflected in the existing medical model documentation and does not require a formal discharge summary as detailed in part 2.10.A.5 and 2.10.A.6 of these rules.
- E. Considerations for discharge from Level 2-WM services include, but are not limited to:

1. Resolution or diminishing of withdrawal symptoms, that allow the individual to be safely served at a lower service level, such as Level 1-WM;
 2. Symptoms that have not improved or have intensified after engaging in Level 2-WM services and the individual requires a higher service, such as Level 3-withdrawal management (Level 3-WM); or
 3. The individual is unable to participate in Level 2-WM and may require a different support system or delivery mechanism.
- F. If a different level of care is required, the agency providing Level 2-WM services must initiate a referral to the appropriate level of care.

Chapter 5: Behavioral Health Residential and Level 3-Withdrawal Management Services

5.1 Authority and Applicability

- A. Chapter 5 establishes the standards for agencies electing to provide behavioral health residential and/or Level 3-Withdrawal Management (Level 3-WM) services. The authority to promulgate these service-specific requirements that apply to BHEs electing to provide this service comes from Sections 27-50-502(1), 27-50-106, 27-50-301(5), 27-71-105(1), and 27-50-107(3)(b), C.R.S.
- B. These rules are established to create standards for agencies seeking an endorsement to provide behavioral health residential and/or Level 3-WM.
- C. In addition to the overall endorsement associated with this Chapter 5, agencies must hold the relevant sub-endorsement(s) to provide these services, as detailed below. The sub-endorsements build in alignment with the natural progression of the continuum of care, with parts that detail applicability standards as noted in parts 5.4 through 5.11 of this Chapter.
- D. Agencies must elect a treatment type sub-endorsement to provide services to individuals, which may include mental health treatment services, substance use disorder treatment services, or both.
- E. Agencies are not required to serve all treatment types within their selected sub-endorsement(s). If the agency does not provide a service needed by an individual, the agency must ensure that care coordination for the needed service occurs.
- F. Agencies providing behavioral health residential services must meet the standards in:
1. This part 5.1 through part 5.3 of this Chapter; and
 2. The standards required for the sub-endorsement(s) of the agency that are set forth in these rules, including treatment type(s) provided.
- G. Agencies providing Level 3-WM services must meet the standards in:
1. This part 5.1 through part 5.2 of this Chapter; and
 2. The standards required for the sub-endorsement(s) of Level 3-WM services provided by the agency as set forth in part 5.6 and/or part 5.11 of this Chapter.
- H. The continuum of behavioral health residential and Level 3-WM services are set forth in the following section of this Chapter:

1. Clinically monitored services, part 5.4 of this Chapter, including:
 - a. Level one mental health transitional living homes: part 5.4 of this Chapter.
 2. Clinically managed services, part 5.5 through part 5.9 of this Chapter, including:
 - a. ASAM 3.1-type services: part 5.5 of this Chapter.
 - b. Level 3.2-WM services: part 5.6 of this Chapter.
 - c. ASAM Level 3.3 services: part 5.7 of this Chapter.
 - d. Level two mental health transitional living homes: part 5.8 of this Chapter.
 - e. ASAM 3.5-type services: part 5.9 of this Chapter.
 3. Medically monitored services, part 5.10 through 5.11 of this Chapter, including:
 - a. ASAM 3.7-type services, part 5.10 of this Chapter.
 - b. Level 3.7-WM services, part 5.11 of this Chapter.
- I. If the agency provides services to both mental health and substance use disorder treatment types, they must meet the standards of all relevant sub-endorsement(s) set forth in this Chapter as noted above.

5.2 Behavioral Health Residential and Level 3-Withdrawal Management (Level 3-WM) Services Standards

- A. This part 5.2 applies to all agencies providing behavioral health residential and/or Level 3-Withdrawal Management (Level 3-WM) services.

5.2.1 Service Delivery and Setting

- A. The agency must promote safety and avoid abuse, including psychological abuse, for all individuals served by the agency. The agency must prioritize the living space assignment process to ensure person-centered and trauma-informed services are received by the individual and overall milieu. Factors to be considered in the determination of a safe living space assignment may include, but are not limited to:
1. Age (child, youth or adult);
 2. Gender identity;
 3. Cultural needs identified during the assessment process;
 4. The individual's sex (male, female, intersex);
 5. Individual's ability to interact safely with others; and
 6. The individual's requests.
- B. The agency must have physical barriers such as doors and walls, and personnel oversight of activities to ensure safety for all personnel and individuals served. This management may also include, but is not limited to:

1. Personnel oversight, such as workstations that separate living space assignments;
2. Video or other monitored oversight that promptly notifies personnel of unexpected movement in the milieu; and
3. Other practical arrangements that support the safe management of the individuals receiving services.

5.2.2 Personnel

- A. Agencies providing behavioral health residential and/or Level 3-WM services must have on-site personnel twenty-four (24) hours per day, seven (7) days per week.
 1. This coverage may include a combination of personnel qualified to provide treatment to individuals receiving services as well as personnel who are trained to provide milieu management services.
 2. Personnel qualified to provide treatment may also provide milieu management, as noted below.
 3. On-site personnel must be sufficient to address the needs of the individuals served as well as the safety of personnel providing oversight. See the relevant sub-endorsement(s) in this Chapter for specific ratios of individuals served to personnel, if applicable.
- B. Minimum agency personnel ratios, percentages and requirements are specific to each physical location where services are being provided. This includes on-call personnel that may assist the site, as needed.
- C. The qualifications and credentialing of personnel providing treatment must be reflective of the population(s) receiving services and meet the minimum standards and ratios present in the relevant sub-endorsement(s), as applicable.
- D. Treatment personnel
 1. For agencies providing clinically managed or medically monitored residential and/or Level 3-WM services, personnel qualified to provide treatment means the following behavioral health professionals acting within their scope of practice and trained in mental health and/or substance use disorder identification and treatment:
 - a. Authorized practitioners;
 - b. Licensees;
 - c. Candidates;
 - d. Counselors-in-training; and
 - e. Interns.
 2. Agencies providing residential substance use disorder, residential co-occurring, and/or Level 3-WM services may also utilize the following as treatment personnel, when applicable:
 - a. Certified addiction specialists (CAS); and

- b. Certified addiction technicians (CAT).

E. Milieu management personnel

1. In addition to the treatment personnel noted in part 5.2.2.D of this Chapter, agencies providing behavioral health residential and/or Level 3-WM services may utilize the following personnel for milieu management:
 - a. Peer support professionals, and
 - b. Group living workers.
 - (1) If utilizing group living workers for milieu management, these personnel must:
 - (a) Be assigned duties and responsibilities that are within their training and scope of practice. They must not perform tasks that are required to be performed by treatment personnel as outlined in part 5.2.2.D; and
 - (b) Be assigned to the clinical director, a licensee, or authorized practitioner for training and oversight of milieu management services provided.
 - (c) If correctional personnel, such as security or correctional officers, are utilized as group living workers within an agency that provides services in a correctional setting, they must be responsive and accountable to the clinical director or other assigned clinical supervisor to ensure the culture of the program is supported.
2. If utilizing peer support professionals for milieu management, the agency must follow standards for recovery support services rendered by peer support professionals in accordance with Chapter 3 of these rules.
3. Agencies that have shifts without credentialed personnel on-site as a result of utilizing CATs, counselors-in-training, interns, peer support professionals, and/or group living workers for milieu management must ensure that consultation with a credentialed person is immediately available. This consultation must be provided by the clinical director, a licensee, or an authorized practitioner.
 - a. Excluding clinically monitored services, this consultation must include an on-site response by the credentialed personnel within thirty (30) minutes if needed.

5.2.3 Service Provisions

- A.** Agencies providing behavioral health residential and/or Level 3-WM services must offer a range of treatment approaches and support services to meet the individual's treatment needs, as determined by the screening and/or assessment process. Services offered may include, but are not limited to:
1. Screening;
 2. Comprehensive assessment;

3. Group and individual counseling;
 4. Motivational enhancement;
 5. Family therapy;
 6. Educational groups;
 7. Occupational and recreational therapy;
 8. Behavioral health pharmacology;
 9. Physical health pharmacology;
 10. Medication management;
 11. Peer, social and recovery support;
 12. Care coordination; and
 13. Support for the development of life skills.
- B. If the agency does not provide a treatment approach or support service necessary to meet the individual's treatment needs, the agency must ensure that care coordination for the needed service occurs.

5.2.4 Documentation and Timeliness

- A. See the behavioral health residential and/or Level 3-WM services sub-endorsement(s) as set forth in this Chapter for relevant documentation and timeliness standards.

5.3 Behavioral Health Residential Services

- A. This part 5.3 applies to all agencies providing behavioral health residential services.
- B. This part 5.3 does not apply to agencies providing only Level 3-WM services.

5.3.1 Service Delivery and Setting

- A. Agencies providing behavioral health residential services must ensure that they can sufficiently provide for the behavioral health needs of all individuals served. These services may occur through direct service provision by agency personnel or through the coordination of services with other agencies endorsed to provide the services an individual requires.
- B. Agencies must prioritize the development of necessary living skills to support the individual's successful integration, or reintegration, into independent or other living situations within their community. This may include services developed for participation by all individuals as well as services tailored to an individual's assessed needs.
- C. Services offered by the agency must be regularly scheduled and relevant to the treatment type and population receiving services.
- D. Agencies providing behavioral health residential services must:

1. Have direct affiliation or close coordination through referral to more and less intensive levels of behavioral health care;
2. Have the ability to conduct or arrange for laboratory and/or toxicology tests to be completed; and
3. Develop and maintain house rules as noted in part 5.3.3.C of this Chapter.

5.3.2 Personnel

- A. All personnel must receive training and demonstrate competency in areas relevant to their specific duties and responsibilities prior to working independently in the residential setting. Training may be provided through formal instruction, self-study courses, or on-the-job training. Personnel training must include, but is not limited to the following topics:
 1. House rules development, implementation, and updating; and
 2. How to access and utilize an individual's psychiatric advanced directive (PAD), when applicable.
 - a. If the individual does not have a PAD completed, personnel must offer to assist in PAD completion if the individual is interested and it is clinically appropriate.

5.3.3 General Provisions

- A. Between 10 pm and 6 am, personnel must conduct, and document safety checks of all individuals served. The intervals in which safety checks are completed must be sufficient to provide for the health and safety of the individuals being served.
- B. The agency must ensure that telephone services available on-site include videophones for hearing or speech-impaired individuals served.
- C. House rules
 1. The agency must establish written house rules and place them in a location where they are always available to individuals and visitors.
 2. The agency must develop policies and procedures regarding house rules which includes a list of all possible actions which may be taken by the agency if any rule is knowingly violated by an individual served, and how the agency will document violations and actions taken.
 3. House rules must address, at a minimum, the following items:
 - a. Smoking and tobacco utilization, including the use of electronic cigarettes, vaporizers, and chewing tobacco;
 - b. Cooking;
 - c. Visitors;
 - d. Telephone usage, including frequency and duration of calls;
 - e. Use of common areas and devices, such as television, radio, and computer;

- f. Consumption of alcohol and marijuana; and
 - g. Pets.
 - (1) Service animals, as determined by the Americans with Disabilities Act (ADA), are not classified as pets. House rules must not limit an individual's right to have a service animal while served by the agency.
 - 4. House rules must not:
 - a. Take the place of, or conflict with, any requirements of these rules; or
 - b. Delay, discourage, or prevent an individual's exercise of their rights.
 - 5. The agency must revisit and update house rules at least annually and allow for collaboration and feedback from individuals.
- D. Court ordered referrals for residential services may require a length of stay that is based on a legal requirement and may not be clinically necessary for the duration of that period of time. The agency is expected to evaluate if the supervising entity's recommendation matches the individual's assessed clinical needs. The agency must address any differences identified with the supervising entity directly and document the results in the individual's record.
- E. See the behavioral health residential services sub-endorsement(s) as set forth in this Chapter for relevant service provision standards.

5.4 Level One Mental Health Transitional Living Home Services

- A. This part 5.4 applies to agencies operating level one mental health transitional living homes. This level of care is defined in Chapter 1 of these rules.

5.4.1 Service Delivery and Setting

- A. Level one mental health transitional living homes shall comply with the requirements of parts 5.1 through this part 5.4, unless otherwise noted.

5.4.2 Personnel

- A. To determine level of oversight needed to ensure safety, the agency shall consider, at a minimum, the following items:
- 1. The acuity and needs of the individuals, and
 - 2. The services outlined in the service plan of an individual.
- B. Personnel shall be sufficient in number to help individuals needing or potentially needing assistance, and to account for the risk of accident, hazards, or other challenging events based on the number of individuals in residence.
- C. When determining personnel requirements, the agency must consider the needs of the individuals receiving services. Oversight of individuals must include on-site and on-call availability of personnel with appropriate training and expertise based on the needs of the individuals.

- D. Personnel must be assigned to complete tasks commensurate with their skills and training. Personnel that are not licensed or credentialed shall not complete specialized screenings, assessments, therapies, or techniques for which they are not qualified.
- E. Only personnel with the appropriate training and expertise may train personnel on specialized techniques beyond general personal care and assistance with activities of daily living as defined in these rules. This includes, but is not limited to, transfers requiring specialized equipment, and assistance with therapeutic diets. Personnel must be evaluated for proficiency in demonstrating the specialized technique before the delivery of a personal service requiring a specialized technique.
 - 1. Documentation regarding training and proficiency in specialized techniques must be included in the personnel files.
- F. A nurse who is employed or contracted by the agency may delegate to other personnel in accordance with the Nurse and Nurse Aide Practice Act pursuant to Article 255 of Title 12, C.R.S., if the nurse is the supervising nurse for the personnel.
- G. The agency shall ensure that personnel comply with all agency policies and procedures and shall not allow personnel to perform any functions which are outside of their job description, scope of practice, or an individual's service plan.
- H. Personnel providing non-medical transportation to individuals must meet the following requirements:
 - 1. Must be eighteen (18) years of age or older to render services;
 - 2. Has at least one year of driving experience;
 - 3. Possesses a valid driver's license;
 - 4. Has provided a copy of their current Colorado motor driving vehicle record, with up to the previous seven years of driving history as applicable; and
 - 5. Has completed a Colorado or national-based criminal history record check.
- I. Vehicles used during the provision of non-medical transportation must be safe and in good working order. To ensure the safety and proper functioning of the vehicles, vehicles must pass a vehicle safety inspection prior to it being used to render services. Inspection requirements must be outlined in the agency's policies and procedures, and records of such inspections must be maintained by the agency.
- J. The agency shall have policies and procedures for determining when personnel are not permitted to provide non-medical transportation based on violations presented on the driver's motor vehicle record.
- K. An agency that uses a separate agency, organization, or personnel to provide services for the mental health transitional living home or a specific individual shall have a written agreement that sets forth the terms of the arrangement. The agreement must specify, at a minimum, the following items:
 - 1. The specific services to be provided;
 - 2. The time frame for the provision of such services;

3. The contractor's obligation to comply with all applicable agency policies and procedures, including personnel qualifications;
 4. How such services will be coordinated and overseen by the agency; and
 5. The procedure for payment of services provided under the contract.
- L. If contract personnel and/or services are used, the agency shall ensure the contractor meets all applicable requirements of these regulations.
- M. Notwithstanding the above criteria, the agency shall retain responsibility to ensure the health, safety and welfare of the individuals, and the provision of necessary services, including but not limited to, the minimum necessary services set forth in part 5.5.1.B.

5.4.3 Service Provisions

- A. The agency shall ensure the provision of accommodations, personnel, and services necessary for the welfare and safety of individuals.
- B. The agency shall make available, either directly or indirectly through contracted services, the following services, sufficient to meet the needs of the individuals. These services must include but are not limited to:
1. A physically safe and sanitary environment that includes, but is not limited to, measures to reduce the risk of potential hazards in the physical environment and that accounts for the unique characteristics of the resident population;
 - a. When a transitional living home utilizes a delayed egress door at an exit point, the exit door must allow full egress in emergencies, and must only be used to assist personnel in maintaining supervision and redirecting individuals back into the care setting.
 - b. Egress alert devices must only be used to assist personnel in redirecting individuals back into the mental health transitional living home when personnel are alerted to an individual's departure, as opposed to restricting the free movement of individuals.
 2. Room and board;
 3. Personnel to assist with personal services;
 4. Assistance with medication;
 5. Life skills training;
 - a. The agency shall support individuals to maintain and develop skills for independent living through regular, structured individual and group engagement opportunities.
 - b. Training opportunities must include therapeutic and habilitative activities to facilitate the development of life skills and promote independent living and must support the pursuit of individual's interests and goals.
 - c. The agency shall document in the record the individual's engagement and progress in life skills training and other training opportunities.

- d. If requested, the agency shall assist an individual with identifying and accessing outside services and community events.
- 6. Intensive case management;
 - a. As appropriate for the needs of the individual, the agency shall:
 - (1) Convene the individual, their legal representative and/or the persons involved in the individual's treatment and care, including medical and behavioral health providers, and persons identified by the individual, for the purpose of care planning and coordination, in order to facilitate wellness, self-management, and recovery of the whole person.
 - (2) Provide proactive and intentional outreach and engagement with the individual and their identified support persons to build necessary trust and support.
 - (3) Assess for support needs, risk factors and health related social needs and support the individual in accessing care, resources, and services to address health related social needs including but not limited to:
 - (a) Food security
 - (b) Housing stability and security
 - (c) Personal safety
 - (d) Access to health services including preventative health care
 - (e) Physical health concerns for which the individual is not receiving adequate treatment
 - (f) Ongoing behavioral health care needs
 - b. Intensive case management must involve discharge planning in accordance with the requirements of part 2.10.A.6 of these rules.
- 7. Non-medical transportation and access to the community
 - a. The agency shall provide for community access through non-medical transportation services. This includes providing accessible transportation when an individual requires adaptive supports.
- C. Agencies will arrange for the individual to receive community-based behavioral health services.
- D. The agency shall assume responsibility for all services it provides, including those provided by contract.
- E. Services provided by or coordinated by the agency may be provided via telehealth at the discretion of the administrator, to the extent that such services meet the needs of the individual, fulfill the requirements set forth in this Chapter, and account for individuals' preferences for service delivery
- F. Admission and discharge

1. The agency shall ensure, prior to admission and move-in, that an individual's needs can be fully met either directly or through coordination with additional providers. The agency's ability to meet individual needs must be based upon a comprehensive pre-admission assessment of an individual's physical, mental, and social needs, which must be documented in, and become part of, the individual's record. The pre-admission assessment must also include all screening and initial assessment requirements set forth in part 2.12 of these rules.
2. An agency shall not admit any individual who:
 - a. Needs regular 24-hour medical or nursing care,
 - b. Has an acute physical illness which cannot be safely managed through medication or prescribed therapy
3. The agency shall arrange for the transfer or transition of care for any individual who has an acute physical illness which cannot be safely managed through medication or prescribed therapy, or for an individual who develops a need for 24-hour medical or nursing care
4. Prior to discharging an individual because of increased care needs, which may include, but are not limited to, changes in health status or where an individual becomes an imminent danger to self or others, the agency shall make documented efforts to meet the individual's needs through other means. The documented efforts must include:
 - a. Taking all measures necessary to protect the individual and others, including following agency policies and procedures for behavioral and physical health emergencies, as required per parts 2.10.D and 2.10.E of these rules;
 - b. Reassessing the individual and revising their service plan to identify the individual's current needs and what services the agency will provide or coordinate to meet those needs or address newly assessed risks; and
 - c. Ensuring all personnel are aware of any revisions to the service plan and are properly trained to provide supervision and support consistent with the service plan.
5. The agency shall coordinate a voluntary or involuntary discharge with the individual, the individual's legal representative and/or the persons, including medical and behavioral health providers, who will be responsible for services provided to the individual per the discharge plan.
6. In the event an individual is transferred to another health care provider for additional care, the agency shall arrange to evaluate the individual prior to readmission or shall discharge the individual in accordance with the discharge procedures set forth in this Chapter.
7. When an individual is discharged, it is the responsibility of the agency to develop a discharge plan, and provide care coordination to facilitate, to the extent possible, the individual's transition to an appropriate level of care. Care coordination efforts must be documented and maintained within the individual's record.

G. Practitioner assessment

1. The agency shall have policies and procedures that are consistent with state and federal law for promptly contacting the individual's authorized practitioner for assessment when:
 - a. The individual experiences a significant change in their baseline status;
 - b. The individual has known exposure to a communicable disease;
 - c. The individual develops any condition which would have initially precluded admission to the agency;
 - d. The individual has any observed or reported unfavorable reactions to medications;
 - e. The individual is affected by a medication error; and/or
 - f. The individual engages in a pattern of refusing medications or medical recommendations.
2. The agency shall ensure that any of the events in this part 5.4.3.G of this Chapter are documented in the individual's record.
3. As applicable, the individual's legal representative must be promptly notified any time assessment is indicated per this part.

5.4.4 Documentation and Timeliness

A. Comprehensive individual assessment

1. Within ten (10) calendar days of admission, the agency shall complete a comprehensive assessment that meets the requirements set forth in part 2.12 of these rules as well as the requirements of this part 5.4.4.A. The assessment must reflect information requested and received from the individual, the individual's representative if requested by the individual, and an authorized practitioner. Information from the comprehensive assessment must be used to establish an individualized service plan.
2. The comprehensive assessment must include all the following items:
 - a. Information from the comprehensive pre-admission assessment described in part 5.4.3.F.1;
 - b. Information regarding the individual's overall health and physical functioning ability, including supports needed with activities of daily living;
 - c. Communication ability and any specific needs to facilitate effective communication;
 - d. Food and dining preferences, unique dietary needs, allergies, and restrictions;
 - e. Reactions to the environment and others, including changes that may occur at certain times or in certain circumstances;
 - f. Routines and interests;
 - g. Safety awareness;

- h. Types of physical, mental, and social support required;
 - i. History of or potential risk of harm to self or others, including aggressive behaviors, and any known approaches to prevent future occurrences including previously developed safety plans.
 - 3. The comprehensive assessment must be documented in writing and kept in the individual's health information record.
 - 4. The comprehensive assessment must be updated for each individual at least every six (6) months and whenever the individual's condition changes from baseline status.
 - B. Individual service plan
 - 1. An initial service plan, based upon information from the pre-admission assessment described in part 5.4.3.G.1 of this Chapter, must be developed within twenty-four (24) hours of admission and must address, at a minimum, an individual's daily support needs, including assistance with activities of daily living, medication management, behavioral and physical health diagnoses, and support needs.
 - 2. Within fourteen (14) calendar days of completion of the comprehensive assessment, the agency shall develop a comprehensive service plan. In addition to the requirements of part 2.13.1 of these rules, the service plan must:
 - a. Be developed with input from the individual and the individual's representative, if applicable;
 - b. Reflect the most current assessment information;
 - c. Promote individual choice, mobility, independence and safety;
 - d. Detail specific personal service needs and preferences along with the supports necessary to meet those needs; personal service needs must consider:
 - (1) individual prioritized needs for life skills training, and
 - (2) medical and therapeutic care needs;
 - e. Identify all external service providers along with care coordination arrangements;
 - f. Identify engagement opportunities that match the individual's personal choices and needs; and
 - g. Outline a plan for ensuring the individual's behavioral health care needs are met, which may include access to community-based services.
 - 3. The agency shall be responsible for the coordination of individual care services with external service providers identified in the individual service plan.
 - 4. The agency shall be responsible for implementing recommendations made by the external service providers identified in the individual service plan.
 - 5. As applicable, the agency shall ensure that an individual receives nursing and therapeutic supports prescribed by the individual's authorized practitioner.

6. Only personnel employed or contracted by the agency may provide or assist with nursing or therapeutic services on behalf of the agency.
7. If the agency utilizes delayed egress or egress alert devices, it must be noted within the individual's service plan.
8. The service plan must be updated for each individual at least every six (6) months and whenever the individual's condition changes from baseline status.

C. Records

1. In addition to the requirements set forth in part 2.11 of these rules, individual records must contain, but not be limited to, the following minimum items:
 - a. Current practitioner orders;
 - b. Individualized service plan;
 - c. Daily progress notes, in accordance with part 2.13.2 of these rules, which must include information on individual status, well-being, and engagement, as well as documentation regarding any out of the ordinary event or issue that affects an individual's physical, behavioral, cognitive and/or functional condition, along with the action taken by personnel to address that individual's changing needs; and
 - d. Documentation of physical and mental health care services received including any on-going services provided by external service providers.

5.5 Clinically Managed Residential Services, Including ASAM 3.1-Type Services

- A. This part 5.5 applies to agencies providing ASAM 3.1-type clinically managed behavioral health residential services.
- B. This part 5.5 does not apply to agencies providing only Level 3-WM services.
- C. This part 5.5 does not apply to recovery residences, as defined in BHA rule section 21.500 of 2 CCR 502-1.

5.5.1 Service Delivery and Setting

- A. These services are intended for individuals who may benefit from twenty-four (24) hour structure and supportive services to develop, practice, and integrate coping skills in preparation for reintegration into their community of choice. Group homes, community corrections agencies, or other supportive living environments that provide twenty-four (24) hour on-site personnel, a focus on community re-integration, and treatment services on-site are examples of this level of care.
- B. Agencies must ensure individuals receiving services have at least one (1) of the following concerns to address during their residential episode of care:
 1. A history of mental health, substance use, or co-occurring disorders;
 2. A lack of stable or supportive housing options;
 3. Unemployment or education concerns; and/or
 4. Social or psychological dysfunction that necessitates this twenty-four (24) hour structure.

- C. Agencies must provide services that include (1) motivational enhancement to increase the individual's level of readiness to change and (2) individual monitoring and support to facilitate the discovery of the individual's needs. Services must also prioritize continued engagement in treatment services beyond the residential episode of care.
- D. The length of stay allows individuals to remain in residential services for a sufficient period of time to familiarize themselves with and integrate the skills obtained into regular use.
- E. Support systems
 - 1. Agencies must:
 - a. Ensure the availability of telehealth or on-site consultation with an authorized practitioner or nurse twenty-four (24) hours per day, seven (7) days per week;
 - b. Ensure the availability of consultation with emergency services twenty-four (24) hours per day, seven (7) days per week; and
 - c. Have the capacity to arrange for medication-assisted treatment (MAT) and/or psychiatric medications in a timely manner for individuals served.
 - (1) This may include services provided through coordination and referral but must not exceed twenty-four (24) hours from the time the need is identified to when arrangements are made.

5.5.2 Personnel

- A. Agencies must maintain an individual-to-personnel ratio not exceeding twenty to one (20:1) at all times, per physical location. This includes nighttime and weekend hours.

5.5.3 Service Provisions

- A. Services must be regularly scheduled and include a minimum of five (5) hours of planned treatment services per week for each individual in care.

5.5.4 Documentation and Timeliness

- A. Agencies must complete and document the following items in the individual's record within twenty-four (24) hours of admission:
 - 1. All required demographic, intake and consent paperwork, as specified in part 2.11 of these rules;
 - 2. Screenings, as required in part 2.12.1 of these rules;
 - 3. The initial assessment as required in part 2.12.2 of these rules; and
 - 4. The initial service plan, addressing immediate needs and other relevant concerns identified in the initial assessment, as required in part 2.13.1 of these rules.
- B. Screenings and assessments conducted in accordance with this part 5.5.4.A must be used to determine appropriateness for this level of care.

- C. As soon as possible, but no later than ten (10) calendar days after an individual's admission, the agency must complete and document the comprehensive assessment for the individual, as required in part 2.12.3 of these rules.
- D. As soon as possible, but no later than three (3) calendar days after an individual's comprehensive assessment is completed, the agency must complete and document an individualized and comprehensive service plan, informed by the comprehensive assessment, as required in part 2.13.1 of these rules.
- E. If the individual's comprehensive assessment indicates they may benefit from further evaluation, medication, and/or specialty behavioral health care to address mental health, substance use-specific, or co-occurring needs, the agency must ensure their individualized treatment needs are addressed during the episode of care. The individual record must contain documentation reflecting how these assessed needs were met.
- F. Service plan reviews and revisions must be completed and documented in the individual's record when there is a change in the individual's level of functioning or service needs, but in no case may service plan reviews and revisions occur later than:
 - 1. Monthly for the first six (6) months after admission, and
 - 2. At least quarterly for the remainder of time that the individual remains in residential services.
- G. Progress notes must be present in the individual's record, in accordance with part 2.13.2 of these rules and must be completed at least weekly for this level of care.

5.5.5 Treatment Type Standards for Residential Services, Including ASAM 3.1-Type Services

- A. Agencies that provide mental health-only or co-occurring residential services must ensure that individuals served meet at least one (1) of the following criteria:
 - 1. Are diagnosed with a serious mental illness (SMI) or comorbid diagnoses at a mild to moderate level defined in the DSM-5-TR, or
 - 2. Have sufficient collateral information present that indicates a high probability of a serious mental illness or comorbid diagnoses at a mild to moderate level as defined in the DSM-5-TR.
- B. Agencies that provide co-occurring or substance use disorder-only residential services at an ASAM 3.1-type must ensure the following personnel requirements are met:
 - 1. If utilizing certified addiction technicians (CAT), these personnel do not comprise more than twenty-five percent (25%) of the agency's total personnel, and
 - 2. If utilizing counselors-in-training and/or interns, these personnel do not comprise more than twenty-five percent (25%) of the agency's total personnel.

5.6 Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM) Services

- A. This part 5.6 applies to agencies providing withdrawal management services at an ASAM 3.2-WM level of care.
- B. This part 5.6 does not apply to agencies providing behavioral health residential services only.

5.6.1 Service Delivery and Setting

- A. Level 3.2-WM services provide a twenty-four (24) hour setting in which individuals may withdraw from substances while supervised by personnel, responsible for the implementation of medical provider-approved protocols.
- B. Agencies must develop policies and procedures to address service delivery expectations. These policies and procedures must address, but are not limited to the following:
 - 1. Consultation with specialized clinical and medical professionals for individualized withdrawal management care;
 - 2. Coordinating an individual's transition into other levels of care, determined to be appropriate through triage, screening, evaluation, and/or assessment processes completed during the course of Level 3.2-WM services. This may include collaboration with emergency behavioral health services, such as Colorado Crisis Services, as appropriate;
 - 3. Conducting or arranging for laboratory and/or toxicology tests to be completed;
 - 4. Responding to individuals who are assessed as being a current threat to themselves or others. This must include appropriate use of law enforcement and monitoring any use of individual restraint and/or seclusion in accordance with part 2.14 of these rules;
 - 5. Communication with intoxicated individuals leaving treatment against personnel recommendations, including the use of emergency commitments; and
 - 6. Circumstances under which individuals must end Level 3.2-WM services, other than completing services or leaving against personnel recommendations.
- C. Support systems
 - 1. Agencies must:
 - a. Implement protocols that are developed and supported by a physician knowledgeable in addiction medicine;
 - b. Have protocols in place to address an individual's evolving treatment and withdrawal needs, including protocols for if the individual's condition deteriorates and requires medical or nursing care services;
 - c. Have protocols that clearly determine the nature of medical or nursing care required. These protocols must include how to determine when nursing and/or physician care is warranted, and/or when transfer to a medically monitored facility or acute care hospital is necessary;
 - d. Ensure that medical evaluation and consultation is available twenty-four (24) hours per/day; and
 - e. Ensure that medications that are self-administered, monitored, or dispensed at the agency are supervised and documented in accordance with agency policy and procedures, state, and federal law.
- D. Diagnostic criteria

1. Individuals participating in Level 3.2-WM services are generally intoxicated, under the influence, or in any stage of withdrawal from alcohol and/or other drugs.
2. In addition to the ASAM Criteria guidelines detailed in part 2.12.3.C of these rules, individuals participating in Level 3.2-WM services must meet the diagnostic criteria for substance withdrawal disorder, as indicated in the DSM-5-TR.
3. Upon admission to Level 3.2-WM services, the agency must complete the following minimum requirements:
 - a. Collect information regarding the degree of alcohol and/or other drug intoxication as evidenced by breathalyzer, urinalysis, self-report, observation or other evidence-based or best practices;
 - b. A pregnancy screening for pregnancy-capable individuals;
 - c. Taking of vital signs; and
 - d. Administration of a validated clinical withdrawal assessment tool.
- E. The agency must conspicuously post procedures for responding to circumstances and events that warrant entering a divert status.

5.6.2 Personnel

- A. Personnel must be trained in, and evaluated in knowledge of the following areas before providing services independently, if within their scope of practice and job description:
 1. Withdrawal management process;
 2. Monitoring vital signs;
 3. Conducting assessment and triage, including identifying and properly responding to suicidal ideation;
 4. Collecting urine and breath samples; and
 5. Basic counseling and motivational interviewing skills.
- B. Agencies providing Level 3.2-WM must ensure all personnel working with children under the age of eighteen (18) are trained and knowledgeable in child development and engaging children in states of intoxication and withdrawal management care.
- C. Each work shift at an agency must have a minimum of two (2) personnel, whenever one (1) or more individuals are present. At least one (1) of those persons must be treatment personnel as listed in part 5.2.2.D of this Chapter.
- D. The individual-to-personnel ratio must not exceed ten to one (10:1).
- E. The agency personnel requirements below are specific to each physical location where Level 3.2-WM services are provided. This includes on-call personnel that may assist as needed.
 1. At least fifty percent (50%) of the agency's personnel providing Level 3.2-WM services must consist of treatment personnel identified in part 5.2.2.D of this Chapter.

- a. If utilizing counselors-in-training and/or interns, the agency must ensure that all clinical documentation is reviewed and co-signed by a clinical agency supervisor able to supervise pursuant to their scope of practice. Plans for addiction counselor certification must be available for review.
 - b. Full-time personnel must obtain at least an addiction technician certification within eighteen (18) months of employment.
 - 2. Uncertified personnel or personnel without a plan for addiction counselor certification must not comprise more than fifty percent (50%) of an agency's total personnel. This includes group living workers that may be utilized for milieu management.
- F. The person overseeing day-to-day operations for agencies providing Level 3.2-WM services must be one of the following:
- 1. An authorized practitioner,
 - 2. A licensee; or
 - 3. A certified addiction specialist (CAS).

5.6.3 Service Provisions

- A. Agencies must:
- 1. Provide safe management and documentation of signs and symptoms of intoxication and withdrawal;
 - 2. Ensure that transition planning begins at the time of admission to Level 3.2-WM services, to allow for necessary care coordination and transition into ongoing or concurrent treatment services to occur successfully;
 - 3. Provide additional service planning for managing individuals with medical conditions, suicidal ideation, pregnancy, psychiatric conditions, and other conditions which place individuals at additional risk during withdrawal management; and
 - 4. Provide assessments of individual readiness for treatment and services based on the service plan and the assessments and interventions shall be documented in the individual's record.
- B. Medication-assisted treatment (MAT) for withdrawal management
- 1. Agencies must continue individuals on their medication-assisted treatment regimen and will only remove individuals from medications treating opioid use disorders at the individual's request or if it is deemed medically appropriate by an authorized practitioner.
 - 2. Agencies must inform individuals receiving services about access to medication-assisted treatment. Upon the individual's consent, the agency must provide medication-assisted treatment directly.
 - 3. Agencies must obtain a controlled substance license pursuant to section 21.300 of 2 CCR 502-1 from the BHA if they plan to dispense, compound, or administer a controlled substance from stock medication in order to treat a substance use disorder or to treat the withdrawal symptoms of a substance use disorder.

- a. A controlled substance license is not required if the agency intends to provide medication-assisted treatment (MAT) services through prescription writing only, under an independent prescriber's license.
- C. Discharge from Level 3.2-WM services
 - 1. Agencies must ensure referral and care coordination for continued behavioral health treatment that occurs at the time of discharge from Level 3.2-WM services. This may be made available within the agency's structure or through referral.
 - 2. Agencies must provide discharge information as required in part 2.10.A.6 of these rules to the individual and document that it was provided.
 - 3. Agencies must provide the following information to individuals at the time of discharge from Level 3.2-WM services:
 - a. Effects of alcohol and other drugs;
 - b. Risk factors associated with alcohol and other drug abuse for acquiring and transmitting HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome), Tuberculosis (TB), and other infectious diseases, and for pregnancy;
 - c. Availability of testing and pre/post-test counseling for HIV/AIDS, TB, Hepatitis C and other infectious diseases, and pregnancy; and
 - d. Availability of harm-reduction and alcohol and other substance use disorder treatment resources.

5.6.4 Documentation and Timeliness

- A. The following must be addressed within three (3) hours of an individual's arrival at the agency:
 - 1. Personnel must complete the screening and triage process as indicated in part 2.12.1 of these rules to determine the urgency and appropriateness of care within the agency including the need for emergency or urgent medical or psychiatric services;
 - 2. In collaboration with the individual, personnel must develop withdrawal management-focused initial service plan, tailored to the safe withdrawal of the individual from the substance(s) of concern;
 - 3. In addition to required intake documentation and consents as noted in part 2.11 of these rules, the agency must inventory and secure the individual's personal belongings. This must be observed and confirmed through documentation by at least two (2) personnel; and
 - 4. Personnel must monitor and document vitals in real-time.
- B. As soon as clinically feasible, but no later than seventy-two (72) hours following admission of an individual to Level 3.2-WM services, the agency must:
 - 1. Update or amend any intake paperwork or consents that the individual was not able to complete or comprehend due to their state of intoxication upon admission;

2. Complete at least the initial assessment as indicated in part 2.12.2 of these rules, including substance use disorder history and the degree to which the use of substances affects personal and social functioning;
 3. Update the individual's service plan to reflect ongoing treatment needs as identified through the assessment; and
 4. Document referral and care coordination activities to support the individual's transition into beginning or resuming behavioral health treatment services.
- C. Observation and monitoring requirements
1. Agencies must conduct routine monitoring of physical and mental status of the individual throughout their time in Level 3.2-WM services. This must include:
 - a. Vital signs taken and documented in real-time at the following minimum frequency:
 - (1) Every two (2) hours until vitals remain at the individual's baseline for at least four (4) consecutive hours,
 - (2) Then every eight (8) hours thereafter until discharge.
 - (a) Documentation per shift to include all individual monitoring activities.

5.7 Clinically Managed Residential Services, Including ASAM Level 3.3 Services

- A. This part 5.7 applies to agencies providing behavioral health residential services at an ASAM 3.3 level of care.
- B. This part 5.7 does not apply to agencies providing Level 3-WM services only.
- C. This part 5.7 does not apply to services to children under the age of eighteen (18) seeking residential services.

5.7.1 Service Delivery and Setting

- A. These services are intended for individuals who are unlikely to benefit from outpatient services or other residential levels of care due to a temporary or permanent cognitive impairment resulting from an addictive or co-occurring disorder. Therapeutic rehabilitation facilities or traumatic brain injury programs are examples of this level of care.
- B. Agencies shall confirm that individuals served have a history of substance use or co-occurring disorders or difficulty with interpersonal relationships, coping skills, or comprehension that necessitates this twenty-four (24) hour structured recovery environment, in combination with high-intensity clinical services.
- C. If agency personnel determine that an individual served may benefit from deliberately repetitive and/or concrete services, those services shall be delivered on a timeline appropriate to the individual's assessed cognitive needs.
- D. The agency must ensure that treatment is focused on preventing relapse, continued problems and/or continued use, enhancing readiness to change, and promoting the eventual reintegration of the individual into the community.

- E. Individuals with a temporary cognitive impairment may be transferred to another level of care after the impairment has resolved. Individuals with chronic cognitive impairment may remain in this level of care for a longer duration, if assessed as continuing to meet their individual needs.
- F. Support systems
 - 1. Agencies must:
 - a. Ensure the availability of telehealth or on-site consultation with an authorized practitioner or nurse twenty-four (24) hours per day, seven (7) days per week;
 - b. Ensure the availability of consultation with emergency services twenty-four (24) hours per day, seven (7) days per week; and
 - c. Have the capacity to arrange for medication-assisted treatment (MAT) and/or psychiatric medications in a timely manner for individuals served.
 - (1) This may include services provided through coordination and referral but must not exceed twenty-four (24) hours from identifying the need to complete.

5.7.2 Personnel

- A. If utilizing certified addiction technicians (CAT), these personnel must not comprise more than twenty-five percent (25%) of the agency's total personnel; and
- B. If utilizing counselors-in-training and/or interns, these personnel must not comprise more than twenty-five percent (25%) of the agency's total personnel.

5.7.3 Service Provisions

- A. Services must be regularly scheduled services and include a minimum of nine (9) hours of planned treatment services per week.
- B. Services must be delivered in a manner that is matched to the individual's functioning. These services may be provided in a deliberately repetitive manner or with a timeline appropriate to address the cognitive needs of individuals for whom this level of care is considered a medical necessity.

5.7.4 Documentation

- A. Agencies must complete and document the following items in the individual's record within twenty-four (24) hours of admission:
 - 1. All required demographic, intake and consent paperwork, as specified in part 2.11 of these rules;
 - 2. Screenings, as required in part 2.12.1 of these rules;
 - 3. The initial assessment as required in part 2.12.2 of these rules; and
 - 4. The initial service plan, addressing immediate needs and other relevant concerns identified in the initial assessment, as required in part 2.13.1 of these rules.

- B. As soon as possible, but no later than ten (10) calendar days after an individual's admission, the agency must complete and document the comprehensive assessment for the individual, as required in part 2.12.3 of these rules.
- C. As soon as possible, but no later than three (3) calendar days after an individual's comprehensive assessment is completed, the agency must complete and document an individualized and comprehensive service plan, informed by the comprehensive assessment, as required in part 2.13.1 of these rules.
- D. If the individual's comprehensive assessment indicates they may benefit from further evaluation, medication, and/or specialty behavioral health care to address mental health, substance use-specific, or co-occurring needs, the agency must ensure their individualized treatment needs are addressed during the episode of care. The individual record must contain documentation reflecting how these assessed needs were met.
- E. Service plan reviews and revisions must be completed and documented in the individual's record when there is a change in the individual's level of functioning or service needs, but in no case may service plan reviews and revisions occur later than:
 - 1. Monthly for the first six (6) months after admission, and
 - 2. At least quarterly for the remainder of time that the individual remains in residential services.
- F. Progress notes must be present in the individual's record, in accordance with part 2.13.2 of these rules. Progress notes must be completed at least daily for this level of care.

5.8 Level Two Mental Health Transitional Living Home Services

- A. Level two mental health transitional living homes shall comply with the rules in parts 5.1 through 5.4 of this Chapter.
- B. Level two mental health transitional living homes shall ensure that 600 minutes (ten hours) of planned treatment services are provided to each individual on a weekly basis.
- C. Level two mental health transitional living homes must either:
 - 1. Be designated pursuant to part 11.18 of these rules to provide care and treatment to individuals on short-term and long-term certifications on an outpatient basis; or
 - 2. Establish facility agreements with designated facilities in order to treat individuals on short-term or long-term certifications on an outpatient basis.

5.9 Clinically Managed Residential Services, Including ASAM 3.5-Type Services

- A. This part 5.9 applies to agencies providing ASAM 3.5-type clinically managed behavioral health residential services.
- B. This part 5.9 does not apply to agencies providing only Level 3-WM services.

5.9.1 Service Delivery and Setting

- A. These services are intended for individuals who have multifaceted treatment needs requiring a twenty-four (24) hour treatment environment, and who are unable to be properly treated at a lower level of residential care. A variable-length therapeutic community or residential treatment center are examples of this level of care.
- B. Agencies must confirm that any individuals served have multiple treatment considerations to be addressed during the residential episode of care, which may include, but are not limited to the following:
 - 1. A history of mental health, substance use or co-occurring disorders.
 - 2. Engagement in behaviors and/or thought processes that contribute to impaired social, interpersonal, and/or vocational functioning, necessitating this highly structured twenty-four (24) hour treatment environment.
- C. Services provided by the agency must be directed toward developing and enhancing prosocial behaviors, sustaining recovery, reducing relapse risk when applicable, and the promotion of successful reintegration into the community.
- D. Support systems
 - 1. Agencies providing this clinically managed residential service shall:
 - a. Ensure the availability of telehealth or on-site consultation with an authorized practitioner twenty-four (24) hours per day, seven (7) days per week;
 - b. Ensure the availability of consultation with emergency services twenty-four (24) hours per day, seven (7) days per week; and
 - c. Have the capacity to arrange for medication-assisted treatment (MAT) and/or psychiatric medications in a timely manner that must not exceed twelve (12) hours to complete.

5.9.2 Personnel

- A. Agencies must:
 - 1. Ensure that each work shift has a minimum of two (2) personnel on-site, whenever one (1) or more individuals are present in the milieu; and
 - 2. Maintain individual-to-personnel ratios not exceeding twenty to one (20:1) at all times, per physical location, unless otherwise noted. This includes nighttime and weekend hours.

5.9.3 Service Provisions

- A. Services for individuals must be regularly scheduled and include a minimum of ten (10) hours of planned treatment services per week.

5.9.4 Documentation and Timeliness

- A. Agencies must complete and document the following items in the individual's record within twenty-four (24) hours of admission:
 - 1. All required demographic, intake and consent paperwork, as specified in part 2.11 of these rules;

2. Screenings, as required in part 2.12.1 of these rules;
 3. The initial assessment as required in part 2.12.2 of these rules; and
 4. The initial service plan, addressing immediate needs and other relevant concerns identified in the initial assessment, as required in part 2.13.1 of these rules.
- B. Screenings and assessments conducted in accordance with 5.9.4.A must be used to determine appropriateness for this level of care.
- C. As soon as possible, but no later than ten (10) calendar days after an individual's admission, the agency must complete and document the comprehensive assessment for the individual, as required in part 2.12.3 of these rules.
- D. As soon as possible, but no later than three (3) calendar days after an individual's comprehensive assessment is completed, the agency must complete and document an individualized and comprehensive service plan, informed by the comprehensive assessment, as required in part 2.13.1 of these rules.
- E. If the individual's comprehensive assessment indicates they may benefit from further evaluation, medication, and/or specialty behavioral health care to address mental health, substance use-specific, or co-occurring needs, the agency must ensure their individualized treatment needs are addressed during the episode of care. The individual record must contain documentation reflecting how these assessed needs were met.
- F. Service plan reviews and revisions must be completed and documented in the individual's record when there is a change in the individual's level of functioning or service needs, but in no case may service plan reviews and revisions occur later than:
1. Monthly for the first six (6) months after admission, and
 2. At least quarterly for the remainder of time that the individual remains in residential services.
- G. Progress notes must be present in the individual's record, in accordance with part 2.13.2 of these rules. The minimum frequency of progress note completion for this level of care may vary, depending upon the individual's time in the level of care and/or anticipated length of stay.
1. For the first thirty (30) days of the stay, daily progress notes are required.
 2. After the first thirty (30) days where there is an anticipated length of stay of three (3) months or less, providers shall continue required daily progress notes.
 3. After the first thirty (30) days when there is an anticipated length of stay of more than three (3) months, providers shall complete progress notes at a minimum of weekly.

5.9.5 Treatment Type Standards for Clinically Managed Behavioral Health Residential Services and ASAM 3.5-Type Services

- A. Agencies that provide mental health-only or co-occurring residential services must confirm the following:
1. Individuals served meet at least one (1) of the following criteria:

- a. Are diagnosed with a serious mental illness (SMI) or comorbid diagnoses at a moderate level, per the DSM-5-TR, or
 - b. Have sufficient collateral information to indicate there is a high probability that the individual has a serious mental illness or comorbid diagnoses at a moderate level, as defined in the DSM-5-TR.
- B. Agencies that provide co-occurring or substance use disorder-only residential services at an ASAM 3.5-type must ensure the following:
 - 1. If utilizing certified addiction technicians (CAT), these personnel do not comprise more than twenty-five percent (25%) of the agency's total personnel, and
 - 2. If utilizing counselors-in-training and/or interns, these personnel do not comprise more than twenty-five percent (25%) of the agency's total personnel.

5.10 Medically Monitored Residential Services, Including ASAM 3.7-Type Services

- A. This part 5.10 applies to agencies providing ASAM 3.7-Type medically monitored behavioral health residential services.
- B. This part 5.10 does not apply to agencies providing only ASAM Level 3.7-WM services.

5.10.1 Service Delivery and Setting

- A. Medically monitored residential services are intended for individuals whose medical, emotional, behavioral and/or cognitive problems are severe enough to require twenty-four (24) hour medical monitoring, but do not require the full resources of an acute care general hospital or medically managed inpatient treatment program. These services may be offered in free-standing buildings providing residential services or incorporated into specialty units within general health care or psychiatric hospitals.
- B. Agencies must ensure that individuals receiving services receive multiple treatment considerations including but not limited to: a history of mental health, substance use or co-occurring disorders, along with medical, cognitive, or complicated withdrawal management needs that require the structured regimen of twenty-four (24) hour evaluation, observation, and medical monitoring in order to safely provide the necessary behavioral health services.
- C. Agencies must ensure treatment is designed for individuals who have functional limitations in the areas of intoxication/withdrawal potential, biomedical conditions, and/or emotional, behavioral, or cognitive conditions. This level of care focuses on the monitoring of the individual's biomedical needs to promote physical and psychiatric stabilization and allow for continued engagement in a lower level of care once the individual is stabilized.
- D. Support systems
 - 1. Agencies must:
 - a. Ensure the availability of telehealth or on-site consultation with an authorized practitioner or nurse twenty-four (24) hours per day, seven (7) days per week;
 - b. Ensure the availability of consultation with emergency services twenty-four (24) hours per day, seven (7) days per week;

- c. Have the capacity to arrange for medication-assisted treatment (MAT) and/or psychiatric medications in a timely manner for individuals served. This must not exceed eight (8) hours from identifying the need to complete;
- d. Ensure the availability of additional medical specialty consultation, psychological, laboratory and toxicology services; and
 - (1) These services may be provided through consultation or referral; and
- e. Ensure that psychiatric services, if not provided, are available on-site through consultation or referral within eight (8) hours by telehealth or twenty-four (24) hours in-person.

5.10.2 Personnel

A. Agencies must:

- 1. Ensure that each work shift has a minimum of two (2) personnel on-site whenever one (1) or more individuals are present in the milieu;
- 2. Maintain an individual-to-personnel ratio not exceeding twenty to one (20:1) at all times, per physical location. This includes nighttime and weekend hours;
- 3. Utilize an interdisciplinary team that includes physicians, nurses and mental health professionals licensed or certified pursuant to Article 245 of Title 12, C.R.S. that provide twenty-four (24) hour professionally directed evaluation, care and treatment services including administration of prescribed medications, withdrawal management and integrated treatment of co-occurring medical, emotional, behavioral or cognitive conditions;
- 4. Be overseen by a physician licensed pursuant to Article 240 of Title 12, in order to assure the quality of care; and
- 5. Have a nurse as defined in part 1.3 of these rules, responsible for monitoring the individual's progress and/or medication administration twenty-four (24) hours per day, seven (7) days per week.

5.10.3 Service Provisions

- A. Medically monitored residential services must be regularly scheduled and include a minimum of twenty (20) hours of planned treatment services per week.
- B. At the time of admission to the agency, a registered nurse must conduct an alcohol or other drug-focused assessment, if applicable.
- C. As soon as clinically feasible, but no later than twenty-four (24) hours after admission to the agency, an authorized practitioner must perform a physical examination of the individual.
 - 1. Physical examinations performed by authorized practitioners must be completed as necessary for the individual throughout the episode of care.

5.10.4 Documentation and Timeliness

- A. Agencies must complete and document the following items in the individual's record within twenty-four (24) hours of admission:

1. All required demographic, intake and consent paperwork, as specified in part 2.11 of these rules;
 2. Screenings, as required in part 2.12.1 of these rules;
 3. The initial assessment as required in part 2.12.2 of these rules; and
 4. The initial service plan, addressing immediate needs and other relevant concerns identified in the initial assessment, as required in part 2.13.1 of these rules.
- B. Screenings and assessments conducted in accordance with 5.10.4.A of this Chapter must be used to determine appropriateness for this level of care.
- C. As soon as possible, but no later than ten (10) calendar days after an individual's admission, the agency must complete and document the comprehensive assessment for the individual, as required in part 2.12.3 of these rules.
- D. As soon as possible, but no later than three (3) calendar days after an individual's comprehensive assessment is completed, the agency must complete and document an individualized and comprehensive service plan, informed by the comprehensive assessment, as required in part 2.13.1 of these rules.
- E. If the individual's comprehensive assessment indicates they may benefit from further evaluation, medication, and/or specialty behavioral health care to address mental health, substance use-specific, or co-occurring needs, the agency must ensure their individualized treatment needs are addressed during the episode of care. The individual record must contain documentation reflecting how these assessed needs were met.
- F. Service plan reviews and revisions must be completed and documented in the individual's record when there is a change in the individual's level of functioning or service needs, but in no case may service plan reviews and revisions occur later than:
1. Monthly for the first six (6) months after admission, and
 2. At least quarterly for the remainder of time that the individual remains in residential services.
- G. Progress notes must be present in the individual's record, in accordance with part 2.13.2 of these rules. Progress notes must be completed at least daily for this level of care.

5.10.5 Treatment Type Standards for Medically Monitored Behavioral Health Residential Services and ASAM 3.7-Type Services

- A. Agencies that provide mental health-only or co-occurring residential services must ensure the following:
1. Individuals served meet at least one (1) of the following criteria:
 - a. Are diagnosed with a serious mental illness (SMI) or comorbid diagnoses at a severe level, as defined in the DSM-5-TR;
 - b. Have sufficient collateral information that indicates a high probability that the individual has a serious mental illness or comorbid diagnoses at a severe level, as defined in the DSM-5-TR; or

- c. Are diagnosed with a serious mental illness (SMI) or comorbid diagnoses at a mild to moderate level, as defined in the DSM-5-TR, with additional biomedical needs that require a higher level of medical oversight.
- B. Agencies that provide co-occurring or substance use disorder-only residential services at an ASAM 3.7-type must ensure the following:
 - 1. If utilizing certified addiction technicians (CAT), these personnel do not comprise more than twenty-five percent (25%) of the agency's total personnel, and
 - 2. If utilizing counselors-in-training and/or interns, these personnel do not comprise more than twenty-five percent (25%) of the agency's total personnel.

5.11 Medically Monitored Inpatient Withdrawal Management (ASAM Level 3.7-WM) Services

- A. This part 5.11 applies to agencies providing withdrawal management services at an ASAM 3.7-WM level of care.
- B. This part 5.11 does not apply to agencies providing behavioral health residential services only.

5.11.1 Service Delivery and Setting

- A. Level 3.7-WM services are available for individuals who require the oversight of medical and nursing professionals in order to complete a safe period of withdrawal. This level of care provides a twenty-four (24)-hour service in which individuals have prompt access to medical evaluations as needed, as well as an interdisciplinary team available to meet the individual's needs. Services are developed and delivered under the monitoring of a physician. This may be observed as a freestanding withdrawal management center or as a step-down service from an acute care hospital.
 - 1. Services must be provided by licensed medical personnel qualified to supervise withdrawal from alcohol and other drugs through the use of medication and/or medical procedures in residential settings which possess a controlled substances license in compliance with Part 2 of Article 80 of Title 27, C.R.S.
- B. Agencies must develop policies and procedures to address service delivery expectations. These policies and procedures must address, but are not limited to the following:
 - 1. Consultation with specialized clinical and medical professionals for individualized withdrawal management care;
 - 2. Coordinating an individual's transition into other levels of care, determined to be appropriate through triage, screening, evaluation, and/or assessment processes completed during the course of Level 3.7-WM services. This may include collaboration with emergency behavioral health services, such as Colorado Crisis Services, as appropriate;
 - 3. Conducting or arranging for laboratory and/or toxicology tests to be completed;
 - 4. Responding to individuals who are assessed as being a current threat to themselves or others. This must include appropriate use of law enforcement and monitoring any use of individual restraint and/or seclusion in accordance with part 2.14 of these rules;
 - 5. Communication with intoxicated individuals leaving treatment against personnel recommendations, including the use of emergency commitments; and

6. Circumstances under which individuals must end Level 3.7-WM services, other than completing services or leaving against personnel recommendations.
- C. Support systems
1. Agencies must:
 - a. Implement protocols that are developed and approved by a physician knowledgeable in addiction medicine.
 - b. Develop and implement specific admission protocol detail for which substances, including both drugs and alcohol, medical withdrawal management services are provided. This protocol must include processes for customary and atypical withdrawal management from each drug delineated in the admission protocol, and must include at minimum, the following elements:
 - (1) Types of intoxication;
 - (2) Tolerance levels for the individual's drug of choice;
 - (3) Degrees of withdrawal;
 - (4) Possible withdrawal and/or intoxication complications;
 - (5) Other conditions affecting medical withdrawal management procedures;
 - (6) Types of medications used;
 - (7) Recommended dosage levels;
 - (8) Procedures to follow in the event of withdrawal management complications;
 - (9) Daily assessments including expected improvements as well as potential problems; and
 - (10) Expected duration of withdrawal management.
 - c. Ensure that prompt medical evaluation and consultation is available twenty-four (24) hours/day.
 - d. Ensure that hourly nurse monitoring of the individual's progress is available, if medically indicated.
 - e. Ensure that medications that are self-administered, monitored, or dispensed at the facility are supervised and documented in accordance with agency policy and procedures, state, and federal law.
 - f. Ensure referral and care coordination for continued behavioral health treatment occurs. This may be made available within the agency's structure or through referral.
- D. Diagnostic criteria

1. Individuals participating in Level 3.7-WM services are generally intoxicated, under the influence, or in a severe stage of withdrawal from alcohol and/or other drugs. These individuals may have comorbid medical issues that require additional medical oversight.
2. In addition to the ASAM Criteria guidelines detailed in part 2.12.3.C of these rules, individuals receiving Level 3.7-WM services must meet the diagnostic criteria for substance withdrawal disorder, as indicated in the DSM-5-TR.
3. Upon admission to Level 3.7-WM services, the agency must complete the following minimum requirements:
 - a. Collect information regarding the degree of alcohol and/or other drug intoxication as evidenced by breathalyzer, urinalysis, self-report, observation or other evidence-based or best practices;
 - b. A pregnancy screening for pregnancy-capable individuals;
 - c. Taking of vital signs; and
 - d. Administration of a validated clinical withdrawal assessment tool.
- E. The agency must conspicuously post procedures for responding to circumstances and events that warrant entering a divert status.

5.11.2 Personnel

- A. Personnel must be trained in, and evaluated in knowledge of the following areas before providing services independently:
 1. Withdrawal management;
 2. Monitoring vital signs;
 3. Conducting assessment and triage, including identifying and properly responding to, suicidal ideation;
 4. Collecting urine and breath samples; and
 5. Basic counseling and motivational interviewing skills.
- B. Agencies providing Level 3.7-WM must ensure all personnel working with children under the age of eighteen (18) are trained and knowledgeable in child development and engaging children in states of intoxication and withdrawal management care.
- C. Each work shift must have a minimum of two (2) personnel, whenever one (1) or more individuals are present.
- D. Treatment personnel as defined in part 5.3.2.D must be present at a rate that meets the needs of the individuals receiving Level 3.7-WM services.
- E. Agencies must employ, at minimum, the following personnel:
 1. A medical director who is licensed as a physician or medical doctor pursuant to Article 240 of Title 12, C.R.S.,

2. A registered nurse or licensed practical nurse with at least one (1) year of withdrawal management experience; and
 3. Treatment personnel as defined in part 5.3.2.D of this Chapter.
- F. Personnel oversight
1. The person overseeing day-to-day operations for an agency providing Level 3.7-WM services must be the medical director.
 2. The medical director's responsibilities must include, at minimum:
 - a. Quarterly reviews and revisions of drug withdrawal management categories and protocols;
 - b. Reviews of individual withdrawal management plans;
 - c. Reviews of individual prescriptions;
 - d. Direct supervision of individual withdrawal management cases that deviate from standard protocols and/or the individual experiences complications;
 - e. Five (5) hours of monthly supervision of and consultation with personnel providing withdrawal management services;
 - f. Development and implementation of back-up systems for physician coverage when medical director(s) are unavailable and/or for emergencies;
 - g. Review of critical incidents reported in accordance with part 2.16 of these rules; and
 - h. Review of admission, medical exclusion, and medical care policies at least annually.
- G. Agencies must ensure twenty-four (24) hour access to clinical personnel by telehealth and accommodations for unscheduled visits in the event of crises or problem situations.

5.11.3 Service Provisions

- A. Agencies must:
1. Provide safe management and documentation of signs and symptoms of intoxication and withdrawal;
 2. Ensure that transition planning begins at the time of admission to Level 3.7-WM services, to allow for necessary care coordination and transition into ongoing or concurrent treatment services to occur successfully;
 3. Provide additional service planning for managing individuals with medical conditions, suicidal ideation, pregnancy, psychiatric conditions, and other conditions which place individuals at additional risk during withdrawal management; and
 4. Provide assessments of individual readiness for treatment and services based on the service plan and the assessments and interventions shall be documented in the individual's record.

- B. Medication-assisted treatment (MAT) for withdrawal management
1. Agencies must continue individuals on their medication-assisted treatment regimen and will only remove individuals from medications treating opioid use disorders at the individual's request or if it is deemed medically appropriate by an authorized practitioner.
 2. Agencies must inform individuals receiving services about access to medication-assisted treatment. Upon the individual's consent, the agency must provide medication-assisted treatment directly.
 3. Agencies must obtain a controlled substance license pursuant to section 21.300 of 2 CCR 502-1 from the BHA if they plan to dispense, compound, or administer a controlled substance from stock medication in order to treat a substance use disorder or to treat the withdrawal symptoms of a substance use disorder.
 - a. A controlled substance license is not required if the agency intends to provide medication-assisted treatment (MAT) services through prescription writing only, under an independent prescriber's license.
- C. Discharge from Level 3.7-WM services
1. Agencies must ensure referral and care coordination for continued behavioral health treatment occurs at the time the individual is discharged from Level 3.7-WM services. This may be made available within the agency's structure or through referral.
 2. Agencies must provide discharge information as required in part 2.11 of these rules to the individual and document that it was provided.
 3. In addition to these requirements, agencies must provide the following information to individuals at the time of discharge from Level 3.7-WM services:
 - a. Effects of alcohol and other drugs;
 - b. Risk factors associated with alcohol and other drug abuse for acquiring and transmitting HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome), Tuberculosis (TB), and other infectious diseases, and for pregnancy;
 - c. Availability of testing and pre/post-test counseling for HIV/AIDS, TB, Hepatitis C and other infectious diseases, and pregnancy; and
 - d. Availability of harm-reduction and alcohol and other substance use disorder treatment resources.
- D. Agencies must provide medical evaluations completed by authorized practitioners. The medical evaluations must consist of, at minimum:
1. Medical histories including detailed chronologies of substance use disorders;
 2. Identification of current physical addiction including drug types;
 3. Physical examinations to determine appropriateness for outpatient or inpatient medical withdrawal management; and
 4. Appropriate laboratory tests and other evaluations, as indicated.

- E. Medication dispensation and administration procedures
1. Agencies using stock-controlled substances in order to treat a substance use disorder or to treat the withdrawal symptoms of a substance use disorder are required to have a controlled substance services license issued by the BHA and comply with the applicable portion(s) of section 21.300 of 2 CCR 502-1 that deal with a controlled substance license.
 2. Agencies may utilize buprenorphine for medications for opioid use disorder (MOUD) services without requiring an opioid treatment program endorsement. If an agency intends to utilize controlled substances other than/in addition to buprenorphine for MOUD services, the agency must be endorsed as an opioid treatment program, verified through the Drug Enforcement Administration (DEA), and coordinated with the SAMHSA.
 3. Qualified practitioners may prescribe buprenorphine under their own Drug Enforcement Administration (DEA) registration number for individuals admitted to this level of care for withdrawal management or addiction treatment.
 4. Agencies must develop and implement policies and procedures for dispensing medications per standard withdrawal management protocols that are in accordance with applicable state and federal statutes and for the following:
 - a. Individual prescriptions filled and dispensed by a registered pharmacist at a designated pharmacy location;
 - b. Individual prescriptions from medical directors that are filled from stock quantities; and
 - c. Storage and accounting of all medications, including controlled substances.

5.11.4 Documentation and Timeliness

- A. The following must be addressed within three (3) hours of an individual's arrival at the agency:
1. Personnel must complete the screening and triage process as indicated in part 2.12.1 of these rules to determine the urgency and appropriateness of care within the agency including the need for emergency or urgent medical or psychiatric services;
 2. In collaboration with the individual, personnel must develop a withdrawal management-focused initial service plan, tailored to the safe withdrawal of the individual from the substance(s) of concern;
 3. In addition to required intake documentation and consents as noted in part 2.11 of these rules, the agency must inventory and secure the individual's personal belongings. This must be observed and confirmed through documentation by at least two (2) personnel; and
 4. Personnel must monitor and document vitals in real-time.
- B. As soon as clinically feasible, but no later than seventy-two (72) hours following admission of an individual into Level 3.7-WM services, the agency must:
1. Update or amend any intake paperwork or consents that the individual was not able to complete or comprehend due to their state of intoxication upon admission;

2. Complete at least the initial assessment as indicated in part 2.12.2 of these rules, including substance use disorder history and the degree to which the use of substances affects personal and social functioning;
 3. Update the individual's service plan to reflect ongoing treatment needs as identified through the assessment; and
 4. Document referral and care coordination activities to support the individual's transition into beginning or resuming behavioral health treatment services.
- C. The individual record must contain informed consent to receive medical withdrawal management services that includes at minimum:
1. Medications to be used; and
 2. Need to consult with primary care physicians.
- D. Observation and monitoring requirements
1. Agencies must conduct routine monitoring of physical and mental status of the individual throughout their time in Level 3.7-WM services. This must include:
 - a. Vital signs taken and documented in real-time at the following minimum frequency:
 - (1) Every two (2) hours until vitals remain at the individual's baseline for at least four (4) consecutive hours,
 - (2) Then every eight (8) hours thereafter until discharge.
 - (a) Documentation per shift to include all individual monitoring activities.
 2. If medical personnel determine that an individual requires vital signs to be monitored and documented in real-time at a frequency that is less than the minimum requirement above, the rationale and plan for this variance must be documented in the individual's record. Non-medical personnel must not make or document such a determination.

Chapter 6: Emergency and Crisis Behavioral Health Services

6.1 Authority and Applicability

- A. Chapter 6 establishes the standards for and is applicable to BHEs electing to provide behavioral health crisis and emergency services. The authority to promulgate these service-specific requirements that apply to BHEs electing to provide these services comes from Sections 27-50-502(1), 27-50-106, and 27-50-107(3)(b), C.R.S.

6.2 General Provisions

- A. All agencies providing residential services to individuals shall comply with the residential and overnight requirements set forth in part 2.26 of these rules.
- B. Each component within the behavioral health crisis response system must provide services in a trauma-informed, culturally responsive manner.

- C. Agencies must incorporate peer support professionals in accordance with Chapter 3 of these rules into the services they provide, when clinically appropriate.

6.3 Walk-In Crisis Services

6.3.1 Applicability

- A. These rules set forth in this section 6.3 are established to create standards for and apply to agencies with an endorsement to provide walk-in crisis services.

6.3.2 General Provisions

- A. Each walk-in crisis agency must obtain a 27-65 designation and be in compliance with Section 27-60-104, C.R.S.
- B. All walk-in crisis agencies are required to obtain a Children and Families endorsement pursuant to Chapter 8 of these rules.
- C. Walk-in crisis services must be accessible to all individuals throughout the state of Colorado twenty-four (24) hours per day, seven (7) days per week, and 365 days per year. Every walk-in crisis services agency must have the ability to provide information and referrals to anyone in need, and crisis assessment when indicated, including, if appropriate, access and clinically appropriate transportation to crisis stabilization in a crisis stabilization unit. Walk-in crisis service agencies must collaborate with other agencies endorsed pursuant to this Chapter 6, and community-based organizations.
- D. A walk-in crisis agency must have the capacity to:
 - 1. Screen and triage every individual who presents at the agency, with any presenting problem including acute and chronic substance use and/or intellectual and developmental disability;
 - 2. Coordinate multiple simultaneous requests for services;
 - 3. Work closely with community partners, family members or caregivers; and
 - 4. Work with local hospitals to develop accepted clearance practices to divert the individual in crisis from emergency departments for purpose of verifying medical stability prior to residential or inpatient admission.
- E. Walk-in crisis agencies must employ an integrated care model based on evidence-based practices that consider an individual's physical and emotional health.
- F. Walk-in crisis agencies shall manage and prevent elopement of individuals on an emergency mental health hold using strategies in conformity with state and federal laws.
- G. Walk-in crisis agencies must develop crisis safety plans in collaboration with the individual in crisis and/or their family member(s) or other social supports. Safety plans should include psychiatric advanced directives and referrals/warm hand offs to health and social services and supports, as needed.
- H. Follow-up services must be provided to every individual and must include:

1. Follow-up to each individual and authorized caregiver and/or family member(s) by phone or in-person, based on clinical need and individual preferences. The first follow-up must be within twenty-four (24) hours after services were provided. Follow-up attempts must be documented in the individual's record. Follow-up communications must be compliance with state and federal data protection laws.
2. Follow-up communication may be conducted face-to-face, via telehealth, or via telephone only, based on an individual's clinical need and preferences.

6.3.3 Service Provisions

- A. Walk-in crisis services must include screening as defined in part 2.12.1 of these rules, triage, crisis assessment, and referrals to appropriate resources. Individuals in crisis must be screened and triaged within fifteen (15) minutes of arrival.
 1. Walk-in crisis agencies are exempt from assessment requirements in Part 2.12.2 and 2.12.3 of these rules. Walk-in crisis agencies shall complete a crisis assessment, in full, on a BHA-created form that is available on BHA's website, if clinically indicated by the initial screening in part 2.12.1 of these rules.
- B. Prior to an individual leaving a walk-in crisis agency, screenings must be reviewed by a crisis professional who is licensed or a candidate receiving supervision from a licensee or authorized practitioner.
 1. Walk-in crisis agencies shall refer all individuals seeking crisis services to appropriate resources based on the level of care indicated by the screening or crisis assessment.
- C. Walk-in crisis services must include:
 1. Brief intervention, stabilization and de-escalation intended to maintain stability in the community, whenever possible to include such activities as:
 - a. On-site interventions, including solution-focused crisis counseling, for immediate de-escalation of presenting behavioral health issues.
 - b. Coordination with other providers involved in the individual's or individual's family's care.
 - c. Skill development, psychosocial education and initial identification of resources needed to stabilize the presenting situation.
 - d. Crisis prevention strategies, including resources to cope with presenting emotional symptoms, behaviors, and existing circumstances to avoid future crises.
 - e. Immediate coordination with other crisis providers when needed (e.g., crisis stabilization units and respite, psychiatric emergency services).
 - f. Prioritization of remaining in the community, especially for children. Prioritize crisis response in home and community-based settings, including schools, recreational centers, homeless shelters, and other community centers for children.
 - g. Lethal means restriction.

- h. Peer support to reduce stigma and build connection.
 - i. Identifying and engaging natural supports.
 - 2. Substance use services:
 - a. Walk-in crisis agencies shall provide harm reduction interventions, including the administration of opioid receptor antagonists to reverse an overdose, if needed.
 - b. Evaluation of withdrawal management needs. Walk-in crisis agencies may offer withdrawal management services if endorsed to provide such services.
 - c. Evaluation of appropriateness for medication-assisted treatment (MAT) and referrals to providers that can initiate treatment as indicated.
 - 3. Physical health screen, if indicated, to inform crisis planning and/or as part of the clearance practice.
 - a. Physical health screens may be provided by qualified walk-in crisis agency personnel or through coordination or referral to a medical provider.
 - 4. Referrals:
 - a. Walk-in crisis agency personnel are responsible for referrals and warm hand-offs to health and social services and supports, including withdrawal management and medication-assisted treatment, as needed.
 - b. Walk-in crisis agency personnel must make documented efforts to schedule follow-up appointments within seven (7) business days of referral.

6.3.4 Personnel Requirements

- A. A walk-in crisis agency must be staffed twenty-four (24) hours per day, seven (7) days per week, and 365 days per year.
- B. A walk-in crisis agency must include a number of trained professionals on their team which may include licensees, authorized practitioners, peer support professionals, case managers, nurses, and other trained crisis personnel.
- C. A walk-in crisis agency must employ sufficient personnel to ensure that the provision of services meets the needs of individuals. At minimum, the agency must have two (2) personnel on-site at all times.
- D. A walk-in crisis agency must always be staffed by crisis professionals who can lead the crisis assessment and intervention. This may include crisis professionals receiving supervision from a licensee or authorized practitioner.
- E. A walk-in crisis services agency must have access to a licensee or authorized practitioner within fifteen (15) minutes via telehealth if one is not available onsite.
- F. Every agency endorsed to provide walk-in crisis services must employ or contract with a peer support professional who may lead initial engagement and assist with follow-up services. Any recovery support services rendered by peer support professionals shall be provided in accordance with part 3.1 through 3.5 of these rules.

- G. A walk-in crisis agency must include a personnel member trained in working with children, families and their caregivers who experience crisis.
- H. A walk-in crisis agency must develop a training plan for personnel to ensure expertise in addressing and responding to individuals with physical or intellectual/developmental disabilities (I/DD), traumatic brain injury, severe mental illness, serious emotional disturbance, substance use disorders, co-occurring disorders, and other cognitive or neurodiverse needs who are in crisis.
- I. A walk-in crisis agency may develop contractual relationships with local providers with expertise in working with the populations referenced in part 6.3.4.H of this Chapter above. These providers must be engaged during or immediately after initial face-to-face intervention as needed to support individuals in crisis who do not already have an existing relationship with a provider. Telehealth may be used to secure expertise for individuals served by the mobile crisis response team with a physical or I/DD.
- J. Providers seeking crisis professional status must complete training required by the BHA found on the BHA website. Status will be tracked on a yearly basis by the BHA.

6.4 Crisis Stabilization Units

6.4.1 Applicability

- A. These rules set forth in this section 6.4 are established to create standards for and apply to agencies with an endorsement to operate a crisis stabilization unit (CSU).

6.4.2 Standards for crisis stabilization services

- A. Crisis stabilization services must meet the requirements of part 2.12 of these rules, including, but not limited to requirements for screening, initial assessment, and comprehensive assessment, with the following additions:
 - 1. Comprehensive assessments must be completed within twenty-four (24) hours of admission of an individual;
 - 2. Medical and medication treatment in accordance with parts 11.8 and 11.17.13 of these rules and coordination with medical services;
 - 3. Peer support, in accordance with Chapter 3 of these rules, when clinically appropriate;
 - 4. Discharge and service planning in accordance with part 2.10 and 2.13 of these rules;
 - 5. Safety planning:
 - a. Safety planning is required, and safety plans must be developed in collaboration with the individual and the individual's family members and/or other social supports, if not clinically contraindicated.
 - b. Safety plans must include psychiatric advance directives.
 - 6. Care coordination and referral services.
- B. Crisis stabilization services must include, at a minimum:
 - 1. Medication management; and

2. Individual and/or group counseling.
- C. The agency shall ensure individuals admitted for crisis stabilization services cannot be appropriately treated in a less restrictive setting.
- D. The individual must be assessed for continued appropriateness for treatment in the crisis setting at least every three (3) days.
1. When an individual's assessment indicates the individual should be transferred to a different setting but placement in that setting is delayed due to lack of availability, the agency shall document that in the service plan, and continue reassessing the individual in accordance with part 6.5.2.A above.
 2. Assessments for continued stays in the crisis stabilization setting past seven (7) days must include consideration regarding whether the individual would be more appropriately served, and should be transferred to, a different level of care.

6.4.3 Crisis Stabilization Unit Staffing Requirements

- A. In addition to the walk-in crisis service staffing requirements listed in part 6.3.4 of these rules, crisis stabilization units must have:
1. Access to an authorized practitioner upon admission; and
 2. At minimum, one (1) on-site personnel member qualified to administer medications.

6.5 Mobile Crisis Services

6.5.1 Applicability

- A. The rules set forth in this section 6.5 are established to create standards for and apply to agencies with an endorsement to provide mobile crisis services pursuant to Section 27-60-104, C.R.S.

6.5.2 General Provisions

- A. Mobile crisis service agencies are intended to provide a timely paired mobile response as described in part 6.5.3.B to a behavioral health crisis in the community. Mobile crisis service agencies must provide referrals and facilitate transitions to other crisis agencies, behavioral health entities, and community-based services as clinically indicated.
- B. All agencies providing mobile crisis services or responding to crisis calls shall meet critical incident reporting procedures in accordance with part 2.16 of these rules.

6.5.3 Service Provisions

- A. Mobile crisis service agencies must have the capacity to:
1. Intervene where the crisis occurs;
 2. Coordinate multiple simultaneous requests for services;
 3. Work closely with law enforcement, emergency medical services, crisis hotlines, schools, and hospital emergency departments; and

4. Serve priority populations.
- B. An agency's mobile crisis response teams must arrive at the community-based location where a crisis occurs within two (2) hours of accepting a dispatch request for rural and frontier areas as defined in Section 23-76.5-101(6), C.R.S. and within one (1) hour of accepting a dispatch request for urban areas, including dispatch from the statewide hotline/988 either face-to-face or using telehealth operations.
1. The mobile crisis service agency shall develop policies for dispatch criteria related to serving:
 - a. Populations listed in part 6.5.4.E of this Chapter
 - b. Individuals of all ages
 - c. Individuals demonstrating aggressive behavior
 - d. Individuals who are uninsured or unable to pay for services
 - e. Individuals who may lack Colorado residency or legal immigration status
 2. If the statewide hotline/988 requests a mobile crisis response, a mobile crisis service agency shall immediately accept the request which means to affirm the request from the hotline and immediately dispatch the mobile crisis response team. Rejected requests are subject to review from the BHA or their designee.
- C. Mobile crisis service agencies must operate twenty-four (24) hours per day, seven (7) days per week, and 365 days per year in providing community-based crisis intervention, screening, crisis assessment on a BHA created form that is available on the BHA's website, and referrals to appropriate resources.
- D. The mobile crisis service agency must complete screening requirements as defined in part 2.12.1 of these rules. In addition to these screening requirements, the mobile crisis service agency must also attempt to collect the following information:
1. Strengths and resources of the individual experiencing the crisis, their family members, and other social supports
 2. Recent inpatient hospitalizations and/or any current relationship with a behavioral health provider
 3. Medications prescribed, medications taken recently, current prescriber and information about the individual's ongoing medication regimen
- E. The screening process referenced in this section's subpart D above must also include a rapid determination as to whether the crisis warrants medical or law enforcement response.
- F. The mobile crisis service agency must administer a crisis assessment, in full, on a BHA-created crisis assessment form that is available on the BHA's website if clinically indicated by the initial screening in part 2.12.1 of these rules.

- G. Mobile crisis service agencies through mobile crisis response teams shall develop crisis safety plans in collaboration with individuals in crisis and their authorized family members and/or other social supports, unless clinically contraindicated. The safety plan shall be in writing and copies of the plan must be offered to the individual, the individual's caregiver when applicable, and to other service providers or social supports when authorized by the individual.
 - 1. Safety plans must include any psychiatric advance directives in effect.
 - 2. Safety plans shall also include:
 - a. Short-term strategies for immediate stabilization
 - b. Long-term strategies to support a return to the pre-crisis level of functioning
 - c. Referrals to services, supports, and resources identified by the mobile crisis team.
- H. Mobile crisis teams of a mobile crisis service agency must follow-up with an individual and authorized caregiver and/or family member(s) by phone or in-person, based on clinical need and individual preferences, within twenty-four (24) hours from when services are provided. Follow-up attempts must be documented in the individual's record.
- I. Mobile crisis response teams of a mobile crisis service agency must provide brief intervention, stabilization and de-escalation services intended to maintain stability in the community, whenever possible. This may include but is not limited to:
 - 1. On-site interventions, including solution-focused crisis counseling, for immediate de-escalation of presenting behavioral health issues.
 - 2. Coordination with other providers involved in the individual's or family's care.
 - 3. Skill development, psychosocial education and initial identification of resources needed to stabilize the presenting situation.
 - 4. Crisis prevention strategies and resources to cope with presenting emotional symptoms, behaviors and existing circumstances and avoid future crises.
 - 5. Immediate coordination with other crisis providers, including peer support professional services, when needed. Other crisis providers may include walk-in centers, crisis stabilization units and respite, psychiatric emergency services.
 - 6. Prioritization of remaining in the community, especially for children and young people. Prioritize crisis response in home and community-based settings, including schools, recreational centers, homeless shelters, and other community centers for children.
 - 7. Provide harm reduction interventions, including the administration of an opioid receptor antagonist to reverse an overdose, when needed.
 - 8. Evaluation of appropriateness for medication-assisted treatment (MAT) and referrals to providers that can initiate treatment as indicated.
- J. Mobile crisis response teams of a mobile crisis service agency must provide or coordinate clinically appropriate and accessible transportation to an appropriate level of care as needed following a response. An agency's mobile crisis team may only provide transportation directly if they are appropriately licensed by their county as a secure transportation provider.

6.5.4 Personnel Requirements

- A. All mobile crisis service agencies must include a mobile crisis response team.
 - 1. Every mobile crisis response team must include a licensee or authorized practitioner, or
 - 2. Must have a licensee or authorized practitioner immediately available via telehealth.
 - 3. Mobile crisis response teams may also include a number of trained professionals on their teams including emergency medical technicians, community paramedics, peer support professionals, mobile crisis case managers, nurses, and other trained crisis personnel.
- B. Every mobile crisis response team must include a crisis professional who can lead the crisis assessment and intervention.
- C. Every agency endorsed to provide mobile crisis services must employ or contract with a peer support professional who can be included in the mobile crisis response team as appropriate and available, and who may take the lead on initial engagement and assist with follow-up services.
 - 1. A peer support professional must be available for follow-up services within one (1) business day of the crisis response.
- D. Every mobile crisis response team must include a personnel member with specific training and expertise in serving children and their caregivers who experience crisis.
- E. Personnel on a mobile crisis response team must be trained in responding to individuals with physical or intellectual/developmental disabilities (I/DD), traumatic brain injury, severe mental illness, serious emotional disturbance, substance use disorders, co-occurring disorders, and other cognitive or neurodiverse needs who are in crisis.
- F. Mobile crisis service agencies may develop contractual relationships with local providers with expertise working with the populations referenced in 6.4.4.H of this Chapter. These providers must be engaged during or immediately after initial face-to-face intervention as needed to support individuals in crisis who do not already have an existing relationship with a provider. Telehealth may be used to secure expertise for individuals served by the mobile crisis response team with a physical disability or I/DD.
- G. Mobile crisis service agencies must develop a training plan to ensure expertise in addressing specific population needs as described in part 6.3.4.H of this section. If not utilizing contractual relationships to meet requirements in part 6.5.4.F of this section, the plan must address training for serving populations described in that part.

6.6 Respite Care Services

6.6.1 Applicability

- A. These rules set forth in this section 6.6 are established to create standards for and apply to agencies with an endorsement to provide residential or community-based respite care services.

6.6.2 General Provisions

- A. Residential or community-based respite care services provide temporary or short-term care by a licensee, authorized practitioner, candidate or other personnel based on the level of care being provided and is designed for an individual that has experienced a self-defined crisis. Crisis respite is intended to be a flexible intervention or set of services based on the presenting concerns of the individual in a self-defined crisis and must have the capacity to:
 - 1. Provide supports necessary to alleviate the conditions leading to the initial crisis; and
 - 2. Enhance an individuals' sense of safety and agency in managing their crisis.
- B. Residential or community-based respite care services include a range of short-term services twenty-four (24) hours per day, seven (7) days per week, and 365 days per year. Respite care services shall be flexible to ensure that the individual's daily routine is maintained.
- C. Length of stay determinations must be ongoing, transparent to the individual and family to the extent allowable under state and federal privacy laws, and jointly determined by the individual, family, respite provider, and treatment team.
- D. In order to be eligible for residential or community-based respite services, an individual that has experienced a behavioral health crisis must:
 - 1. Be referred by personnel within other agencies endorsed pursuant to this Chapter 6;
 - 2. Agree to residential or community-based respite services;
 - 3. Not meet emergency procedure criteria outlined in Section 27-65-106, C.R.S., Care and Treatment for Persons with Mental Illness;
 - 4. Present a minimal risk of significant withdrawal complications;
 - 5. Cooperate with program guidelines; and
 - 6. Be able and willing to participate, with accommodations if needed, in forming a service plan.

6.6.3 Service Provisions

- A. Services must be intended to improve/maintain the condition and functional level of the individual and prevent relapse or hospitalization while providing a safe environment to address precipitating factors to the crisis. Services must include structure, support, and care coordination, and may include but not be limited to the following:
 - 1. Comprehensive assessment as described in part 2.12.3 of these rules;
 - 2. Assistance with monitoring, completing, or prompting of activities of daily living (ADLs);
 - 3. Assistance with medical and physical health needs, including medication administration and monitoring;
 - 4. Life skills and environmental maintenance;
 - 5. Assistance/supervision needed by an individual to participate in social, recreational and community activities;
 - 6. Referral to and establishing a stronger connection to community resources;

7. Relationship building;
8. Safety planning;
9. Stigma reduction; and
10. Monitoring of personal hygiene, nutritional support, safety, and environmental maintenance.

6.6.4 Personnel Requirements

- A. Respite agency personnel shall be multidisciplinary, with the intention of subclinical stabilization, responsive to the unique needs of the individual. Respite agency personnel shall include expertise in meeting the need of children if the agency holds a Children and Families endorsement, which includes but is not limited to:
 1. Child and family peer support providers; psychiatrists, psychiatric nurse practitioners, or physicians; and social workers, counselors, and crisis specialists;
 2. Have personnel who can assess physical health needs and deliver care for most minor physical health challenges;
 3. Have an identified pathway to transfer the child to more medically staffed services, if needed; and
 4. Ensure that personnel have child and family expertise and experience, training in trauma-responsive care and cultural responsiveness.
- B. Peer support professionals must be utilized in accordance with Chapter 3 of these rules if providing residential or community-based respite services.
- C. Every respite agency must include a licensee or authorized practitioner. This licensee or authorized practitioner must be immediately available via telehealth.

6.6.5 Respite Care Settings

- A. Respite care services may be provided in residential or community-based settings.
 1. Residential respite care services must comply with residential and overnight requirements in accordance with part 2.26 of these rules.
 2. Community-based respite care services may be provided in the individual's home or community as a temporary relief from stressful situations or environments, or to provide additional support in the individual's home environment.

6.7 Acute Treatment Services

6.7.1 Applicability

- A. These rules set forth in this section 6.7 are established to create standards for and apply to agencies with an endorsement to operate an acute treatment unit (ATU).

6.7.2 Standards for Acute Treatment Services

- A. Agencies providing acute treatment unit services must be designated pursuant to Chapter 11 of these rules.
- B. The agency shall ensure the admission/discharge criteria and service planning requirements in part 2.10 and 2.13.1 of these rules, as well as assessment requirements in parts 2.12.2 and 2.12.3 of these rules are met with the following additions:
 - 1. The agency shall ensure individuals admitted for acute treatment services are age eighteen (18) years or older, in need of psychiatric care, and cannot be appropriately treated in a less restrictive setting.
 - 2. The individual shall be assessed for continued appropriateness for treatment in the acute treatment services setting at least every three (3) days. Individual stays may be extended when such extension is determined to be the most appropriate course of treatment based on an updated individual assessment and service plan, as follows:
 - a. When an individual's assessment indicates the individual should be transferred to a different setting but placement in that setting is delayed due to lack of availability, the agency shall document that in the service plan, and continue to reassess the individual in accordance with part 6.7.2.B.2.
 - b. Assessments for continued stays in the acute treatment services setting past ten (10) days shall include consideration regarding whether the individual would be more appropriately served, and should be transferred to, a different level of care.
 - 3. An individual may only be admitted into a locked setting if there is no less restrictive appropriate alternative and admitting to a locked facility is in compliance with Chapter 11 of these rules.
 - 4. An individual may be admitted into a 27-65 designated facility on a voluntary basis, as long as the following requirements are met and the individual signs a form that documents the following:
 - a. The individual is aware the setting is locked.
 - b. The individual has the ability to exit the setting with personnel assistance.
 - 5. An individual who is an imminent danger to self or others may only be admitted to acute treatment services upon completion of the agency's comprehensive assessment and determination that the individual's safety and the safety of others can be maintained.
 - 6. If an individual is admitted and personnel subsequently determine the individual's behavior cannot be safely and successfully treated in the acute treatment services location, the agency shall make arrangements to transfer the individual to the nearest hospital or other appropriate level of care for further assessment and evaluation.
 - 7. The agency shall have policies that identify when an individual requires a physical health assessment by a qualified licensed practitioner, including, but not limited to:
 - a. Within twenty-four (24) hours of admission;
 - b. When there is a significant change in the individual's condition;
 - c. When the individual has evidence of a possible infection, such as swelling or open sores;

- d. When the individual experiences an injury or accident that might cause a change in condition;
 - e. When the individual has known exposure to a communicable disease; or
 - f. When the individual develops any condition that would have initially precluded admission to the acute treatment service setting.
 - 8. The agency shall ensure the individual's service plan is created within twenty-four (24) hours after admission. Such service plan shall include any special dietary instructions, physical or cognitive limitations, and a description of the services which the agency will provide to meet the needs identified in the individual's assessment(s).
 - a. The individual may request a modification of the services identified in the service plan at any time.
 - b. The service plan shall include goals of the acute treatment services stay and standards to be met for discharge.
- C. The agency shall ensure acute treatment services meet personnel training requirements in accordance with part 2.14.3 of these rules, with the following additions:
 - 1. The agency's administrator shall have training in assessment skills, nutrition, and identifying and dealing with behavioral health crises and behavior management, and be responsible for the overall direction and supervision of personnel;
 - 2. The agency's clinical director shall have training in assessment and identifying and treating individuals who display behaviors that are common to individuals with severe and persistent mental health disorders; and
 - 3. The agency shall ensure the staffing level in each physical location providing acute treatment services is adequate to provide services to meet the needs of the individuals at the location, in accordance with the individuals' service plans.
- D. The agency shall ensure compliance with parts 2.15 and part 11.17.15 of these rules, regarding medication administration, storage, handling, and disposal.
- E. The agency shall establish written house rules for the acute treatment services setting which do not violate or contradict rules found in this Chapter 6, and which do not restrict an individual's rights. Such house rules shall be provided to the individual upon admission and be prominently posted at the location services are provided.
- F. Alternate building standards. The following building standards shall apply only to the physical locations in which acute treatment services are provided.
 - 1. The interior environment shall be clean and sanitary, free of hazards to health and safety, including:
 - a. Layout, finishes, and furnishings must minimize the opportunity for residents to injure themselves or others.
 - b. Interior areas, finishes, and furnishings must be maintained in good repair and promote sanitary conditions. All spaces shall have adequate heat, lighting, and ventilation sufficient for its intended use and individual needs.

- c. Windows that can be accessed by individuals must have security glazing or other appropriate security features to reduce the possibility of injury or elopement.
 - d. Items/substances that could be used for self-harm or harm to others, including, but not limited to, sharp knives and cleaning solutions, must be appropriately labeled and stored in a safe manner, inaccessible to individuals.
 - e. The physical location shall be maintained free of infestations of insects and rodents and all openings to the outside must be screened.
 - f. An adequate supply of safe, potable water must be available.
 - g. Hot water shall not be more than 120 degrees Fahrenheit at taps which are accessible by individuals, and there must be a sufficient supply of hot water to meet the needs during peak usage.
- G. The agency shall provide a clean, sanitary, and secure exterior environment for the year-round use of individuals, free of hazards to health and safety.
 - 1. Exterior areas must be maintained to prevent hazardous slopes, holes, or other hazards, and must be kept free of high weeds and grass, garbage, and/or rubbish.
 - 2. Secure outdoor areas shall be fenced or enclosed to prevent elopement and protect the safety and security of individuals.
- H. The agency shall ensure the following standards are met regarding the physical operation of the acute treatment services location:
 - 1. The agency's physical operation shall be in compliance with all applicable:
 - a. Local zoning, housing, fire, and sanitary codes and ordinances of the city, city and county, or county where the location is situated.
 - b. State and local plumbing laws and regulations, including that plumbing must be maintained in good repair, free of the possibility of backflow and back siphonage through the use of vacuum breakers and fixed air gaps, in accordance with state and local codes.
 - c. Sewage disposal requirements, including that sewage must be discharged into a public sewer system or disposed of in a manner approved by the local health department, or local laws if no local health department exists, and the Colorado water quality control commission.
 - 2. The agency shall have common areas adequate to accommodate all individuals, including a designated dining area capable of seating all individuals, and meeting the following accessibility requirements:
 - a. All common areas and dining areas must be accessible to individuals using an auxiliary aid without requiring transfer from a wheelchair to walker or from a wheelchair to a regular chair.
 - b. Doors to individual accessible rooms shall be at least thirty-two (32) inches wide.
 - c. A minimum of two entryways shall be provided for ingress and egress from the building by individuals using a wheelchair.

3. The following requirements must be met for bedrooms:
 - a. No individual may be assigned to any room other than a regularly designated bedroom. Temporary occupancy of a room not designated as a bedroom is permissible on a limited basis when the use of the assigned bedroom is contraindicated due to circumstances related to individual safety or emergent issues. Justification for such placement, and the length of placement, shall be documented in the individual record.
 - b. No more than two (2) individuals shall reside in a bedroom.
 - c. Each bedroom for individuals must have at least 100 square feet for a single individual, or 120 square feet for two residents. Bathroom areas and closets shall not be included in the determination of square footage.
 - d. Each individual shall have separate storage facilities adequate for personal Articles, such as a closet or locker, available inside their bedroom. Shelves may be provided for folded garments in lieu of hanging garments.
 - e. Each bedroom must include a comfortable, standard-sized bed with a clean mattress, mattress protector, pillow, rollaway-type beds, cots, folding beds, or bunk beds are not permitted.
 - f. The bedroom shall have a safe and sanitary method to store the individual's towel, such as a breakaway towel rack.
 - g. Extension cords and multiple-use electrical sockets shall be prohibited in individual bedrooms.
 - h. The bedroom shall include a chair unless contraindicated, in which case alternate seating shall be provided in close proximity to the bedroom.
4. The following standards must be met for bathrooms:
 - a. Each floor with bedrooms must have at least one bathroom which can be accessed without entering a bedroom.
 - b. The physical location of the agency's operations must have at least one full bathroom accessible to any individual using an auxiliary aid, including properly installed grab bars at each tub and/or shower, and adjacent to each toilet.
 - c. Bathtubs and shower floors must have non-skid surfaces.
 - d. Toilet seats shall be constructed of non-absorbent materials and free of cracks.
 - e. Individuals must have individualized personal care Articles and supplies, such as soap and towels, and such Articles and supplies shall not be shared.
 - f. Toilet paper must be available at all times in each bathroom.
 - g. Liquid soap and paper towels must be available at all times in the common bathrooms.
5. The following standards must be met for seclusion rooms:

- a. The seclusion room must be constructed to prevent an individual from hiding, escaping, being injured, or dying by suicide, and must be free of all protrusions, sharp corners, hardware, fixtures or other devices, and furnishings which may cause injury to the individual.
 - b. The seclusion room must maintain a temperature appropriate for the season.
 - c. The seclusion room must be located in a manner affording direct observation of the individual by personnel.
 - d. The seclusion room must have a window that allows someone outside the room to see into all of the corners of the room. All windows in the seclusion room must be constructed to prevent breakage and otherwise prevent self-harm.
 - e. Doors to the seclusion room shall be at least thirty-two (32) inches wide and must open outward.
 - f. Light fixtures and other electrical outlets in the seclusion room must be limited to those required and necessary, must be recessed, and must be constructed to prevent self-harm. Such fixtures and outlets must be controlled by labeled on/off switches located outside the seclusion room.
6. The agency shall meet the following requirements regarding linen and laundry:
- a. The agency may have laundry room(s) with residential-style washer(s) and dryer(s) in an area with adequate square footage and ventilation for the number of washers and/or dryers included in the space.
 - b. The laundry room(s) must not be used for storage of soiled or clean linen.
 - c. There must be a separate enclosed area for receiving and holding soiled linen until ready for pickup or processing, in addition to a separate enclosed area for clean linen storage.
 - d. There must be hand-washing, or other appropriate hand-sanitizing, facilities in each area where unbagged, soiled linen is handled.

Chapter 7: Emergency and Involuntary Substance Use Disorder Commitment Services

7.1 Authority and Applicability

- A. Chapter 7 establishes the standards for emergency and involuntary commitment of a person with a substance use disorder. The authority to promulgate these rules necessary to carry out the BHA's programs for emergency and involuntary commitment of a person with a substance use disorder comes from Section 27-50-107(3), C.R.S. and Section 27-50-502(1), C.R.S. authority for BHA administration of these programs is found in Section 27-50-105(1)(pp), C.R.S. and Section 27-50-105(1)(qq), C.R.S.
- B. These rules are established to create standards for agencies seeking an endorsement to provide services to individuals on emergency substance use disorder commitments pursuant to Section 27-81-111, C.R.S. and Section 27-81-112, C.R.S.
- C. All agencies providing services to individuals on emergency substance use disorder commitments shall meet the standards in this Chapter 7. If the agency requires a BHE license, the agency shall comply with Chapter 2 of these rules.

7.2 Emergency Substance Use Disorder Commitment Services

- A. Emergency commitment policies and procedures, based on compliance with Section 27-81-111, C.R.S., shall be developed and implemented by the licensed and appropriately endorsed agency providing withdrawal management services pursuant to Chapter 4 (Outpatient and High Intensity Outpatient Services) or Chapter 5 (Residential Services) of these rules. Such policies and procedures shall require agency personnel to:
 - 1. Ascertain if grounds for commitment exist;
 - 2. Assure that individuals and their legal representatives receive copies of the application for emergency commitment forms and are advised verbally and in writing of the right to challenge commitment through the courts; and,
 - 3. Determine when grounds for emergency commitment no longer exist.
- B. The treatment agency administrator shall designate, in writing, qualified personnel who meet the criteria established in part 5.6.2.F of these rules, to assume responsibility for accepting, evaluating, informing, and providing treatment to individuals on an emergency commitment.
- C. Applications for emergency commitments must be prepared on BHA designated forms available on the BHA website.
- D. Daily evaluations shall be completed for the continuance of an emergency commitment. Daily evaluations shall be documented in the individual record.
- E. If individuals on an emergency commitment require treatment in other licensed and appropriately endorsed withdrawal management programs, transfers shall be managed by the programs that initially authorized the commitments.
- F. When transferring individuals, withdrawal management programs shall use BHA designated transfer forms available on the BHA website. Completed copies shall be given to:
 - 1. Individuals and/or their legal representatives; and,
 - 2. The withdrawal management programs to which individuals are being transferred.
- G. When a child is transferred and/or the child's emergency commitment has been discontinued, parents or legal guardians who have given permission for treatment must receive copies of transfer form and emergency commitment form.
- H. When it is determined that grounds for an emergency commitment no longer exist, the individual must be transferred to voluntary status and the emergency commitment shall be discontinued and documented. A copy of the emergency commitment form that specifies discontinuation of the emergency commitment must be given to the individual and made part of the individual record as described in part 2.11 of these rules.
- I. Discharge summaries, as outlined in part 2.10.A.6 of these rules must be submitted to the BHA, the referring source, and to the referral agency in accordance with state and federal confidentiality laws and regulations.

7.3 Involuntary Substance Use Disorder Commitment Services

- A. These rules are established to create standards for agencies seeking an endorsement to provide services for individuals on involuntary substance use disorder commitments pursuant to Section 27-81-112, C.R.S.

7.3.1 General Provisions

- A. Involuntary commitment policies and procedures must be developed and implemented based on and in compliance with Section 27-81-112, C.R.S.
- B. The BHA may delegate physical custody of individuals involuntarily committed to an appropriate approved treatment agency pursuant to Section 27-81-112(5), C.R.S.
- C. Passes may be issued to individuals on involuntary commitments in residential settings only if they are directly related to treatment. Passes shall not be issued during the initial thirty (30) days of treatment, except in emergencies, as defined in part 1.2 of these rules, and with BHA approval.
- D. The following information shall be reported to the BHA using the process outlined on the BHA website:
1. Non-compliance with program requirements shall be reported within three (3) business days;
 2. Non-compliance with court orders shall be reported within 24 hours;
 3. Failure to appear for admission to treatment shall be reported within 24 hours;
 4. Leaving treatment in violation of court orders shall be reported within 24 hours;
 5. Failure to return from passes shall be reported within 24 hours; and,
 6. Monthly treatment status reports shall be due by the 15th day of the month.
- E. Discharge summaries, as outlined in part 2.10.A.6 of these rules shall be submitted to the BHA, the referring source, and to the referral agency in accordance with state and federal confidentiality laws and regulations.
- F. An agency may not grant an individual's requests for early discharge and/or transfer to other treatment programs without first obtaining BHA approval.

7.3.2 Personnel Requirements

- A. Primary counselors for individuals on an involuntary commitment, means the following behavioral health professionals trained in substance use disorder identification and treatment and acting within their scope of practice:
1. Authorized practitioner;
 2. Licensee;
 3. Certified addiction specialist (CAS); or,
 4. Candidate personnel.

- B. All of the personnel noted in part 7.3.2.A above shall complete at least fourteen (14) hours of training in interviewing techniques related to engaging individuals in treatment.
- C. Copies of primary counselor credentials and other relevant documentation shall be maintained in counselor personnel files as described in part 2.5.G of these rules.

Chapter 8: Services for Children and Families

8.1 Authority and Applicability

- A. Chapter 8 establishes standards for agencies seeking an endorsement to provide services for children and families. Rules include requirements for individual assessment, treatment and patient rights. The authority for these standards comes from Section 27-50-502(1)(a)(I), C.R.S. authority to promulgate these rules establishing additional competencies related to serving priority populations, including children, comes from Section 27-50-502(6) C.R.S., and for children Sections 27-50-301(3)(c), C.R.S., 27-50-301(5), C.R.S., and 27-50-107(3), C.R.S.
- B. These rules are established to create standards for agencies seeking an endorsement to provide psychotherapy services, as defined in part 1.2 of these rules, and services for children and families. Services for children and families include Behavioral Health Early Intervention and Outpatient Services as outlined in part 4.1 through 4.4.3 of these rules, Behavioral Health High-Intensity Outpatient Services as outlined in part 4.6 through 4.7.4 of these rules, Behavioral Health Residential Services as outlined in part 5.1 through 5.3.3 of these rules and part 5.5 through part 5.6 of these rules and part 5.9 through 5.9.5 of these rules and Emergency and Crisis Behavioral Health Services as outlined in part 6.1 through 6.7.2 of these rules.
- C. All agencies providing psychotherapy services and children and family services must meet the standards in this Chapter 8. If the agency requires a BHE license, the agency shall comply with Chapter 2 of these rules.
- D. An agency with a Children and Families endorsement must also have at least one other endorsement of these rules.

8.2 Behavioral Health Services for Children

8.2.1 Criminal History Record Check

- A. In addition to criminal background checks required under part 2.6.D of these rules, agencies must, prior to hiring or accepting new personnel, submit to the Federal Bureau of Investigation (FBI) a complete set of fingerprints taken by a qualified law enforcement agency to obtain any criminal record held by the FBI, for each prospective personnel. Payment of the fee for the criminal record check is the responsibility of the agency. No direct contact with children may take place until the background check is cleared by the FBI.

8.3 Rights of Children

- A. Parents or legal guardians must be contacted without the child's written or verbal consent, unless notifying the parent or legal guardian would be inappropriate or detrimental to the minor's care and treatment, as authorized by Section 12-245-203.5(7), C.R.S., if:
 - 1. The child presents or communicates a danger to self or others, including a person who is identifiable by the person's association with a specific location or entity.

- B. Section 27-65-104(1), C.R.S. allows children who are fifteen (15) years of age or older, with or without the consent of a parent or legal guardian, to knowingly consent to mental health services, which includes the provision of psychotropic medications.

8.3.1 Rights of Children Receiving Outpatient Services

- A. Agencies must obtain parental or legal guardian consent for children under fifteen (15) years of age, with the following exception:
1. Section 12-245-203.5(2), C.R.S., allows psychotherapy services, as defined in Section 12-245-202(14)(a), C.R.S., to be provided to a child who is twelve (12) years of age or older, with or without the consent of the child's parent or legal guardian, if the child is knowingly and voluntarily seeking such services and the provision of psychotherapy services is clinically indicated and necessary to the child's well-being. The following mental health professionals are the only professionals within an agency allowed to provide outpatient psychotherapy services in an outpatient setting to a child who is twelve (12) years of age or older, without the consent of the child's parent or legal guardian:
 - a. A professional person as defined in Section 27-65-102(27), C.R.S., which means a person licensed to practice medicine in this state, a psychologist licensed to practice in this state, or a person licensed and in good standing to practice medicine in another state or a psychologist licensed to practice and in good standing in another state who is providing medical or clinical services at a treatment facility in this state that is operated by the Armed Forces of the United States, the United States Public Health Service, or the United States Department of Veterans Affairs;
 - b. A mental health professional licensed pursuant to Article 245, of Title 12, C.R.S., which in accordance with Section 12-245-203.5, C.R.S., includes:
 - (1) A licensed psychologist or a psychologist candidate pursuant to Section 12-245-301 through -309, C.R.S.;
 - (2) A licensed clinical social worker or a licensed social worker candidate pursuant to Section 12-245-401 through -410, C.R.S.;
 - (3) A marriage and family therapist licensed or a licensed marriage and family therapist candidate pursuant Section 12-245-501 through -506, C.R.S.;
 - (4) A licensed professional counselor or a licensed professional counselor candidate pursuant to Section 12-245-601 through -607, C.R.S.; and,
 - (5) A licensed addiction counselor or an addiction counselor candidate licensed pursuant to Section 12-245-801 through -806, C.R.S.
 2. A child may not refuse psychotherapy services when a mental health professional and the child's parent or legal guardian agree psychotherapy services are in the best interest of the child.
 3. If the child voluntarily seeks psychotherapy services on their own behalf pursuant to Section 12-245-203.5(2)(a), C.R.S.:

- a. The mental health professional may notify the child's parent or legal guardian of the psychotherapy services given or needed, with the child's consent, unless notifying the parent or legal guardian would be inappropriate or detrimental to the child's care and treatment.
 - b. The mental health professional shall engage the child in a discussion about the importance of involving and notifying the child's parent or legal guardian and shall encourage such notification to help support the child's care and treatment; and,
 - c. Notwithstanding the provisions of Section 12-245-203.5(3)(a), C.R.S., a mental health professional may notify the child's parent or legal guardian of the psychotherapy services given or needed, without the child's consent, if, in the professional opinion of the mental health professional, the child is unable to manage the child's care or treatment.
4. A mental health professional shall fully document in the child's individual record, when the mental health professional attempts to contact or notify the child's parent or legal guardian and whether the attempt was successful or unsuccessful, or the reason why, in the mental health professional's opinion, it would be inappropriate to contact or notify the child's parent or legal guardian.
 - a. If the child seeks psychotherapy services on their own behalf pursuant to Section 12-245-203.5(2)(a), C.R.S., documentation must be included in the child's individual record, along with a written statement signed by the child, indicating the child is voluntarily seeking psychotherapy services.
5. In addition to the individual rights specified in part 2.7 of these rules, children who meet the requirements of part 8.3.1.A.1, without the consent of a parent or legal guardian, have the right to:
 - a. Consent to release of information

8.3.2 Rights of Children in Hospitalization

- A. In addition to the individual rights specified in part 2.7 of these rules, and notwithstanding any other provision of law, a child who is fifteen (15) years of age or older, with or without the consent of a parent or legal guardian, has the right to consent to receive behavioral health services to be rendered by an agency, a professional person, or a mental health professional pursuant to Section 27-65-104(1), C.R.S., in any practice setting;
 1. Consent to voluntary hospitalization for mental health services;
 2. Object to hospitalization and to have that objection reviewed by the court under the provision of Section 27-65-104(6), C.R.S.; and
 3. Consent to release of information.
- B. Children who are under the age of fifteen (15), have the right to object to hospitalization and to have a guardian ad litem appointed pursuant to Section 27-65-104(6)(b),(c), C.R.S.

8.4 Screening and Assessment of Children

- A. Agencies shall follow screening as required in part 2.12.1 of these rules.

- B. Agencies shall follow the requirements of part 2.12.2 and part 2.12.3 of these rules in addition to the following:
1. Comprehensive assessments must include an evaluation of the family's, or legal guardian's social determinants of health, as well as needs and strengths that may pertain to the child's treatment. If family or legal guardian basic needs are identified, including, but not limited to, food, clothing, shelter and health, this must be addressed in the individualized and family-oriented service plan and referral made to the identified services and supports, if needed. Such comprehensive assessments will maintain the confidentiality of participants records in accordance with applicable state and federal laws.
 2. The comprehensive assessment must explore how the identified family members, natural supports or legal guardians will be involved in whole person and Two (2) -Generational behavioral health services. In the event that any person's involvement is contraindicated, the clinical rationale must be documented.
 3. The comprehensive assessment must also include a trauma assessment specific to children, which can include but is not limited to: an ACEs screen, or a pediatric ACEs screener. This shall be completed with the child utilizing any standardized screening tool.
 - a. Parent(s) or legal guardian(s) shall be included, unless involvement in the screen is contraindicated, then the clinical rationale must be documented in the individual record. If completing the aces screen, parent(s) and/or legal guardian(s) shall complete this separately.
 - b. For clarity and accuracy, a child under the age of twelve (12), must be given the option to answer the questions verbally to the provider.
 4. The comprehensive needs and strengths assessment must be incorporated into the service plan, reassessment, and discharge plan, when or where appropriate, and assess and triage for the needs of a child, who are at least seventeen (17) years of age who is expected to require behavioral health services and supports beyond the age of eighteen (18). This may include, but is not limited to:
 - a. Housing and/or housing stability;
 - b. Insurance or lack of insurance;
 - c. Transportation;
 - d. Employment and/or education;
 - e. Social supports;
 - f. Medical/dental needs; and
 - g. Food security and/or insecurity

8.5 Service Planning for Children and Families

- A. Agencies shall follow part 2.13 of these rules, service planning and reviews, in addition to the following:

1. The service plan must be developed in collaboration with the child, and the child's parent or legal guardian and be signed by the child, if the child is over the age of twelve (12), and by the parent or legal guardian. In the event that involvement of the parent or legal guardian is contraindicated, the rationale shall be documented.
 - a. In all instances where prescription psychiatric medications are to be ordered as a part of a mental health treatment program, the following information shall be provided, in an accessible manner, to the child and parent(s) or legal guardian(s).
 - (1) The name(s) of the medication being prescribed.
 - (2) The usual uses of the medication(s).
 - (3) The reasons for ordering the medication(s) for the child.
 - (4) A description of the benefits expected.
 - (5) The common side effects and common discomforts, if any.
 - (6) The major risks, if any.
 - (7) The probable consequences of not taking the medication(s).
 - (8) Any significant harmful drug or alcohol interactions, or food interactions.
 - (9) Appropriate treatment alternatives, if any; and,
 - (10) That the child may withdraw agreement to take the medication at any time.
2. A copy of the service plan shall be provided, upon request, to the child, if they are over the age of twelve (12), and parent or legal guardian. In the event that involvement of the parent or legal guardian would be detrimental to the child's health, safety, or welfare, the rationale shall be documented.
3. The service plan shall be individualized and use a Two (2)- Generational approach to include family driven goals and objectives that address the child and family services, supports, needs and building on their strengths and natural supports as identified in the assessment.
4. Service plans must be implemented in partnership with children and families. Service plans must support planning and transition to another services and/or setting.

Chapter 9: Women's and Maternal Behavioral Health Treatment

9.1 Authority and Applicability

- A. Chapter 9 establishes the standards for agencies electing to provide Women's and Maternal Behavioral Health Treatment. Authority to promulgate rules establishing requirements for individual assessment, treatment, and patient rights, comes from Sections 27-50-107(3) and 27-50-502(1)(a)(b), C.R.S. authority to promulgate these rules establishing additional competencies related to serving priority populations comes from Section 27-50-502(6), C.R.S. additionally, the BHA has authority to administer the treatment program for high-risk pregnant women created pursuant to Sections 27-80-112 and 27-80-113, C.R.S. authority for BHA administration of this program is found in Section 27-50-105, C.R.S. authority to promulgate rules required for the administration of this program comes from Section 27-50-107(3)(a), C.R.S.
- B. All agencies providing Women's and Maternal Behavioral Health Treatment services shall meet the standards in this Chapter 9. If the agency requires a BHE license, the agency shall comply with Chapter 2 of these rules.
- C. An agency with a Women's and Maternal Behavioral Health Treatment endorsement shall also have at least one level of care endorsement to provide substance use disorder treatment pursuant to Chapters 4 through 7 of these rules.

9.1.1 General Provisions

- A. Personnel shall have documented training, experience, and access to supervision in women-specific issues and services. Training and experience may include topics such as:
 - 1. Trauma-informed care;
 - 2. Trauma;
 - 3. Women's and/or pregnancy-related health during the reproductive years;
 - 4. Infertility;
 - 5. Pregnancy loss;
 - 6. Infant loss;
 - 7. Perinatal mood and anxiety disorders;
 - 8. Stigma and substance use disorder among pregnant and parenting women/ individuals and perinatal substance exposure;
 - 9. Body image/disordered eating;
 - 10. Relationship violence/ healthy relationships;
 - 11. Dyadic attachment/parenting;
 - 12. American Society of Addiction Medicine (ASAM) Criteria for parents or prospective parents receiving addiction treatment concurrently with their children; and,
 - 13. Child welfare reporting requirements and alternatives.
- B. Treatment for behavioral health shall be provided to and/or coordinated with family members, unless clinically contraindicated. Clinical contraindications to this provision and referrals for dyadic and/or family treatment must be documented in the individual record.

- C. Agencies shall make every attempt to offer any pregnant or postpartum women/individuals' admission to treatment within forty-eight (48) hours and shall demonstrate compliance with part 9.1.5.D.
- D. Agencies providing gender specific women's and/or pregnancy-related behavioral health treatment may include the following components:
 - 1. Emotional and physical safety of individuals take precedence over all other considerations in the delivery of services, as outlined within trauma-informed principles;
 - 2. Services designed to increase women's and/or pregnancy-related access to wraparound services, and engagement and retention of individuals (such as peer services, transportation, childcare);
 - 3. Women-only therapeutic environments;
 - 4. Women-specific service needs and topic areas;
 - 5. Program services shall directly address trauma issues currently manifesting in the individual's life, either through direct service provision or by referral; and,
 - 6. Multiple modalities that meet the specific needs of women (group and individual therapy, case management and opportunities for women to be in treatment with their children where possible).
- E. Agency policy and procedures must include the criteria for interventions offered and expected outcomes of services delivered.

9.1.2 Screening

- A. In addition to the part 2.12.1 of these rules, screening shall include all the following unless clinically contraindicated:
 - 1. Screening and documentation of individual's need for prenatal/postpartum care (where applicable), primary medical care and family planning services; and
 - 2. Screening and documentation of child safety issues and/or referrals for children in the individual's home that need behavioral health and/or medical care utilizing an evidence-based instrument or best practice approach.

9.1.3 Treatment

- A. Service plans shall be established in accordance with part 2.13 of these rules and shall address each of the need areas identified in part 9.1.3.B and 9.1.3.C.
- B. When not clinically contraindicated the following topic areas shall be addressed in treatment or through comprehensive care coordination as outlined in part 2.9.G and the following, when applicable:
 - 1. Reductions or elimination of substance use;
 - 2. Individual safety;
 - 3. Child safety;

4. Trauma;
 5. Parenting, including attachment and co-regulation;
 6. Ways in which behavioral health impacts family and relationships across the lifespan;
 7. Primary care, medical care, lactation, pelvic health, dental health, reproductive health, and family planning care;
 8. Mental health, including parental mental health conditions; and
 9. Nutrition assessment in relation to pregnancy, lactation, early childhood, and behavioral health.
- C. Any agency that qualifies to provide services pursuant to Sections 25.5-5-202(1)(r), 27-80-112, C.R.S. and 27-80-113, C.R.S., in regard to the Treatment Program for High-Risk Pregnant Women, shall make available, in addition to substance use and addiction counseling and treatment:
1. Needs assessment services;
 2. Preventive services;
 3. Rehabilitative services;
 4. Care coordination;
 5. Psychosocial counseling;
 6. Intensive health education;
 7. Home visits;
 8. Transportation;
 9. Development of provider training;
 10. Child care;
 11. Child care navigation; and,
 12. Other necessary components of residential or outpatient treatment or care.

9.1.4 Services for Pregnant and Postpartum Women/Individuals

- A. Pregnant women/individuals shall be given priority admission and/or care coordination to treatment for substance use disorders.
1. Agencies cannot deny services to pregnant and postpartum women/individuals due to sobriety status.
- B. Agencies shall develop policies and procedures for service delivery to pregnant and postpartum women/ individuals, which shall include circumstances under which pregnant and postpartum women/individuals may be discharged from treatment.

1. Pregnant women/individuals may not be discharged from treatment solely for failure to maintain abstinence from substance use.
 2. Every effort shall be made to retain pregnant and postpartum women/individuals in treatment for the duration of their pregnancies in order to maintain an optimal period of abstinence from substance use.
- C. Every attempt shall be made to admit pregnant women/individuals to treatment within forty-eight (48) hours of first contact between the woman/individual and the admitting program.
- D. If a pregnant woman/individual is not admitted to treatment within forty-eight (48) hours of first contact, the reason shall be clearly documented in their individual record. If the individual is working with a care coordinator through their managed care entity or managed service organization, the care coordinator shall be informed. Interim services shall be provided consisting of the following at minimum:
1. Referral for prenatal care;
 2. Information on the effects of alcohol and drug use on the fetus and perinatal individual;
 3. Daily phone contact with the individual for those seeking residential care; and,
 4. Education regarding the transmission and prevention of communicable diseases such as Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), Tuberculosis (TB), and Hepatitis A, B, or C.
- E. Pregnant and postpartum women/individuals shall be linked to prenatal and postpartum care immediately and barriers to accessing prenatal and postpartum care including, but not limited to transportation to care, must be addressed, and documented in their individual record.
- F. If a pregnant or postpartum woman/individual declines prenatal or postpartum care, this shall be documented in the individual record, and offers for care shall continue to be offered at a minimum of one attempted contact monthly and documented. If no contact occurs within six (6) months, the reason shall be documented, and the agency is no longer required to contact.
1. This does not include individuals who have completed their treatment goals or disengaged from treatment.

Chapter 10: Services for Criminal Justice-Involved Individuals

10.1 Authority and Applicability

- A. Chapter 10 establishes the standards for and applies to BHEs providing services to criminal justice involved individuals, including specific criminal justice programs. The BHA has authority for administration of DUI treatment programs pursuant to Article 2 of Title 42, C.R.S., and Alcohol and Drug Driving Safety Education or Treatment pursuant to Section 42-4-1301.3, C.R.S. and Section 27-50-105(1)(vv)(ww), C.R.S. authority to promulgate rules required for the administration of this program comes from Section 27-50-107(3)(a), C.R.S. authority to promulgate rules establishing requirements for individual assessment and treatment comes from Section 27-50-502(1)(a)(I), C.R.S.

- B. Services for criminal justice-involved individuals must generally be intended for individuals who are referred into education and/or treatment services as a result of, or in connection to, involvement with the criminal justice system. This does not include juvenile justice system services that are regulated by the responsible state agencies as indicated in Section 19-2.5-1401, C.R.S.
- C. Services for criminal justice-involved individuals must involve a continuum of education and/or treatment options available to individuals as they proceed through the criminal justice system. These services must be available across multiple settings, including community-based and locked facility-based settings. Services offered must vary depending upon the needs of the individual and the specific criminal justice program endorsement.
- D. These rules are established to create standards for BHEs seeking endorsements to provide education and/or treatment services, as defined in part 10.1.1 of this Chapter, for individuals involved with the criminal justice system. This criminal justice endorsement and all corresponding sub-endorsements may not be held alone, but in addition to appropriate corresponding endorsement(s) and sub-endorsement(s) for the type of services being provided.

10.1.1 Definitions

“Contact Hours”, for the purposes of parts 10.5 through 10.9 of this Chapter means the time that an individual participates in Level I Education, Level II Therapeutic Education, and/or Level II Treatment.

“Credit Hours”, for the purposes of parts 10.5 through 10.9 of this Chapter means the time that an individual participates in non-DUI/DWAI specific education or treatment. These hours may be granted towards education and/or treatment requirements for DUI/DWAI services within the parameters set forth in this part 10.5.11.

“Education and/or Treatment” means the programs developed that are structured in such a manner to provide a continuum of education and treatment for each individual as they proceed through the criminal justice system and may include but shall not be limited to, attendance at self-help groups, group counseling, individual counseling, outpatient treatment, inpatient treatment, day care, or treatment in a therapeutic community. Education and treatment are to be accessible by all individuals involved in the criminal justice system, pursuant to Section 16-11.5-102, C.R.S.

“Enhanced Outpatient Services,” or “EOP,” means services in which an individual receives an increased number of therapeutic contacts and interactions with personnel, intended to expedite stabilization of assessed behavioral health concerns. The goal is to stabilize the individual to allow for more effective engagement in education and other treatment services.

“Program(s)” for the purpose of this Chapter, means the systems of education and treatment services addressing abuse of substances which can be utilized by individuals who are placed on probation, incarcerated with the Department of Corrections, placed on parole, or placed in community corrections, pursuant to Sections 16-11.5-102(1)(b), C.R.S. and 42-4-1301.3, C.R.S.

“Telehealth,” in addition to the requirements of part 1.2 and 2.9 of these rules, telehealth services for the purpose of this Chapter 10, does not include consistent and regular in-session use of audio-only telehealth services.

10.1.2 Assessment and Placement in Services

- A. Unless otherwise noted, BHEs endorsed to provide treatment programming to criminal justice-involved individuals must receive placement recommendation(s) for each individual served, completed by the referring supervising entity. The BHE is expected to evaluate if the supervising entity's recommendation matches the individual's assessed clinical need(s). The BHE is expected to address any differences identified with the supervising entity directly and document results in the individual's record.
- B. The type of placement recommendation(s) from the supervising entity will vary depending upon the type of supervising entity and the individual's type of offense leading to the treatment referral. BHEs must include a copy of the referral paperwork, demonstrating treatment in accordance with the placement initial assessment and treatment recommendation(s) from the supervising entity, in the individual's record.
- C. If a BHE is unable to obtain a copy of the placement recommendation(s) from the supervising entity there must be documentation of attempt(s) to obtain the paperwork from the referral source, if applicable.
- D. BHEs must assess for and prioritize the delivery of services that support the individual's placement in the community, including reintegration into the community if incarcerated. This must include engagement of the individual's identified support system throughout the episode of care, as permitted by the individual.

10.1.3 Personnel Training

- A. All BHE personnel providing education and/or treatment services to individuals involved in the criminal justice system must:
 - 1. Be knowledgeable about the criminal justice system, including the sequential intercept model and the processes and phases through which an individual moves in the criminal justice system;
 - 2. Be knowledgeable of the principles of risk, need, and responsivity;
 - 3. Be knowledgeable about the criminal justice system in the state of Colorado, including competency restoration services, as explained in Chapter 12 of these rules, and situations involving individuals determined to be not guilty by reason of insanity (NGRI); and
 - 4. Attend at least one (1) training during their active licensing or approval term unique to individuals involved in the criminal justice system.
 - 5. Personnel providing curriculum-driven education and/or treatment services, including but not limited to DUI/DWAI programming, to individuals involved in the criminal justice system must be trained in the curriculum and be qualified to provide such services, as indicated in parts 10.4 through 10.9 of this Chapter.
- B. The above training requirements may be satisfied by completing the BHA-developed criminal justice services curriculum on the statewide Learning Management System (LMS), once developed and available in the LMS.
- C. BHEs endorsed to provide programming to DUI/DWAI-involved individuals must maintain proof of completion of the training in personnel files and provide verification to the BHA upon request.

10.1.4 Documentation

- A. In addition to documentation requirements applicable to the BHE's license and selected endorsement(s), individual records must include documentation of intentional collaboration and communication with the supervising entity. Collaboration and communication efforts must include, but are not limited to:
 - 1. Ongoing communication and coordination of care with supervising entities;
 - 2. Case consultation;
 - 3. Development of referral processes; and
 - 4. Incorporation of issues related to criminal justice involvement into ongoing service planning processes.
- B. Identified RNR principles must be incorporated in the individual's record and addressed in treatment services, as appropriate.
- C. Documentation in the individual record must reflect and demonstrate personnel's knowledge of the criminal justice system including, for example, the proper use of criminal justice system terminology. Documentation must also demonstrate an understanding of how involvement in the criminal justice system relates to providing care for the individual.
- D. Documentation in the individual's record must reflect how, the individual's identified support system is engaged throughout the episode of care.
 - 1. If the individual does not permit support system involvement, it is clinically contraindicated, or the individual is unable to identify a support system, the record must reflect efforts to help the individual build a recovery-focused support system. This may include post-treatment referral(s) and peer recovery support services, as applicable.
- E. Individual records must reflect efforts to deliver services necessary based on the individual's assessment and service planning process. This must involve documentation of care coordination with other providers, resources, and support systems as necessary.
- F. Documentation in the individual's record must reflect service delivery that is person-centered, trauma-informed, harm reduction focused, physically and programmatically accessible, and culturally and linguistically appropriate for all individuals served.
 - 1. This may include connecting to referrals, and/or providing translation and/or interpreter services for those individuals that need this service to receive treatment.
- G. BHEs endorsed to provide programming to criminal justice-involved individuals must provide individuals with a complete copy of the participant materials and workbook associated with the curriculum being used, when applicable.
 - 1. BHEs must supply materials and workbooks associated with curriculum in ways that reasonably accommodate the individual's needs and facilitate access, utilization, and understanding of the information.
 - 2. BHEs must supply youth with age-appropriate materials/workbooks.

10.2 Enhanced Outpatient Services (EOP)

10.2.1 Applicability

- A. BHEs endorsed to provide an EOP level of programming to criminal justice-involved individuals must meet all requirements set forth in part 4.3 of these rules in addition to parts 10.1 and 10.2 of this Chapter.
- B. BHEs providing EOP level of services must be intended for individuals who are assessed as needing increased services for immediate stabilization, but not appropriate for more intensive levels of care. EOP services are often utilized by individuals who require stabilization prior to engaging in required education or treatment services and a recommendation or referral may be received for this level of care from a supervising entity.
- C. BHEs providing EOP level of services are appropriate for individuals with substance-related disorders, mental health disorders, or co-occurring disorders if:
 - 1. The behavioral health disorders are of moderate or high severity, as defined in the DSM-5-TR;
 - 2. Require additional stabilization; and
 - 3. May be safely managed in this level of care.
- D. BHEs providing EOP level of services must be endorsed by the BHA to provide this level of care. If the BHE refers the individual to another provider to address stabilization needs that are identified through the assessment and service planning process, the referring BHE must be responsible for care coordination and communication of progress updates with the supervising entity.

10.2.2 EOP Service Provisions

- A. BHEs providing EOP level of services must provide between three (3) and eight (8) treatment contact hours per week for individuals.
- B. BHEs providing EOP level of services must be conducted over a minimum of two (2) calendar days per week.
- C. BHEs providing EOP level of services must be provided by personnel as defined in part 4.3.2 of these rules.
- D. The treatment duration in EOP services must be determined by one (1) or more of the following treatment personnel, acting within their scope of practice:
 - 1. Authorized practitioners;
 - 2. Licensees;
 - 3. Certified addiction specialists (CAS); and/or
 - 4. Candidates.
- E. Determination of treatment duration must be based on the individual's assessment, continued screened/assessed needs while attending services, and documented progress towards treatment goals.

1. When a supervising entity recommends a treatment duration or a specific number of hours in EOP services that is not justified by the individual's assessment, the BHE must address the discrepancy with the supervising entity, provide alternative service recommendations to the supervising entity, and document the result of the collaboration in the individual's record.
 2. In the instance where this collaboration does not result in alignment with the assessed treatment recommendations, the BHE must follow the supervising entity's recommendation.
- F. Services attended while in EOP level of care must be variable and responsive to the individual's behavioral health needs as identified in the assessment and service plan, unless otherwise decided per this part 10.2.2.D.
1. EOP services attended must not include education related to the originating offense.

10.3 Intensive Outpatient Services (IOP)

10.3.1 Applicability

- A. BHEs endorsed to provide an IOP level of programming to criminal justice-involved individuals (including ASAM Criteria Level 2.1) must meet all requirements set forth in part 4.6 of these rules in addition to parts 10.1 and 10.3 of this Chapter.

10.3.2 IOP Service Provisions

- A. The treatment duration in IOP services must be determined by one (1) or more of the following treatment personnel, acting within their scope of practice:
1. Authorized practitioners;
 2. Licensees;
 3. Certified addiction specialists (CAS); and/or
 4. Candidates.
- B. Determination of treatment duration must be based on the individual's assessment and documented progress towards treatment goals.
1. When a supervising entity recommends a treatment duration or a specific number of hours in IOP services that is not justified by the individual's assessment the BHE must address the discrepancy with the supervising entity, provide alternative service recommendations to the supervising entity, and document the results of the collaboration in the individual's record.
 2. In the instance where this collaboration does not result in alignment with the assessment treatment recommendations, the BHE must follow the supervising entity's recommendation.

10.4 Criminal Justice Services Programs

10.4.1 Authority and Applicability

- A. This part 10.4 details standards for and applies to BHEs with an endorsement to provide substance use disorder education and treatment for individuals involved in the criminal justice system programming, pursuant to Section 16-11.5-102, C.R.S., and
- B. Parts 10.5 through 10.9 of this Chapter detail standards for and apply to BHEs endorsement to provide DUI/DWAI Level I and Level II education and treatment programming, pursuant to Sections 42-4-1301.3(3)(c), C.R.S. and 27-81-106, C.R.S.

10.4.2 General Provisions

- A. Individuals convicted of misdemeanor or felony offenses who are assessed as needing substance use disorder treatment, as indicated in Section 16-11.5-102, C.R.S. and in accordance with current standardized assessment and placement protocol of the referring supervising entity, must receive court-ordered education, treatment, and care coordination services.
- B. All BHEs admitting out of state offenders must identify and notify the interstate compact unit for adult offender supervision pursuant to Section 17-27.1-101, C.R.S.
- C. Services must be based on the results of current screening and assessments.
- D. BHEs must render treatment to individuals involved in the criminal justice system according to the placement recommendation(s) provided by the referring supervising entity.
- E. Education, treatment and care coordination services, as indicated by assessment and included in the service plan, must be provided for by the BHE or through referrals.
- F. BHEs must have a written memorandum of understanding with community supports or other agencies to provide agreed upon services, as well as any specific data and/or information needed for individualized services. Agreements as to disclosure of information must be in compliance with state and federal law.
- G. Education and treatment must be a minimum of nine (9) months or as required by the referring supervising entity.
 - 1. The BHE is expected to address any discrepancies regarding court-ordered length of stay in services with the supervising entity and document in the individual's record.
- H. Frequency and intensity of education and treatment services must be based on assessments and at minimum one (1), two (2) hour session per week.
- I. The following content/topics must be presented during treatment:
 - 1. Physiological and psychological effects of alcohol, controlled substances, and other drugs;
 - 2. Signs and symptoms of substance use disorders;
 - 3. Stress management and substance use disorders;
 - 4. Anger management and substance use disorders;
 - 5. Behavioral triggers leading to substance use disorders;
 - 6. Drugs in the workplace; and

- 7. Legal issues and substance use disorders.
- J. BHEs must implement treatment curricula that are written in manual format and are evidence-based or best practices. These materials must be provided in the language and modality of frequently encountered limited English proficiency groups.
- K. Education and treatment sessions must not include administrative procedures or breaks in accounting for their duration.
- L. BHE personnel working directly with individuals must have documented qualifications and training in forensic populations and criminal justice systems.
- M. Drug and alcohol toxicology collection must be observed by trained personnel when requested by the referral source.
- N. Records must contain monthly documentation of communication with the criminal justice referral source describing progress toward specific treatment goals. BHEs must be responsible for monitoring and reporting to referring courts or their representatives the individual's progress with ancillary services.
- O. BHEs must have written documentation in an individual's record that the individual has received services to assist in continued community placement, or community reintegration, whichever is applicable.

10.5 Driving Under the Influence/Driving While Ability Impaired (DUI/DWAI) Services

10.5.1 Authority and Applicability

- A. Authority to establish the endorsement of BHEs to provide DUI/DWAI Level I and Level II Education and Treatment programming is provided by Sections 42-4-1301.3(3)(c), C.R.S. and 27-81-106, C.R.S.

10.5.2 Levels of DUI/DWAI Program Endorsements

- A. BHEs seeking an endorsement to provide DUI/DWAI education and/or treatment programming in Colorado shall identify in their application the level of services they plan to provide. DUI/DWAI education and treatment services include:
 - 1. Level I Education, part 10.6 of this Chapter, and Level II Therapeutic Education, part 10.7 of this Chapter;
 - 2. Level II Treatment (Tracks A - D), part 10.8 of this Chapter; or
 - 3. Level II Treatment Track F (Level II Four (4) Plus), part 10.9 of this Chapter.
- B. Locked correctional facilities may provide DUI/DWAI education services only.
- C. BHEs shall not provide DUI/DWAI education or treatment services they are not endorsed to provide.

10.5.3 General DUI/DWAI Services Provisions

- A. The following provisions are applicable to all levels of DUI/DWAI services:

1. BHEs must develop and implement policies and procedures related to the provision of DUI/DWAI services. Personnel must have access to and be knowledgeable about the BHEs policies, procedures, and state and federal laws and regulations relevant to their respective duties.
- B. All BHEs must have:
1. A formalized process for referring individuals to higher or lower levels of care;
 2. A process to ensure individual data is accurate and submitted within seven (7) calendar days of service or change in status and entered into the Treatment Management System (TMS), unless prohibited by state or federal law;
 3. A process for how the BHE must determine a method of service delivery that best meets the needs of the individual. This process must include but not be limited to:
 - a. A plan for regular review, evaluation, and modification of service delivery to continue meeting the individual's needs; and
 - b. A referral process to BHEs and/or other agencies that provide alternate methods of service delivery, if not available through the current BHE.
 4. A process addressing how concurrent treatment provider(s) may be utilized or engaged to ensure coordination of individualized services is available to the individual. This must include a plan for data and exchange of information related to the individualized services received;
 5. A process for how granting of DUI/DWAI services credit hours, as noted in this part 10.5.11, must be achieved. This includes providing DUI/DWAI services credit for individuals assessed as needing mental health services to address primary treatment concerns, and/or referral into non-English-speaking treatment options;
 6. A process for how individuals will be monitored for drug and alcohol use while participating in education and/or treatment services must occur. This process must include a plan for responding and incorporation of monitoring results into the individual's services.
 7. Groups for ADDS education and treatment services must be restricted to those arrested, convicted of or receiving deferred prosecutions, pending prosecution, sentences, or judgments for DUI/DWAI.
 8. Individuals with DUI/DWAI must not be treated in offender-specific groups with individuals with other offenses unless they need these groups as determined by the assessment and supported by the service plan.
- C. Prior to admission of an individual for DUI/DWAI services, the BHE must obtain a current ADDS program screening and referral for placement. This screening and referral may be completed by a supervising entity as a condition of probation, parole, or pretrial services.
1. If a BHE is unable to obtain a copy of the ADDS or other court paperwork at the time the individual is admitted, there must be documentation of attempt(s) to obtain the paperwork from referral source, if applicable.

2. If the court paperwork is unavailable, or the individual is pretrial, the BHE must conduct a screening of the individual using an evidence-based or best practices screening process and instrument, following track placement guidelines as indicated in the legal supplement.
- D. Prior to admission, BHEs must complete a screening for:
1. Congruence of level and track assignment with ADDS evaluation, if available. Any deviation or discrepancy must be addressed with the referral source prior to engaging the individual in DUI/DWAI services;
 2. The individual's number of DUI/DWAI-related offenses. If the individual is pre-sentenced with three or more prior convictions of DUI/DWAI-related offenses, or newly sentenced with four or more DUI/DWAI-related offenses, they must be immediately referred to a BHE endorsed to provide Level II Four Plus programming, as defined in part 10.9 of this Chapter, the referral source must be notified;
 3. Youth status for the individual and clinical appropriateness for placement in DUI/DWAI education and/or treatment groups. If the youth is not clinically appropriate for placement in a DUI/DWAI education or treatment group with adults, the BHE must develop an age and developmentally appropriate intervention for the youth. If the BHE is unable to accommodate the youth's treatment needs, the BHE must refer the youth to another BHE endorsed to provide DUI/DWAI programming and the referral source must be notified; and
 4. Ability to provide necessary services as identified through the screening or the individual's court order. If the BHE does not provide the necessary services, the BHE must:
 - a. Refer the individual back to an ADES with documentation of which service(s) will not be provided within the BHE and identified referrals and suggestions for alternative services; and
 - b. Be responsible for monitoring and reporting to referring courts or their representatives the individual's progress with concurrent services.
- E. BHEs must document collaboration with recent or concurrent treatment service providers in accordance with all applicable federal and state confidentiality laws and regulations in the individual's record.
- F. Level I Education, Level II Therapeutic Education, and Level II Treatment must not be combined, nor must contact hours completed for one count as contact hours completed in another.
- G. Individuals must not be reported as finishing Level I Education or Level II Therapeutic Education until all required content/topics have been completed over the minimum required contact hours and weeks.
- H. BHEs must provide individuals with an orientation of the DUI/DWAI program requirements and anticipated timelines for completion. Documentation of the orientation must be maintained in the individual record.

10.5.4 DUI/DWAI Reporting and Data Requirements

- A. BHEs providing Level I Education, Level II Therapeutic Education, and Level II Treatment must submit information into the Treatment Management System (TMS), including but not limited to DUI/DWAI reporting system (DRS) submissions.
- B. BHEs must maintain access to TMS by submitting approval form(s) annually. These form(s) are available on the BHA's website.
- C. Prior to releasing any treatment information, BHEs shall obtain releases of information in accordance with all applicable federal and state confidentiality laws and regulations.
 - 1. Identifying information of the judicial district in which an individual committed a DUI/DWAI offense shall not be put into TMS and/or the individual's DRS record without a valid release of information for the assigned judicial district. This includes pre-sentenced DUI/DWAI individuals.
- D. DRS requirements
 - 1. At admission and throughout the duration of treatment:
 - a. A DRS record must be entered into TMS for all individuals enrolled in DUI/DWAI education and/or treatment.
 - b. The admission date for the DRS must be the date of enrollment with the BHE providing DUI/DWAI programming.
 - c. If the individual discharges from services and readmits, a new DRS with a current date of admission must be input into TMS.
 - (1) Information in the individual's DRS record must be updated in TMS in a timely manner, not to exceed more than seven (7) calendar days after a service is provided or a change in status.
- E. Affidavit of enrollment requirements
 - 1. BHEs must provide individuals assigned to a Level II Treatment Track, as defined in parts 10.8, and 10.9 of this Chapter, Track with a Division of Motor Vehicles affidavit of enrollment upon request, or by the next scheduled session. This form may be found on the BHA's website.
 - 2. BHEs must provide proof of enrollment and status in Level II Education and Treatment, as defined in parts 10.7 through 10.9 of this Chapter including discharge, to the Colorado Department of Revenue, Division of Motor Vehicles via the Treatment Management System (TMS), within seven (7) calendar days of the service, in accordance with state and federal confidentiality laws, and Sections 42-2-132 and 42-2-114, C.R.S.
- F. At discharge of treatment
 - 1. BHEs must provide a copy of the discharge DRS, validated with signature of authorized personnel, to individuals and referral sources upon discharge from education and/or treatment.
 - 2. An initial copy of the discharge DRS must be provided to individuals at no charge.
 - 3. The discharge DRS shall not be withheld from the individual for any reason including, but not limited to, collection of outstanding balances.

4. The discharge DRS must reflect all DUI/DWAI services the individual completed in a given episode of care. This includes any non-DUI/DWAI specific services, or services provided by non-DUI/DWAI endorsed programs, reviewed and granted towards DUI/DWAI credit hours.
5. BHEs must obtain a copy of all validated discharge DRS records for individuals who have completed any prior DUI/DWAI services for DUI/DWAI treatment requirement.
6. If the individual successfully completed DUI/DWAI education services while incarcerated for the current offense, the community-based BHE endorsed to provide DUI/DWAI programming shall not require the individual to repeat the completed education.
7. If the discharge DRS from a previous treatment episode is not available, the BHE must outreach the BHA for a record search.

10.5.5 Training

- A. Personnel providing DUI/DWAI services must:
 1. Receive the "Understanding the ADDS Evaluation" training; and,
 2. Be trained in or otherwise knowledgeable of, interlock enhancement counseling (IEC).
- B. All personnel accessing the TMS must receive training by authorized BHA representatives.
- C. BHEs must maintain proof of completion of training in personnel files and provide verification to the BHA upon request.

10.5.6 Provision of DUI/DWAI Services

- A. BHEs must use and adhere to a curriculum written in a manual form that is evidence-based or best practices specific to DUI/DWAI, unless otherwise noted.
- B. BHEs must assign individuals to a specific group or individual session, unless clinical reason is documented for change in service delivery.
- C. Personnel conducting DUI/DWAI education and treatment must meet the minimum qualifications as noted in the specific sub-endorsements for education and treatment in parts 10.6 through 10.9 of this Chapter.
- D. Hours of attendance must only be granted for education or treatment contacts and must not include administrative procedures or breaks.
- E. If telehealth services do not best meet the needs of the individual and the BHE endorsed to provide DUI/DWAI programming cannot accommodate in-person services, the BHE must refer the individual to a provider that can meet the individual's needs.

10.5.7 Testing and Monitoring

- A. BHEs must ensure that testing and/or monitoring of individuals served for alcohol and drug use occurs during the course of services. This testing and monitoring may be completed on-site or through a third-party testing entity.

1. If the BHE elects to collect toxicology samples on-site, the BHE must ensure that samples will be safely collected, packaged, stored, and transferred to the lab for testing, as well as address all points of this part 10.5.8.
 2. Drug and alcohol toxicology collection that occurs on-site must be observed by trained personnel.
 3. If testing is completed by a third-party testing entity, there must be documentation of the BHE's effort(s) to obtain test results.
- B. The testing and/or monitoring schedule and method of collection must be determined by the BHE endorsed to provide DUI/DWAI programming or in collaboration with the supervising entity.
- C. Method of testing and/or monitoring may include but is not limited to the following:
1. Urinalysis;
 2. Breath analysis;
 3. Continuous alcohol monitoring;
 4. Mobile/remote breath testing;
 5. Direct and indirect biomarker testing; and
 6. Drug and other testing as appropriate.
- D. With appropriate written consent or assent, the BHE shall coordinate and share testing and/or monitoring results with the supervising entity.

10.5.8 Youth DUI/DWAI Education and Treatment

- A. BHEs endorsed to provide DUI/DWAI education and treatment programming must have the ability to provide youth DUI/DWAI education and treatment or assist in direct referral and care coordination for the individual to another BHE that is endorsed to provide these DUI/DWAI programs for youth.
- B. BHEs providing DUI/DWAI services to youth under the age of eighteen (18) shall obtain a Children and Families services endorsement in accordance with Chapter 8 of these rules.
- C. BHEs must hold youth that receive a DUI/DWAI to the same requirements under ADDS education and treatment services.
- D. BHEs must use clinical judgment when determining age-appropriate placement of youth in a DUI/DWAI group, including but not limited to:
1. Providing a separate group for youth, when possible; and
 2. Providing individual sessions to meet the developmental needs of the youth if group placement is not clinically indicated or available.

10.5.9 Content of Records for DUI/DWAI Services

- A. Individual records must be maintained for all levels of DUI/DWAI education and treatment, and in addition to the requirements set forth under part 2.11 of these rules, must contain at least the following:
 - 1. Court documents regarding classification, referral and placement;
 - 2. Attendance, individualized progress notes, and course completion data;
 - 3. Descriptions of content and topics covered during each session;
 - 4. Relevant reports and records of communication with the supervising entity regarding participation and termination of the episode of care; and
 - 5. Copies of discharge DRS.
- B. Additional content of record requirements must be noted within the specific DUI/DWAI endorsements in parts 10.6 through 10.9 of this Chapter.

10.5.10 DUI/DWAI Education and Treatment Credit for Specialized Services Attended

- A. BHEs endorsed to provide DUI/DWAI programming must consider and be authorized to grant Level I and Level II Education and Treatment credit for services an individual received at non-DUI/DWAI or out-of-state treatment providers. Services considered may include DUI/DWAI-specific education and treatment, substance use disorder education and treatment, mental health or co-occurring disorder services, or other clinically necessary services.
- B. The granting of credit hours must be based on the assessed clinical need for services that support reduced engagement in impaired driving behaviors and activities.
- C. Credit toward Level I and Level II Education and Treatment requirements are allowed on an hour-for-hour and week-for-week basis. No more than two (2) clinical contact hours per week must be documented for credit. Extra credit hours must not be permitted for individual counseling.
- D. If the DUI/DWAI services credit hours being considered occurred previously, the BHE must:
 - 1. Complete a new assessment;
 - 2. If valid written consents or assents in place, obtain and review sufficient documentation of prior education and/or treatment, which includes at a minimum:
 - a. Admission and discharge date;
 - b. Description of services completed;
 - c. Progress on goals;
 - d. Discharge status; and
 - e. Copy of discharge summary.
- E. If the DUI/DWAI services credit hours being considered are concurrent, the BHE must:
 - 1. If valid written consents or assents in place, refer the individual to an additional treatment provider, as indicated by the clinical assessment.

2. Coordinate between the individual and the concurrent treatment provider.
 3. Document collaboration and care coordination in the individual's record and service plan.
- F. Credit hours must be assigned only if progress in treatment can be demonstrated in the clinical record review.
- G. The granting of any education or treatment credit is subject to the following criteria:
1. Education or treatment must have occurred after the date of the last DUI/DWAI offense.
 2. Any hours considered must have been completed in-person or through telehealth.
 3. All levels of care are subject to the maximum of two (2) credit hours/week, including higher intensity services such as EOP, IOP, partial hospitalization, and residential.
 4. Only partial track credit must be considered for treatment completed exclusively in a non-community-based facility, such as while incarcerated.
- H. DUI/DWAI services credit hours must not be granted if:
1. The hours were completed in a virtual class and/or webinar format and/or in-person or telehealth support group setting that does not include active facilitation and engagement with one (1) or more of the following treatment personnel, acting within their scope of practice for the behavioral health service being considered for credit hours;
 - a. Authorized practitioners;
 - b. Licensees;
 - c. Certified addiction specialists (CAS);
 - d. Candidates;
 - e. Certified addiction technicians (CAT); and
 - f. Counselors-in-training and/or interns.
 2. The hours were completed prior to the last date of DUI/DWAI offense;
 3. The individual has a diagnosed substance use disorder and exhibits continued risky substance use related to their DUI/DWAI offense. The determination of risky substance use may include but is not limited to the following considerations: drug/alcohol screening/monitoring, individual self-report, observation by the professional, or another manner documented by the professional.
 4. The documented evidence of completed hours or services shows insufficient progress towards goals.
- I. Documentation requirements
1. Documentation of rationale for granting or denying of credit hours must be included in the individual's record.

2. All supporting documentation used for consideration in granting or denying of education and treatment credit must be maintained in the individual's record.
3. The BHE endorsed to provide DUI/DWAI programming shall enter all hours of education or treatment credit granted in the individual's DRS.
 - a. For DUI/DWAI services credit hours achieved prior to current episode of care where a DRS record of that care is not provided, the BHE endorsed to provide DUI/DWAI programming must enter hours in a separate DRS record using the actual admission and discharge dates from the prior provider.
- J. If treatment credits are not granted pursuant to part 10.5.11.H of this section, the individual must complete all the court mandated hours of treatment assigned by the referring supervising entity.

10.5.11 Ignition Interlock Enhancement Counseling (IEC)

- A. IEC must be made available to all individuals who currently or will have an ignition interlock device installed in their vehicle during the episode of care.
 1. If the BHE endorsed to provide DUI/DWAI programming does not provide IEC services, documentation of referral and collaboration with another BHE endorsed to provide DUI/DWAI programming that offers IEC services must be maintained in the individual's record.
- B. BHEs must ask DUI/DWAI-involved individuals about their ignition interlock requirements upon admission and thereafter as needed.
 1. Documentation of this inquiry must be maintained in the individual's record.
- C. BHEs must inform all individuals that participation in IEC is voluntary for DUI/DWAI-involved individuals assigned to Level II Treatment Tracks B, C, or D, as defined in part 10.8 of this Chapter.
 1. Participation in IEC is mandatory for DUI/DWAI-involved individuals assigned to Level II Four Plus who have an interlock device installed at any time while participating in Level II Four Plus services and BHEs endorsed to provide Level II Four Plus programming must encourage completion prior to the end of phase 3, as defined in part 10.9.4 of this Chapter.
- D. IEC may be completed:
 1. In-person; or
 2. Utilizing telehealth.
- E. IEC must be provided using a BHA-approved curriculum.
 1. All BHE personnel providing IEC services must be trained in the curriculum.
- F. Progress notes and service plans must reflect an individual's participation in IEC, whether offered by the BHE or through referral.
- G. BHEs must enter ten (10) hours into the individual's DRS towards Level II Treatment requirements upon successful completion of all IEC requirements.

1. If referred out for IEC services, DRS record entry is completed by the BHE endorsed to provide DUI/DWAI programming that initiated the referral.
2. BHEs may enroll individuals in IEC concurrent to Level II Therapeutic Education or Level II Treatment.

10.6 Level I Education (which includes ASAM Level 0.5)

- A. BHEs endorsed to provide Level I Education programming shall meet the requirements in parts 10.1 and 10.5, and 4.2 of these rules in addition to this part 10.6.
- B. Level I education may be completed:
 1. In-person; or
 2. Utilizing telehealth.
- C. Level I Education may be provided by a certified addiction technician (CAT), certified addiction specialist (CAS), licensee, authorized practitioner, or a candidate for a mental health professional license.
- D. BHEs endorsed to provide Level I Education programming must use and adhere to a curriculum written in a manual form that is evidence-based or are best practices specific to DUI/DWAI.
 1. Education about the interlock device and Colorado's current interlock laws and requirements must be a required topic in the legal session of Level I Education groups.
- E. Level I Education must be twelve (12) contact hours of instruction.
 1. No more than four (4) contact hours must be conducted in one (1) calendar day.
 2. Groups must not exceed twenty (20) individuals receiving services.
 3. Missed groups may be made up by attending another education session that covers the missed content.
- F. There are no additional content of record or assessment requirements for this level of care.

10.7 Level II Therapeutic Education (which includes ASAM Level 0.5)

- A. BHEs endorsed to provide Level II Therapeutic Education programming shall meet the requirements in parts 10.1 and 10.5 and 4.2 of these rules in addition to this part 10.7.
- B. Level II Therapeutic Education may be completed:
 1. In-person; or
 2. Utilizing telehealth.
- C. Level II Therapeutic Education must be provided by a certified addiction technician (CAT), certified addiction specialist (CAS), licensee, authorized practitioner, or a candidate for a mental health professional license.

1. If a counselor-in-training and/or intern is involved in the facilitation of Level II Therapeutic Education, the group may be co-facilitated and documentation signed by a CAS or mental health professional licensed pursuant to Article 245 of Title 12, C.R.S.
- D. BHEs endorsed to provide Level II Therapeutic Education programming must use and adhere to a curriculum written in a manual form that is evidence-based or best practices specific to DUI/DWAI.
 1. Education about the interlock device and Colorado's current interlock laws and requirements must be a required topic in the legal session of Level II Therapeutic Education groups.
 2. Missed content of the curriculum must be made up in compliance with the requirements of curriculum authors.
- E. Level II Therapeutic Education must consist of twenty-four (24) contact hours.
 1. No more than two (2) contact hours must be granted per week.
 2. Individuals must attend for a minimum of twelve (12) weeks for completion.
 3. Groups must not exceed twelve (12) individuals receiving services.
 4. Must not be combined with Level II Treatment unless clinical rationale is documented. The combined time in Level II Therapeutic Education and Level II Treatment must not be less than the minimum number of weeks required for the assigned Level II Treatment Track.
- F. The BHE must provide the screening(s) required in part 2.12.1 of these rules to DUI/DWAI-involved individuals assigned to education-only services upon admission. The BHE must arrange for care coordination needs of the individual, if clinically indicated in the screening results.
- G. BHEs endorsed to provide Level II Therapeutic Education and Treatment programming are subject to the full requirements of Chapter 2 of these rules.
- H. If the individual transitions between BHEs endorsed to provide DUI/DWAI programming during the course of services, the discharging BHE must provide the individual with a discharge DRS reflecting partial completion of treatment requirements and the supervising entity must be notified.

10.8 Level II DUI/DWAI Outpatient Treatment (which includes ASAM Level 1.0, Treatment Tracks A through D)

- A. BHEs endorsed to provide Level II Outpatient Treatment programming shall meet the requirements in parts 10.1 and 10.5, and 4.3 of these rules in addition to this part 10.8.
- B. Treatment must be completed:
 1. In-person; or
 2. Utilizing telehealth.
- C. Treatment may be provided by a CAS, licensee, authorized practitioner, or a candidate for a mental health professional license.

1. If a CAT, counselor-in-training, and/or intern is involved in facilitation of treatment, the group must be co-facilitated and documentation co-signed by a CAS, licensee, or authorized practitioner pursuant to Article 245 of Title 12, C.R.S.
- D. Treatment must consist of services that:
1. Are evidence-based or best practice curriculum specific to DUI/DWAI;
 2. Are necessary behavioral health services, as determined by the individual's assessment and service plan; or
 3. Are a combination of (1) and (2) noted above.
- E. The BHE endorsed to provide DUI/DWAI programming is responsible for recording clinical contact hours in the TMS database.
1. A maximum of two (2) clinical contact hours of DUI/DWAI treatment credit may be granted per week of participation.
 2. Services provided in any level of care may count towards the individual's assigned track requirement.
 3. Clinical contact hours or weekly requirements must only be assigned in the DRS if progress in treatment can be demonstrated in a clinical record review.
 4. Clinical contact hours attended must be conducted over the minimum number of weeks associated with the treatment Track assigned.
 5. Make-up sessions for missed treatment sessions are not permitted.
- F. If a Track has not been assigned by an ADES or the BHE is unable to obtain documentation of Track placement, the BHE must assign a Track based on the BHA Track placement guidelines located within the legal supplement.
- G. Track requirements
1. Track A individuals whose breath or blood alcohol content was below the statutorily defined PDD level, did not refuse breath or blood testing and who have one (1) offense for DUI/DWAI. Track A is a minimum forty-two (42) telehealth or in-person hours of group and/or individual treatment conducted over twenty-one (21) or more weeks.
 2. Track B individuals whose breath or blood alcohol content was at or above the statutorily defined PDD level or refused breath or blood testing and who have one (1) offense for DUI/DWAI. Track B is a minimum of fifty-two (52) telehealth or in-person hours of group and/or individual treatment conducted over twenty-six (26) or more weeks.
 3. Track C individuals whose breath or blood alcohol content was below the statutorily defined PDD level, did not refuse breath or blood testing, and who have two (2) or more offenses for DUI/DWAI. Track C is a minimum of sixty-eight (68) telehealth or in-person hours of group and/or individual treatment conducted over thirty-four (34) or more weeks.

- 4. Track D individuals whose breath or blood alcohol content was at or above the statutorily defined PDD level or refused breath or blood testing, and who have two (2) or more offenses for DUI/DWAI. Track D is a minimum of eighty-six (86) telehealth or in-person hours of group and/or individual treatment conducted over forty-three (43) or more weeks.
- 5. Track F; refer to this part 10.9, Level II Four Plus Treatment.
- H. Level II treatment must be conducted only after Level II Therapeutic Education has been completed unless there is documented assessment and clinical rationale to do otherwise.
- I. The assessment must be updated at the onset of treatment, and as required in Chapter 2 of these rules thereafter.
- J. Using the initial service plan as a basis, a revised service plan and subsequent reviews must be developed for individuals in treatment in accordance with part 2.13.1 of these rules.
- K. Treatment group sessions must not be less than two (2) hours of therapeutic contact, and the two hours must not include administrative procedures and breaks.
- L. Treatment groups must not exceed twelve (12) individuals receiving treatment.
- M. Individual treatment sessions must not be less than one (1) hour of therapeutic contact, and administrative procedures and breaks must not count towards the duration.
- N. Individuals are expected to attend group one (1) time per week. Clinical rationale for any changes in frequency of group attendance (fewer or more) must be documented. At minimum, a BHE shall require individuals to attend at least one (1) group or individual session per month.
- O. Credit toward clinical contact hours for treatment provided by an agency outside of a BHE endorsed to provide DUI/DWAI programming may be granted in accordance with this part 10.5.11.

10.9 Level II Four Plus Treatment (Track F)

10.9.1 General provisions

- A. BHEs endorsed to provide Level II Four Plus services shall meet the requirements in part 4.3 of these rules and parts 10.1, 10.5 of this Chapter, and this part 10.9.
- B. BHEs endorsed to provide DUI/DWAI Level II Four Plus programming shall:
 - 1. Have an active BHE license issued by the BHA, pursuant to Chapter 2 of these rules.
 - 2. Have provided Level II DUI/DWAI treatment services for at least twelve (12) months.
- C. BHEs endorsed to provide DUI/DWAI Level II Four Plus programming must:
 - 1. Document active collaboration with referral sources and concurrent treatment entities to meet individualized cross-system needs; and
 - 2. Be able to provide or refer to clinically relevant in-person services.

10.9.2 Training

- A. In addition to meeting training requirements in part 2.5 of these rules and this part 10.5.6, the BHE endorsed to provide Level II Four Plus programming must ensure that personnel involved in the provision of Level II Four Plus services attend no less than two (2) BHA-provided sessions during their active approval or licensing term that address the provision of Level II Four Plus services.
- B. BHEs must maintain documentation of all training sessions attended in personnel records and provide verification to the BHA, upon request.

10.9.3 Service Provisions

- A. Level II Four Plus must be completed as in-person services.
 - 1. Telehealth may only be utilized if clinically indicated for the individual, or if the individual is unable to attend in-person. Documentation must be present in the individual record stating why telehealth was utilized.
- B. There must not be a designated "Level II Four Plus Treatment Group," as all services must be individualized and based on the individual's assessment.
- C. Length of stay in Level II Four Plus must be determined by competency and phase progression with a minimum of one-hundred eighty (180) clinical contact hours received in no less than eighteen (18) months.
 - 1. The number of clinical contact hours attended will vary throughout an individual's treatment episode, depending upon the current phase and individual's treatment needs and progress.
 - 2. Contact hours must not include DUI/DWAI education unless clinically indicated for the individual.

10.9.4 Level II Four Plus Competencies and Phases

- A. Level II Four Plus must be structured and provided as follows:
 - 1. The individual must demonstrate proficiency in all of the competencies contained within each phase prior to progressing into the next (higher) phase.
 - 2. The BHE endorsed to provide Level II Four Plus programming must document that each individual was provided a copy of the phases and competencies as part of the orientation phase of treatment.
 - 3. Individual progress towards Level II Four Plus completion must be a combination of treatment and phase competency progress.
 - 4. The BHE endorsed to provide Level II Four Plus programming must review each individual's phase and competency achievements at a minimum every sixty (60) days in collaboration with available members of the individual's multidisciplinary team.

- a. For the purposes of Level II Four (4) Plus Treatment, multidisciplinary team means a team consisting of at least the endorsed DUI/DWAI program and the supervising entity. The MDT may include other professionals relevant to the individual's assessed treatment needs. Available members of the MDT must be consulted by the agency in Level II Four Plus phase progression, service planning, changes in levels of treatment, and discharge process.
- B. All individuals in Level II Four Plus who have an interlock device installed in their vehicle must complete IEC.
 - 1. The BHE endorsed to provide Level II Four Plus programming must make every effort to ensure the individual completes IEC prior to the end of phase 3.

10.9.5 Level II Four Plus Care Coordination

- A. The BHE endorsed to provide Level II Four Plus programming must establish and regularly maintain collaborative relationships with other agencies, treatment providers, referral sources, or any other entities involved in the individual's multidisciplinary team.
- B. BHEs endorsed to provide Level II Four Plus treatment must provide care coordination, where applicable, to ensure individual service needs are addressed.

10.9.6 Level II Four Plus Assessments

- A. All Level II Four Plus services must be driven by an evidence-based or best practices assessment process and resulting individualized service plan.
- B. Level II Four Plus assessments must include incorporation of standardized screening tools specifically designed to evaluate individuals in each of the following areas:
 - 1. Cognitive functioning;
 - 2. Traumatic brain injury;
 - 3. Adverse childhood experiences (ACEs);
 - 4. Grief and loss;
 - 5. Co-occurring mental health issues; and
 - 6. Polysubstance use concerns.
- C. Level II Four Plus assessment must inform the determination of what combination of services the individual must complete that are non-DUI/DWAI Therapeutic Education and Treatment strategies. These services include, but are not limited to:
 - 1. Individual counseling;
 - 2. Group therapy, unless clinically contraindicated;
 - 3. Family/other supportive therapy, if applicable;
 - 4. Medication-assisted treatment, if applicable;
 - 5. Residential treatment, if applicable;

6. DUI/DWAI Level II Therapeutic Education or Level II Treatment, if applicable;
 7. Other education or treatment as indicated by the initial and ongoing clinical assessment.
- D. BHEs endorsed to provide Level II Four Plus programming must ensure that personnel completing the assessment are properly credentialed and hold a valid certification to use the specific assessment instrument. Certification must be attained from entities or professionals authorized to provide such training regarding the instrument.
- E. Clinically indicated services may be offered within the BHE or via external referral.
1. If at any time during the treatment episode a need is identified that the BHE endorsed to provide Level II Four Plus programming does not provide, the program must refer the individual to an appropriately licensed and/or credentialed facility or professional.
 2. The BHE endorsed to provide Level II Four Plus programming must document evidence of communication with the other agency regarding assessment results, service plans, the individual's participation, and progress.

10.9.7 Level II Four Plus Service Planning and Reviews

- A. Level II Four Plus service planning and reviews must be administered in accordance with part 2.13.1 of these rules and this Chapter 10.
- B. BHEs endorsed to provide Level II Four Plus Treatment must conduct service plan, phase, and competency reviews at a minimum of every sixty (60) days. Reviews must be conducted in collaboration with available members of the individual's multidisciplinary team, in accordance with state and federal confidentiality laws.
- C. All services determined to be necessary for the individual must be incorporated into the service plan, whether offered by the BHE endorsed to provide Level II Four Plus programming or another provider.

10.9.8 Level II Four Plus Discharge Planning and Process

- A. Level II Four Plus discharge planning must be administered in accordance with part 2.10 of these rules and must include a warm handoff when possible. A validated copy of the discharge DRS must be provided to the individual and receiving BHE endorsed to provide Level II Four Plus programming, when applicable, and as appropriate under state and federal confidentiality laws.
- B. Consideration must be given to an individual's needs for post-discharge clinical needs and peer recovery support services.

Chapter 11: Designation of Facilities for the Care and Treatment of Persons with Mental Health Disorders (Title 27, Article 65, C.R.S.)

11.1 Authority

- A. Chapter 11 establishes standards for and is applicable to facilities that are designated pursuant to Article 65 of Title 27, C.R.S. the authority to promulgate these rules establishing minimum standards for the Care and Treatment of Persons with Mental Health Disorders comes from Sections 27-50-107(3) and 27-65-128, C.R.S.
- B. Facilities designated pursuant to this Chapter 11 shall be subject to the following rule compliance timeline:

1. Upon these rules going into effect, the BHA shall take immediate action on rule violations that impact the health, safety, and welfare of persons receiving services provided by a designated facility.
 2. All designated facilities shall be in full compliance of these rules by July 1, 2024.
- C. On an annual basis, the BHA will review the effectiveness of these rules and produce a written report of the results of this review to the state board of human services. This review will include engagement with stakeholders and may include, but is not limited to, analysis of grievance data and trends in enforcement actions taken by the BHA. The BHA will provide this report annually to SBHS by September 1 starting September 1, 2024. The BHA will present information in the report to SBHS at the board's next session following submission of the written report unless the board and the BHA agree that presentation of the report occur at a different session of the board. If it is determined based on this review that changes to these rules are advised, the BHA shall propose these changes to the state board of human services for promulgation in accordance with Section 26-1-107, C.R.S.

11.2 Definitions

"Bedridden" means a form of immobility that can present as the inability to ambulate or move about independently or with the assistance of an auxiliary aid, and also requires assistance in turning and repositioning in bed. Such immobility may be due to medical orders or due to incapacitation.

"Behavioral Health Crisis Response Team", as defined in Section 27-65-102(4), C.R.S., means a mobile team that responds to people in the community who are in a behavioral health crisis and includes at least one licensed or bachelor-degree-level behavioral health worker. A "Behavioral Health Crisis Response Team" includes, but is not limited to, a co-responder model, mobile crisis response unit, or a community response team.

"Certified Peace Officer", as defined in Section 27-65-102(6), C.R.S., means any certified peace officer as described in Section 16-2.5-102, C.R.S.

"Child", for the purposes of this Chapter 11, means the same as "Minor".

"Colorado Crisis Services" means the statewide behavioral health crisis response system offering individuals mental health, substance use or emotional crisis help, information and referrals.

"Court-Ordered Evaluation" means an evaluation ordered by a court pursuant to Section 27-65-106, C.R.S.

"Discrimination" for the purposes of this Chapter 11, has the same meaning as 27-65-117, C.R.S.

"Emergency Medical Services Facility" means a general hospital with an emergency department or a freestanding emergency department, as defined in Section 25-1.5-114(5), C.R.S.

"Emergency Medical Service Provider" means a person who holds a valid emergency medical service provider certificate or license issued by the Health Department as provided in Article 3.5 of Title 25, C.R.S.

"Emergency Medical Treatment and Labor Act (EMTALA)", means the federal Emergency Medical Treatment and Labor Act of 1986, found at 42 U.S.C. § 1395dd (2020).

"Facility" for the purposes of this Chapter 11 means:

- A. Pursuant to Section 27-65-102(15), C.R.S., a public hospital or a licensed private hospital, Behavioral Health Entity, institution, or residential child care facility that provides treatment for persons with mental health disorders.
- B. Any facility, as defined in part 1.2 of these rules, or unit(s) designated by the BHA pursuant to Title 27, Article 65, C.R.S. and this Chapter.

“Facility Personnel” or “Community- Based Personnel” means:

- A. A professional person as defined in this Chapter;
- B. A registered professional nurse as defined in Section 12-255-104(11), C.R.S.;
- C. A licensed marriage and family therapist, as defined in Section 12-245-501(3), C.R.S., licensed professional counselor, as defined in Section 12-245-601(2), C.R.S., or licensed addiction counselor, as defined in Section 12-245-801(10), C.R.S.; or,
- D. A licensed clinical social worker licensed as defined in Section 12-245-401(7), C.R.S.

“Gravely Disabled” means a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about or providing for the person’s essential needs without significant supervision and assistance from other people. As a result of being incapable of making these informed decisions, a person who is gravely disabled is at risk of substantial bodily harm, dangerous worsening of any concomitant serious physical illness, significant psychiatric deterioration, or mismanagement of the person’s essential needs that could result in substantial bodily harm. A person of any age may be “Gravely Disabled”, but the term does not include an person whose decision-making capabilities are limited solely by the person’s developmental disability.

“Immediate Screening” means the determination of whether a person meets criteria for an emergency mental health hold.

“Imminent Danger” means a situation in which a person’s risk status is believed to immediately indicate actions that could lead to a person’s harm of self or others.

“Independent Professional Person” means a professional who evaluates a minor’s condition as an independent decision-maker and whose recommendations are based on the standard of what is in the best interest of the minor. The professional person may be associated with the admitting facility if the professional person is free to independently evaluate the minor’s condition and need for treatment and has the authority to refuse admission to any minor who does not satisfy the statutory standards specified in Section 27-65-104(2), C.R.S.

“Individual” for the purposes of this Chapter 11, has the same meaning as respondent as defined in Section 27-65-102(29), C.R.S.

“Intervening Professional”, a person who is statutorily permitted to enact an emergency mental health hold, means a person who is of the following:

- A. A professional person as defined in Section 27-65-102(27), C.R.S.;
- B. A physician assistant licensed pursuant to Section 12-240-113, C.R.S.;
- C. An advanced practice registered nurse, as defined in Section 12-255-104(1), C.R.S.;
- D. A registered professional nurse, as defined in Section 12-255-104(11), C.R.S., who has specific mental health training as identified by the BHA;

- E. A clinical social worker licensed pursuant to Part 4 of Article 245 of Title 12, C.R.S.;
- F. A marriage and family therapist licensed pursuant to Part 5 of Article 245 of Title 12, C.R.S.;
- G. A professional counselor licensed pursuant to Part 6 of Article 245 of Title 12, C.R.S.;
- H. An addiction counselor licensed pursuant to Part 8 of Article 245 of Title 12, C.R.S.

"Involuntary Medication" means psychiatric medication administered without a person's consent.

"Involuntary Transportation Form" means the report and application allowing for immediate transport of a person, in need of an immediate screening for treatment, to a clinically appropriate facility.

"Involuntary Transportation Hold" means the ability to transport a person in need of an immediate screening to determine if the person meets criteria for seventy-two (72) hour treatment and evaluation. The involuntary transportation hold does not extend or replace the timing or procedures related to a seventy-two (72) hour treatment and evaluation hold or a person's ability to voluntarily apply for mental health services.

"Lay Person" means a person identified by another person who is detained on an involuntary emergency mental health hold pursuant to Section 27-65-106, C.R.S., certified for short-term treatment pursuant to Section 27-65-109, C.R.S., or certified for long-term care and treatment pursuant to Section 27-65-110, C.R.S., who is authorized to participate in activities related to the person's involuntary emergency mental health hold, short-term treatment, or long-term treatment, including court appearances, discharge planning, and grievances. The person may rescind the lay person's authorization at any time.

"Mental Health Disorder" includes one or more substantial disorders of the cognitive, volitional, or emotional processes that grossly impairs judgment or capacity to recognize reality or to control behavior. An intellectual or developmental disability is insufficient to either justify or exclude a finding of a mental health disorder pursuant to the provisions of Article 65 of Title 27, C.R.S.

"Minor", for this Chapter 11, means a person under eighteen (18) years of age; except that the term does not include a person who is fifteen (15) years of age or older who is living separately and apart from the person's parent or legal guardian and is managing the person's own financial affairs, regardless of the person's source of income, or who is married and living separately and apart from the person's parent or legal guardian.

"Objects to Hospitalization" means that a minor, with the necessary assistance of hospital staff, has written the minor's objections to continued hospitalization and has been given an opportunity to affirm or disaffirm such objections forty-eight (48) hours after the objections are first written.

"Patient Representative" means a person designated by a mental health facility to process patient complaints or grievances or to represent patients who are minors pursuant to Section 27-65-104(4), C.R.S.

"Petitioner", pursuant to Section 27-65-102(25), C.R.S., means any person who files any petition in any proceeding in the interest of any person who allegedly has a mental health disorder or is allegedly gravely disabled.

"Physician", for the purposes of this Chapter 11, means a person licensed to practice medicine in this state pursuant to Article 240 of Title 12, C.R.S.

“Placement Facility” means a public or private behavioral health provider that has a written agreement with a designated facility to provide care and treatment to any individual undergoing mental health evaluation or treatment by a designated facility. A placement facility may be but is not limited to, a general hospital, nursing care facility, adult residential facility or licensed residential child care facility.

“Professional Person” has the same meaning as described in Section 27-65-102(27), C.R.S.

“Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act)”, means the federal Protection and Advocacy for Persons with Mental Illness Act of 1986, Pub. L. No. 99-319 (1986).

“Psychiatric Medication” is a medication being used to treat psychiatric illness for the individual including, but not limited to, anti-psychotics, antidepressants, and other medications that may have other medical uses but are accepted within the medical profession for psychiatric use as well.

“Qualified Medication Administration Person” or “QMAP” means a person who passed a competency evaluation administered by the Department of Public Health and Environment before July 1, 2017, or passed a competency evaluation administered by an approved training entity on or after July 1, 2017, and whose name appears on the Department of Public Health and Environment’s list of persons who have passed the requisite competency evaluation.

“Residential Child Care Facility” has the same meaning as set forth in Section 26-6-903(29) C.R.S. a residential child care facility may be eligible for designation by the commissioner pursuant to Article 65 of Title 27, C.R.S.

“Respondent”, for the purposes of Chapter 11, has the same meaning as described in Section 27-65-102(29), C.R.S.

“Secure Transportation Provider” means a provider licensed pursuant to Section 25-3.5-310, C.R.S. to provide public or private secure transportation services.

“Secure Treatment Facility” for the purposes of these rules, means the state operated mental health hospitals.

“Subsequent Hold” means additional, up to 72-hour hold, when appropriate placement options could not be found during the initial hold period and the person continues to meet criteria for an emergency mental health hold.

“Therapy or Treatments Using Special Procedures” for the purposes of this part 11.10, means a therapy that requires informed consent specific to additional requirements of the treatment, including but not limited to electroconvulsive therapy, feeding tubes for eating disorder treatment, and behavior modifications using transcranial magnetic stimulation.

“Transitional Measures” means physical guidance, prompting techniques of short duration, or an initial temporary approved physical positioning of an individual at the onset or in response to a re-escalation during a physical management, for the purpose of quickly and effectively gaining physical control of that individual in order to prevent harm to self or others.

11.3 27-65 Designation Requirement

- A. These rules are established to create standards for agencies seeking a 27-65 designation to provide involuntary treatment services pursuant to Article 65 of Title 27, C.R.S.

- B. All agencies providing involuntary treatment services pursuant to Article 65 of Title 27, C.R.S. shall meet the standards in this Chapter 11. If the facility requires a BHE license, the facility shall also comply with Chapter 2 and the other Chapters specific to any endorsements held by the facility. If the facility requires approval as a behavioral health safety net provider, the facility shall also comply with Chapter 12.
- C. Any facility licensed by a state agency to include the Colorado Department of Public Health and Environment or the division of child welfare within the Colorado Department of Human Services providing involuntary mental health services whether inpatient or outpatient, shall seek a 27-65 designation.
- D. In order to provide involuntary services described in this Chapter 11, a facility, other than an emergency medical services facility, must receive a designation based on their compliance with the service standards described in this Chapter.
- E. A designated facility must also comply with regulations specific to the involuntary services it provides, which may include:
 - 1. Involuntary short-term and long-term care and treatment designation (part 11.16 of this Chapter); and/or,
 - 2. Involuntary outpatient care and treatment (part 11.17 of this Chapter).

11.3.1 27-65 Designation General Standards

- A. The 27-65 designated facility shall only provide services for which it holds/has a 27-65 designation, approval, and/or another BHA license.
- B. Facility designation applies only to the physical location(s) listed on the 27-65 designation certificate from BHA and not to any other non-designated physical locations operated by the facility.
 - 1. Psychiatric units within a medical hospital and units that are separate from a main building must be designated separately for involuntary services.
 - 2. Locations serving individuals under certification on an outpatient basis pursuant to Section 27-65-111, C.R.S. must also be designated.
- C. The 27-65 designated facility shall ensure all operations, locations, and services, including contracted services or personnel, comply with laws, regulations, and standards as required by 2 CCR 502-1.
- D. Any 27-65 designated facility, must develop, implement, and every three (3) years review the following policies and procedures, unless such a facility has an active BHE license or safety net approval and has implemented policies and procedures listed below that address 27-65 designated services:
 - 1. The governing body shall have policies and procedures regarding administrative and/or clinical oversight of the 27-65 designated services and requirements.
 - 2. Personnel needed for services and ratios;
 - 3. Training schedules and demonstration of training for personnel;
 - 4. Emergency and crisis protocol;

5. Record protection, sharing, and retention protocol;
 6. Disclosure of intervention, treatment, and/or medication;
 7. Policies and procedures regarding the use/non-use of seclusion, restraint, and/or physical management pursuant to part 11.9 of this Chapter;
 8. Continuity and transfer of care upon admittance and discharge from the facility;
 9. The change to voluntary status process for an individual at the facility;
 10. Communication of rights of individuals;
 11. Facility rules and how they are communicated to individuals receiving services, including visitation expectations;
 12. How the facility will manage and maintain the statutory rights individuals have to keep and use their own clothes and possessions, including cell phones and money;
 13. Critical incident reporting; and
 14. Facility process for removal and reinstatement of individual rights.
- E. Any additional details regarding applicable policies and procedures in this Chapter must be followed in addition to those in this part.

11.3.2 Critical Incident Reporting

- A. A critical incident includes but is not limited to the following:
1. Breach of confidentiality: any unauthorized disclosure of protected health information as described in HIPAA, incorporated in part 1.2 of these rules; 42 C.F.R. Part 2, as incorporated in part 1.2 of these rules; and/or Sections 27-65-101 through -131, C.R.S.
 2. Death: including the death of an individual inside of or outside of the facility's physical location while an individual is receiving services or where an individual has attempted to receive services from the facility within the past thirty (30) calendar days.
 3. Elopement: absconding from a mental health hold, certification, emergency/involuntary commitment, or a secure facility where an individual is being held as a result of a court order. This includes any unauthorized absence of a minor, when a minor cannot be accounted for or when there is reasonable suspicion to believe the minor has absconded.
 4. Any instance in which an individual cannot be located following a search of the facility, the facility grounds, and the area surrounding the facility, and:
 - a. There are circumstances that place the individual's health, safety, or welfare at risk; or,
 - b. The individual has been missing for eight (8) hours.
 5. Medication diversion: any medication diversion as defined in part 1.2 of these rules. If the diverted drugs are injectable, the facility shall also report the full name and date of birth of any individual who diverted the injectable drugs, if known.

6. Medication error: medication error that resulted or could have resulted in harm to the individual.
 7. Medical emergency: any suicide attempt/self-injury, other form of serious injury, health emergency, overdose or serious illness of an individual which occurred on facility premises or in the presence of facility personnel.
 8. Any instance involving physical, sexual, or verbal abuse of an individual, as described in Sections 18-3-202, 18-3-203, 18-3-204, 18-3-206, 18-3-402, 18-3-404, or 18-3-405, 18-3-405.3, 18-3-405.5, and 18-9-111 (exempting, however, the phrase "intended to harass"), C.R.S. by another individual, personnel, or a visitor to the facility.
 9. Any instance that results in any of the following serious injuries to an individual:
 - a. Brain or spinal cord injuries;
 - b. Life-threatening complications of anesthesia or life-threatening transfusion errors or reactions; or,
 - c. Second- or third-degree burns involving twenty percent (20%) of more of the body surface area of an adult or more fifteen percent (15%) or more of the body surface area of a minor.
 10. Any instance involving caretaker neglect of an individual, as defined in Section 26-3.1-101(2.3), C.R.S.
 11. Any instance involving misappropriation of an individual's property, meaning patterns of loss or single incidences of deliberately misplacing, exploiting, or wrongfully using, either temporarily or permanently, an individual's belongings or money without the individual's consent.
 12. Any occurrence involving the malfunction or intentional or accidental misuse of care equipment that occurs during treatment or diagnosis of an individual and that significantly or adversely affects or, if not averted, would have significantly adversely affected an individual.
- B. Critical incidents must be reported to the BHA within one (1) business day after the incident. Critical incidents must also be reported to the BHA within one (1) business day of when the facility determines that a reportable incident has occurred and the BHA requests such reporting. Critical incidents must be reported to the BHA within one (1) business day on a BHA-created form posted on the BHA website.
- C. The BHA may conduct scheduled or unscheduled site reviews for specific monitoring purposes and investigation of critical incidents reports in accordance with:
1. BHA policies and procedures,
 2. Regulations that protect the confidentiality and individual rights in accordance with Sections 27-65-101 through -131, C.R.S.; HIPAA, as incorporated by reference in part 1.2 of these rules; and, 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules,
 3. Controlled substance licensing, Section 27-81-113, C.R.S., Section 27-80-212, C.R.S., and Section 18-18-503, C.R.S.

- D. The BHA shall have access to relevant documentation required to determine compliance with these rules.
- E. The facility must:
 - 1. Establish written policies and procedures for reporting and reviewing all critical incidents occurring at the facility;
 - 2. Submit critical incidents reports to the BHA using state prescribed forms that can be obtained from the BHA's website. This is not in lieu of other reporting mandated by state statute or federal guidelines;
 - 3. Make available a report with the investigation findings for review by the BHA, upon request; and,
 - 4. Maintain critical incidents reports for a minimum of three (3) years following the incident unless it would violate any other federal or state law.
- F. Nothing in this part shall be construed to limit or modify any statutory or common law right, privilege, confidentiality, or immunity.

11.4 27-65 Designation Approval Procedures

11.4.1 Application Process

- A. Entities applying for 27-65 designation shall submit an application to the BHA on a state approved form, available on the BHA website.
- B. Facilities providing twenty-four (24) hour inpatient or acute crisis care, must apply for a separate 27-65 designation based on the unique physical address of each site. If two or more buildings or units share a physical address, each building or unit must be designated separately for 27-65 services.
- C. The BHA will provide written notice to the applicant within thirty (30) calendar days of receipt of a complete application.
- D. The BHA will act on an application within ninety (90) calendar days of receipt of the completed application. The applicant may be approved for 27-65 designation, granted provisional approval, or the application may be denied.
- E. An applicant that is found to be in compliance with these rules shall be approved as a facility designated to provide mental health services effective for up to a one (1) year period.
- F. A basis for denial of a 27-65 designation application includes a health care or residential child care facility's withdrawal, revocation, loss of its license to operate.
- G. If the application for 27-65 designation is denied, the reason(s) for denial listing deficiencies in the application shall be provided in a certified letter to the address of the applicant as shown on the application or as subsequently furnished in writing by the applicant. If an applicant disagrees with the decision, the applicant, if within sixty (60) days of receiving notice of the decision, may request a hearing to review the denial pursuant to Sections 24-4-105 and 24-4-106, C.R.S. (see part 2.24.5 of these rules); or upon remedying the noted deficiencies, may re-apply for 27-65 designation in accordance with this part 11.4.

11.4.2 Provisional 27-65 Designation

- A. Provisional approval may be granted for a period not to exceed ninety (90) calendar days if, after initial inspection and review of an application:
 - 1. The applicant is in substantial compliance with these rules and is temporarily unable to conform to all the minimum standards required under these rules. No provisional 27-65 designation shall be issued to an applicant if the operation of the facility may adversely affect individual health, safety, or welfare;
 - 2. Compliance will be achieved within the ninety (90) day duration of the provisional license; and
 - 3. The applicant has a reasonable plan or schedule in writing for achieving compliance and provides a written copy of the plan to the BHA.
- B. The applicant shall provide proof that attempts are being made to conform and comply with applicable rules.
- C. A second provisional approval for a period not to exceed ninety (90) calendar days may be granted under the same criteria if necessary to achieve compliance.
- D. If the applicant is not able to come into compliance within one hundred and eighty (180) calendar days from the date of initial provisional license granted, the application may be denied with a right to request a hearing as described in part 11.4.1.G of this rule.

11.4.3 27-65 Re-Designation

- A. A facility seeking 27-65 designation renewal shall provide the Department with a completed 27-65 designation application at least sixty (60) calendar days prior to the expiration of the existing 27-65 designation.
- B. 27-65 designation renewal applications received by the BHA after the current 27-65 designation expiration date has passed shall be returned to the facility by certified first class mail and/or through electronic means with written notification that the 27-65 designation is no longer in effect. Applicants may reapply for an initial 27-65 designation in accordance with part 11.4.1 of these rules.
- C. 27-65 designation renewal applications that are received by the BHA fewer than sixty (60) calendar days prior to the expiration of their existing 27-65 designation is a basis from which the BHA may deny the renewal application. If the BHA denies the renewal application for being untimely, the BHA will provide the facility with notice of the decision by certified first class mail. If the facility disagrees with the decision, it may request a hearing as described in part 11.4.1.G of this rule. Alternatively, any facility that submits its renewal application fewer than sixty (60) calendar days prior to the expiration of the current 27-65 designation and does not receive a new 27-65 designation prior to that date and/or notice that the BHA decided to deny the renewal application may reapply for an initial 27-65 designation in accordance with part 11.4.1 of these rules.
- D. Failure of a facility seeking renewal of a designation to accurately answer or report any information requested by the BHA shall be considered good cause to deny the 27-65 designation renewal application.

- E. Facilities designated to provide care and treatment to persons with mental health disorders pursuant to Section 27-65-101 through -131, C.R.S., shall receive an annual review for compliance.
- F. Facilities shall be notified in writing of non-compliance areas and the need for a plan of action as outlined in part 2.23.H.2 of these rules. A probationary 27-65 designation may be granted.
- G. A facility in compliance with applicable BHA rules and state and federal regulations shall be granted 27-65 designation effective through the expiration date, for a period not to exceed one (1) year.

11.4.4 Conditional 27-65 Designation

- A. A conditional 27-65 designation may be granted to a facility out of compliance with applicable BHA or state and federal regulations prior to issuance of a renewal designation or during a current designation period. The facility will be notified in writing of non-compliance areas and the need for a plan of action (see part 2.23.H.2 of these rules).
- B. A conditional 27-65 designation will replace the current 27-65 designation for a period not to exceed ninety (90) calendar days.
- C. Administrative and treatment activities may be limited by a conditional 27-65 designation as set forth in the conditional designation while the facility addresses corrective actions.
- D. A conditional 27-65 designation may be re-issued for an additional period not to exceed ninety (90) calendar days if substantial progress continues to be made and it is likely that compliance can be achieved by the date of expiration of the second conditional license.
- E. If the facility fails to comply with or complete a plan of action in the time or manner specified, or is unwilling to consent to the conditional 27-65 designation, the modification to a conditional 27-65 designation shall be treated as a revocation of the 27-65 designation and the facility shall be notified by certified mail of the deficiencies and reason for action, the BHA may then institute proceedings to effect the revocation per Section 24-4-104(3), C.R.S.

11.4.5 Change in Designation

- A. If a facility makes a change in its designation status or decides to drop its 27-65 designation, it shall notify the BHA in writing no later than thirty (30) calendar days prior to the desired effective date. The facility shall submit a written plan for the transfer of care for the persons with mental health disorders if the facility will no longer treat those individuals. This plan shall be submitted no later than ten (10) business days prior to the effective date.

11.4.6 Rule Waivers

- A. Rule waivers may be applied for as described in part 2.22 of these rules.

11.4.7 Enforcement and Adverse Actions

- A. 27-65 designated facilities are subject to enforcement measures outlined in part 2.24 of these rules and intermediate restrictions as outlined in part 2.24.4 of these rules.
- B. Appeals of adverse actions shall be conducted in accordance with the state administrative procedure act, Section 24-4-101 through -109, C.R.S.

11.5 Data Reporting Requirements for All 27-65 Designated Facilities [Effective July 1, 2024]

- A. Each facility designated for 27-65 services by the BHA, pursuant to Article 65 of Title 27, C.R.S., shall file an annual report with the BHA. The report shall be submitted in the format and timeframe required by the BHA. This data shall include individuals on emergency mental health holds and/or individuals on short-term or long-term certifications that are being treated in placement facilities under the auspices of the 27-65 designated facility.
- B. For each 27-65 designated facility, the annual report shall include:
 - 1. Facility name;
 - 2. County, and address of the facility; and
 - 3. Type of facility as defined in Section 27-65-102(15), C.R.S.
- C. The facility must maintain confidentiality over the data sets. The reports generated from these data sets are also confidential; but the BHA may release aggregated information contained in the reports so long as the total number of individuals in any aggregate data group (including county or facility name) is greater than thirty (30). If the total number in such a data group is less than or equal to thirty (30), the BHA may release this information by redacting such number.

11.5.1 Data Reporting General Standards

- A. Facilities must submit their annual data report to the BHA by July 1 of each year for the most recent, complete calendar year covering January 1 through December 31. The report must meet the requirements in this part 11.5 of these rules.
- B. The BHA will annually request from the Department of Public Health and Environment a list of licensed facilities that may provide emergency services pursuant to Article 65 of Title 27, C.R.S. the facility list shall include, but is not limited to:
 - 1. General hospitals;
 - 2. Hospital units;
 - 3. Psychiatric hospitals; and,
 - 4. Community clinics.
- C. If a facility on the list provided by the Department of Public Health and Environment does not report to the BHA, the BHA will contact the facility to confirm that the facility did not provide involuntary care to a person pursuant to Title 27, Article 65, C.R.S. during the reporting cycle.
 - 1. If a facility is found to have provided involuntary care to a person pursuant to Title 27, Article 65, C.R.S. and did not submit an annual report, an annual report will be requested.
 - 2. If a facility refuses to provide the statutorily required report, the BHA may submit a complaint to the office of the ombudsman for behavioral health access to care.
- D. The facility must maintain confidentiality over the data sets. The reports generated from these data sets are also confidential; but the BHA may release aggregated information contained in the reports so long as the total number of persons in any aggregate data group (including county or facility name) is greater than thirty (30). If the total number in such a data group is less than or equal to thirty (30), the BHA may release this information by redacting such number.

- E. The data report requirements, by service type, shall include the following types below in this part 11.5.

11.5.2 Seventy-Two (72) Hour Treatment and Evaluation (Emergency Mental Health Holds)

- A. The facility is required to maintain a data set sufficient to report the following disaggregated numbers to the BHA annually by July 1, for the most recent, complete calendar year covering January 1 through December 31 and shall include as permitted by HIPAA, as incorporated by reference in part 1.2 of these rules; 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules ; and Section 27-65-101 through-131, C.R.S.:
1. For each individual on an involuntary emergency mental health hold, the facility shall report the individual's:
 - a. Client ID;
 - b. Date of birth;
 - c. Gender;
 - d. Race and ethnicity; and
 - e. County of residence.
 2. Who initiated the involuntary emergency mental health hold? (Each hold can only meet the requirements of one category listed below):
 - a. Certified peace officer;
 - b. Court; or
 - c. Intervening professional.
 3. If applicable, what kind of intervening professional initiated the involuntary emergency mental health hold?
 - a. Professional person;
 - b. Physician assistant;
 - c. Advanced practice registered nurse;
 - d. Registered professional nurse;
 - e. Licensed clinical social worker;
 - f. Licensed marriage and family therapist;
 - g. Professional counselor; or
 - h. Licensed addiction counselor.
 4. The reason(s) for the involuntary emergency mental health hold (each hold can meet the requirements of multiple categories listed below):

- a. Danger to self;
 - b. Danger to others; or
 - c. Gravely disabled.
- 5. Disposition of the involuntary emergency mental health hold (each hold can only meet the requirements of one category listed below):
 - a. Released without need for further mental health services;
 - b. Referred for further mental health care and treatment on a voluntary basis;
 - c. Certified for short-term treatment pursuant to Section 27-65-109, C.R.S.;
 - d. Transferred to another designated facility while still on the seventy-two (72) hour hold; or
 - e. Placed on a subsequent hold due to placement issues.
- 6. The length of time the individual had to wait for placement in a facility.
- 7. The challenges encountered while finding placement for the individual, which may include but is not limited to:
 - a. Medical complications;
 - b. Historical aggression/combativeness;
 - c. Intellectual and developmental disorders;
 - d. Infectious disease;
 - e. No bed available; and/or
 - f. Other important barriers to placement.
- 8. If applicable, the reason(s) for the subsequent involuntary emergency mental health hold, which may include but is not limited to:
 - a. Medical complications;
 - b. Historical aggression/combativeness;
 - c. Intellectual and developmental disorders;
 - d. Infectious disease;
 - e. No bed available; and/or
 - f. Other circumstances that prompted subsequent involuntary emergency mental health hold.
- 9. The total number of involuntary transportation holds received by the facility, as well as total numbers by outcome of the required screening, including at least:

- a. Total number of involuntary transportation hold screenings resulting in the placement of an involuntary emergency mental health hold;
- b. Total number of involuntary transportation hold screenings resulting in a referral for further mental health care and treatment on a voluntary basis; and
- c. Total number of involuntary transportation hold screenings resulting in a release without need for further mental health services.

11.5.3 Short and Long-Term Certifications

- A. The facility is required to maintain a data set sufficient to report the following disaggregate numbers to the BHA annually by July 1, for the most recent, complete calendar year covering January 1 through December 31 and shall include as permitted by HIPAA, as incorporated by reference in part 1.2 of these rules; 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules; and Section 27-65-101 through-131, C.R.S.:
 - 1. For each individual, who was on a certification, the facility shall report the individual's:
 - a. Client ID;
 - b. Date of birth;
 - c. Gender;
 - d. Race and ethnicity; and
 - e. County of residence.
 - 2. Type of certification (each certification can only meet the requirements of one category listed below):
 - a. Short-term;
 - b. Extended short-term;
 - c. Long-term; or
 - d. Extended long-term.
 - 3. Status of certification:
 - a. Inpatient; or
 - b. Outpatient.
 - 4. Who initiated the certification (each certification can only meet the requirements of one category listed below):
 - a. Court order; or
 - b. Professional person.
 - 5. Reason(s) for the certification (each certification can meet the requirements of multiple categories listed below):

- a. Danger to self;
 - b. Danger to others; or
 - c. Gravely disabled.
- 6. Start date of certification.
- 7. End date of certification.
- 8. Start time of certification.
- 9. End time of certification.
- 10. The services that were provided during the certification.
- 11. Outcome of the certification (each certification can only meet the requirements of one category listed below):
 - a. Certification extended;
 - b. Successfully discharged and referred for further mental health care and treatment on a voluntary basis;
 - c. Voluntarily discharged;
 - d. Transferred for continued involuntary treatment;
 - e. Unable to locate individual for treatment;
 - f. Discontinued with treatment compliance concerns;
 - g. Unable to transfer to another facility;
 - h. Discontinued due to lack of payment to treatment providers; or
 - i. Other circumstances of the outcome of the certification.
- 12. Employment status:
 - a. Unemployed;
 - b. Employed (full time);
 - c. Employed (part time);
 - d. Student;
 - e. Military service; or
 - f. Disability.
- 13. Housing status:
 - a. Independent living;

- b. Lives with parent/guardian/caregiver;
- c. Unhoused;
- d. Shelter;
- e. Temporary housing;
- f. Halfway house;
- g. Alternative care facility;
- h. Nursing home;
- i. Group home; or
- j. Residential child care facility.

11.5.4 Voluntary Individuals

- A. The facility is required to maintain a data set sufficient to report the following disaggregate numbers to the BHA annually by July 1 for the most recent, complete calendar year covering January 1 through December 31, a record of each individual who accessed mental health treatment voluntarily pursuant to Section 27-65-103, C.R.S., each individual's record and data report shall include as permitted by HIPAA, as incorporated by reference in part 1.2 of these rules; 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules; and Section 27-65-101 through-131, C.R.S.:

- 1. Client ID;
- 2. Date of birth;
- 3. Gender;
- 4. Race and ethnicity; and
- 5. County of residence.

11.5.5 Involuntary Medications

- A. In addition to the reporting of involuntary medications pursuant to part 11.8.5, the facility is required to maintain data sets sufficient to report the following disaggregate numbers to the Department annually by July 1 for the most recent, complete calendar year covering January 1 through December 31, a record of each individual who was given involuntary psychiatric medication pursuant to Section 27-65-106, C.R.S., each individual's record and data report shall include as permitted by HIPAA, as incorporated by reference in part 1.2 of these rules; 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules; and Section 27-65-101 through-131, C.R.S.:

- 1. Client ID;
- 2. Date the procedure was initiated;
- 3. Date of birth;

4. Gender;
5. Race and ethnicity;
6. Type of order:
 - a. Emergency; or
 - b. Court-ordered.
7. Type of medication (specified use of involuntary medication):
 - a. Antipsychotics - typical;
 - b. Antipsychotics - atypical;
 - c. Antidepressants;
 - d. Mood stabilizers; or
 - e. Anxiolytics/hypnotics.

11.5.6 Involuntary Treatment

- A. The facility is required to maintain data sets sufficient to report the following disaggregate numbers to the Department annually by July 1 for the most recent, complete calendar year covering January 1 through December 31, a record of each individual who underwent involuntary treatments pursuant to Section 27-65-106, C.R.S., each individual's record and data report shall include as permitted by HIPAA, as incorporated by reference in part 1.2 of these rules; 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules; and Section 27-65-101 through-131, C.R.S.:
1. Client ID;
 2. Date of birth;
 3. Gender;
 4. Race and ethnicity; and
 5. Type of treatment:
 - a. Seclusion;
 - b. Restraint; or
 - c. Both seclusion and restraint.
 6. Date, time, and length of seclusion and/or restraint episode per individual.

11.5.7 Electroconvulsive Therapy (ECT) Procedures

- A. The facility is required to maintain data sets sufficient to report the following disaggregate numbers to the Department annually by July 1 for the most recent, complete calendar year covering January 1 through December 31, a record of each individual who underwent electroconvulsive therapy, each individual's record and data report shall include as permitted by HIPAA, as incorporated by reference in part 1.2 of these rules; 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules; and Section 27-65-101 through-131, C.R.S.:
1. Client ID;
 2. Date of birth;
 3. Gender;
 4. Race and ethnicity;
 5. Date, time, and length of ECT; and
 6. Status:
 - a. Voluntary ECT; or
 - b. Involuntary ECT.

11.5.8 Imposition of Legal Disability or Deprivation of a Right

- A. The facility is required to maintain data sets sufficient to report the following disaggregate numbers to the BHA annually by July 1 for the most recent, complete calendar year covering January 1 through December 31, a record of each individual with an imposition of legal disability or deprivation of a right during treatment pursuant to Section 27-65-127, C.R.S., each individual's record and data report shall include as permitted by HIPAA, as incorporated by reference in part 1.2 of these rules; 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules; and Section 27-65-101 through-131, C.R.S.:
1. Client ID;
 2. Date of birth;
 3. Gender;
 4. Race and ethnicity; and
 5. Specific right deprived.

11.5.9 Data Requirements for Emergency Medical Services Facilities [Effective July 1, 2024]

- A. The data reporting required in this section is subject to limitations set forth in HIPAA, as incorporated by reference in part 1.2 of these rules; 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules; and Section 27-65-101 through-131, C.R.S.

- B. An emergency medical services facility, as defined in part 11.2 of these rules, providing care to an individual pursuant to Article 65 of Title 27, C.R.S. is required to maintain a data set sufficient to report the following disaggregate numbers to the BHA annually pursuant to Section 27-65-106(9), C.R.S., in the format and timeframe required by the BHA as provided on the BHA website.
- C. For each facility, the annual report shall include:
1. The name, county, and address of each facility site where the service was provided.
 2. Gender;
 3. Race and ethnicity;
 4. County of residence;
 5. If the individual arrived at the facility through an emergency transportation hold;
 6. A record of each individual who had an involuntary emergency mental health hold resolved (this includes release without need for further mental health services, referral for voluntary treatment, or transferred to from the facility) at the facility;
 7. The outcome of each individual involuntary emergency mental health hold resolved at the facility (each hold can only meet the requirements of one category listed below):
 - a. Released without the need for further mental health services;
 - b. Referred for voluntary treatment; or
 - c. Transferred to a 27-65 designated facility for continued involuntary services.
 8. Who initiated the involuntary emergency mental health hold (each hold can only meet the requirements of one category listed below):
 - a. Certified peace officer;
 - b. Court; or
 - c. Intervening professional.
 9. The reason for the involuntary emergency mental health hold (each hold can meet requirements of multiple categories below):
 - a. Dangerous to self;
 - b. Dangerous to others; or
 - c. Gravely disabled.

11.6 Personnel Requirements for 27-65 Designated Facilities

11.6.1 Safety

- A. Any personnel who are physically or mentally unable to adequately and safely perform duties that are essential functions may not be assigned duties as a direct care personnel or volunteer at a 27-65 designated facility. Facilities shall outline criteria in their policies and procedures for determining whether a person is able to safely perform duties in its policies and procedures.
- B. The facility shall not employ or allow any personnel who are under the influence of a controlled substance, as defined in Sections 18-18-203 through -207, C.R.S. or who are under the influence of alcohol in the workplace. This does not apply to personnel using controlled substances under the direction of a physician and in accordance with their health care provider's instructions, as long as it does not pose a safety risk to the person, other personnel, or individuals.
- C. The facility shall employ sufficient personnel to ensure that the provision of services meets the needs of individuals. The facility shall:
 - 1. Ensure that each shift has a minimum of two (2) personnel, whenever one (1) or more individuals are present in the milieu;
 - 2. Maintain individual-to-personnel ratios not exceeding a one to six (1:6) trained staff member(s) to individual ratio at all times; and
 - 3. Inpatient staffing ratios do not apply to outpatient certification services.
- D. If the facility is a hospital, the facility must comply with staffing requirements pursuant to Section 25-3-128, C.R.S. in lieu of compliance with part 11.6.1.C.
- E. The facility shall ensure that, at minimum, one of the following qualified personnel is available to administer medications at all times:
 - 1. Licensed practical nurse, registered nurse, advanced practice registered nurse, physician, physician's assistant, pharmacist, or qualified medication administration person (QMAP).

11.6.2 Leadership Personnel Requirements and Responsibilities

- A. Facility director
 - 1. The facility director is responsible for the following:
 - a. Overall direction and responsibility for the individuals, program, facility, and fiscal management;
 - b. Overall direction and responsibility for supervision of personnel;
 - c. The selection and training of a capable personnel member who can assume responsibility for management of the facility in the director's absence; and
 - d. The establishment of relationships and maintaining contact with allied facilities, services, and mental health resources within the community.
 - 2. Qualifications of a facility director:

- a. The facility director shall have, at minimum, received a bachelor's degree from an accredited college or university and have three (3) years of verified experience in the human services field, one of which was in a supervisory or administrative position; or,
 - b. The facility director shall have, at minimum, received a master's degree from an accredited college or university and have two (2) years of verified experience in the human services field, one of which was in a supervisory or administrative position.
 3. Assistant or acting facility director:
 - a. In each facility, there shall be a specifically designated personnel member capable of acting as a substitute for the facility director during their absence. The duties and responsibilities of the acting facility director shall be clearly defined within the facility's policies and procedures in order to avoid confusion and conflict among other personnel and individuals.
 - b. If the facility director is regularly absent from the facility for more than fifty percent (50%) of their working hours, an assistant or acting director shall be appointed who meets the qualifications outlined in part 11.6.2.A.2 of this section.
- B. Clinical director
 1. The clinical director is responsible for assuring that there is adequate training and supervision for personnel, that multidisciplinary personnel members are practicing within their scope, and that ethical standards are upheld.
 2. Qualifications of a clinical director:
 - a. The clinical director shall possess a master's degree or doctoral degree in a mental health related field or a bachelor's degree in a mental health related field plus five (5) years of related work experience.
 - b. The clinical director shall possess a valid clinical license to practice medicine and/or behavioral health services in the state of Colorado.

11.6.3 Personnel Training Requirements for 27-65 Designated Facilities

- A. In addition to trainings identified in part 2.5.I of these rules, facilities designated for 27-65 services under these rules shall develop policies and procedures for personnel training curriculum and schedules in order to meet the following requirements. Facilities may choose to use an annual certification of competency in lieu of training which shall be stored in the personnel file; the facility shall develop appropriate policies, procedures and testing to assure and demonstrate personnel competency. Training shall be conducted in a trauma-informed, culturally, and linguistically competent manner.
- B. All personnel supervising or providing direct care and treatment for individuals with mental health disorders shall receive annual training or annual facility certification of competency on the provisions of these rules and the requirements of Section 27-65-101 through -131, C.R.S.
- C. All personnel who order or administer involuntary medications (including prescribers, nursing personnel, and QMAPs) shall receive annual training or annual facility certification of competency on Chapter 11 of these rules and the legal rationale underlying involuntary medication of individuals.

- D. All supervisory and direct care personnel shall receive annual training or annual facility certification of competency in the recognition and response to common side effects of psychiatric medications. These personnel shall be trained to respond to emergency drug reactions in accordance with the facility's policies.
- E. All personnel who administer seclusion, restraint, and physical management techniques shall receive training and/or certification at minimum pursuant to this part 11.9.3.
- F. All program administrators and program supervisory personnel shall receive annual training or annual facility certification of competency on alternative or representative medical decision making, including, but not limited to advance directives, medical durable powers of attorney, and proxy decision making, and guardianships.
- G. Specific personnel of placement facilities, as determined by the 27-65 designated facility and its policies and procedures, shall receive annual facility training or annual certification of competency on the provisions of these rules and the requirements of Section 27-65-101 through-131, C.R.S. the 27-65 designated facility is responsible for ensuring that this annual training occurs at placement facilities and documenting all relevant placement facility training.

11.7 Individual Records

11.7.1 General Procedures for Individual Records

- A. The professional person and/or the facility providing an evaluation, care, and/or treatment shall keep records detailing all care and treatment received by the individual, and the records must be made available, upon the individual's written authorization, to the individual's attorney or the individual's personal physician in accordance with federal and state laws. The records are permanent records and must be retained in accordance with Section 27-65-123(4), C.R.S.
- B. Except as provided in this part 11.7.1.B, all information obtained and records prepared in the course of providing any services to any individual pursuant to any provision of Article 65 of Title 27, C.R.S., are confidential and privileged matter. The information and records may be disclosed only:
 - 1. In communications between qualified professional personnel in the provision of services or appropriate referrals;
 - 2. When the individual designates other persons to whom information or records may be released; but, if an individual is a ward or conservatee and the ward's or conservatee's guardian or conservator designates, in writing, persons to whom records or information may be disclosed, the designation is valid in lieu of the designation by the recipient; except that nothing in this section compels a physician, psychologist, social worker, nurse, attorney, or other professional personnel to reveal information that has been given to the individual in confidence by members of an individual's family or other informants;
 - 3. To the extent necessary to make claims on behalf of a recipient of aid, insurance, or medical assistance to which recipient may be entitled;
 - 4. If the BHA has promulgated rules for the conduct of research, such rules must include, but are not limited to, the requirement that all researchers must sign an oath of confidentiality. All identifying information concerning individuals, including names, addresses, telephone numbers, and social security numbers, must not be disclosed for research purposes;
 - 5. To the courts, as necessary for the administration of Article 65 of Title 27, C.R.S.;

6. To persons authorized by an order of court after notice and opportunity for hearing to the individual to whom the record or information pertains and the custodian of the record or information pursuant to the Colorado rules of civil procedure;
 7. To family members upon admission of an individual with a mental health disorder for inpatient or residential care and treatment. The only information that may be released pursuant to this part 11.7.1.B.7 is the location and fact of admission of the person with a mental health disorder who is receiving care and treatment. The disclosure of location is governed by HIPAA and 42 C.F.R. Part 2 and the procedures in Section 27-65-124, C.R.S. and is subject to review pursuant to Section 27-65-124, C.R.S.; and/or,
 8. To family members or a lay person actively participating in the care and treatment of a person with a mental health disorder, regardless of the length of the participation. This disclosure is governed by HIPAA, as incorporated by reference in part 1.2 of these rules; and 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules; and the procedures in Section 27-65-124 (2) and is subject to review pursuant to Section 27-65-124, C.R.S. The information released pursuant to this subpart is limited to one (1) or more of the following:
 - a. The diagnosis;
 - b. The prognosis;
 - c. The need for hospitalization and anticipated length of stay;
 - d. The discharge plan;
 - e. The medication administered and side effects of the medication; and
 - f. The short-term and long-term treatment goals.
 9. In accordance with state and federal law, to the facility designated pursuant to the federal "Protection and Advocacy for Mentally Ill Individuals Act", 42 U.S.C. Sec. 10801 et seq., and as the governor's protection and advocacy system for Colorado.
- C. Nothing in part 11.7.2 of these rules precludes the release of information to a parent or legal guardian concerning the minor.
1. Nothing in Article 65 of Title 27, C.R.S., renders privileged or confidential any information, except written medical records and information that is privileged pursuant to Section 13-90-107, C.R.S., concerning observed behavior that constitutes a criminal offense committed upon the premises of any facility providing services pursuant to Article 65 or any criminal offense committed against any individual while performing or receiving services pursuant to Article 65 of Title 27, C.R.S.
 2. This section does not apply to physicians or psychologists eligible to testify concerning a criminal defendant's mental condition pursuant to Section 16-8-103.6, C.R.S.
- D. All facilities shall maintain and retain permanent records, including all applications as required pursuant to Section 27-65-106(3), C.R.S.
1. Outpatient or ambulatory care facilities shall retain all records for a minimum of seven (7) years after discharge from the facility for individuals who were eighteen (18) years of age or older when admitted to the facility, or until twenty-five (25) years of age for individuals who were under eighteen (18) years of age when admitted to the facility.

2. Inpatient or hospital care facilities shall retain all records for a minimum of ten (10) years after discharge from the facility for individuals who were eighteen (18) years of age or older when admitted to the facility, or until twenty-eight (28) years of age for individuals who were under eighteen (18) years of age when admitted to the facility.
3. Nothing in this section prohibits or limits the sharing of information by a state institution of higher education police department to authorized university administrators pursuant to Section 23-5-141, C.R.S.

11.7.2 Request for Release of Information Procedures

- A. This section provides for the release of information only and is not deemed to authorize the release of the written medical record without authorization by the individual or as otherwise provided by law.
 1. When a family member requests the location and fact of admission of a person with a mental health disorder pursuant to Section 27-65-123(1)(g), C.R.S., the treating professional person or the professional person's designee, who must be a professional person, shall decide and document the rationale in the individual's record to whether to release or withhold such information. The location must be released if consistent with HIPAA, as incorporated by reference in part 1.2 of these rules, and 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules, unless the treating professional person or the professional person's designee determines, after an interview with the individual, that release of the information to a particular family member would not be in the best interests of the individual.
 - a. Any decision to withhold information requested pursuant to Section 27-65-123(1), C.R.S., is subject to administrative review pursuant to this section upon request of a family member or the individual.
 2. The treating facility shall make a record of the information given to a family member.
 3. For the purposes of request for release of information in this section, an adult person having a similar relationship to an individual with a mental health disorder as a spouse, lay person, parent, child, or sibling of an individual with a mental health disorder may also request the location and fact of admission concerning an individual with a mental health disorder.
 4. When a family member requests information concerning an individual with a mental health disorder, the treatment professional person or the professional person's designee, shall determine whether the individual is capable of making a rational decision in weighing the individual's confidentiality interests and the care and treatment interests implicated by the release of information. The treating professional person or the professional person's designee shall then determine whether the individual consents or objects to the release of information.
- B. For purposes of this section, the treating professional person's designee shall be a professional person.
- C. Information must be released or withheld in the following circumstances:

1. If the treating professional person or the professional person's designee makes a finding that the individual is capable of making a rational decision concerning the individual's interests and the individual consents to the release of information, the treating professional person or the professional person's designee shall order the release of the information unless the professional person or the professional person's designee determines that the release would not be in the best interest of the individual with a mental health disorder.
 2. If the treating professional person or the professional person's designee makes a finding that the individual with a mental health disorder is capable of making a rational decision concerning the individual's interests and the individual objects to the release of information, the treating professional person or the professional person's designee shall not order the release of information.
 3. If the treating professional person or the professional person's designee makes a finding that the individual with a mental health disorder is not capable of making a rational decision concerning the individual's interests, the treating professional person or the professional person's designee may order the release of the information if the professional person or the professional person's designee determines that the release would be in the best interests of the individual.
 4. Any determination of individual capacity:
 - a. Must be used only for the limited purpose of this section.
 - b. A decision by a treating professional person or the professional person's designee concerning the capability of an individual with a mental health disorder is subject to administrative review upon the request of the individual.
 - c. A decision by a treating professional or the professional person's designee to order the release or withholding of information is subject to administrative review upon the request of either a family member or the individual with a mental health disorder.
 - d. The director of the treating facility shall make a record of any information given to a family member.
- D. Procedures for administrative and judicial review of information release/withholding when requested:
1. When administrative review is requested, the director of the facility providing care and treatment to an individual with a mental health disorder, shall cause an objective and impartial review of the decision to withhold or release information.
 2. The director of the facility shall conduct the review if the director is a professional person.
 - a. If the director is not available or if the director cannot provide an objective and impartial review, the review must be conducted by a professional person designated by the facility director.
 3. The review must include, but is not limited to, an interview with the individual with a mental health disorder.
 4. The facility providing care and treatment shall document the review of the decision

5. If an individual with a mental health disorder objects to the release or withholding of information, the individual and the individual's attorney, if any, must be provided with information concerning the procedures for administrative review of a decision to release or withhold information. The individual must be informed of any information proposed to be withheld or released, and to whom, and be given a reasonable opportunity to initiate the administrative review process before information concerning the individual's care and treatment is released.
6. A family member whose request for information is denied must be provided with information concerning the procedures for administrative review of a decision to release or withhold information.
7. An individual with a mental health disorder may file a written request for review by a court, under Section 27-65-124, C.R.S., of a decision made upon administrative review to release information to a family member requested and proposed to be released.
8. If judicial review is requested by the individual, under Section 27-65-124, C.R.S., the court shall hear the matter within ten (10) days after the request, per Section 27-65-124, C.R.S., and the court shall give notice to the individual with a mental health disorder and the individual's attorney, the treating professional person, and the person who made the decision upon administrative review of the time and place of the hearing.
 - a. The hearing must be conducted in the same manner as other civil proceedings before the court per Section 27-65-124, C.R.S.
9. Unless specifically stated in an order by the court, an individual does not forfeit any legal right or suffer legal disability by reason of the provisions of Article 65 of Title 27, C.R.S.
10. In order to allow an individual with a mental health disorder an opportunity to seek judicial review, the treating facility or the treating professional person or the professional person's designee shall not release information requested until five (5) days after the determination upon administrative review of the director or the director's designee is received by the individual.
11. Once judicial review is requested, the treating facility or the treating professional person or the professional person's designee shall not release information except by court order.
12. If the individual with a mental health disorder indicates an intention not to appeal a determination upon administrative review that is adverse to the individual concerning the release of information, the information may be released less than five (5) days after the determination upon review is received by the individual.

11.7.3 Documentation in Individual Records

- A. 27-65 designated involuntary emergency services facilities shall be exempt from completing a comprehensive assessment as described in part 2.12.3 of these rules, an initial assessment as described in part 2.12.2 of these rules and a service plan as described in part 2.13.1 of these rules.
- B. Screening shall follow requirements as outlined in part 2.12.1 of these rules and must also contain the following:
 1. Substance use in the past 24 hours:
 - a. What, how much, when;

2. Current medications; and
 3. Psychiatric advance directives, psychiatric and/or medical assessment documentation.
- C. Crisis assessments must be completed in full on a BHA-created form, available on the BHA website, within 24 hours of admission when determining involuntary hold.
1. The elements from this form can be integrated into a facility's electronic health record system.
- D. The BHA-created standardized evaluation form pursuant to 27-65-106(6)(b), C.R.S., available on the BHA website must be documented in full in the individual record.
- E. If the treating professional person at the designated facility pursues short-term or long-term certification of an individual, all corresponding court documents must also be part of the individual record.
- F. Safety planning documentation must contain the following:
1. Emergency services facilities will develop crisis safety plans with individuals who are detained or assessed/evaluated and are not placed on emergency mental health holds prior to discharge or transfer.
 2. Safety planning must be done in collaboration with the individual in crisis and their family members and/or other social supports (if desired by the individual).
- G. Discharge instructions and care coordination instructions must contain the following in both the individual's clinical record and available as instructions for the individual:
1. A summary of why the individual was detained or evaluated for an emergency mental health hold;
 2. Detailed information as to why the evaluating professional determined the individual no longer meets the criteria for an emergency mental health hold pursuant to Section 27-65-106, C.R.S. or certification pursuant to Section 27-65-109, C.R.S.;
 3. Whether the individual may receive services on a voluntary basis pursuant to parts 11.14.2.I through 11.14.2.I of these rules;
 4. If the individual's medications were changed or the individual was newly prescribed medications during the emergency mental health hold, a clinically appropriate supply of medications, as determined by the judgment of a licensed health-care provider, for the individual until the individual can access another provider or follow-up appointment. Facility must assist in care coordination for the follow-up appointment, if needed;
 5. A safety plan for the individual and, if applicable, the individual's lay person where indicated by the individual's mental health disorder or mental or emotional state;
 6. Notification to the individual's primary care provider, if applicable and/or known;
 7. A referral to appropriate services, if such services exist in the community, if the individual is discharged without food, housing, or economic security. Any referrals and linkages must be documented in the individual's record;

8. The phone number to call or text the Colorado Crisis Services hotline and information on the availability of peer support services;
 9. Information on how to establish a psychiatric or medical advance directive if one is not presented;
 10. Medications that were changed during the emergency mental health hold, including previously prescribed upon admission, and which medications, if any, were changed or discontinued at the time of discharge;
 11. A list of any screening or diagnostic tests conducted during the emergency mental health hold, if requested;
 12. A summary of therapeutic treatments provided during the emergency mental health hold; if requested;
 13. Any laboratory work, including blood samples or imaging that was completed or attempted, if requested;
 14. The person's vital signs upon discharge from the emergency mental health hold, if requested;
 15. A copy of any psychiatric advance directive presented to the facility, if applicable; and
 16. How to contact the discharging facility if needed.
- H. The facility shall document in the individual's record whether the individual accepted the discharge instructions.
- I. The facility shall provide the discharge instructions to the individual's parent or legal guardian if the individual is under eighteen (18) years of age, and to the individual's lay person, when possible and if consistent with state and federal law.
- J. Upon discharge, the facility shall discuss with the individual, the individual's parent or legal guardian, or the individual's lay person the statewide care coordination infrastructure established in Section 27-60-204, C.R.S. to facilitate a follow-up appointment for the individual within seven (7) calendar days after the discharge. Facilities shall comply with part 11.7.3.J of this Chapter, when the statewide care coordination infrastructure created in Section 27-60-204, C.R.S. is fully operational, as determined by the BHA. The BHA shall immediately notify facilities when the statewide care coordination infrastructure is available to assist individuals with discharge.
- K. The facility shall, at a minimum, attempt to follow-up with the individual, the individual's parent or legal guardian, or the individual's lay person within forty-eight (48) hours after discharge.
- L. The facility is encouraged to utilize peer support professionals, as defined in Section 27-60-108(2)(b), C.R.S., when performing follow-up care with individuals and in developing a continuing care plan pursuant to this part 11.7.3.G.1 through 3. The facility may facilitate follow-up care through contracts with community-based behavioral health providers or the Colorado Behavioral Health Crisis Hotline. If the facility facilitates follow-up care through a third-party contract, the facility shall obtain authorization from the individual to provide follow-up care, any denial of authorization from the individual shall be documented in the individual record.

- M. If the individual is enrolled in Medicaid, the facility is not required to meet the requirements of this part 11.7.3.J through 11.7.3.M and instead, the facility shall notify the individual's relevant Managed Care Entity, as defined in Section 25.5-5-403(4), C.R.S., of the individual's discharge and need for ongoing follow-up care prior to the individual's discharge.
- N. If the facility contracts with a Behavioral Health Entity and/or a safety net provider, as defined in Section 27-50-101(7), C.R.S., to provide behavioral health services to an individual on or following an emergency mental health hold, the facility shall work with the Behavioral Health Entity and/or safety net provider in order to meet the requirements of this part 11.7.3.J through 11.7.3.M.
- O. The facility shall encourage the individual to designate a family member, friend, or other persons as a lay person to participate in the individual's discharge planning and shall notify the individual that the individual is able to rescind the authorization of a lay person at any time. If the individual designates a lay person and has provided necessary authorization, the facility shall attempt to involve the lay person in the individual's discharge planning. The facility shall notify the lay person that the individual is being discharged or transferred.
- P. Involuntary emergency services facilities must ensure that an individual and authorized caregiver and/or family member(s) receive follow-up by phone or telehealth within forty-eight (48) hours, conducted by any member of the responding team or by an associated hospital follow-up program. Purpose of the follow-up appointment shall be documented in the individual's clinical record.

11.8 Psychiatric Medications

11.8.1 Informed Consent

- A. In all instances where prescription medications are to be ordered as a part of a mental health treatment program, the following information in these part 11.8.1.A through 11.8.1.D shall be provided, consistent with federal and state law, to the individual and legal guardian(s) and communicated both written and verbally. For individuals, between the ages of fifteen (15) and eighteen (18), the following information may be provided to the individuals' parent(s) or legal guardian(s). When an individual has designated another to act concerning medication issues pursuant to a medical durable power of attorney, advanced directive, or proxy, the information shall be provided to that person also. The facility shall have policies and procedures for documenting in the clinical record that the required information was given to the individual, parent, or guardian and consent obtained before initial administration of medication(s).
 - 1. The name(s) of the medication being prescribed;
 - 2. The usual uses of the medication(s);
 - 3. The reasons for ordering the medication(s) for this individual;
 - 4. A description of the benefits expected;
 - 5. The common side effects and common discomforts, if any;
 - 6. The major risks, if any;
 - 7. The probable consequences of not taking the medication(s);
 - 8. Any significant harmful drug or alcohol interactions, or food interactions;

9. Appropriate treatment alternatives, if any;
 10. That the individual may withdraw agreement to take the medication at any time; and
 11. Ensure that medication will not interfere or negatively interact with any of the individual's other prescribed medication(s).
- B. If an individual has established an advance directive concerning psychiatric medication and the advance directive is still in effect, the physician or advanced practice registered nurse shall follow the directive unless contraindicated in a psychiatric emergency. The rationale for overriding an advance directive shall be clearly documented in the individual's clinical record.
- C. The provider with prescriptive authority or their designee shall offer to answer inquiries regarding the medication(s).
- D. No individual shall be threatened with or subjected to adverse consequences by facility personnel solely because of a failure to accept psychiatric medication voluntarily.

11.8.2 Prescribing, Handling, & Administration of Psychiatric Medication(s)

- A. All psychiatric medication(s) shall be administered on the written order of a professional person authorized by statute to order such medications. Verbal medication orders may be given according to facility policies.
- B. The facility shall have written policies and procedures regarding part 11.8.1 of these rules for informed consent, and the following:
1. Documentation of the administration of medication, medication variances/errors, and adverse medication reactions related to medication administration;
 2. Notification to a professional person authorized by statute to order such medications in case of medication errors and/or medication reactions/events;
 3. Discontinuance of medication;
 4. Disposal of medications;
 5. Acceptance of verbal, fax, or electronically transmitted medication orders; and
 6. Medication shortages and substitutions.
- C. Facilities shall ensure all clinical staff are aware of and have access to the medication formulary.
- D. Facilities shall ensure their providers have access to the medications on the medication formulary when prescribing medications to treat behavioral health disorders.
- E. Facilities shall note in the individual's clinical record all prescription medications administered to the individual by a facility including:
1. The name and dosage of medication;
 2. The reason for ordering the medication;
 3. The time, date and dosage when medication(s) is administered;

4. The name and credentials of the person who administered the medication;
5. The name of the prescribing physician or advanced practice registered nurse to order such medication; and
6. If the medication is administered as an emergency medication or a court-ordered medication.

11.8.3 Involuntary Psychiatric Medications

- A. These rules for involuntary psychiatric medications do not apply to refusal of non-psychiatric medications or medical emergencies. If an individual refuses medications intended to treat general medical conditions and that refusal is likely to cause or precipitate a medical emergency, those professionals who are authorized to order and administer medications may take action in accordance with generally accepted medical practice in an emergency situation.
- B. Psychiatric emergency conditions: individuals who are detained pursuant to Sections 27-65-106, -107, -108.5, -109, or -110, C.R.S., and refuse psychiatric medication may be administered psychiatric medication(s) ordered up to twenty-four (24) hours without consent under a psychiatric emergency condition. The least intrusive means should be used to address the psychiatric emergency.
- C. An emergency condition exists if:
 1. The individual is determined to be in immediate and substantial danger of harming self or others, as evidenced by symptoms which have in the past reliably predicted dangerousness in that particular individual; or,
 2. By a recent overt act, including, but not limited to, a credible threat of bodily harm, an assault on another person or self-destructive behavior that demonstrates an immediate and substantial threat to self or others.
- D. A reasonable attempt to obtain voluntary acceptance of psychiatric medication shall be made prior to the use of involuntary medication.
- E. Continuation of a psychiatric emergency:
 1. If the psychiatric emergency has abated because of the effect of psychiatric medications and the authorized practitioner is of the opinion that psychiatric medication is necessary to keep the emergency in abeyance beyond seventy-two (72) hours, then within that seventy-two (72) hours the following steps shall be taken:
 - a. The facility shall send a written request for a court hearing for an order to administer the medication involuntarily;
 - b. A documented concurring consultation with another authorized practitioner shall be obtained. The consultation shall include an examination of the individual and a review of the clinical record including an assessment as to whether the psychiatric emergency condition continues to exist; and

- c. If a concurring consultation is not obtained within seventy-two (72) hours, then emergency psychiatric medication shall be discontinued until such concurring consultation is obtained and documented, except in cases where life threatening consequences could result from an abrupt medication discontinuation. Under these circumstances, the individual shall be safely taken off the medication according to standards of medical practice, with corresponding clinical documentation.
 - 2. In no case shall an individual receive emergency psychiatric medication(s) involuntarily for a period exceeding ten (10) days without an order from a court of competent jurisdiction, including continuation orders from the court.
 - 3. The individual shall be notified of the right to contact their attorney and/or the court of competent jurisdiction at the time the written request for court-ordered medication is made. This notification shall be documented in the clinical record. If an individual chooses to exercise this right, the 27-65 designated facility shall aid the individual, if necessary, in accomplishing the foregoing.
- F. The specific facts outlining behaviors supporting the finding of the emergency condition shall be detailed in the clinical record. Every twenty-four (24) hours thereafter until such time a final court order is issued, the emergency is resolved, or the individual accepts psychiatric medications voluntarily, the facility shall document the behaviors that substantiated the need to continue the emergency medication, and the physician shall reorder the psychiatric medications.
- G. During the course of emergency medication administration, the individual shall be offered the medication on a voluntary basis each time the medication is given. If the individual voluntarily consents to take the medication(s), and the attending physician determines that the individual will likely continue to accept the medication on a voluntary basis and no longer requires involuntary medications, this shall be documented in the record and the involuntary medication procedures shall be terminated.
- H. If the individual again refuses to voluntarily accept medication(s) and their clinical condition returns to an emergency situation, pursuant to part 11.8.3.C of these rules, the emergency psychiatric medication procedures may be re-instituted.

11.8.4 Non-Emergency Involuntary Medications (Court Ordered Medications)

- A. In non-emergency situations in which an individual, who is detained pursuant to Sections 27-65-106, -107, -108.5, -109, -110, or -111, C.R.S., would benefit from the administration of a psychiatric medication, but the individual does not consent, the facility shall petition the court to obtain permission to administer such medication. The following conditions must be documented in the petition:
- 1. The individual is incompetent to effectively participate in the treatment decision;
 - 2. Treatment by psychiatric medication is necessary to prevent a significant and likely long-term deterioration in the individual's mental condition or to prevent the likelihood of the individual causing serious harm to self or others;
 - 3. A less intrusive appropriate treatment alternative is not available; and
 - 4. The individual's need for treatment by psychiatric medication is sufficiently compelling to override any bonafide and legitimate interest of the individual in refusing treatment.

- B. The petition shall specify what class or name of psychiatric medication is being recommended as potentially beneficial to the individual.
- C. No psychiatric medications shall be administered without the individual's consent until a court order is received authorizing involuntary use, except under emergency conditions under part 11.8 of these rules.

11.8.5 Involuntary Medication Data Reporting

- A. In addition to the involuntary medication data reporting requirements pursuant to 11.5.5, the 27-65 designated facility shall maintain a log of all cases where involuntary medications were administered.
- B. The record must contain, at a minimum, the following:
 - 1. Individual's name and identifying number;
 - 2. Specified use of involuntary medication;
 - 3. Physician or other professional authorized by law ordering involuntary medication;
 - 4. Date/time each involuntary medication was administered and reason for use of involuntary medication;
 - 5. Date/time involuntary medication was discontinued; and
 - 6. Reason for discontinuation of involuntary medication(s).
- C. If the facility uses a medication administration record or another mechanism which meets the criteria listed in this part 11.8.5.B, can correlate this information as required in this part 11.8.5.D, and places the information in the clinical record, that mechanism may be used in lieu of a separate log.
- D. The facility shall have the ability to determine, at a minimum:
 - 1. The aggregate number of individuals receiving emergency and involuntary psychiatric medications during a specified period of time; and
 - 2. The start and stop dates for each individual's involuntary medication treatment.
- E. If the facility is licensed as a BHE, the facility must incorporate the use of this data into the quality improvement program in accordance with part 2.17 of these rules.

11.9 Seclusion, Restraint, and Physical Management

11.9.1 General Provisions

- A. The following rules covering seclusion, restraint, and physical management apply to all facilities that use seclusion, restraint, and/or physical management. If a facility has decided to use seclusion, restraint, and/or physical management, the facility shall use seclusion, restraint, and/or physical management only in accordance with the rules in this part 11.9.
- B. These rules do not supersede any requirements under Section 26-20-101 through-111, C.R.S.

- C. If any provision of this part 11.9 conflicts with any provision concerning the use of seclusion, restraint, and/or physical management on an individual with an intellectual or developmental disability as stated in Article 10.5 of Title 27, C.R.S., Article 10 of Title 25.5, C.R.S. or any rule adopted pursuant to those Articles, the provisions of those Articles or rules prevail.
- D. Individuals being detained under Sections 27-65-106 through -110, C.R.S., may be secluded or restrained involuntarily under the conditions in this part; otherwise, there must be a signed informed consent for such an intervention as subject to part 2.11 of this rule.
- E. A facility may only use seclusion, restraint, and/or physical management:
 - 1. In cases of emergency, as defined at Section 26-20-102(3), C.R.S., to be a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to affect such bodily harm; and,
 - 2. After less restrictive alternatives, including but not limited to after all attempts to verbally direct or de-escalate the individual have failed; or
 - 3. After a determination that such alternatives would be inappropriate or ineffective under the circumstances.
- F. A facility that uses seclusion, restraint, and/or physical management pursuant to the provisions of part 11.9.1.E of this section, may only use such seclusion, restraint, and/or physical management:
 - 1. For the purpose of preventing the continuation or renewal of an emergency;
 - 2. For the period of time necessary to accomplish its purpose; and
 - 3. In the case of physical restraint, with no more force than is necessary to limit the individual's freedom of movement.
- G. In addition to the circumstances described in this part 11.9.1.F, a facility that is designated by the commissioner of the BHA in the State Department to provide treatment pursuant to Sections 27-65-106, 27-65-109, or 27-65-110, C.R.S., to an individual with a mental health disorder, as defined in Section 27-65-102(22), C.R.S., may use seclusion to restrain an individual with a mental health disorder when the seclusion is necessary to eliminate a continuous and serious disruption of the treatment environment.
- H. Seclusion, restraint, and/or physical management must never be used:
 - 1. As a punishment or disciplinary sanction,
 - 2. As a means of coercion,
 - 3. As part of an involuntary service plan or behavior modification plan,
 - 4. For convenience,
 - 5. For the purpose of retaliation, or
 - 6. For the purpose of protection, unless:
 - a. The restraint or seclusion is ordered by a court; or

- b. In an emergency, as provided for in this part 11.9.1.F.1 above.
- I. Physical management for individuals under the age of eighteen (18) must always be considered as restraint and follow the restraint order rules pursuant to part 11.9.13 of this Chapter.

11.9.2 Policies and Procedures Regarding Seclusion, Restraint, and Physical Management

- A. Facilities shall have and shall implement written policies and procedures that describe the situations in which the use of seclusion, restraint, and/or physical management are considered appropriate in the facilities and personnel who can order their use. The policies and procedures must include the requirements in this part 11.9 and Section 26-20-101 through -111, C.R.S. these policies and procedures must also include:
 - 1. For a facility that does not authorize the use of seclusion, restraint, and/or physical management of any type, a policy statement noting the prohibition against the use of seclusion, restraint, and/or physical management and the procedures that personnel will utilize in lieu of seclusion, restraint, and/or physical management.
 - 2. For a facility that utilizes seclusion, restraint, and/or physical management, a policy statement regarding the review process for the use of seclusion, restraint, and/or physical management. The review process must include a provision for terminating the seclusion, restraint, and/or physical management episode when the reviewer does not concur with the order for continuation.
 - a. If the reviewer is not an authorized practitioner, then the order must be discontinued by an authorized practitioner.
 - 3. Personnel shall ensure that no individual endures harm or harassment when secluded and/or restrained.
 - 4. A policy statement that a facility shall ensure that the care and treatment are skillfully and humanely administered with full respect for the individual's dignity, pursuant to Section 27-65-101(1)(a), C.R.S.
 - 5. Protocols for when the use of restraint, seclusion, and/or physical management is appropriate, and the restrictions on the use of these techniques, the facility may impose more, but not fewer, restrictions on the use of these techniques than is required by this Chapter.
 - 6. Details on the type of physical management interventions that personnel are approved to use.
 - 7. Details on how seclusion, restraint, and/or physical management will be altered to include any necessary accommodations the individual may need, including but not limited to, changing emergency interventions to not restrain hands and ability to communicate for those individuals that speak sign language.

11.9.3 Personnel Training

- A. The facility shall ensure that all personnel involved in utilizing seclusion, restraint, and/or physical management are trained in the use of seclusion, restraint, and/or physical management as described in this part 11.9.

- B. The facility shall ensure that personnel are trained to explain, where possible, the use of seclusion, restraint, and/or physical management to the individual who is to be secluded, restrained, or physically managed and to the individual's designated representative, if appropriate.
- C. Training must be standardized and evaluated every three (3) years to ensure incorporation of evidence-based best practices for seclusion, restraint, and/or physical management.
- D. Training must be provided to personnel within the first month of their orientation period and annually thereafter unless training is needed sooner.
- E. Personnel shall obtain certification in cardiopulmonary resuscitation (CPR), including periodic recertification as needed to maintain certification.
- F. Training must include at minimum, but is not limited to:
 - 1. The safe use of seclusion, restraint, and/or physical management including content related to the risks of positional asphyxia, aspiration, traumatization, and recognize and respond to signs of physical distress of an individual who is secluded, restrained, and/or physically managed;
 - 2. Address concepts related to prevention and non-physical interventions such as de-escalation and mediation;
 - 3. Educate personnel of how their culture, language, biases, values, and perceptions influence their response and escalation of person involved; and
 - 4. Understanding and recognizing underlying behavioral health and physical health conditions, medications, and their potential effects as well as how age, developmental level, cultural background, language, history of physical or sexual abuse, and prior experience with seclusion, restraint, and/or physical management will influence an individual's responses to seclusion, restraint, and physical management.
- G. Personnel must demonstrate knowledge and application of seclusion, restraint, and physical management training on an annual basis when working with persons over the age of twenty-one (21), and on a semi-annual basis when working with youth twenty (20) years old and younger.

11.9.4 Standards of Care Upon Admission

- A. At admission, the facility shall inform both the individual and the individual's legal representative, as applicable, of the facility's policy regarding the use of seclusion, restraint, and physical management during an emergency behavioral health episode for individuals in a treatment program. This must, as is reasonable under the circumstances, be communicated, if feasible, in a language and modality accessible to the individual.
- B. Upon an individual's admission, personnel shall collaborate with the individual and the individual's legal representative, when applicable, to formulate strategies that may minimize the potential for a behavioral health emergency event that requires interventions of seclusion, restraint, and/or physical management.
- C. A facility electing to utilize seclusion, restraint, and/or physical management shall assess each individual upon admission regarding:
 - 1. Assault and trauma history;

2. Seclusion, restraint, and/or physical management history;
3. Individual's risk factors for a behavioral emergency, and individually identified strategies to avoid seclusion, restraint, and/or physical management; and
4. The facility shall ascertain any applicable behavioral health advance directives.

11.9.5 Use of Physical Management

- A. Physical management for individuals under the age of eighteen (18) must always be considered as restraint and follow the restraint order rules pursuant to part 11.9.13 of this Chapter.
- B. Physical management shall only be used on an emergency basis for a maximum of one (1) minute, when the situation places the individual or others at imminent risk of serious physical harm after all attempts to verbally direct or de-escalate the person have failed.
 1. If physical management is used for longer than one (1) minute, the intervention is restraint, pursuant to Section 26-20-102(6), C.R.S., and personnel must follow the restraint order rules pursuant to part 11.9.7 of this Chapter.
- C. To ensure the safety of each individual and personnel, each facility shall designate emergency physical management techniques to be utilized during emergency situations.
- D. The term "physical management" does not include briefly holding an individual in order to comfort them.
- E. The physical management continuum may include:
 1. Utilizing transitional measures;
 2. Placing one's hands on an individual to physically guide and/or physically control the individual;
 3. Use of an approved restraint method specified in the facility's policies and procedures to maintain safety of the individual;
 4. Placing an individual into an approved prolonged restraint method specified in the facility's policies and procedures; or
 5. Physical management may be used to move or escort an individual into seclusion.
 - a. Seclusion, in itself, is not a form of physical management.
- F. Physical management must be documented in the clinical record to include the following:
 1. Documentation of the behavioral necessity for physical management and any de-escalation techniques attempted prior to utilizing physical management.
 2. Documentation of the approved physical management method utilized.

11.9.6 Use of Seclusion

- A. If an order for seclusion is verbal, the verbal order must be received by a registered nurse or other trained licensed personnel, such as a licensed practical nurse while the emergency safety intervention is being initiated by personnel or immediately after the emergency safety situation begins.
 - 1. The physician or other authorized practitioner permitted to order seclusion must verify the verbal order in a signed written form in the individual's record. Signatures must be entered into the record no more than twenty-four (24) hours after the event.
 - 2. The physician or other authorized practitioner to order seclusion must be available to personnel for consultation, at least by telephone, throughout the period of the emergency safety intervention.
- B. Within one (1) hour of the initiation of the original order of seclusion an authorized practitioner, such as a registered nurse or physician assistant, trained in the use of emergency safety interventions and permitted to assess the physical and psychological well-being of the individual, shall conduct a face-to-face assessment of the physical and psychological well-being of the individual including but not limited to:
 - 1. The individual's physical and psychological status;
 - 2. The individual's behavior;
 - 3. The appropriateness of the intervention measures; and
 - 4. Any complications resulting from the intervention.
- C. When the one (1) hour assessment described in this part 11.9.6.B is conducted by a registered nurse or a physician assistant, that personnel must consult with the attending physician when the assessment is completed.
- D. Results of the one (1) hour assessment must determine if continued emergency interventions need to be re-ordered by the authorized practitioner.
 - 1. Assessment results and continuation order, if applicable, must be contained in the clinical record.
- E. Seclusion occurs any time an individual is placed alone in a room and not allowed to leave.
- F. Seclusion must be used only when other less restrictive methods have failed.
 - 1. Documentation of less restrictive methods and the outcome must be contained in the clinical record.
- G. Seclusion must not be used for punishment, for the convenience of personnel, or as a substitute for a program of care and treatment.
- H. Seclusion rooms must be lighted, clean, safe, and have a window for personnel to observe.
- I. Seclusion rooms must be a minimum of one hundred (100) square feet, unless the facility is licensed as a hospital and the seclusion room size is in compliance with applicable CDPHE regulations.
- J. Relief periods from seclusion must be offered for reasonable access to toilet facilities.

11.9.7 Use of Restraint

- A. If an order for restraint is verbal, the verbal order must be received by a registered nurse or other trained licensed personnel, such as a licensed practical nurse, while the emergency safety intervention is being initiated by personnel or immediately after the emergency safety situation begins.
 - 1. The physician or other authorized practitioner permitted to order restraint must verify the verbal order in a signed written form in the individual's record. Signatures must be entered into the record no more than twenty-four (24) hours after the event.
 - 2. The physician or other authorized practitioner to order restraint must be available to personnel for consultation throughout the period of the emergency safety intervention.
- B. An individual in physical restraint must be released from such restraint within fifteen (15) minutes after the initiation of physical restraint, except when precluded for safety reasons pursuant to part 11.9.1 of this section.
- C. Within one (1) hour of the initiation of the original order for the emergency safety intervention, an authorized practitioner, such as a registered nurse or physician assistant, trained in the use of emergency safety interventions and permitted to assess the physical and psychological well-being of the individual, shall conduct a face-to-face assessment of the physical and psychological well-being of the individual including but not limited to:
 - 1. The individual's physical and psychological status;
 - 2. The individual's behavior;
 - 3. The appropriateness of the intervention measures; and
 - 4. Any complications resulting from the intervention.
- D. When the one (1) hour assessment described in this part 11.9.7.C is conducted by a registered nurse or a physician assistant, that personnel must consult with the attending physician when the assessment is completed.
- E. Results of the one (1) hour assessment must determine if continued emergency interventions need to be reordered by the authorized practitioner.
 - 1. Assessment results and continuation order, if applicable, must be contained in the clinical record.
- F. The decision to restrain must be based on a current clinical assessment and may also be based on other reliable information including information that was used to support the decision to take the individual into custody for treatment and evaluation. The fact that an individual is being evaluated or treated under Sections 27-65-106 through 27-65-111 [effective July 1, 2024], C.R.S., must not be the sole justification for the use of restraint.
- G. Restraint includes chemical restraint, mechanical restraint, and physical restraint.
- H. Mechanical restraints may be used only for the purpose of preventing such bodily movement that is likely to result in imminent injury to self or others. Mechanical restraint must not be used solely to prevent unauthorized departure.
- I. Restraint of an individual by a chemical spray is not permissible.

- J. The type of restraint must be appropriate to the type of behavior to be controlled, the physical condition of the individual, the age of the individual, and the type of effect restraint may have upon the individual.
- K. Restraint must be applied only if alternative interventions have failed. Justification for immediate use of restraint without first attempting alternative interventions must be documented in the clinical record; however, alternative techniques are not required if the alternatives would be ineffective or unsafe when the individual's behavior could cause harm to self or others.
- L. The term "restraint" as used in this section, does not include restraints used while the facility is engaged in transporting an individual from one facility location to another facility location when it is within the scope of that facility's powers and authority to conduct such transportation pursuant to Section 26-20-101 through -111, C.R.S.
- M. No physical or mechanical restraint of an individual may place excess pressure on the chest or back of that individual, cover the individual's face, or inhibit or impede the individual's ability to breathe.

11.9.8 Chemical Restraint

- A. If an order for chemical restraint is verbal, the verbal order must be received by a registered nurse or other trained licensed personnel, such as a licensed practical nurse, while the emergency safety intervention is being initiated by personnel or immediately after the emergency safety situation begins.
 - 1. The physician or other authorized practitioner permitted to order chemical restraint must verify the verbal order in a signed written form in the individual's record. Signatures must be entered into the record no more than twenty-four (24) hours after the event.
 - 2. The physician or other authorized practitioner to order chemical restraint must be available to personnel for consultation, throughout the period of the emergency safety intervention.
- B. An order for a chemical restraint, along with the reasons for its issuance, must be recorded in writing at the time of its issuance.
- C. An order for a chemical restraint must be signed at the time of its issuance by such authorized practitioner, who is present at the time of the emergency.
- D. An order for a chemical restraint, if authorized by telephone, must be transcribed and signed at the time of its issuance by personnel with the authority to accept telephone medication orders who is present at the time of the emergency.
- E. Personnel trained in the administration of medication shall make notations in the record of the individual as to the effect of the chemical restraint and the individual's response to the chemical restraint.

11.9.9 Explanation to Individual in Seclusion/Restraint

- A. In any situation in which seclusion/restraint is utilized, information must be given to the secluded/restrained individual, and the individual's legal representative when applicable, as soon as possible after they have been secluded or restrained. The individual must be given a clear explanation of:
 - 1. The reasons for use of such intervention;

2. The observation procedure, the desired effect; and
 3. The circumstances under which the procedure will be terminated.
- B. That the explanation has been given to the individual and the individual's legal representative, when applicable, must be documented in the clinical record.
- C. As soon as possible, upon termination of seclusion and/or restraint, personnel shall debrief with the individual and assess for any traumatic stress that may have been triggered as a result of seclusion/restraint.

11.9.10 Observation & Care of Individuals in Seclusion and/or Restraint

- A. An individual who is in seclusion/restraint must be observed in-person by trained facility personnel at no more than ten (10) feet physical distance from the individual.
1. Such observation, along with the behavior of the individual, must be documented every fifteen (15) minutes.
- B. Unless contraindicated by the individual's condition, such observation must include consistent efforts to interact personally with the individual throughout the episode.
- C. Ongoing provisions must be made for nursing care, hygiene, diet, and motion of any restrained limbs throughout the episode.
- D. Facility personnel must maintain a continuous line-of sight throughout the episode with the individual held in mechanical restraints.
- E. For individuals held in mechanical restraints, facility personnel must observe the individual at least every fifteen (15) minutes to ensure that:
1. The individual is properly positioned;
 2. The individual's blood circulation is not restricted;
 3. The individual's airway is not obstructed; and
 4. The individual's other physical needs are met, pursuant to this part 11.9.10.
- F. For individuals held in mechanical restraints, the facility shall offer relief periods of at least ten (10) minutes as often as every two (2) hours, so long as relief from the mechanical restraint is determined by personnel to be safe pursuant to part 11.9.1 of this section.
- G. Personnel must document relief periods both offered and granted.
- H. The individual must have access to food at least every four (4) hours.
- I. The individual must have access to fluids and toileting upon request or during offered relief periods but must at minimum be offered every two (2) hours.
1. During such relief periods, personnel shall ensure proper positioning of the individual and provide movement of limbs, as necessary.
- J. Personnel must provide assistance for use of necessary toileting methods.

1. Appropriate toileting does not include the use of adult diapers if not typically used by the individual when not restrained or secluded.
 2. If the individual typically uses adult diapers they are to be changed immediately if soiled.
- K. Personnel shall maintain the individual's dignity and safety during relief periods.
- L. Cameras and other electronic monitoring devices must not replace face-to-face observations.
- M. To the extent that the duties specified in Section 26-20-101 through -111, C.R.S. are more protective of individual's rights or are in conflict with the provisions in this part 11.9, the provisions of Section 26-20-101 through -111, C.R.S. shall apply.

11.9.11 Continued Use of Seclusion and/or Restraint

- A. Personnel must document efforts to assure that the use of seclusion/restraint are as brief as possible.
- B. The original order of seclusion/restraint of an individual must not exceed one (1) hour without an order for continued seclusion/restraint from an authorized practitioner. A verbal order, including telephone or other electronic orders, may be used if followed by a written order from the authorized practitioner.
- C. Seclusion/restraint must not be ordered on an "as needed" basis.
- D. A new written order is required every four (4) hours and shall include a documented examination by an authorized practitioner.
- E. Continued seclusion/restraint in excess of twenty-four (24) hours shall require an administrative review.
1. The administrative reviewer shall be a different authorized practitioner with the authority and knowledge necessary to review clinical information and reach a determination that the extension of a seclusion and/or restraint episode beyond twenty- four (24) hours is clinically necessary.
 2. If the administrative reviewer does not concur with the order for continuation of seclusion/restraint, the order must be discontinued and the authorized practitioner in charge of treatment shall be notified of such discontinuation.
- F. An administrative review must be initiated at the conclusion of each twenty-four (24) hour period of continuous use of seclusion/restraint.

11.9.12 Documentation Requirements

- A. Each facility must ensure that an appropriate notation of the use of seclusion, restraint and/or physical management is documented in the record of the individual who was secluded, restrained, and/or physically managed and must be completed before the end of the shift of the personnel involved in the seclusion, restraint and/or physical management episode(s). Each facility shall document the following in the individual's record:
1. Specifics of the episode including identified triggers, precipitating events, the individual's specific behavior(s) and the nature of the danger;
 2. Type of restraint, if utilized;

3. Specific date and times of initiation and discontinuation of seclusion, restraint and/or physical management and total length of time individual is secluded, restrained, and/or physically managed;
 4. A description of specific non-physical and least restrictive interventions that were attempted prior and the individual's response;
 5. Identification of personnel involved in the initiation and application of the seclusion, restraint and/or physical management;
 6. Notification to an authorized practitioner within one (1) hour of the seclusion/restraint intervention;
 7. Care provided while the individual was secluded, restrained, and/or physically managed, including:
 - a. Observations conducted;
 - b. Assessments of position, respiration, circulation, and range of motion;
 - c. Documentation of ongoing 15-minute observation and care checks, as subject to applicable rules, along with relief periods both offered and granted for food, fluid, and/or toileting;
 - d. Interventions provided to promote comfort and safety as well as expedite release;
 - e. The individual's response to these interventions; and
 - f. The effect of the restraint or seclusion on the individual;
 8. Documentation that the individual, and the individual's legal representative if applicable, was given a clear explanation of the reasons for use of such intervention, the observation procedure, the desired effect, and the circumstances under which the intervention will be terminated including criteria for release and individual understanding of that criteria; and,
 9. Documentation that personnel debriefed the incident with the individual and assessed for trauma, processed the traumatic event, and identified triggers.
- B. Any administrative reviewer shall document the clinical justification for the continued use of seclusion/restraint in the individual's chart. The justification must include:
1. Documentation that the authorized practitioner ordering the continuous use of seclusion/restraint in excess of four (4) hours has conducted a face-to-face evaluation of the individual within the previous four (4) hours;
 2. Documentation of the ongoing behaviors or findings that warrant the continued use of seclusion/restraint and other assessment information as appropriate;
 3. Documentation of a plan for ongoing efforts to actively address the behaviors that resulted in the use of seclusion/restraint;
 4. A determination of the clinical appropriateness of the continuation of seclusion/restraint; and

5. A summary of the information considered by the reviewer and the result of the administrative review with the date, time and signature of the person completing the review.
- C. Information regarding use of seclusion/restraint must be readily accessible to authorized persons for review. The facility shall have the ability to gather data as follows:
 1. Each seclusion/restraint episode including date and time the episode started and ended, specific to each individual over the period of one complete calendar year from January 1 through December 31.

11.9.13 Additional Procedures and Requirements for Seclusion/Restraint of a Youth

- A. Procedures for youth must include the following in addition to the requirements found in this part 11.9, unless otherwise required in this part 11.9.13.
- B. This part 11.9.13 does not apply to adult individuals over the age of twenty-one (21).
- C. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the youth's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).
 1. Physical management is always considered restraint for an individual under age eighteen (18) and must follow the restraint order rules pursuant to this part 11.9 of this Chapter.
- D. Orders for seclusion/restraint must be by an authorized practitioner in the facility to order seclusion/restraint and trained in the use of emergency safety interventions. Federal regulations at 42 C.F.R. Part 441.151, the federal regulations issued by the United States Secretary of Health and Human Services found at 42 C.F.R. Part 441.151 (Feb. 2023), which are hereby incorporated by reference. No later editions or amendments are incorporated. These regulations are available at no cost from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Communications, 5600 Fishers Lane, Rockville, MD 20857 or at <https://www.ecfr.gov/current/Title-42>. These regulations are also available for public inspection and copying at the Behavioral Health Administration, 710 S. Ash Street, Unit C140, Denver, CO 80246, during regular business hours. This requires that inpatient psychiatric services for individuals under age twenty-one (21) be provided under the direction of a physician.
 1. If the individual's treatment team assigned physician is available, only they can order seclusion/restraint. If they are not available, then another team physician may make the order.
- E. A physician or other authorized practitioner must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with personnel.
- F. If the order for seclusion/restraint is verbal, the order must be received by a registered nurse or other trained licensed personnel, such as a licensed practical nurse, while the emergency safety intervention is being initiated by personnel or immediately after the emergency safety situation begins.
 1. The physician or other authorized practitioner permitted to order restraint or seclusion must verify the verbal order in a signed written form in the youth's record. Signatures must be entered into the record no more than twenty-four (24) hours after the event.

2. The physician or other authorized practitioner to order restraint or seclusion must be available to personnel for consultation, at least by telephone, throughout the period of the emergency safety intervention.
- G. Each order for seclusion/restraint must be limited to no longer than the duration of the emergency safety situation.
- H. Under no circumstances may the total order time exceed:
 1. Four (4) hours for persons ages eighteen (18) to twenty-one (21);
 2. Two (2) hours for persons ages nine (9) to seventeen (17); or
 3. One (1) hour for persons under the age of nine (9).
- I. Within one (1) hour of the initiation of the order of the emergency safety intervention a physician, or other authorized practitioner trained in the use of emergency safety interventions and permitted to assess the physical and psychological well-being of the youth, must conduct a face - to - face assessment of the physical and psychological well-being of the individual including but not limited to:
 1. The youth's physical and psychological status;
 2. The youth's behavior;
 3. The appropriateness of the intervention measures; and
 4. Any complications resulting from the intervention.
- J. Results of the one (1) hour assessment must be documented in the individual's record.
- K. Notification of parent(s) and/or legal guardian(s), when applicable:
 1. The facility must notify the parent(s) and/or legal guardian(s) of the individual who has been in seclusion or restraint as soon as possible after the initiation of each emergency safety intervention.
 2. The facility shall document in the individual's record that the parent(s) or legal guardian(s) have been notified of the emergency safety intervention, including date and time of the notification and the name of personnel providing the notification.

11.10 Therapy or Treatment Using Special Procedures

11.10.1 Informed Consent for Therapy/Treatment Using Special Procedures

- A. Therapies using stimuli such as electroconvulsive therapy (ECT), use of feeding tubes for eating disorder treatment, and transcranial magnetic stimulation (TMS), require special procedures for consent and shall be governed by this part 11.10 of these rules.
- B. Prior to the administration of a therapy listed in part 11.10.1.A of these rules, written informed consent shall be obtained and documented in the clinical record reflecting agreement by both the individual being treated and their legal guardian, if one has been appointed or alternative decision maker if one exists.

1. If the individual undergoing treatment using special procedures is a minor, fifteen (15) years of age or older, the clinical record shall reflect informed consent by both the minor and their guardian(s).
 - a. If the minor is unable to consent to the special procedure due to their mental illness, as determined by an evaluation of capacity, this shall be documented in the clinical record.
 - (1) The tool used to determine capacity shall be administered by an authorized practitioner within their scope of practice and be maintained in the clinical record.
 - (2) An evidence-based standardized tool for assessing decision-making capacity shall be utilized.
 2. If the minor is fourteen (14) years of age or younger, written informed consent from the parent, legal custodian or legal guardian shall be obtained in addition to the requirements listed in part 11.10.1.E, and maintained in the clinical record.
- C. In the case of electroconvulsive therapy (ECT), a consent form shall be used, and procedures set forth in Sections 13-20-401 through 13-20-403, C.R.S. shall be followed. An informed consent for ECT means:
1. It is freely and knowingly given and expressed in writing; and
 2. The consent agreement entered into by the individual or other person(s) shall not include exculpatory language through which the individual or other person(s) is made to waive, or appear to waive, any of their legal rights, or to release the facility or any other party from liability for negligence.
- D. Electroconvulsive treatment (ECT) may be performed on a minor who is sixteen (16) years of age or older, but under eighteen (18) years of age only if two individuals licensed to practice medicine in Colorado and specializing in psychiatry approve the treatment, and the parent or guardian of the minor consents to the treatment.
1. The minor aged sixteen (16) to eighteen (18) must have a diagnosis consistent with ECT best practices.
- E. ECT may be performed on a minor who is fifteen (15) years of age or younger when:
1. Two individuals licensed to practice medicine in Colorado, and specializing in psychiatry, approve the treatment. One (1) of the individuals must also specialize in child and adolescent psychiatry;
 2. Other less invasive treatments have failed;
 3. ECT is performed by at least one (1) physician, or physician's designee, who is trained and credentialed in ECT; and
 4. The minor's parent, legal custodian, or legal guardian consents to the treatment; or
 - a. A court issues an order for treatment pursuant 27-65-113, C.R.S.
- F. Electroconvulsive treatment (ECT) requires a concurring consultation by a licensed psychiatrist prior to administration of the treatment. Such consultation shall be noted in the clinical record.

- G. The facility shall document that the following has been explained to the individual:
1. The reason for such treatment information;
 2. The nature of the procedures to be used in such treatment, including their probable frequency and duration;
 3. The probable degree and duration of improvement or remission expected with or without such treatment;
 4. The nature, degree, duration, and probability of the side effects and significant risks of such treatment, commonly known by the medical profession, the possible degree and duration of memory loss, the possibility of permanent irrevocable memory loss, and the remote possibility of death;
 5. The reasonable alternative treatments, if any, and why the professional person is recommending the specific treatment;
 6. That the individual has the right to refuse or accept the proposed treatment and has the right to revoke their consent for any reason at any time, either orally or in writing;
 7. That there is a difference of opinion within the medical profession on the use of some treatments;
 8. An offer to answer any inquiries concerning the recommended special procedures; and
 9. The number of treatments expected over a specified period of time to achieve maximum benefit.
- H. Informed consent for the special procedure shall be renewed each time the prescribed course of treatments determined through clinical assessment have been completed
- I. Feeding tubes for eating disorder treatment may be used within a designated facility when:
1. Informed written consent is required pursuant to this Section 11.10 from both patient and patient's parent, legal guardian, or custodian if the patient is fifteen (15) years of age or older; or
 - a. If the patient, fifteen (15) years of age or older, does not consent or objects to continued use of an involuntary feeding tube, patient may seek review pursuant to Section 27-65-104(6) C.R.S.
 2. If the patient is fourteen (14) years of age or younger, only written informed consent from the parent, legal guardian, or custodian is required.

11.10.2 Involuntary Treatment Using Special Procedures

- A. In the event the individual or the legal guardian refuses to or cannot consent, treatments referenced in part 11.10.1.A of these rules using special procedures shall be administered only under the following circumstances:
1. With a prior court order for the treatments using special procedure; or,

2. In an emergency in which the life of the individual is in immediate danger because of the individual's condition. In an emergency situation in which the individual is unable to grant informed consent and sufficient time does not exist to petition the court for an order prior to the administration of the specific therapy, the individual's physician, in consultation with the director of the facility or their designee, may, after careful and informed deliberation and under procedures adopted by the facility, order a special procedure without consent.

B. Policies and procedures:

1. Each designated facility shall adopt written policies and procedures for administration of special procedures in accordance with these rules and applicable statutes.

11.11 Continuity of Care & Transfer of Care

11.11.1 Continuity of Care

- A.** Each facility shall adopt and implement a written policy for continuity of care. The policy shall include at a minimum the following:
1. Access to all necessary care and services within the facility, and coordination with any other current mental health care providers or other systems of care or support as appropriate;
 2. Coordination of care with the individual's previous mental health care providers or medical providers as appropriate, including retrieval of psychiatric and medical records;
 3. Coordination of the individual's care with family members, guardians, and other interested parties as appropriate and in a manner that reflects the individual's culture; and/or
 4. The facility shall facilitate access to proper medical care and shall be responsible for coordinating mental health treatment with medical treatment provided to the individual.

11.11.2 Transfer of Care: Non-Emergent

- A.** The individual shall only be transferred to another 27-65 designated or placement facility when adequate arrangements for care by the receiving facility have been made and documented in the clinical record. Transfer coordination shall include at least one discharge planning conference, face-to-face or by telephone, with participants from both facilities and the individual and their guardian, whenever possible.
- B.** At least twenty-four (24) hours advance notice of transfer shall be given to individuals under certification, unless knowingly waived in writing by the individual and guardian, if applicable and as appropriate, except in cases of a medical emergency. Notice of such transfer shall also be provided to the court of competent jurisdiction and the individual's attorney.
- C.** The transferring facility shall ask the individual to indicate two (2) persons to whom notification of transfer should be given and shall notify such persons within twenty-four (24) hours of notification to the individual. Such notification shall be made by the transferring facility with the appropriate written authorization. Actions taken under part 11.11 of these rules, shall be documented in the clinical record.

11.12 Requirements for Placement Facilities

- A. Facilities with a 27-65 designation may provide mental health services directly or through the use of a placement facility contract. Whenever a placement facility is used there must be a written agreement with the 27-65 designated facility. In either case, the 27-65 designated facility is responsible for assuring an appropriate treatment setting for individuals and services provided in accordance with these rules. Whenever a placement facility is used, the 27-65 designated facility shall be responsible for the care provided by the placement facility as well as placement facility compliance with these rules. Policies and procedures must be in place outlining the 27-65 designated facility's responsibilities and procedures for oversight of placement facilities as outlined in this section.
- B. Emergency departments are not eligible to be placement facilities. Only the following Colorado licensed facilities are eligible to be placement facilities:
 - 1. Nursing homes;
 - 2. Residential child care facilities providing mental health services;
 - 3. Non-psychiatric hospitals providing inpatient medical services;
 - 4. Alternative care facilities; and
 - 5. Mental health transitional living homes.
- C. All agreements between 27-65 designated facilities and placement facilities and all supplemental agreements and amendments shall be submitted in writing to the BHA no later than ten (10) business days after the effective date of the agreement or amendment.
- D. Whenever a 27-65 designated facility uses a placement facility, the agreement shall include:
 - 1. An annual training plan for placement facility personnel that provides at a minimum training regarding mental health disorders, these rules, Article 65 of Title 27, C.R.S., and appropriate, safe behavioral interventions. The implementation of the training plan shall be monitored regularly by the 27-65 designated facility;
 - 2. A requirement that supervision of direct care personnel be provided by: professional persons licensed in Colorado to practice medicine or licensed Colorado psychologists employed by or under contract with the designated facility; designated professional persons licensed in Colorado to practice medicine; or licensed Colorado psychologists employed by the placement facility to be responsible for direct care supervision provided that the placement facility and the designated facility are operated by the same corporate facility;
 - 3. A requirement that assures the necessary availability and supervision of placement facility personnel in order to carry out the contract; and
 - 4. A requirement that the placement facility adheres to these rules through the placement facility agreement.
- E. Placement facility agreements shall be executed and signed at least every two years and submitted to the BHA when the 27-65 designated facility submits its application for continued designation.

- F. A placement facility can be used by a 27-65 designated facility, at its discretion under the provisions of these regulations, in order to provide care to any individual undergoing mental health evaluation or treatment. 27-65 designated facilities shall not place individuals in a placement facility unless all of the applicable provisions of these rules are met and placement in such facilities are appropriate to the clinical needs of each individual. When a placement facility is required, the least restrictive facility possible and available must be used, consistent with the clinical needs of the individual.
- G. A placement facility shall not provide services beyond the scope of its license.

11.13 Procedures for Involuntary Transportation Holds

- A. This Section 11.13 is meant to provide a summary of the obligations and standards set forth in Section 27-65-101 through -131, C.R.S., with regard to involuntary transportation holds. This section is only enforceable with regard to designated facilities.
- B. An individual may be placed on an involuntary transportation hold pursuant to Section 27-65-107, C.R.S. if the certified peace officer or emergency medical services provider believes the individual is experiencing a behavioral health crisis or is gravely disabled, and as a result, without professional intervention, the individual may be a danger to self or others.
 - 1. The certified peace officer or emergency medical services provider may then take the individual into protective custody and transport the individual to an outpatient mental health facility, or a facility designated by the commissioner or other clinically appropriate facility designated by the commissioner.
 - 2. If such a service is not available, the individual may be taken to an emergency medical services facility.
- C. The involuntary transportation form to be completed in full (on the BHA-provided M 0.5 form available on the BHA website) prior to transportation shall include:
 - 1. The circumstances under which the individual's condition was called to the certified peace officer's or emergency medical services (EMS) provider's attention and further stating sufficient facts obtained from personal observations or obtained from others whom the certified peace officer or emergency medical services provider reasonably believes to be reliable, to establish that the individual is experiencing a behavioral health crisis or is gravely disabled and, as a result it is believed that without professional intervention the individual may be a danger to the individual's self or others;
 - 2. The name of the individual and date and time the individual was placed on the involuntary transportation hold;
 - 3. The name of the facility to which the individual will be transported; and
 - 4. The signature of the certified peace officer or EMS provider placing the involuntary transportation hold.
- D. A copy of the involuntary transportation form must be given to the individual who was placed on the involuntary transportation hold.
- E. A copy of the involuntary transportation form must be given to the facility and made part of the individual's medical record.

- F. An individual may not be placed on a transportation hold if an intervening professional or certified peace officer has assessed the individual during the same emergency event and determined the individual does not meet the criteria for an emergency mental health hold.
- G. If a behavioral health crisis response team is known to be available in a timely manner, the certified peace officer or emergency medical services provider shall access the behavioral health crisis response team prior to transporting an individual involuntarily.
- H. Individuals may not be transported involuntarily for longer than six (6) hours.
- I. Once the individual is presented to an outpatient mental health facility or facility designated by the commissioner, an intervening professional shall screen the individual immediately. If an intervening professional is not immediately available, the individual must be screened within immediately, but no more than eight (8) hours pursuant to Section 27-65-107(4)(a)(I), C.R.S., after the individual's arrival at the facility to determine if the individual meets criteria for an emergency mental health hold.
- J. Once the screening is completed and if the individual meets criteria, the intervening professional shall first pursue voluntary treatment and evaluation. If the individual refuses or the intervening professional has reasonable grounds to believe the individual will not remain voluntarily, the intervening professional may place the individual under an emergency mental health hold pursuant to Section 27-65-106, C.R.S.

11.13.1 Individual Rights for Involuntary Transportation

- A. The following rights must be explained to the individual prior to transporting them involuntarily and provided in written form:
 - 1. To not be detained under an emergency transportation hold pursuant to this Section for longer than fourteen (14) hours, to not be transported for longer than six (6) hours, and to receive a screening within eight (8) hours after being presented to the receiving facility. Section 27-65-107(4)(a)(I), C.R.S., does not prohibit a facility from holding the individual as authorized by state and federal law, including the federal "Emergency Medical Treatment and Labor Act," 42 U.S.C. Sec. 1395dd, or if the treating professional determines that the individual's physical or mental health disorder impairs the individual's ability to make an informed decision to refuse care and the provider determines that further care is indicated.
 - 2. To request a phone call to an interested party prior to being transported. If the certified peace officer or EMS provider believes access to a phone poses a physical danger to the individual or someone else, the receiving facility shall make the call on the individual's behalf immediately upon arrival at the receiving facility.
 - 3. To wear the individual's own clothes and keep and use personal possessions that the individual had in the individual's possession at the time of detainment. A facility may temporarily restrict an individual's access to personal clothing or personal possessions until a safety assessment is completed. If the facility restricts an individual's access to personal clothing or personal possessions, the facility shall have a discussion with the individual about why the individual's personal clothing or personal possessions are being restricted. A licensed medical professional or a licensed mental health professional shall conduct a safety assessment as soon as possible. The licensed professional shall document in the individual's medical record the specific reasons why it is not safe for the individual to possess the individual's personal clothing or personal possessions.

4. To keep and use the individual's cell phone, unless access to the cell phone causes the individual to destabilize or creates a danger to the individual's self or others, as determined by a provider, facility personnel, or security personnel involved in the individual's care.
 5. To have appropriate access to adequate water and food and to have the individual's nutritional needs met in a manner that is consistent with recognized dietary practices.
 6. To be treated fairly, with respect and recognition of the individual's dignity and individuality.
 7. To file a grievance with the BHA, the Department of Public Health and Environment (CDPHE), or the Office of the Ombudsman for Behavioral Health Access to Care established pursuant to Section 27-80-303, C.R.S.
- B. An individual's rights may only be denied if access to the item, program, or service causes the individual to destabilize or creates a danger to the individual's self or others, as determined by a licensed mental health provider or professional person involved in the individual's care or transportation. Denial of any right must be entered into the individual's treatment record or BHA-approved form, available on the BHA website. Information pertaining to a denial of rights contained in the individual's treatment record must be made available, upon request, to the individual, the individual's attorney, or the individual's lay person.

11.13.2 Individual Rights for Receiving Individuals on Involuntary Transportation Holds

- A. An individual detained pursuant to this section at an outpatient mental health facility or facility designated by the commissioner, must receive a copy of a form with the individual rights described in this part 11.13.1 on it if they were not provided a copy of the rights prior to transport.
1. If an individual detained pursuant to this part 11.13 is transported to an emergency medical services facility, the involuntary transportation hold expires upon the facility receiving the person for screening by an intervening professional.
- B. The receiving emergency medical services facility must offer to make a phone call on the individual's behalf if the transporting EMS professional or certified peace officer determined that access to a phone prior to transport could pose a physical danger to the individual's self or others.
- C. A facility may temporarily restrict an individual's access to personal clothing or personal possessions until a safety assessment is completed. If the facility restricts an individual's access to personal clothing or personal possessions, the facility shall have a discussion with the individual about why the individual's personal clothing or personal possessions are being restricted and document this in the clinical record.
- D. The individual may keep and use their cell phone, unless access to the cell phone causes the individual to destabilize or creates a danger to the individual's self or others, as determined by a provider, facility personnel, or security personnel involved in the individual's care. If a cell phone is restricted, the reason for this must be explained to the individual and documented in the clinical record.

1. An individual's rights may only be denied if access to the item, program, or service causes the individual to destabilize or creates a danger to the individual's self or others, as determined by a licensed provider involved in the individual's care or transportation. Denial of any right must be entered into the individual's treatment record or BHA-approved form, available on the BHA website. Information pertaining to a denial of rights contained in the individual's treatment record must be made available, upon request, to the individual, the individual's attorney, or the individual's lay person.
 - a. If an individual speaks sign language and their rights to their cell phone has been denied, when communicating outside the facility they must have access to communication devices that provide written/video/closed caption.
 2. Once the screening is completed and if the individual meets criteria, the intervening professional shall first pursue voluntary treatment and evaluation. If the individual refuses or the intervening professional has reasonable grounds to believe the individual will not remain voluntarily, the intervening professional may place the individual under an emergency mental health hold pursuant to Section 27-65-106, C.R.S.
- E. If the individual is placed on an emergency mental health hold, they must be advised of and provided with a copy of the associated individual rights as described in part 11.14.3 of this Chapter.

11.14 Procedures for Emergency Mental Health Holds

11.14.1 General Procedures

- A. This section 11.14 is meant to provide a summary of the obligations and standards set forth in Section 27-65-101 through -131, C.R.S., with regard to emergency mental health holds. This section is only enforceable with regard to designated facilities.
- B. An individual may be placed on an emergency mental health hold for seventy-two (72) hours pursuant to Section 27-65-106, C.R.S., if the individual has a mental health disorder and, as a result of the mental health disorder, is an imminent danger to the individual's self or others or is gravely disabled.
 1. The certified peace officer may take the individual into protective custody and transport the individual to a facility designated by the commissioner for an emergency mental health hold. If such a facility is not available, the certified peace officer may transport the individual to an emergency medical services facility. The certified peace officer may request assistance from a behavioral health crisis response team for assistance in de-escalating and preparing the individual for transportation, or an emergency medical services provider in transporting the individual; or,
 2. When an intervening professional reasonably believes that an individual appears to have a mental health disorder and, as a result of the mental health disorder, appears to be an imminent danger to the individual's self or others or appears to be gravely disabled, the intervening professional may cause the individual to be taken into protective custody and transported to a facility designated by the commissioner for an emergency mental health hold. If such a facility is not available, the certified peace officer may transport the individual to an emergency medical services facility. The intervening professional may request assistance from a certified peace officer, a secure transportation provider, or a behavioral health crisis response team for assistance in detaining and transporting the individual, or assistance from an emergency medical services provider in transporting the individual.

- C. The emergency mental health hold form, available on the BHA website, shall be completed by an intervening professional or certified peace officer and include the following:
 - 1. The circumstances under which the individual's condition was brought to the attention of the intervening professional or certified peace officer;
 - 2. A description of facts, either through direct observation by the intervening professional or peace officer or obtained from others believed to be reliable, establishing that the individual has a mental health disorder, and as a result of the mental health disorder, is an imminent danger to self or others, is gravely disabled, or is in need of immediate evaluation for treatment;
 - 3. Date/time the individual was placed on the emergency mental health hold; and
 - 4. Who brought the individual's condition to the attention of the intervening professional or certified peace officer.
- D. A copy of the emergency mental health hold form must be given to the individual who was placed on the emergency mental health hold.
- E. A copy of the emergency mental health hold form must be given to the facility and made part of the individual's record.
- F. Once the individual is receiving care and treatment in a designated involuntary short-term treatment facility, the individual shall receive treatment and care for the duration of their emergency mental health hold.
- G. The individual must be released before seventy-two hours have elapsed if, in the opinion of the professional person overseeing treatment, the individual no longer requires evaluation and treatment.
- H. At the expiration of the emergency mental health hold, the individual must be:
 - 1. Released;
 - 2. Referred for further care and treatment on a voluntary basis; or
 - 3. Certified for short-term treatment pursuant to Section 27-65-109, C.R.S.

11.14.2 Court Orders for Screening & Evaluation

- A. Pursuant to Section 27-65-106(1)(c), C.R.S., any individual may petition the court in the county in which the individual resides or is physically present requesting an evaluation of the individual's condition and alleging that the individual appears to have a mental health disorder and, as a result of the mental health disorder, appears to be a danger to the individual's self or others or appears to be gravely disabled.
- B. A court may order that an individual be taken into custody and placed in a designated facility for seventy-two (72) hour treatment and evaluation.
- C. Pursuant to Section 26-65-106(4)(a), C.R.S., the petition for a court-ordered evaluation must contain the following:
 - 1. Name and address of the petitioner, and the petitioner's interest in this case;

2. Name of the individual for whom evaluation is sought, and if known, the address, age, gender, marital status, occupation, and any animals or dependent children in the individual's care;
 3. Allegations of fact indicating the individual may have a mental health disorder and, as a result of the mental health disorder, is a danger to self or others or is gravely disabled;
 4. The name and address of every person responsible for the care, support, and maintenance of the individual, if available; and
 5. The name, address, and telephone number of the attorney, if any, who has most recently represented the individual. If there is not attorney, there shall be a statement as to whether, to the best knowledge of the petitioner, the individual meets criteria established by the legal aid agency operating in the county or city and county for it to represent the individual.
- D. Upon receipt of a petition, the court shall identify a facility designated by the commissioner, an intervening professional, or a certified peace officer to provide screening of the individual to determine whether probable cause exists to believe the allegations.
- E. Following the screening, the facility, intervening professional, or certified peace officer designated by the court shall file a report with the court and may initiate an emergency mental health hold at the time of screening. The report must include a recommendation as to whether probable cause exists to believe that the individual has a mental health disorder and is a danger to self or others or is gravely disabled. The report must also specify whether the individual will voluntarily receive evaluation or treatment.
- F. A copy of the confidential screening report must be provided to the individual and the individual's attorney or personal representative.
- G. If the court determines that the individual has a mental health disorder and is a danger to self or others or is gravely disabled, and efforts have failed to obtain cooperation from the individual to receive treatment voluntarily, the court must issue an order for a certified peace officer or secure transportation provider to take the individual into custody and transport the individual to a designated facility for seventy-two (72) hour evaluation and treatment.
1. At the time the individual is taken into custody, a copy of the petition and the order for evaluation must be given to the individual and promptly to the one lay person designated by the individual and to the person in charge of the facility named in the order or the individual's lay person designee. If the individual refuses to accept a copy of the petition and the order for evaluation, such refusal must be documented in the petition and the order for evaluation.
- H. When an individual is transported to an emergency medical services facility or a facility designated by the commissioner, the facility may detain the individual under an emergency mental health hold for evaluation for a period not to exceed seventy-two (72) hours from the time the emergency mental health hold was placed or ordered. Nothing in this section prohibits an emergency medical services facility from involuntarily holding the individual in order to stabilize the individual as required pursuant to the federal "Emergency Medical Treatment and Labor Act", 42 U.S.C. Sec. 1395dd, or if the treating professional determines that the individual's physical or mental health disorder impairs the individual's ability to make an informed decision to refuse care and the provider determines that further care is indicated.

1. If, in the opinion of the person in charge of the evaluation, the individual can be properly cared for without being detained, the individual shall be provided services on a voluntary basis.
 2. If the person in charge of the evaluation determines the individual should be released, the person in charge of the evaluation may terminate the emergency mental health hold.
- I. Each individual detained for an emergency mental health hold pursuant to part 11.14 of this Chapter, shall receive an evaluation as soon as possible after the individual is presented to the facility and shall receive such treatment and care as the individual's condition requires for the full period that the individual is held.
- J. The evaluation may include an assessment to determine if the individual continues to meet the criteria for an emergency mental health hold and requires further mental health care in a facility designated by the commissioner. The evaluation must state whether the individual should be:
1. Released;
 2. Referred for further care and treatment on a voluntary basis; or
 3. Certified for short-term treatment pursuant to Section 27-65-109, C.R.S.
- K. Each evaluation must be completed using a standardized form approved by the commissioner available on the BHA website (the elements from this form can be integrated into a facility's electronic health record system) and may be completed by a professional person; a licensed advanced practice registered nurse with training in psychiatric nursing; or a licensed physician assistant, a licensed clinical social worker, a licensed professional counselor, or a licensed marriage and family therapist who has two years of experience in behavioral health safety and risk assessment working in a health-care setting.
1. If the professional person conducting the evaluation does not hold two (2) years' experience, they may conduct the evaluation and a professional person that holds the required experience must review, provide clinical consultation as needed, and provide their signature to the evaluation.
- L. If the personnel conducting an evaluation pursuant to part 11.14 of this Chapter is not a professional person and the evaluating personnel recommends the detained individual be certified for short-term treatment pursuant to Section 27-65-109, C.R.S., the evaluating personnel shall notify the facility of the recommendation. A certification may only be initiated by a professional person.
- M. If an individual is evaluated at an emergency medical services facility and the evaluating professional determines that the individual continues to meet the criteria for an emergency mental health hold pursuant to part 11.14 of this Chapter, the emergency medical services facility shall immediately notify the BHA if the facility cannot locate appropriate placement. Once notified, the BHA shall support the emergency medical services facility in locating an appropriate placement option on an inpatient or outpatient basis, whichever is clinically appropriate.
- N. If an appropriate placement option cannot be located pursuant to this part 11.14.2.N and the individual continues to meet the criteria for an emergency mental health hold pursuant to part 11.14 of these rules and the individual has been medically stabilized, the emergency medical services facility may place the individual under a subsequent emergency mental health hold.

1. If the facility places the individual under a subsequent emergency mental health hold, the facility shall immediately notify the BHA, the individual's lay person, and the court, and the court shall immediately appoint an attorney to represent the individual.
 2. The facility may notify the court where the individual resides by mail.
 - a. Once the court is notified, the emergency medical services facility is not required to take any further action to provide the individual with an attorney unless specified in part 11.14.3 of this Chapter.
 3. The emergency medical services facility shall notify the BHA after each emergency mental health hold is placed.
 4. If the individual has been recently transferred from an emergency medical services facility to a facility designated by the commissioner and the designated facility is able to demonstrate that the facility is unable to complete the evaluation before the initial emergency mental health hold is set to expire, the designated facility may place the individual under a subsequent emergency mental health hold and shall immediately notify the BHA and lay person.
- O. The BHA shall maintain data on the characteristics of each individual placed on a subsequent emergency mental health hold pursuant to this part 11.14.2. The BHA may contract with facilities coordinating care or with providers serving within the safety net system developed pursuant to Section 27-63-105, C.R.S., to meet the requirements of this part 11.14.

11.14.3 Individual Rights for Emergency Mental Health Holds

- A. The following rights apply to anyone receiving evaluation, care, or treatment pursuant to Article 65 of Title 27, C.R.S. and must be explained to the individual and provided in written form:
1. Nothing in Article 65 of Title 27, C.R.S., limits the right of any individual to make a voluntary application at any time to any public or private facility or professional person for mental health services, including but not limited to evaluation, care, and/or treatment, either by direct application in-person or by referral from any other public or private facility or professional person.
 - a. Subject to Section 15-14-316(4), C.R.S., a ward, as defined in Section 15-14-102(15), C.R.S., may be admitted to a hospital or institutional care and treatment for a mental health disorder with the guardian's consent for as long as the ward agrees to such care and treatment. The guardian shall immediately notify in writing the court, that appointed the guardian, of the admission.
 - b. Medical and legal status of all voluntary individuals receiving treatment for mental health disorders in inpatient or custodial facilities must be reviewed at least once every six (6) months.
 - c. Voluntary individuals are afforded all rights and privileges customarily granted by hospitals to individuals they serve.

- d. Any individual receiving an evaluation or treatment pursuant to Article 65 of Title 27, C.R.S., is entitled to medical and psychiatric care and treatment, with regard to services listed in Section 27-65-101, C.R.S., and services listed in rules authorized by Section 27-66-102, C.R.S., suited to meet the individual's specific needs, delivered in such a way as to keep the individual in the least restrictive environment, and delivered in such a way as to include the opportunity for participation of family members in the individuals program of care and treatment when appropriate.
- 2. To be told the reason for the individual's detainment and the limitations of the individual's detainment, including a description of the individual's right to refuse medication, unless the individual requires emergency medications, and that the detainment does not mean all treatment during detainment is mandatory;
- 3. To request a change to voluntary status;
- 4. To be treated fairly, with respect and recognition of the individual's dignity and individuality, by all employees of the facility with whom the individual comes in contact;
- 5. To not be discriminated against on the basis of age, race, ethnicity, religion, culture, spoken language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity, or gender expression;
- 6. To retain and consult with an attorney at any time;
 - a. Except that, unless specified in this part 11.14.2.N of this Chapter, the facility is not required to retain an attorney on behalf of the individual but must allow the individual to contact an attorney;
- 7. To continue the practice of religion;
- 8. Within twenty-four (24) hours after the individual's request, to see and receive the services of a patient representative who has no direct or indirect clinical, administrative, or financial responsibility for the individual;
- 9. To have reasonable access to telephones or other communication devices and to make and to receive calls or communications in private;
 - a. Facility personnel shall not open, delay, intercept, read, or censor mail or other communications or use mail or other communications as a method to enforce compliance with facility personnel;
- 10. To wear the individual's own clothes, keep and use the individual's own personal possessions (including but not limited to personal medical devices and/or auxiliary aids), and keep and be allowed to spend a reasonable sum of the individual's own money.
 - a. A facility may temporarily restrict an individual's access to personal clothing or personal possessions, until a safety assessment is completed.
 - b. If the facility restricts an individual's access to personal clothing or personal possessions, the facility shall have a discussion with the individual about why the individual's personal clothing or personal possessions are being restricted.

- c. A licensed medical professional or a licensed mental health professional shall conduct a safety assessment as soon as possible. The licensed professional shall document in the individual's medical record the specific reasons why it is not safe for the individual to possess the individual's personal clothing or personal possessions.
 - d. The facility shall periodically conduct additional safety assessments to determine whether the individual may possess the individual's personal clothing or personal possessions, with the goal of restoring the individual's rights established pursuant to this section.
- 11. To have the individual's information and records disclosed to family members and a lay person pursuant to Section 27-65-123, C.R.S.;
- 12. To have the individual's treatment records remain confidential, except as required by law;
- 13. To not be fingerprinted, unless required by law;
- 14. To have appropriate access to adequate water, hygiene products, and food and to have the individual's nutritional needs met in a manner that is consistent with recognized dietary practices;
- 15. To have appropriate access to non-psychiatric medications necessary to maintain an individual's health, including but not limited to pain medications that may be controlled substances, as ordered and/or overseen by a physician or other authorized medical practitioner of record;
- 16. To keep and use the individual's cell phone, unless access to the cell phone causes the individual to destabilize or creates a danger to the individual's self or others, as determined by a provider, facility personnel member, or security personnel involved in the individual's care;
- 17. To not be photographed, except upon admission for identification and administrative purposes. Any photographs must be confidential and must not be released by the facility except pursuant to a court order. Nonmedical photographs must not be taken or used without appropriate consent or authorization;
- 18. To have personal privacy to the extent possible during the course of treatment;
- 19. To have frequent and convenient opportunities to meet with visitors in accordance with the facility's current visitor guidelines. Each individual may see the individual's attorney, clergyperson, or physician at any time;
- 20. An individual's rights may only be denied if the item, program, or service causes the individual to destabilize or creates a danger to the individual's self or others, as determined by a licensed provider involved in the individual's care. Denial of any right must in all cases be entered into the individual's treatment record. Information pertaining to a denial of rights contained in the individual's treatment record must be made available, upon request, to the individual, or the individual's attorney; and,
- 21. Any person receiving evaluation, care, or treatment pursuant to Article 65 of Title 27, C.R.S., must be given the opportunity to exercise the persons right to register and to vote in primary and general elections.

- a. The facility or facility providing evaluation, care, or treatment shall assist the individual, upon the individual's request, to obtain voter registration forms and mail ballots and to comply with any other prerequisite for voting.

11.14.4 Additional Considerations

- A. The facility shall develop written policies that include the procedures for managing individual funds or property that include at minimum:
 1. A written inventory of all personal belongings shall be conducted upon admission. This inventory shall be signed and reviewed by facility personnel and the individual and shall be maintained in the individual's clinical record.
 2. A process for storing all inventoried items in a secure location during the individual's stay in the facility.
 3. A process for returning all inventoried property to the individual upon discharge or sending the property with the individual if they are transferred to another facility for care and treatment. The individual and facility personnel shall sign the inventory form indicating that all items were returned or that all items were present in the bag for transport.
- B. For the purpose of Article 65 of Title 27, C.R.S., the treatment by prayer in the practice of religion of any church that teaches reliance on spiritual means alone for healing is considered a form of treatment.
- C. Any individual receiving an evaluation or treatment pursuant to Article 65 of Title 27, C.R.S., may petition the court pursuant to Section 13-45-102, C.R.S., for release to a less restrictive setting within or without a treating facility or release from a treating facility when adequate medical and psychiatric care and treatment are not administered;
 1. If at any time during an emergency mental health hold of an individual who is confined involuntarily the facility personnel requests the individual to sign in voluntarily and the individual elects to do so, the following advisement shall be given orally and in writing and an appropriate notation shall be made in the individual's medical record by the professional person or the professional person's designee (this does not apply to an individual on an emergency mental health hold in an emergency medical services facility):

"NOTICE

The decision to sign in voluntarily should be made by you alone and should be free from any force or pressure implied or otherwise. If you do not feel that you are able to make a truly voluntary decision, you may continue to be held at the hospital involuntarily. As an involuntary individual, you will have the right to protest your confinement and request a hearing before a judge."

11.14.5 Individual Rights for Receiving Individuals on Emergency Mental Health Holds

- A. Each person receiving evaluation, care, or treatment pursuant to any provision of Article 65 of Title 27, C.R.S., has the individual rights specified in part 11.14.3 of this Chapter and shall be provided with a written copy and advised of such rights by the facility.

- B. A facility may temporarily restrict an individual's access to personal clothing or personal possessions until a safety assessment is completed. If the facility restricts an individual's access to personal clothing or personal possessions, the facility shall have a discussion with the individual about why the individual's personal clothing or personal possessions are being restricted and document this in the chart.
- C. The individual may keep and use their cell phone, unless access to the cell phone causes the individual to destabilize or creates a danger to the individual's self or others, as determined by a provider, facility personnel member, or security personnel involved in the individual's care. If a cell phone is restricted, the reason for this must be explained to the individual and documented in the chart.
- D. An individual's rights may only be denied if access to the item, program, or service causes the individual to destabilize or creates a danger to the individual's self or others, as determined by a licensed provider involved in the individual's care or transportation. Denial of any right must be entered into the individual's treatment record or BHA-approved form available on the BHA website. Information pertaining to a denial of rights contained in the individual's treatment record must be made available, upon request, to the individual, the individual's attorney, or the individual's lay person.
 - 1. Once the screening is completed and if the individual continues to meet criteria for an emergency mental health hold, the intervening professional shall first pursue voluntary treatment and evaluation. If the individual refuses or the intervening professional has reasonable grounds to believe the individual will not remain voluntarily, the intervening professional may keep the individual under an emergency mental health hold pursuant to Section 27-65-106, C.R.S.

11.14.6 Procedures for Subsequent Emergency Mental Health Holds

- A. If the facility places the individual under a subsequent emergency mental health hold, the facility shall immediately notify the BHA, the individual's lay person, and the court, and the court shall immediately appoint an attorney to represent the individual. The facility may notify the court where the individual resides by mail.

11.14.7 Procedures for Individuals Who Meet Criteria for an Emergency Mental Health Hold but Require Inpatient Medical Treatment Prior to Placement

- A. If an individual meets criteria for an emergency mental health hold but requires medical treatment prior to being placed psychiatrically, they may receive treatment on a medical unit of the same hospital under the following conditions:
 - 1. Unless the medical unit is designated for 27-65 services by the BHA, the hospital must follow the hospital's policies and procedures for ensuring individual safety while receiving medical services.
 - 2. Reasonable efforts shall be made to ensure ligature risk is minimized in the individual's room on the medical unit; these efforts shall be documented in the individual's clinical record.

11.15 Additional Procedures for Minors

- A. This section 11.15 is meant to provide a summary of the obligations and standards set forth in Section 27-65-101 through -131, C.R.S., with regard to minors. This section is only enforceable with regard to designated facilities.

11.15.1 Consent and Rights of a Minor

- A. Notwithstanding any other provision of law, a minor who is fifteen (15) years of age or older, whether with or without the consent of a parent or legal guardian, may consent to receive mental health services to be rendered by a facility, a professional person, or mental health professional licensed pursuant to Parts 3, 4, 5, 6, or 8 of Article 245 of Title 12, C.R.S., in any practice setting.
 - 1. Such consent is not subject to disaffirmance because of age.
 - 2. The professional person or licensed mental health professional rendering mental health services to a minor may, with or without the consent of the minor, advise the minor's parent or legal guardian of the services given or needed.
- B. Any individual receiving evaluation or treatment pursuant to any of the provisions of Article 65 of Title 27, C.R.S., is entitled to a written copy of all the corresponding designated service individual's rights enumerated and a minor child shall receive written notice of the minor's rights as provided. The list of rights must be prominently posted in all evaluation and treatment facilities. Minor's rights include:
 - 1. To refuse to sign the admission consent form; and,
 - 2. To revoke consent of treatment at a later date;
 - a. If minor's consent is revoked after admission, a review of the minor's need for hospitalization must be initiated immediately
 - 3. Nothing in part 11.15 of these rules limits a minor's right to seek release from the facility pursuant to any other provision of law.
 - 4. Services shall be suited to meet the individual's needs, delivered in such a way as to keep the individual in the least restrictive environment, and delivered in such a way as to include the opportunity for participation of family members in the individual's program of care and treatment, when appropriate.

11.15.2 Hospitalization Treatment Procedures for Minors

- A. The following treatment procedures apply to any minor receiving evaluation, care, or treatment pursuant to Article 65 of Title 27, C.R.S. and must be explained to the individual and provided in written form:
 - 1. A minor who is fifteen (15) years of age or older or a minor's parent or legal guardian, on the minor's behalf, may make a voluntary application for hospitalization.
 - 2. An application for hospitalization on behalf of a minor who is under fifteen (15) years of age and who is a ward of the Department must not be made unless a guardian ad litem has been appointed for the minor or a petition for the same has been filed with the court by the facility having custody of the minor; except that such an application for hospitalization may be made under emergency circumstances requiring immediate hospitalization, in which case the facility shall file:
 - a. A petition for appointment of a guardian ad litem within seventy-two (72) hours after application for admission is made,
 - b. And the court shall immediately appoint a guardian ad litem.

- c. Procedures for hospitalization of a minor may proceed pursuant to this section once a petition for appointment of a guardian ad litem has been filed, if necessary.
- 3. Whenever an application for hospitalization is made, an independent professional person shall interview the minor and conduct a careful investigation into the minor's background, using all available sources, including, but not limited to, the minor's parents or legal guardian, the minor's school, and any other social service facilities.
- 4. Prior to admitting a minor for hospitalization, the independent professional person shall make the following findings:
 - a. That the minor has a mental health disorder and is in need of hospitalization;
 - b. That a less restrictive treatment alternative is inappropriate or unavailable; and,
 - c. That hospitalization is likely to be beneficial, improve condition and/or prevent further regression.
- 5. An interview and investigation by an independent professional person is not required for a minor who is fifteen (15) years of age or older and who, upon the recommendation of the minor's treatment professional person, seeks voluntary hospitalization with the consent of the minor's parent or legal guardian.
- 6. A need for voluntary continued hospitalization must be formally reviewed every two (2) months and must fulfill the requirements of Section 19-1-115(8), C.R.S., when the minor is fifteen (15) years of age or older and consenting to hospitalization.
 - a. Review must be conducted by an independent professional person who is not a member of the minor's treatment team; or if the minor, minor's physician, and the minor's parent or legal guardian do not object to the need for continued hospitalization, the review required may be conducted internally by hospital personnel.
 - b. The independent professional person shall determine whether the minor continues to meet the criteria specified in part 11.15.2.A.1 through part 11.15.2.A.4 of this Chapter and whether continued hospitalization is appropriate and shall, at a minimum, conduct an investigation pursuant to this part 11.15.2.A.1 through part 11.15.2.A.4 of these rules.
 - c. Ten (10) days prior to the review, the patient representative at the mental health facility shall notify the minor of the date of the review and shall assist the minor in articulating to the independent professional person the minor's wishes concerning continued hospitalization.
- 7. Every six (6) months the review required pursuant to part 11.15.2.A.6 of this Chapter of this section shall be conducted by an independent professional person who is not a member of the minor's treating team and who has not previously reviewed the minor pursuant to part 11.15.2.A.6 of this Chapter.

11.15.3 Objection to Hospitalization Process for Minors

- A. When a minor does not consent to or objects to continued hospitalization, the need for such continued hospitalization must, within ten (10) days, be reviewed pursuant to part 11.15.2.A.6 of this Chapter by an independent professional person who is not a member of the minor's treatment team and who has not previously reviewed the minor pursuant to part 11.15.3.A of this Chapter.
1. The minor shall be informed of the results of the review within three (3) days after the review's completion.
 - a. If the conclusion reached by the professional person is that the minor no longer meets the standards for hospitalization specified in part 11.15.2.A.1 through part 11.15.2.A.4 of this Chapter, the minor shall be discharged with clinically indicated discharge planning and notice to parent, guardian, or caregiver, as appropriate.
- B. If twenty-four (24) hours after being informed of the results of the review specified in part 11.15.3.A of this Chapter, a minor continues to affirm the objection to hospitalization, the facility director or the director's duly appointed representative shall advise the minor that the minor has the right to retain and consult with an attorney at any time and that the director or the director's duly appointed representative shall file, within three (3) days after the request of the minor, a statement requesting an attorney for the minor or, if the minor is under fifteen (15) years of age, a guardian ad litem. The minor, the minor's attorney (if any) and the minor's parent, legal guardian, or guardian ad litem (if any) shall be given written notice that a hearing upon the recommendation for continued hospitalization may be had before the court or a jury upon written request directed to the court pursuant to part 11.15.3.D of this Chapter.
- C. Whenever the statement requesting an attorney is filed with the court, the court shall ascertain whether the minor has retained an attorney, and, if the minor has not, the court shall, within three (3) days, appoint an attorney to represent the minor, or if the minor is under fifteen (15) years of age, a guardian ad litem. Upon receipt of a petition filed by the guardian ad litem, the court shall appoint an attorney to represent the minor under fifteen years of age.
- D. The minor or the minor's attorney or guardian ad litem may, at any time after the minor has continued to affirm the minor's objection to hospitalization pursuant to part 11.15.3.B of this Chapter, file a written request that the recommendation for continued hospitalization be reviewed by the court or that the treatment be on an outpatient basis. If review is requested, the court shall hear the matter within ten (10) days after the request, and the court shall give notice of the time and place of the hearing to the minor; the minor's attorney (if any), the minor's parents or legal guardian; the minor's guardian ad litem (if any), the independent professional person, and the minor's treatment team. The hearing must be held in accordance with Section 27-65-113, C.R.S.; except that the court or jury shall determine that the minor is in need of care and treatment if the court or jury makes the following findings:
1. That the minor has a mental health disorder and is in need of hospitalization;
 2. That a less restrictive treatment alternative is inappropriate or unavailable; and,
 3. That hospitalization is likely to be beneficial.
- E. At the conclusion of the hearing, the court may enter an order confirming the recommendation for continued hospitalization, discharge the minor, or enter any other appropriate order.
- F. A minor may not again object to hospitalization pursuant to this part 11.15.3 until ninety (90) days after conclusion of proceedings.

- G. In addition to the rights specified in Section 27-65-119, C.R.S. for individuals receiving evaluation, care, or treatment, a written notice specifying the rights of minor children under this section must be given to each minor upon admission to hospitalization.
- H. A minor who no longer meets the standards for hospitalization specified in this part 11.15 must be discharged.

11.16 Involuntary Short-Term and Long-Term Care and Treatment Designation (Inpatient Services)

11.16.1 Applicability

- A. The involuntary short-term and long-term care and treatment designation allows facilities to provide care and treatment to individuals on involuntary mental health holds, short-term certifications, and long-term certifications on an inpatient basis.
- B. Facilities designated for involuntary short-term and long-term services must be in compliance with the following rules:
 - 1. Parts 2.7 through 2.13 and parts 2.23 through 2.25 of these rules with the following exception:
 - a. Part 2.7.A.3 of these rules
 - 2. Parts 11.1 through 11.15 and 11.16 of this Chapter.
- C. Facilities that may become designated to provide involuntary short-term and long-term care and treatment include acute treatment units (ATU), crisis stabilization units (CSU), residential child care facilities, and hospitals. ATUs must become designated to meet the requirements of their service endorsement.
- D. This section 11.16 is meant, in part, to provide a summary of the obligations and standards set forth in Section 27-65-101 through -131, C.R.S., with regard to involuntary short-term care and treatment. This section is only enforceable with regard to designated facilities.

11.16.2 Procedures for Emergency Mental Health Holds

- A. With every emergency mental health hold and petition to court for involuntary treatment resulting in a change of legal status, the facility shall advise an individual of their rights set forth in part 11.16.5 of this Chapter, and there shall be evidence of such advisement in the individual's clinical record.
- B. Procedures for emergency mental health holds may be found in part 11.14 of this Chapter.

11.16.3 Procedures for Short-Term Certifications on an Inpatient Basis

- A. An individual may be certified for not more than three (3) months for short-term treatment under the following conditions:
 - 1. The professional personnel of the facility detaining the individual on an emergency mental health hold has evaluated the individual and has found that the individual has a mental health disorder and, as a result of the mental health disorder, is a danger to the individual's self or others or is gravely disabled;

2. The individual has been advised of the availability of, but has not accepted, voluntary treatment; but, if reasonable grounds exist to believe that the individual will not remain in a voluntary treatment program, the individual's acceptance of voluntary treatment does not preclude certification;
 3. The facility or community provider that will provide short-term treatment has been designated by the commissioner to provide such treatment; and,
 4. The individual, the individual's legal guardian, and the individual's lay person, if applicable, have been advised of the individual's right to an attorney and right to contest the certification for short-term treatment. [effective July 1, 2024]
- B. The facility is responsible for ensuring the individual receive all court paperwork (or ensuring the attorney has provided it).
- C. The facility or court shall ask the individual to designate a lay person whom the individual wishes to be informed regarding certification. If the individual is incapable of making such a designation at the time the certification is delivered, the individual must be asked to designate a lay person as soon as the individual is capable.
- D. In addition to the certification, the individual must be given a written notice that a hearing upon the individual's certification for short-term treatment may be had before the court or a jury upon written request directed to the court pursuant to Section 27-65-109(6), C.R.S.
- E. The notice of certification must be signed by a professional person who participated in the evaluation. The notice of certification must:
1. State facts sufficient to establish reasonable grounds to believe that the individual has a mental health disorder and, as a result of the mental health disorder, is a danger to the individual's self or others or is gravely disabled;
 2. Be filed with the court within forty-eight (48) hours, excluding Saturdays, Sundays, and court holidays, after the date of the certification;
 3. Be filed with the court in the county in which the individual resided or was physically present immediately prior to being taken into custody;
 4. Provide recommendations if the certification should take place on an inpatient or outpatient basis [effective July 1, 2024]; and
 5. Within twenty-four (24) hours after the date of certification, copies of the certification must be personally delivered from the evaluating facility to the individual, the BHA, and a copy must be kept by the evaluating facility as part of the individual's record, if applicable.
- F. Upon certification of the individual, the facility designated for short-term treatment has custody of the individual.
- G. The individual or the individual's attorney may at any time file a written request that the certification for short-term treatment or the treatment be reviewed by the court or that the treatment be on an outpatient basis.
1. If the individual requests the review, the court shall hear the matter within ten (10) days after the request, and the court shall give notice to the individual and the individual's attorney and the certifying and treating professional person of the time and place of the hearing.

2. The hearing must be held in accordance with Section 27-65-113, C.R.S.
 3. At the conclusion of the hearing, the court may enter or confirm the certification for short-term treatment, discharge the individual, or enter any other appropriate order.
 - a. Upon the release of any individual in accordance with Section 27-65-112, C.R.S., the facility shall notify the clerk of the court within five (5) days after the release.
 4. If the professional person in charge of the evaluation and treatment believes that a period longer than three (3) months is necessary to treat the individual, the professional person shall file with the court an extended certification at least thirty (30) days prior to the expiration date of the original certification.
 5. An extended certification for treatment must not be for a period of more than three (3) months.
 6. The individual is entitled to a hearing on the extended certification under the same conditions as an original certification. The attorney initially representing the individual shall continue to represent the individual unless the court appoints another attorney.
- H. An individual certified for short-term treatment may be discharged upon the signature of the treating medical professional and the medical director of the facility.
- I. A facility or program shall make the individual's discharge instructions available to the individual, the individual's attorney, and the individual's legal guardian, if applicable, within seven (7) days after discharge, if requested.
1. A facility or program that is transferring an individual to a different treatment facility or to an outpatient provider shall provide all treatment records to the facility or provider accepting the individual at least twenty-four (24) hours prior to the transfer.

11.16.4 Procedures for Long-Term Certifications on an Inpatient Basis

- A. The facility is responsible for ensuring the individual receives all court paperwork (or ensuring the attorney has provided it).
- B. Whenever an individual has received an extended certification for treatment pursuant to Section 27-65-109(10), C.R.S., the professional person in charge of the certification for short-term treatment or the BHA may file a petition with the court at least thirty (30) days prior to the expiration date of the extended certification for long-term care and treatment of the individual under the following conditions:
1. The professional personnel of the facility or facility providing short-term treatment has analyzed the individual's condition and has found that the individual has a mental health disorder and, as a result of the mental health disorder, is a danger to the individual's self or others or is gravely disabled;
 2. The individual has been advised of the availability of, but has not accepted, voluntary treatment; but, if reasonable grounds exist to believe that the individual will not remain in a voluntary treatment program, the individual's acceptance of voluntary treatment does not preclude an order pursuant to this section; and
 3. The facility that will provide long-term care and treatment has been designated by the commissioner to provide the care and treatment.

- C. Every petition for long-term care and treatment must include a request for a hearing before the court filed thirty (30) calendar days prior to the expiration of six (6) months after the date of original certification and provide a recommendation as to whether the certification for long-term care and treatment should take place on an inpatient or outpatient basis.
 - 1. A copy of the petition must be delivered personally to the individual for whom long-term care and treatment is sought and electronically delivered to the individual's attorney of record simultaneously with the filing.
- D. Within ten (10) days after receipt of the petition, the individual or the individual's attorney may request a hearing before the court or a jury trial by filing a written request with the court.
- E. The court or jury shall determine whether the conditions of this part 11.16.4, are met and whether the individual has a mental health disorder and, as a result of the mental health disorder, is a danger to the individual's self or others or is gravely disabled.
- F. The court shall issue an order of long-term care and treatment for a term not to exceed six (6) months, discharge the individual for whom long-term care and treatment was sought, or enter any other appropriate order.
- G. An order for long-term care and treatment must grant physical custody of the individual to the BHA for placement with a facility or facility designated by the commissioner to provide long-term care and treatment. The BHA may delegate the physical custody of the individual to a facility designated by the commissioner and the requirement for the provision of services and care coordination.
- H. When a petition contains a request that a specific legal disability be imposed or that a specific legal right be deprived, the court may order the disability imposed or the right deprived if the court or a jury has determined that the individual has a mental health disorder or is gravely disabled and that, as a result, the individual is unable to competently exercise the specific legal right or perform the function for which the disability is sought to be imposed.
 - 1. Any interested person may ask leave of the court to intervene as a co petitioner for the purpose of seeking the imposition of a legal disability or the deprivation of a legal right.
- I. An original order of long-term care and treatment or any extension of such order expires on the date specified, unless further extended as provided in this part 11.16.4.
- J. If an extension is being sought, the professional person in charge of the evaluation and treatment shall certify to the court at least thirty (30) days prior to the expiration date of the order in force that an extension of the order is necessary for the care and treatment of the individual subject to the order in force, and a copy of the certification must be simultaneously delivered to the individual and electronically delivered to the individual's attorney of record.
 - 1. At least twenty (20) days before the expiration of the order, the court shall give written notice to the individual and the individual's attorney of record that a hearing upon the extension may be had before the court or a jury upon written request to the court within ten (10) days after receipt of the notice.
 - 2. If a hearing is not requested by the individual within such time, the court may proceed ex parte.
 - 3. If a hearing is timely requested, the hearing must be held before the expiration date of the order in force.

4. If the court or jury finds that the conditions of this part 11.16 continue to be met and that the individual has a mental health disorder and, as a result of the mental health disorder, is a danger to others or to the individual's self or is gravely disabled, the court shall issue an extension of the order.
 5. Any extension must not exceed six (6) months, but there may be as many extensions as the court orders pursuant to this section.
- K. An individual certified for long-term care and treatment may be discharged from the facility upon the signature of the treating professional person and medical director of the facility, and the facility shall notify the BHA prior to the individual's discharge.
1. The facility shall make the individual's discharge instructions available to the individual, the individual's attorney, the individual's lay person, and the individual's legal guardian, if applicable, within one (1) week after discharge, if requested.
- L. A facility that is transferring an individual to a different facility or to an outpatient program shall provide all treatment records to the facility or provider accepting the individual at least twenty-four (24) hours prior to the transfer.

11.16.5 Individual Rights for Short-Term and Long-Term Care Treatment

- A. The facility shall furnish all persons receiving evaluation, care, or treatment under any provisions of Article 65 of Title 27, C.R.S., with a written copy of the rights listed under part 11.14.3 of this Chapter (translated into a language or modality accessible that the individual understands if feasible) upon admission. If the individual is not able to read the rights, the individual shall be read the rights in a language that the individual understands, if feasible, or provided access to a modality to assist in understanding. Minors must receive a separate written notice of individual rights as outlined in Section 27-65-104, C.R.S.
- B. The facility shall post the following list of rights (in the predominant languages of the community in which it operates and explained, if feasible, in a language or modality accessible to the individual) in prominent places frequented by individuals and their families receiving services and the facility shall assist the individual in exercising the below rights, in addition to the rights found in part 11.14.3 of this Chapter:
1. To meet with or call a personal clinician, spiritual advisor, counselor, crisis hotline, family member, workplace, childcare provider, or school at all reasonable times;
 2. To receive and send sealed correspondence, as well as to be given the assistance of facility personnel if the individual is unable to write, prepare, or mail correspondence. Facility personnel shall not open, delay, intercept, read, or censor mail or other communications or use mail or other communications as a method to enforce compliance with facility personnel;
 - a. To have access to letter-writing materials, including postage, and to have personnel members of the facility assist the individual if the individual is unable to write, prepare, and mail correspondence;
 3. To have the individual's behavioral health orders for scope of treatment or psychiatric advance directive reviewed and considered by the court as the preferred treatment option for involuntary administration of medications unless, by clear and convincing evidence, the individual's directive does not qualify as effective participation in behavioral health decision making;

4. To have frequent and convenient opportunities to meet with visitors and to see the individual's attorney, clergyperson, or physician at any time;
 - a. The facility may not deny visits by the individual's attorney, religious representative or physician at any reasonable time.
 - b. The facility will provide privacy to maintain confidentiality of communication between an individual and spouse or significant other, family member(s), personnel, attorney, physician, certified public accountant and religious representative, except that if disclosure is required by law, then such privacy may be terminated;
 5. To have personal privacy to the extent possible during the course of treatment; and,
 6. To have access to a representative within the facility who provides assistance to file a grievance.
 7. An individual may be photographed upon admission for identification and the administrative purposes of the facility. The photographs are confidential and must not be released by the facility except pursuant to court order.
 - a. Nonmedical photographs shall not be taken or used without appropriate consent or authorization.
- C. Facilities providing care and treatment to minors shall post the minor's rights information of section 11.15.1, in addition to the following list of rights (in languages and modality appropriate for understanding) in prominent places frequented by individuals and their families receiving services.

11.16.6 Individual Rights Restrictions for Short-Term and Long-Term Care Treatment

- A. As set forth in Section 27-65-119, C.R.S., an individual's statutory rights, and rights listed in parts 11.14.3 and 11.16.5 of this Chapter, may be limited or denied if access to the right would endanger the safety of the individual or another person in close proximity and may only be denied by a person involved in the individual's care.
 1. A person involved in the individual's care means a person that is either providing care directly to the individual or directing the care of the individual."
- B. Any individual whose rights are denied or violated pursuant to this section has the right to file a complaint against the facility with the BHA and the Department of Public Health and Environment.
- C. Except as otherwise provided in part 11.16.6.A of this Chapter, each denial of an individual's right shall be made on a case-by-case basis and the reason for denying the right shall be documented in the individual record and shall be made available, upon request, to the individual, the individual's legal guardian, or the individual's attorney.
- D. Except as otherwise provided in part 11.16.6.A of this Chapter, restrictions on rights in parts 11.14.3.A.9, 11.14.3.A.10, 11.14.3.A.15, 11.14.3.A.17, and 11.14.3.A.19 and part 11.16.5.B.1 of this Chapter, shall be evaluated for therapeutic necessity on an ongoing basis and the rationale for continuing the restriction shall be documented at least every seven (7) calendar days.

- E. A facility shall not intentionally retaliate or discriminate against a person or employee for contacting or providing information to any official or to an employee or any state protection and advocacy facility, or for initiating, participating in, or testifying in a grievance procedure or in an action for any remedy authorized pursuant to this this section.
1. Under Section 27-65-119(6), C.R.S., any facility that violates this commits an unclassified misdemeanor and shall be fined not more than one thousand dollars.

11.16.7 Individual Rights Restrictions in Secure Treatment Facilities

- A. A facility, through a professional person treating individuals in a secure treatment setting may limit or deny rights listed in this Chapter for good cause based upon the safety and security needs of the personnel and other individuals in the facility. Safety and security policies applicable to the unit shall be incorporated into the individual's service plan. The following procedures shall be adhered to:
1. The BHA shall approve of safety and security policies for each facility unit that places any limit on the rights set forth in part 11.16 of this Chapter, as well as the policy and criteria for placement of an individual committed under Article 65 of Title 27, C.R.S., in secure treatment facilities.
 2. The safety and security policies for each facility unit shall be posted in the unit. The secure facility personnel shall provide a copy of the unit policy upon an individual's request.
 3. Any good cause restriction of rights based upon the safety and security policy of the facility unit shall be noted in the individual's record. The order for restriction shall be signed by the professional person providing care and treatment and shall be reviewed at least every thirty (30) days.
 4. No safety or security policy may limit an individual's ability to send or receive sealed correspondence. However, to prevent the introduction of contraband into the secure treatment facility, the policy may require that the individual open the correspondence in the presence of unit personnel.
 5. No safety or security policy may limit an individual's right to see their attorney, clergy, or physician at reasonable times. However, the safety and security policy may provide that advance notice be given to the secure treatment facility for such visits so that the secure facility can adequately personnel for the private visit and take any measures necessary to ensure the safety of the visit.
 6. For the purposes of this rule, placement of individuals in secure treatment facilities on units that are locked at night:
 - a. Individuals transferred to a secure treatment facility from the Department of Corrections, who are serving sentences in the Department of Corrections, may be placed on units in which the bedroom doors are locked during sleeping hours.
 - b. Individuals who are newly admitted to a secure treatment facility may be placed on units in which the bedroom doors are locked during sleeping hours, for a time period not to exceed sixty (60) calendar days. After sixty (60) calendar days, these individuals will not be placed on a unit with locked doors during sleeping hours unless an individualized assessment is made, and the treatment team determines that the individual is imminently dangerous to self or to others; this must be documented in the individual's record.

- c. Sleeping hours shall begin no earlier than 9:00 p.m., end no later than 8:00 a.m., and shall not exceed 8-1/2 hours.
- d. Individuals shall be provided an effective means of calling for assistance when in a locked room during sleeping hours. The secure treatment facility shall provide personnel to promptly assist an individual with their individual needs including, but not limited to, personnel assigned to a day hall where personnel will be able to hear and respond to individuals who knock on their room doors. An intercom call system may also be used. Personnel shall monitor each individual's well-being through visual observation checks every fifteen (15) minutes.
- e. As set forth in Section 27-65-127, C.R.S., an individual's rights may be limited or denied under court order by an imposition of legal disability or deprivation of a right.
- f. Information pertaining to the denial of any right shall be made available, upon request, to the individual or their attorney.

11.16.8 Admissions Requirements & Disclosures

- A. The facility shall develop written admission criteria based on the facility's ability to meet the individual's needs. Admission criteria shall be based upon a comprehensive assessment of the individual's mental health, physical health, substance use, and capacity for self-care. The assessment shall determine the level of intervention and supervision required, including medication management, behavioral health services and stabilization prior to return to the community.
- B. Acute treatment units shall not admit individuals with a mental health disorder into a locked setting unless there is no less restrictive alternative and unless they are otherwise in compliance with the requirements of Article 65 of Title 27, Colorado Revised Statutes.
- C. Individuals may be admitted to a locked setting as a voluntary or involuntary individual. If voluntary, the individual shall sign a form that documents the following information:
 - 1. The individual is aware that the facility is locked.
 - 2. The individual may exit the facility with personnel assistance and/or permission.
 - 3. The individual may leave the facility at any point in time, unless they present as a danger to self or others, or is gravely disabled as defined in Section 27-65-102(17), C.R.S.
 - 4. An individual who is imminently suicidal or homicidal shall only be admitted to the locked facility, upon completion of the facility's assessment and the facility's determination that the individual's safety and the safety of others can be maintained by the facility. If an individual is admitted and facility personnel determine that their behavior cannot be safely and successfully treated at the ATU, then personnel shall make arrangements to transfer the individual to the nearest hospital for further assessment and disposition.
- D. A facility shall not admit or keep any individual who meets the following exclusion criteria:
 - 1. Is consistently incontinent unless the individual or personnel is capable of preventing such incontinence from becoming a health hazard.
 - 2. Is under the age of eighteen (18) unless the facility has a separate locked unit dedicated to minors.

3. Is bedridden with limited potential for improvement.
 4. Has a communicable disease or infection that is:
 - a. Reportable under the Department of Public Health and Environment's regulations (6 CCR 1009-1 (6/14/2023) and 6 CCR 1009-2 (05/15/2023)) which are hereby incorporated by reference. No later editions or amendments are incorporated. The rules are available at no cost from the Colorado Secretary of State at <https://www.sos.state.co.us>. Individuals may inspect a copy at the Behavioral Health Administration, 710 S. Ash Street, Unit C140, Denver, CO 80246, during regular business hours); and
 - b. Potentially transmittable in a facility unless the individual is receiving medical or drug treatment for the condition and the admission is approved by a physician.
 5. Has acute withdrawal symptoms, is at risk of withdrawal symptoms, or is incapacitated due to a substance use disorder and facility does not have appropriate capacity/endorsements to address issues of withdrawal.
- E. The facility shall maintain a current list of individuals and their assigned room.

11.16.9 Required Disclosures to Individuals Upon Admission

- A. There shall be written evidence of consent to treat, and the following upon admission to the individual or individual's legal representative, as appropriate. Acknowledgements shall specify the understanding between the parties regarding, at a minimum:
1. Charges;
 2. Services included in the rates and charges;
 3. Types of services provided by the facility, those services which are not provided, and those which the facility will assist the individual in obtaining;
 4. Transportation services;
 5. Therapeutic diets;
 6. A physically safe and sanitary environment;
 7. Personal services;
 8. Protective oversight;
 9. Presence and purpose of any video monitoring;
 10. Social and recreational activities;
 11. A provision that the facility must give individuals thirty (30) calendar days' notice of closure;
 12. Management of personal funds and property;
 13. Facility rules, established pursuant to part 11.16.11 of this Chapter;

14. Staffing levels based on individual needs; and
15. Types of daily activities, including examples of such activities that will be provided.

11.16.10 Environment and Safety

- A. All individuals being treated under these regulations shall receive such treatment in a clean and safe environment with opportunities for privacy.
- B. A facility shall only place an individual in a bedroom with video monitoring due to good cause and safety or security reasons which must be noted in the individual record. Individuals shall be notified in writing when placed in bedrooms with video monitoring capabilities.
- C. Each facility shall maintain reasonable security capabilities to guard against the risk of unauthorized departures. The least restrictive method to prevent an unauthorized departure shall be used.
- D. An unlocked facility may place an individual in seclusion to prevent an unauthorized departure when such departure carries an imminent risk of danger for the individual or for others. Under those circumstances, the seclusion procedures in part 11.9 of these rules shall be followed.

11.16.11 Facility rules

- A. The facility shall establish written policies, which shall list all possible actions that may be taken by the facility if any policy is knowingly violated by an individual. Facility policies may not violate or contravene any rule herein, or in any way discourage or hinder an individual's rights.
- B. The facility shall prominently post its policies in writing, which shall be available at all times to individuals. Such policies shall address at least the following:
 1. Smoking;
 2. Cooking;
 3. Visitors;
 4. Telephone usage including frequency and duration of calls;
 5. Use of common areas, including the use of television, radio;
 6. Consumption of alcohol and/or illicit drugs;
 7. Dress; and
 8. Pets, which shall not be allowed in the facility; however, in no event shall such rules prohibit service or guide animals.

11.16.12 Employment of Individuals Receiving Services in 27-65 Designated Facilities

- A. All labor, employment or jobs involving facility operation and maintenance which are of an economic benefit to the facility, shall be treated as work and shall be compensated according to applicable minimum wage or prevailing wage rates.

- B. Maintaining a minimum standard of cleanliness and personal hygiene and personal housekeeping, such as making one's bed or cleaning one's area, shall not be treated as work and shall not be compensated.
- C. Individuals shall not be forced in any way to perform work.
- D. Privileges or release from a designated facility shall not be conditioned upon the performance of work.
- E. Vocational programs and training programs must comply with all applicable federal and state laws.
- F. Vocational programs are not subject to the provisions in part 11.16.12.A of this section unless the program is of economic benefit to the facility.
- G. All work assignments, together with a specific consent form, and the hourly compensation received, shall be noted in the individual's record.

11.16.13 Medical/Dental Care

- A. The facility shall ensure the availability of emergency medical and dental care to meet the individual needs of each individual. The obligation to ensure the availability of emergency medical services shall not be construed as the obligation to pay for such services; however, the facility shall secure these services regardless of source of payment. The facility shall have and adhere to a written plan for providing emergency medical and dental care to include at least:
 - 1. A qualified licensed independent practitioner responsible for the completion of physical examinations within twenty-four (24) hours of admission. Subsequent physical examinations shall be completed at least annually, and as frequently as needed. This information shall be included in the clinical record.
 - a. If the individual refuses to complete a physical examination, documentation must be held in the clinical record of facility efforts.
 - 2. The availability of a qualified licensed independent practitioner or emergency medical facility on a twenty-four (24) hour, seven (7) days a week basis.
 - 3. Emergency medical or dental treatment, when indicated, shall be accessed immediately upon determination that an emergency exists.
 - 4. Whenever indicated, an individual shall be referred to an appropriate specialist for either further assessment or treatment. The facility shall be responsible for securing an appropriate assessment to determine the need for further specialty consultation. This information shall be contained in the clinical record.
- B. Each designated facility must maintain a facility placement agreement with one or more medical hospitals pursuant to part 11.12 of this Chapter.
- C. If an individual on an emergency mental health hold or certification requires inpatient medical care at a hospital, the designated facility shall be responsible for the care and treatment provided by the medical hospital per part 11.12 of this Chapter.

- D. The designated facility shall communicate with the hospital upon the individual being admitted to the medical unit regarding the individual's psychiatric treatment needs, safety considerations, and managing ligature risk while the individual is hospitalized medically consistent with state and federal law.

11.16.14 Physical Health Assessment Policy

- A. The facility shall develop policies and procedures that identify when a physical health assessment by a qualified licensed independent practitioner will be required, including the following indicators:
 - 1. Within twenty-four (24) hours of admission;
 - 2. A significant change in the individual's condition;
 - 3. Evidence of possible infection (open sores, etc.);
 - 4. Injury or accident sustained by the individual that might cause a change in the individual's condition;
 - 5. Known exposure of the individual to a communicable disease; or
 - 6. Development of any condition that would have initially precluded admission to the facility.

11.16.15 Medication Storage, Disposition, and Disposal

- A. All personal medication must be surrendered to the facility to be logged in and stored by the facility. Individuals are not allowed to self-administer medication in the facility.
- B. Personal medication shall be returned to the individual or individual's legal representative, upon discharge or death, except that return of medication to the individual may be withheld if specified in the individual's service if a physician or other authorized medical practitioner has determined that the individual lacks the decisional capacity to possess or administer such medication safely.
- C. Medications shall be labeled with the individual's full name, pursuant to Article 280 of Title 12, C.R.S.
- D. Any medication container that has a detached, excessively soiled, or damaged label shall be returned to the issuing pharmacy for re-labeling or disposed of appropriately.
- E. All medication shall be stored in a manner that ensures the safety of all individuals.
- F. Medication shall be stored in a central location, including refrigerators, and shall be kept under lock and shall be stored in separate or compartmentalized packages, containers, or shelves for each individual in order to prevent intermingling of medication.
- G. Individuals shall not have access to medication that is kept in a central location.
- H. Medications that require refrigeration shall be stored separately in locked containers in the refrigerator. If medication is stored in a refrigerator dedicated to that purpose, and the refrigerator is in a locked room, then the medications do not need to be stored in locked containers.
- I. Prescription and over the counter medication shall not be kept in stock or bulk quantities unless such medication is administered by a licensed medical practitioner.
- J. Medication disposal procedures include:

1. The return of medication shall be documented by the facility.
2. Medication that has a specific expiration date shall not be administered after that date and shall be disposed of appropriately.

11.16.16 Medication Administration

- A. The facility must ensure that medications are administered only by licensed or certified personnel allowed to administer medications under their own scopes of practice, or an unlicensed personnel who are qualified medication administration persons (QMAPs) acting within their own scope of practice.
- B. When using QMAPs to administer medication, the facility shall ensure compliance with 6 CCR 1011-1 Chapter 24 (July 19, 2017), which is hereby incorporated by reference. No later editions or amendments are incorporated. The rule is available at no cost from the Colorado Secretary of State at <https://www.sos.state.co.us>. Individuals may inspect a copy at the Behavioral Health Administration, 710 S. Ash Street, Unit C140, Denver, CO 80246, during regular business hours.
- C. Facilities shall follow psychiatric medication standards as outlined in part 11.8.2 of this Chapter and the following:
 1. Only a licensed nurse may accept telephone orders for medication from a physician or other authorized practitioner. All telephone orders shall be evidenced by a written and signed order and documented in the individual's record and the facility's medication administration record.
 2. These rules apply to medications and treatment which do not conflict with state law and regulations pertaining to acute treatment units and which are within the scope of services provided by the facility, as outlined in the individual agreement or the facility rules.
 3. The facility shall be responsible for complying with professional person or advanced practice registered nurse orders associated with the administration of medication or treatment. The facility shall implement a system that obtains clarification from the physician, as necessary and documents that the physician:
 - a. Has been asked whether refusal of the medication or treatment should result in physician notification.
 - b. Has been notified, where such notification is appropriate.
 - c. Has provided documentation of such notification shall be made in the individual's clinical record.
 - d. Coordinates with external providers or accepts responsibility to perform the care using facility personnel.
 - e. Trains personnel regarding the parameters of the ordered care as appropriate.
 - f. Documents the delivery of the care, including refusal by the individual, of the medication or treatment.

11.16.17 Administration of Oxygen

- A. Individuals may administer oxygen, if the individual is able to manage the administration themselves and personnel shall assist with the administration as needed for safety, when prescribed by a physician and if the facility follows appropriate safety requirements regarding oxygen herein.
- B. Oxygen tanks shall be secured upright at all times to prevent falling over and secured in a manner to prevent tanks from being dropped or from striking violently against each other.
- C. Tank valves shall be closed except when in use.
- D. Transferring oxygen from one container to another shall be conducted in a well-ventilated room with the door shut. Transfer shall be conducted by trained personnel or by the individual for whom the oxygen is being transferred, if the individual is capable of performing this task safely. When the transfer is being conducted, no person, except for a person conducting such transfer, shall be present in the room.
- E. Tanks and other oxygen containers shall not be exposed to electrical sparks, cigarettes, or open flames.
- F. Tanks shall not be placed against electrical panels or live electrical cords where the cylinder can become part of an electric circuit.
- G. Tanks shall not be rolled on their side or dragged.
- H. Smoking shall be prohibited in rooms where oxygen is used or stored. Rooms in which oxygen is used shall be posted with a conspicuous "no smoking" sign.
- I. Tanks shall not be stored near radiators or other heat sources. If stored outdoors, tanks shall be protected from weather extremes and damp ground to prevent corrosion.

11.16.18 Serious Illness, Serious Injury, or Death

- A. Facility policy shall describe the procedures to be followed by the facility in the event of serious illness, serious injury, or death of individuals receiving services, including incident reporting requirements.
- B. The policy shall include a requirement that the facility notify an emergency contact, if one has been provided, when the individual's injury or illness warrants medical treatment or face-to-face medical evaluation. In the case of an emergency room visit or unscheduled hospitalization, a facility must notify an emergency contact immediately.

11.16.19 Service Provisions for Short-Term and Long-Term Care Treatment

- A. Facilities providing short-term and long-term care treatment shall have detailed policies and procedures specific to therapeutic programming provided to individuals while in the facility's care.
- B. Programming shall be trauma-informed, person-centered, and appropriate for the individual's diagnosis.
- C. Programming shall be documented in the individual's treatment plan.
- D. Programming shall be facilitated by appropriate personnel for the type of therapeutic treatment provided.

E. Programming can include the following, but is not limited to:

1. Intensive case management;
2. Assertive community treatment;
3. Peer recovery support services;
4. Individual therapy;
5. Group therapy;
6. Therapeutic activities;
7. Educational and vocational training or activities;
8. Housing and transportation assistance; and/or
9. Transitional assistance.

11.16.20 Content of Records

A. Records shall be kept in conformity with part 2.11 of these rules, applicable federal and state laws, and the following:

1. Demographic and medical information;
2. A cover sheet to contain the following information;
 - a. Individual's full name, including maiden name if applicable;
 - b. Individual's sex, date of birth, gender identity, marital status and social security number, where needed for Medicaid or employment purposes;
 - c. Individual's current address of residence;
 - d. Date of admission;
 - e. Name, address and telephone number of relatives or legal representative(s), or other person(s) to be notified in an emergency;
 - f. Name, address and telephone number of individual's primary physician, and case manager if applicable, and an indication of religious preference, if any, for use in emergency;
 - g. Individual's diagnoses, at the time of admission;
 - h. Current record of the individual's allergies;
3. Medication administration record; and
4. Physician's orders.

B. Initial and comprehensive assessments shall comply with the requirements of parts 2.12.2 and 2.12.3 of these rules and must be completed within twenty-four (24) hours of admission.

- C. Service plans shall comply with the requirements of part 2.13.1 of these rules, and the following:
1. The service plan shall contain specific criteria required for discharge from treatment or to progress to less restrictive treatment alternatives.
 2. If an individual is discharged during an emergency mental health hold without certification by the facility, and a service plan has not been completed, then pertinent information shall be included in the discharge summary.
 3. A physician or other legal prescriber shall be responsible for the component of the plan requiring medication management services.
 4. For individuals certified to short-term or long-term treatment, the service plan shall be reviewed, and revised, if necessary, at least monthly by the personnel responsible for the plan, the treating professional person, any additional personnel involved in care as the facility determines is necessary for the review, the individual, and the legal guardian. This review shall be documented in the record and include progress toward meeting the criteria for termination of treatment and the need for continued involuntary treatment if the individual is certified. If the monthly review is delayed, the reason for such delay shall be noted in the record and the review shall be completed as promptly as possible.
- D. Treatment progress notes shall include the following:
1. Documentation of all treatment procedures including, but not limited to: brief physical restraint, seclusion, mechanical restraint, medications voluntary and involuntary, and other therapies or interventions.
 2. Information regarding the serious injury of or by the individual and the circumstances and outcome.
 3. Documentation of all transfers, whether permanent or temporary, and reasons for transfer.
 4. Legal status and all legal documents related to treatment under Section 27-65-101 through -131, C.R.S.
 5. Consultations and/or case reviews.
 6. Pertinent information from outside facilities or persons or from the individual.
 7. Correspondence to and from relevant facilities and persons.
 8. Consent forms as appropriate for alternative treatments or voluntary treatment.
 9. Use or non-use of psychiatric and medical advance directives.
- E. Discharge information provided to the individual shall include the requirements of part 2.10.A.6. Of these rules, and the following:
1. Specific recommendations regarding prevention of re-hospitalization based on the individual's unique challenges and needs.
- F. Discharge summaries shall comply with the requirements of part 2.10.A.6 of these rules, this part 11.16.20, and the following:

1. Documentation that notice of discharge was provided to the individual or individual's legal representatives as follows:
 - a. At least twenty-four (24) hours in advance of discharge or transfer, in accordance with the rules governing the care and treatment of persons with a mental health disorder in parts 11.14 and 11.16 of this Chapter.
 - b. In cases of a medical or psychiatric emergency, the emergency contact shall be notified as soon as possible.
2. Documentation of discharge coordination with the individual, and, with permission, the individual's family, legal representative, or appropriate facility.
3. For transfers between facilities, documentation of appropriate clinical information and coordination of services between the two facilities, including mode of transportation.
4. Information if the discharge is being made against the advice of the treating professional person.

11.16.21 Management of Personal Funds and Personal Property

- A. The facility shall comply with part 2.26.D.3 of these rules related to management of personal funds and personal property.

11.16.22 Transportation of Individuals

- A. Whenever transportation of an individual is required, the treating personnel of the facility shall assess the individual for danger to self or others and potential for escape. Whenever clinically and safely appropriate, the individual may be transported by other means such as ambulance, care van, private vehicle, and restraints shall not be used, unless consistent with state and federal law, authorized as necessary, and ordered by the treating professional person. If the treating personnel assesses the individual as dangerous to self or others or as an escape risk, the personnel may request transportation by a secure transportation provider or the local sheriff's department.

11.16.23 Secure Transportation Providers

- A. Facilities may utilize a secure transportation provider.
- B. "Class A" secure transportation services are licensed pursuant to CDPHE regulations to use physical restraint during secure transport based on associated regulations.
- C. "Class B" secure transportation services are not licensed pursuant to CDPHE regulations to use physical restraint during secure transport.
- D. For individuals receiving involuntary care in a 27-65 designated facility, when transportation to a medical appointment outside of the 27-65 designated facility is required, a personnel from the 27-65 designated facility who is trained in facility transportation policies and procedures shall accompany and remain with the individual for the duration of the appointment at the outside facility. The individual may be left in an emergency medical services facility's care without a designated facility personnel only if the individual is in a secure area (such as a psychiatric emergency department) and/or if there is trained security personnel present with the individual at all times; these provisions for safety/security must be noted in the designated facility's individual chart.

11.16.24 Secure Transport Requests

- A. Any requests for transportation from the sheriff's department shall be filed with the court of appropriate jurisdiction and shall include:
 - 1. Statements from the treating Colorado licensed physician or psychologist supporting the need for transportation by the sheriff's department;
 - 2. Recommendations concerning the use of mechanical restraints and the impact that handcuffs or shackles would have on the individual;
 - 3. Recommendations for soft restraints, not handcuffs or shackles, if the findings of the assessment support the use of mechanical restraint;
 - 4. Recommendations concerning the placement and management of the individual during the time they will be absent from the 27-65 designated facility due to court hearings;
 - 5. Recommendations of considerations for management of the individual based on the individual's age, physical abilities, culture, medical and psychiatric status and/or stability.
- B. Notice of the request for transportation by the sheriff's department shall be given to the individual and their attorney at least twenty-four (24) hours prior to the time it is filed with the court. This notice shall not be required during the time an emergency mental health hold is in effect or in an emergency situation with an individual under certification or when the individual signs a waiver which has been clearly explained.
- C. Requesting transportation by the sheriff's department does not require a finding of danger to self or others or an escape risk if the sheriff's department is willing to transport the individual without the use of mechanical restraints.

11.16.25 Termination of Certification for Short-Term and Long-Term Treatment

- A. Prior to July 1, 2024, an original or extended certification for short-term treatment issues pursuant to Section 27-65-109, C.R.S., or an order or extension for certification for long-term care and treatment pursuant to Section 27-65-110, C.R.S., terminates as soon as the professional person in charge of treatment of the individual determines the individual has received sufficient benefit from the treatment for the individual to end involuntary treatment. Beginning July 1, 2024, an original or extended certification for short-term treatment issues pursuant to Section 27-65-109, C.R.S., or an order or extension for certification for long-term care and treatment pursuant to Section 27-65-110, C.R.S., terminates as soon as the professional person in charge of treatment of the individual and the BHA determine the individual has received sufficient benefit from the treatment for the individual to end involuntary treatment.
- B. Whenever a certification or extended certification is terminated, the professional person in charge of providing treatment shall notify the court in writing within five (5) days after the termination.
- C. Before termination, an individual who leaves a facility may be returned to the facility by order of the court without a hearing or by the superintendent or director of the facility without a court order.
- D. After termination, an individual may be returned to the facility only in accordance with Article 65 of Title 27, C.R.S.

- E. Facilities designated for involuntary care and treatment of individuals are required to notify the BHA whenever an individual certification is terminated. 27-65 designated facilities must submit required documentation directly to the BHA using the prescribed BHA method available on BHA's website.

11.17 Involuntary Outpatient Care & Treatment Designation

11.17.1 Applicability

- A. The involuntary outpatient care and treatment designation allows facilities to provide care and treatment to individuals on short-term and long-term certifications on an outpatient basis.
- B. Facilities designated for involuntary outpatient care and treatment must be in compliance with the following rules:
 - 1. Parts 2.7 through 2.13 and parts 2.23 through 2.25 of these rules with the following exception
 - a. Part 2.7.A.3 of these rules
 - 2. Parts 11.1 through 11.15 and 11.17 of this Chapter.
- C. This section 11.17 is meant, in part, to provide a summary of the obligations and standards set forth in Section 27-65-101 through -131, C.R.S., with regard to involuntary outpatient care and treatment. This section is only enforceable with regard to designated facilities.

11.17.2 Procedures for Certification to Outpatient Treatment

- A. An individual who has been treated as an inpatient under a short-term or long-term certification for mental health treatment at a designated facility may be treated on an outpatient basis if the following conditions are met:
 - 1. A professional person who has evaluated the individual and who is on the personnel of the inpatient designated facility determines that while the individual continues to meet the requirements for certification, professional judgment is that with appropriate treatment modalities in place the individual is unlikely to act dangerously in the community.
 - 2. Certification on an outpatient basis is the appropriate disposition suited to the individual's needs.
 - 3. The designated facility that will hold the certification on an outpatient basis has documentation of the results of a physical examination within the last year, or documented attempts to obtain information.
- B. In addition to the requirements in Chapter 4 of these rules, the outpatient treatment provider shall develop a service plan for the individual receiving treatment on an outpatient basis with the goal of the individual finding and sustaining recovery. The service plan must include measures to keep the individual or others safe, as informed by the individual's need for certification. The service plan may include, but is not limited to:
 - 1. Intensive case management;
 - 2. Assertive community treatment;
 - 3. Peer recovery support services;

4. Individual or group therapy;
 5. Day or partial-day programming activities;
 6. Intensive outpatient programs;
 7. Educational and vocational training or activities; and
 8. Housing and transportation assistance.
- C. The individual, the individual's legal guardian, the individual's patient representative or the individual's lay person, or any party at any court hearing may contest an individual's treatment regimen, including court-ordered medications, at any court hearing related to the individual's certification for treatment.
- D. Primary oversight of outpatient certifications at designated facilities must be provided by a professional person. The professional person assigned to the individual's case must also be available for clinical supervision and/or consultation to personnel providing clinical services to the individual at the designated facility in which the individual is receiving outpatient certification treatment.
- E. Primary clinical services at the designated facility, including but not limited to individual therapy, must be provided by a licensee or authorized practitioner receiving clinical supervision and/or consultation from the assigned professional person.

11.17.3 Enforcement of Outpatient Certification [Effective July 1, 2024]

- A. The facility responsible for providing services to an individual on a certification on an outpatient basis shall proactively reach out to the individual to engage the individual in treatment on a weekly basis and including visits to the individual's known places or residence. Documentation of all visits and attempts must be included in the clinical record.
- B. If the individual refuses treatment or court-ordered medication and is decompensating psychiatrically, the court may order a certified peace officer or secure transportation provider to transport the individual to an appropriate, least restrictive designated facility in collaboration with the BHA and the provider holding the certification.
1. The individual does not need to be imminently dangerous to the individual's self or others for the facility to request, and the court to order, transportation to a facility for the individual to receive treatment and court-ordered medications.
- C. The facility responsible for providing services to an individual on a certification on an outpatient basis shall provide the court information on the facility's proactive outreach to the individual and the professional person's and psychiatric advanced practice registered nurse's basis for medical opinion.
- D. If an individual is placed in a more restrictive setting, the individual has the right to judicial review within ten (10) days after filing a written request.
- E. In addition to any other limitation on liability, an agency or facility providing care to an individual placed on short-term or long-term certification on an outpatient basis is only liable for harm subsequently caused by or to an individual who:
1. Has been terminated from certification despite meeting statutory criteria for certification pursuant to Sections 27-65-109 or 27-65-110, C.R.S.; and,

2. Provided services to the individual not within the scope of the individual's professional license or was reckless or grossly negligent in providing services.
 3. A provider is not liable if an individual's certification is terminated, despite meeting criteria for certification, if the provider is unable to locate the individual despite proactive and reasonable outreach.
- F. An individual certified for short-term treatment on an outpatient basis may be discharged upon the signature of the approved professional person overseeing the individual's treatment, and the professional person shall notify the BHA prior to the discharge.
- G. A facility or program shall make the individual's discharge instructions available to the individual, the individual's attorney, and the individual's legal guardian, if applicable, within seven (7) days after discharge, if requested.
1. A facility or program that is transferring an individual to a different treatment facility or to an outpatient provider shall provide all treatment records to the facility or provider accepting the individual at least twenty-four (24) hours prior to the transfer.
- H. The individual, their legal guardian, the patient representative or lay person, or any party may object to the individual's treatment, including court-ordered medications, at any court hearing related to the individual's certification to treatment.

11.17.4 Individual Rights for Involuntary Outpatient Treatment [Effective July 1, 2024]

- A. The facility shall provide all individuals receiving evaluation, care, or treatment on a certified outpatient basis, with a written copy of the rights listed under part 11.14.3 of this Chapter, in addition to this part 11.17.4.B (translated into a language that the individual understands if feasible) upon admission and upon each renewal of certification. If the individual is not able to read the rights, the individual shall be read the rights in a language that they understand.
- B. The facility shall post the following list of rights (in languages predominantly used by the population of individuals served), in addition to those enumerated in part 11.14.3 of this Chapter in prominent places frequented by individuals and their families receiving services:
1. To request a change to voluntary status. A change to voluntary status may be denied by the supervising professional person or an advanced practice registered nurse with training in psychiatric nursing responsible for the individual's treatment if the professional person or advanced practice registered nurse with training in psychiatric nursing determines reasonable grounds exist to believe that the individual will not remain in a voluntary treatment program;
 - a. If a discrepancy exists for the determination of voluntary status between the professional person and the advanced practice nurse with training in psychiatric nursing, the determination for the individual to change to voluntary status must defer to the assessment from the professional person.
 2. To be treated fairly, with respect and recognition of the individual's dignity and individuality, by all employees of the treatment facility with whom the individual comes in contact;
 3. To appropriate treatment, which must be administered skillfully, safely, and humanely. An individual shall receive treatment suited to the individual's needs that must be determined in collaboration with the individual;

4. To not be discriminated against on the basis of age, race, ethnicity, religion, culture, spoken language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity, or gender expression;
 5. To retain and consult with an attorney at any time;
 6. Within forty-eight (48) hours after the individual's request, to see and receive the services of a patient representative, including a peer specialist;
 7. To have the individual's behavioral health orders for scope of treatment or psychiatric advance directive reviewed and considered by the court as the preferred treatment option for involuntary administration of medications unless, by clear and convincing evidence, the individual's directive does not qualify as effective participation in behavioral health decision-making;
 8. To have the individual's information and records disclosed to adult family members and a lay person pursuant to Section 27-65-123, C.R.S.;
 9. To have access to a representative within the facility who provides assistance to file a grievance; and
 10. To have the right to file a motion with the court at any time to contest the certification.
- c. As set forth in Section 27-65-127, C.R.S., an individual's rights, as set forth in Section 27-65-101 through -131, C.R.S. and this Chapter, may be limited or denied under court order by an imposition of legal disability or deprivation of a right.
- d. Information pertaining to the denial of any right shall be made available, upon request, to the individual or their attorney.

11.17.5 Service Planning [Effective July 1, 2024]

- A. Service plans shall comply with the requirements of part 2.13.1 of this Chapter, and the following:
1. The service plan shall contain specific criteria required for discharge from treatment or to progress to less restrictive treatment alternatives;
 2. A physician or other legal prescriber shall be responsible for the component of the plan requiring medication management services; and,
 3. For individuals certified to short-term or long-term treatment, the service plan shall be reviewed, and revised, if necessary, at least monthly by the personnel responsible for the plan, the treating professional person, the individual and the legal guardian. This review shall be documented in the record and include progress toward meeting the criteria for termination of treatment and the need for continued involuntary treatment if the individual is certified. If the monthly review is delayed, the reason for such delay shall be noted in the record and the review shall be completed as promptly as possible.
 4. The service plan may include, but is not limited to:
 - a. Intensive case management services;
 - b. Assertive community treatment;
 - c. Peer recovery services;

- d. Individual and/or group therapy;
- e. Day or partial-day programming activities;
- f. Intensive outpatient programs;
- g. Educational and/or vocational training and activities; or
- h. Housing and transportation assistance

Chapter 12: Behavioral Health Safety Net Provider Approval

12.1 Authority and Applicability

- A. Chapter 12 establishes standards for behavioral health safety net providers, including comprehensive community behavioral health providers and essential behavioral health safety net providers, and the behavioral health safety net approval process. The statutory authority to promulgate these rules is set forth in Sections 27-50-107(3)(c), 27-50-301(5), 27-50-304(7), and 27-50-502(1) through (5), C.R.S. Chapter 12 additionally establishes standards for additional competencies related to serving priority populations where behavioral health safety net providers may be eligible for enhanced rates. The statutory authority to promulgate these rules is set forth in Section 27-50-502(6), C.R.S.
- B. To be eligible for enhanced service delivery payments set forth in Section 27-50-502(2),(3), C.R.S., a behavioral health safety net provider must be approved by the BHA. This approval does not guarantee enhanced service delivery payments.
- C. Approved behavioral health safety net providers shall be subject to the following rule compliance timeline:
 - 1. Upon these rules going into effect, the BHA shall take immediate action pursuant to Section 27-50-505, C.R.S. on rule violations that impact the health, safety, and welfare of individuals receiving services provided by an approved safety net provider.
 - 2. All approved safety net providers shall be in full compliance of these rules by July 1, 2024.
- D. Provider participation in the behavioral health safety net system is voluntary. The rules in this Chapter must be followed, as applicable, by all entities and persons that are seeking to be or are approved behavioral health safety net providers to be eligible for public funding as part of the state of Colorado's Behavioral Health Safety Net System created pursuant to Section 27-50-301 through -304, C.R.S.

12.2 Approval

- A. Approval by the BHA as a behavioral health safety net provider shall be predicated upon the following:
 - 1. Evidence of current licensure in good standing by the BHA, Department of Public Health and Environment, Department of Regulatory Agencies, and/or other state agency where applicable, unless otherwise exempt from licensing by state or federal rule or statute.
 - a. Behavioral health providers, including but not limited to federally qualified health centers, that are exempt from licensure but require federal recognition shall provide documentation to demonstrate current recognition.

2. Compliance with the requirements of this Chapter 12.
 - a. Part 12.4 of this Chapter shall apply only to essential behavioral health safety net providers.
 - b. Part 12.5 of this Chapter shall apply only to comprehensive community behavioral health providers.

12.3 Safety Net Standards

12.3.1 General Requirements

- A. The behavioral health safety net provider shall ensure all operations, locations, and services, including contracted services and/or personnel, comply with applicable federal and state laws, regulations, and standards.
- B. The behavioral health safety net provider shall provide services in conformity with endorsement-specific requirements as found in Chapters 3 through 10 of these rules, for all services delivered by the provider as part of the behavioral health safety net provider's approval. This must include:
 1. Appropriate personnel, including but not limited to authorized practitioners, licensees, peer support professionals, and others, with qualifications, responsibilities and experience that correspond to the size and capacity of the provider.
- C. When determining personnel needs, the behavioral health safety net provider must consider how they will comply with the no refusal requirements set forth in part 12.4.3.D for essential behavioral health safety net providers and part 12.5.3.D. For comprehensive community behavioral health providers.
- D. The behavioral health safety net provider shall provide services in alignment with the following competencies of the behavioral health safety net system:
 1. Proactively engaging priority populations, with adequate care coordination throughout the care continuum;
 2. Incorporating and demonstrating trauma-informed care practices throughout the care experience;
 3. Promoting person-centered care and cultural and linguistic competence;
 4. Utilizing evidence-based and evidence-informed programming to promote quality services; and
 5. Demonstrating competency in de-escalation techniques.

12.3.2 Policies and Procedures

- A. The behavioral health safety net provider's policies and procedures must demonstrate how the agency will provide care in alignment with the required competencies of behavioral health safety net providers set forth in part 12.3.1 of this Chapter.
- B. The behavioral health safety net provider shall have written policies and procedures that address:
 1. The rights of individuals seeking or receiving care

- a. The policy must ensure that each individual or, when applicable, the individual's designated representative, has the right to:
 - (1) Participate in all decisions involving the individual's care or treatment;
 - (2) Be informed about whether the agency is participating in teaching programs, and to provide informed consent prior to being included in any clinical trials relating to the individual's care;
 - (3) Refuse any drug, test, procedure, service or treatment and to be informed of risks and benefits of this action;
 - (4) Receive care and treatment, in compliance with state statute, that is free from discrimination on the basis of physical or mental disability, race, ethnicity, socio-economic status, religion, gender expression, gender identity, sexuality, culture, and/or languages spoken; recognizes an individual's dignity, cultural values and religious beliefs; as well as provides for personal privacy to the extent possible during the course of treatment;
 - (5) Be informed of, at a minimum, the first names and credentials of the personnel that are providing services to the individual. Full names and qualifications of the service providers must be provided upon request to the individual or the individual's designated representative or when required by DORA;
 - (6) Give informed consent for all treatment and services. Personnel must obtain informed consent for treatment they provide to the individual;
 - (7) Register grievances with the agency and the BHA and be informed of the procedures for registering these grievances including contact information;
 - (8) Be free of abuse and neglect;
 - (9) Be free from the improper application of restraints or seclusion;
 - (10) Expect that the agency in which the individual is admitted can meet the identified and reasonably anticipated care, treatment, and service needs of the individual;
 - (11) Receive care from the agency in accordance with the individual's needs;
 - (12) Have the confidentiality of their individual records maintained as required by applicable federal and state law;
 - (13) Receive care in a safe setting;
 - (14) Be notified if referrals to other providers are to entities in which the agency has a direct or indirect financial benefit, including a benefit that has financial value, but is not a direct monetary payment;
 - (15) Formulate medical and psychiatric advance directives and have the agency comply with such directives in compliance with applicable state statute.

2. When admitting, discharging, triaging, and denying services to individuals:
 - a. Essential behavioral health safety net providers must ensure their policies and procedures align with the requirements of parts 12.4.2 and 12.4.3 of this Chapter
 - b. Comprehensive community behavioral health providers must ensure their policies and procedures align with the requirements of parts 12.5.2 and 12.5.3 of this Chapter
3. How an agency will respond in a crisis to promote the safety of individuals, personnel and community members, including when an individual demonstrates physical aggression or agitation.
4. How telehealth services are deployed, how individual preference for in-person services are addressed, and when based on diagnosis or other need, telehealth services are not appropriate.
5. Safety of personnel and individuals when delivering services in-home and in-community.
6. Personnel training requirements, which must include training in:
 - a. De-escalation techniques;
 - b. Culturally and linguistically appropriate service delivery in accordance with the requirements of part 12.3.4 of this Chapter;
 - c. Trauma-informed care practices and service delivery.
7. Personnel background checks
 - a. The agency must obtain, prior to hire or contract of new personnel, unless the personnel is a volunteer whose service does not involve unsupervised direct contact with individuals receiving services, a name-based criminal history record check for each prospective personnel or volunteer.
 - (1) If the prospective personnel has lived in Colorado for more than three (3) years at the time of application, the agency shall obtain a name-based criminal history report conducted by the Colorado Bureau of Investigation (CBI).
 - (2) If the prospective personnel has lived in Colorado for three (3) years or less at the time of application, the agency shall obtain a name-based criminal history report for each state in which the prospective personnel has lived during the past three (3) years, conducted by the respective states' bureaus of investigation or equivalent state-level law enforcement agency, or a national criminal history report conducted by the federal bureau of investigation.
 - b. The agency shall bear the cost of obtaining a name-based criminal history record check for each prospective personnel.
 - c. If an agency contracts with a staffing agency for the provision of services, it shall require that the staffing agency meet the requirements of this part 12.3.2.B.7.

- d. When determining whether a prospective personnel is eligible for hire if the criminal history record check reveals the person has a conviction or plea of guilty, active deferred judgment, or nolo contendere, the agency shall have a policy that includes:
 - (1) Written criteria and procedures for evaluating which convictions or complaints make prospective personnel unacceptable for hire, or for existing personnel, unacceptable for retention, including:
 - (a) Factors to be considered when determining whether a prospective personnel is eligible for hire or contract when their name-based criminal history record check reveals a conviction or plea of guilty, active deferred judgment, or nolo contendere, including, but not limited to:
 - 1. The nature and seriousness of the offense;
 - 2. The nature of the position and how the offense relates to or may impact the duties of the position; experience in the criminal justice system is not necessarily a disqualifier and, in certain circumstances, an agency may determine that some lived experiences would benefit a particular position;
 - 3. The length of time since the conviction or plea;
 - 4. Whether such conviction is isolated or part of a pattern; and,
 - 5. Whether there are mitigating or aggravating circumstances involved.
8. Clinical supervision
- a. The agency must ensure that all personnel providing behavioral health services, with the exception of peer support professionals, receive clinical supervision, as defined in this part 12.3.2.B.8.
 - b. The agency will develop policies and procedures for supervision that address the following:
 - (1) Supervisee's mandatory disclosure statement that clearly states they are under supervision and by whom;
 - (2) Requirements for regular evaluation of the supervisee's progress with a rubric that is tied to the responsibilities assigned;
 - (3) Documentation and frequency of supervisor reviews and feedback provided;
 - (4) Maximum number of supervisees a supervisor oversees; and
 - (5) How supervision/consultation is covered by personnel with comparable credentials when the usual supervisor is not available.

- c. Clinical supervisors must at minimum:
 - (1) Meet the standard qualifications for clinical supervision as defined by their professional practice board.
 - (2) Deliver clinical supervision within the supervisor's professional practice license and ethical standards for:
 - (a) Those that are licensed or seeking professional licensure; or
 - (b) When supervising personnel that are not seeking or not eligible for professional licensure, such as group living workers, the supervisor must follow standards in the Colorado Mental Health Practice Act, as defined in Article 245 of Title 12, C.R.S.
 - (3) Dedicate time between the supervisor and supervisee to instruct, model, and encourage self-reflection by the personnel receiving supervision regarding acquisition of clinical and administrative skills. Clinical supervisor will determine skills through observation, evaluation, feedback, and mutual problem-solving.
 - (4) Address ethics and ethical dilemmas as aligned with the appropriate professional practice board.
 - (5) Provide professional direction based on experience, expertise, and/or for ethical or safety concerns.
 - (6) Ensure that safety and crisis management plans are followed and that clinical supervisors are available to personnel for assistance in crisis situations and processing of the crisis event afterwards.
 - (7) Document date, duration, and the content of supervision session for their supervisee(s), which may include a professional development plan. All documents pertaining to clinical supervision must be provided to the supervisee and the BHA upon request.
- d. Personnel-specific clinical supervision requirements
 - (1) Licensees and authorized practitioners will be provided with clinical supervision and/or consultation at minimum upon request of the licensee or authorized practitioner or at times of individual emergency.
 - (2) Candidates will be provided with clinical supervision at a rate that will meet their licensing requirements for the license they are pursuing or at a minimum of one (1) hour every two (2) weeks, whichever provides a higher level of clinical supervision.
 - (3) All clinical documentation completed by a counselor-in-training and/or intern still in pursuit of their clinical degree must be reviewed and co-signed by a clinical supervisor able to supervise pursuant to their scope of practice.

- (4) Personnel not seeking or not eligible for licensure, but that are providing clinical services, will be provided clinical supervision at a frequency that ensures treatment to individuals is appropriate, safe, and in line with assessment treatment needs and the individual's treatment goals.

9. Critical incident reporting

a. A critical incident includes but is not limited to the following:

- (1) Breach of confidentiality: any unauthorized disclosure of protected health information as described in HIPAA, as incorporated by reference in part 1.2 of these rules; 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules, and/or Section 27-65-101 through -131, C.R.S.
- (2) Death: including the death of an individual inside of or outside of the agency's physical location while an individual is receiving services or where an individual has attempted to receive services from the agency within the past thirty (30) calendar days.
- (3) Elopement: absconding from a mental health hold, certification, emergency/involuntary commitment, or a secure facility where an individual is being held as a result of a court order. This includes any unauthorized absence of a child, when a child cannot be accounted for or when there is reasonable suspicion to believe the child has absconded.
- (4) Any instance when an individual cannot be located following a search of the agency, the agency grounds, and the area surrounding the agency, and:
 - (a) There are circumstances that place the individual's health, safety, or welfare at risk; or
 - (b) The individual has been missing for eight (8) hours.
- (5) Medication diversion: any medication diversion as defined in part 1.2 of these rules. If the diverted drugs are injectable, the agency shall also report the full name and date of birth of any individual who diverted the injectable drugs, if known.
- (6) Medication error: medication error that resulted or could have resulted in harm to the individual.
- (7) Medical emergency: any suicide attempt/self-injury, other form of serious injury, health emergency, overdose, or serious illness which occurred on agency premises or in the presence of agency personnel.
- (8) Any instance involving physical, sexual, or verbal abuse of an individual, as described in Sections 18-3-202, 18-3-203, 18-3-204, 18-3-206, 18-3-402, 18-3-404, 18-3-405, 18-3-405.3, 18-3-405.5, and 18-9-111 (exempting, however, the phrase "intended to harass"), C.R.S. by another individual, personnel, or a visitor to the agency.
- (9) Any instance that results in any of the following serious injuries to an individual:

- (a) Brain or spinal cord injuries;
 - (b) Life-threatening complications of anesthesia or life-threatening transfusion errors or reactions; or,
 - (c) Second- or third-degree burns involving twenty (20%) percent of more of the body surface area of an adult or more fifteen (15%) percent or more of the body surface area of a child.
- (10) Any instance involving caretaker neglect of an individual, as defined in Section 26-3.1-101(2.3), C.R.S.
- (11) Any instance involving misappropriation of an individual's property, meaning patterns of loss or single incidences of deliberately misplacing, exploiting, or wrongfully using, either temporarily or permanently, an individual's belongings or money without the individual's consent.
- (12) Any occurrence involving the malfunction or intentional or accidental misuse of care equipment that occurs during treatment or diagnosis of an individual and that significantly or adversely affects or, if not averted, would have significantly adversely affected an individual.
- b. Critical incidents must be reported to the BHA within one (1) business day after the incident. Critical incidents must also be reported to the BHA within one (1) business day of when the agency determines that a reportable incident has occurred and the BHA requests such reporting.
- c. The BHA may conduct scheduled or unscheduled site reviews for specific monitoring purposes and investigation of critical incidents reports in accordance with:
 - (1) BHA policies and procedures,
 - (2) Regulations that protect the confidentiality and individual rights in accordance with Section 27-65-101 through -131, C.R.S.; HIPAA; as incorporated by reference in part 1.2 of these rules; and, 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules,
 - (3) Controlled substance licensing; Section 27-81-113; Section 27-80-212, C.R.S., and Section 18-18-503, C.R.S.
- d. The BHA shall have access to relevant documentation required to determine compliance with these rules.
- e. The agency must:
 - (1) Establish written policies and procedures for reporting and reviewing all critical incidents occurring at the agency;
 - (2) Submit critical incident reports to the BHA using state prescribed forms available on the BHA website. This is not in lieu of other reporting mandated by state statute or federal guidelines;
 - (3) Make available a report with the investigation findings for review by the BHA, upon request; and,

(4) Maintain critical incident reports for a minimum of three (3) years following the incident.

f. Nothing in this part shall be construed to limit or modify any statutory or common law right, privilege, confidentiality, or immunity.

12.3.3 Care Coordination

A. Behavioral health safety net providers shall work with the individual to identify the individual's service and support needs and preferences and shall carry out care coordination as defined in part 1.1 of these rules to facilitate access to those services and supports.

B. Care coordination must, to the extent possible, be carried out in accordance with the individual's expressed preferences and with involvement of the individual's family, parent, legal representative, advocate, caregiver, and other supports identified by the individual.

C. Care coordination activities may include, as appropriate for the needs and preferences of the individual:

1. Development of person and family-centered service plans that:

a. Promote integrated whole person care across the spectrum of health services.

b. Address each individual's priorities, goals, and the barriers they face.

c. Address access to acute and chronic physical and behavioral health care, peer support networks, social services including income supports, health insurance, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person in alignment with an individual's assessed needs and expressed goals.

2. Facilitating access to needed resources and services to carry out the service plan. This may include, but is not limited to:

a. Conducting application assistance, referrals, and warm hand-offs to access resources and care;

b. Providing accessible, culturally and linguistically appropriate resources and information, including access to resource directories such as OWNPATH;

c. Coordinating with partners to provide specialized services, risk stratification, discharge planning, transition planning, prior authorization, insurance appeal, and medication reconciliation;

d. Identifying the information, social service, and health care systems that an individual will need to access in order to navigate systems, manage their care, and achieve whole person health;

e. Equipping the individual with information through means that are accessible and appropriate for the individual based on their needs and preferences and as required by federal and state statute;

f. Collaborating with other systems and entities providing care coordination services to the individual;

- (1) If care coordination activities necessary to meet the individual's needs and fulfill the service plan are being carried out by an alternate entity, the behavioral health safety net provider shall document the responsibilities of each entity within the record and update the record in response to changes in the individual's needs and/or preferences, and the alternate entity's involvement.
- g. Providing outreach, planning, problem-solving, advocacy, education, and self-management support;
- 3. Deliberate and coordinated planning to prevent disengagement from services, identifying and mitigating risks for individuals, including identifying and implementing prevention strategies to proactively mitigate risk, and connecting individuals to supports to promote ongoing maintenance and prevention.
 - a. Risks may include, but are not limited to, risk of grave disability, risk of danger to self or others, risk of institutionalization, risk of incarceration, risk of overdose, risk of housing and income instability including loss of benefits, and risk for out of home placement for a youth.
 - b. Risk assessment must involve the individual and their service providers, be done on an ongoing basis, and be addressed within the service plan.
 - c. When a risk for disengagement is identified, the service plan must address prevention of and response to an individual disengaging from services including missing appointments.
- 4. Monitoring an individual's progress, engagement, and satisfaction with treatment and recovery in alignment with outcomes identified by the individual.

12.3.4 Culturally and Linguistically Appropriate Services

- A. To ensure the provision of culturally and linguistically appropriate services, the behavioral health safety net provider shall:
 - 1. Ensure all methods and procedures used to assess and evaluate an individual are able to be provided in the preferred language and/or communication method of frequently encountered limited English proficiency (LEP) groups.
 - 2. Develop and maintain general knowledge about the racial, ethnic, and cultural groups in the service area, including each group's diverse cultural health beliefs and practices, preferred languages, health literacy, and other needs in order to inform the provision of culturally and linguistically appropriate services and improve access and quality of services for these groups.
 - 3. Collect and maintain updated information to help understand the composition of the communities in the service area, including the primary spoken languages in order to inform the provision of culturally and linguistically appropriate services and improve access for these communities.

4. Be able to provide oral and written notice to individuals with limited English proficiency in the preferred language and/or communication method of frequently encountered limited English proficiency (LEP) groups of the agency to inform them of their right to receive language assistance services and how to do so. Language assistance services must be free of charge to the individual, be accurate and timely, and protect the privacy and independence of the individual receiving services.
5. Provide documents or messages vital to an individual's ability to access services (for example, registration forms, sliding scale fee discount schedule, after-hours coverage, signage) in languages common in the community served, taking account of literacy and developmental levels and the need for alternative formats. Such materials shall be provided at intake.
6. Provide interpretation and translation services in a manner that meets the needs of the individual.
 - a. In order to ensure complete, accurate, impartial, and confidential communication, family, friends, or other individuals shall not be required, suggested, or used as interpreters. An individual shall not be required to provide their own interpreter. Behavioral health safety net providers shall not rely on an adult accompanying an individual with limited English proficiency (LEP) to interpret or choose to facilitate communication except:
 - (1) In an emergency involving an imminent threat to the safety or welfare of an individual or the public, where there is no qualified interpreter for the individual with limited English proficiency immediately available.
 - (2) Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.
 - (a) Personnel should suggest that a trained interpreter be present in these instances to ensure accurate interpretation and should document the offer and declination in the individual's record.
 - (3) Minor children must not be used as interpreters, nor be allowed to interpret for their parents when the minor is the individual receiving services, unless there is an emergency involving an imminent threat to the safety or welfare of an individual or the public when no other interpreter is available.
 - b. To the extent interpreters are used, and an interpreter is not provided by the individual, the interpreters must be trained to function in a medical and/or behavioral health setting, adhere to accepted interpreter ethics principles, including individual confidentiality and be able to interpret effectively, accurately, and impartially.
7. Provide auxiliary aids and services needed for effective communication, that are Americans with Disabilities Act (ADA) compliant and responsive to the needs of individuals with disabilities (e.g., sign language interpreters, videophones).
8. Implement strategies to recruit, support, and promote personnel that is representative of the demographic characteristics, including primary spoken languages of the communities in the agency's service area.

9. Behavioral health safety net providers are responsible for training personnel on interpretation and translation services available to facilitate services. This includes training personnel on the procedures to access and use such services.

12.4 Essential Behavioral Health Safety Net Providers

12.4.1 Requirements

- A. Essential behavioral health safety net providers shall provide at least one of the following services.
 1. Emergency and/or crisis behavioral health services;
 2. Behavioral health outpatient services;
 3. Behavioral health high-intensity outpatient services;
 4. Behavioral health residential services;
 5. Withdrawal management services;
 6. Behavioral health inpatient services;
 7. Integrated care services;
 8. Hospital alternatives; and/or
 9. Additional services that the BHA determines are necessary in a region or throughout the state.
- B. For services which a BHA endorsement exists in Chapters 3 through 10 of these rules, services shall be provided in conformity with the rules of the endorsement.
- C. When providing services to children and families, essential behavioral health safety net providers shall provide services to children and families in conformity with the standards set forth in Chapter 8 of these rules.
- D. The essential behavioral health safety net provider shall provide clinical services during times that ensure accessibility and meet the needs of the individual population to be served, including evening and/or weekend hours.
 1. These extended hours may include services provided via telehealth, if appropriate.
- E. Essential behavioral health safety net providers offering outpatient behavioral health services must have in-person service offerings in addition to any telehealth services the agency may elect to provide.

12.4.2 Priority Populations

- A. Essential behavioral health safety net providers must serve all priority populations as defined in Section 27-50-101(17), C.R.S., unless:
 1. The agency's approval limits the agency's scope and responsibility to a specific subset of priority population(s); and

2. The provisions in the agency's contract with the BHA or its designee limit the agency's scope and responsibility to a specific subset of priority populations.
- B. When an essential behavioral health safety net provider is approved to serve a subset of priority populations, the agency shall ensure that corresponding admission and exclusion criteria are:
 1. Outlined in the agency's policy developed pursuant to part 12.3.2.B.2 of this Chapter;
 2. Approved by the BHA or its designee;
 3. Publicly available on the provider's website; and
 4. Applied uniformly.
- C. The essential behavioral health safety net provider shall have personnel with scope of practice and training to meet the needs of priority populations within the scope of the services and priority populations that the essential behavioral health safety net provider is approved to provide.

12.4.3 Screening, Triage, and Care Coordination in Alignment with No Refusal Requirements

- A. When an individual attempts to initiate treatment with an essential behavioral health safety net provider, the essential behavioral health safety net provider shall complete an initial screening and triage process to identify the needs of the individual, and to determine the urgency and appropriateness of care with the essential behavioral health safety net provider.
- B. Screenings must collect at least the following information from an individual seeking services:
 1. Identifying information;
 2. Primary complaint/reason for seeking services;
 3. Current behavioral health symptoms, including severity, duration, mental status, and changes or impairments in functioning due to symptoms;
 4. Medical concerns/chronic health issues, including pregnancy and postpartum status; and,
 5. Evaluation of imminent risk, including:
 - a. Suicide risk;
 - b. Danger to self or others;
 - c. Urgent or critical medical conditions, including withdrawal or overdose risk; or
 - d. Other immediate risks, including threats from another person.
 6. Preliminary determination of level of care needed;
 7. Health-related social needs and associated risk factors related to social determinants of health, including but not limited to:
 - a. Food security;
 - b. Housing stability and security;

- c. Personal safety;
 - d. Access to health services including preventative health care;
 - e. Physical health concerns for which the individual is not receiving adequate treatment.
 - 8. Whether an individual is part of an identified priority population and which one.
- C. The essential behavioral health safety net provider shall use these standard criteria for determining whether an agency's clinical scope of practice or treatment capacity are appropriate to meet the needs of the individual, or if the agency will instead provide care coordination to support the individual in accessing alternate services. These criteria are:
- 1. The individual's presenting problem or behavioral health diagnosis is outside the scope of practice of the agency and its personnel, including the age range with which the agency works, or the modalities and interventions in which personnel are trained in.
 - 2. The agency is approved pursuant to part 12.4.2 of this Chapter to serve a subset of priority populations, and the individual does not fall within the priority population(s).
 - 3. The individual presents with the need for a level of care the agency does not provide.
 - 4. The agency cannot provide services within an appropriate time frame per the individual's needs and the agency's capacity.
- D. In accordance with Section 27-50-301(4), C.R.S., unless it is determined, pursuant to the criteria in part 12.4.3.c of this Chapter, that an individual's needs fall outside the scope and capacity of the essential behavioral health safety net provider, the essential behavioral health safety net provider shall not refuse to treat an individual based on the individual's:
- 1. Insurance coverage, lack of insurance coverage, or ability to pay;
 - 2. Clinical acuity level related to the individual's behavioral health condition or conditions, including whether the individual has been certified for short-term treatment or long-term care and treatment pursuant to Article 65 of Title 27, C.R.S.;
 - 3. Readiness to transition out of the Colorado Mental Health Hospital at Pueblo, the Colorado Mental Health Hospital at Fort Logan, or any other mental health institute or licensed facility providing inpatient psychiatric services or acute care hospital providing stabilization because the individual no longer requires inpatient care and treatment;
 - 4. Involvement in the criminal or juvenile justice system;
 - 5. Current involvement in the child welfare system;
 - 6. Co-occurring mental health and substance use disorders, physical disability, or intellectual or developmental disability, irrespective of primary diagnosis, co-occurring conditions, or if an individual requires assistance with activities of daily living or instrumental activities of daily living, as defined in Section 12-270-104(6), C.R.S.;
- a. Essential behavioral health safety net providers shall not deny services to individuals who exhibit inappropriate sexual behaviors.

7. Displays of aggressive behavior, or history of aggressive behavior, as a symptom of a diagnosed mental health disorder or substance use disorder;
 8. Clinical presentation or behavioral presentation in any previous interaction with a provider;
 9. Place of residence; or
 10. Disability, age, race, creed, color, sex, sexual orientation, gender identity, gender expression, marital status, national origin, ancestry, or tribal affiliation.
- E. If the individual's needs exceed the treatment capacity or clinical scope of practice needed to serve the individual, the essential behavioral health safety net provider shall provide a warm handoff to a provider or entity able to provide care for the individual that is within its scope of service, which may include the BHA or its designee.
1. Essential behavioral health safety net providers must also provide warm handoffs for individuals who have health-related social needs that require alternative services outside the scope of the behavioral health safety net system, such as services for housing, food insecurity, and transportation. The essential behavioral health safety net provider shall connect the individual to appropriate resources to initiate those services.
 2. When referring an individual to an alternative provider, entity, or service, geographic location and the individual's ability to access the service location shall be considered.
- F. The essential behavioral health safety net provider shall track the following information for all priority population individuals who were referred to alternative services pursuant to this part. This information must be maintained in a single report that must be made available upon request by the BHA or its designee. This report shall include:
1. Individual demographics, including to which priority population the individual belongs;
 2. Standardized descriptions of the needs of the individual that could not be met and require the individual to be referred to another provider;
 3. The outcome and timeliness of the referral, i.e., the date of the referral and response from the receiving agency; and
 4. Whether the individual was discharged from a higher level of care to a lower level of care and, if so, what level of care the referring provider was seeking to discharge the individual from.
- G. These processes must apply at the time of initial screening, and any time reassessment indicates the individual's needs have changed and fall outside of the scope of the agency.
1. When an essential behavioral health safety net provider initiates a transition in care for an individual or family under the care of the agency, whether the transition is to an alternate agency or an alternate level of care within the agency, the essential behavioral health safety net provider must notify the individual or family via a live conversation and then ensure that appropriate steps are taken to transition the individual or family.
 2. Requirements to not refuse care based on these criteria apply to essential behavioral health safety net providers as a whole. Refusal does not include transferring an individual to an alternative level of care within an essential behavioral health safety net provider or identifying new personnel to support the individual.

12.4.4 Governance

- A. Overall responsibility for the administration of an essential behavioral health safety net provider shall be vested in a director who is a physician or a member of one of the licensed mental health professions unless the essential behavioral health safety net provider is only providing recovery support services. If the director is not a licensed physician or licensed mental health professional, the essential behavioral health safety net provider shall employ or contract with at least one (1) authorized practitioner or licensee to advise the director on clinical decisions.
- B. Each essential behavioral health safety net provider from which services may be purchased shall:
 - 1. Be under the control and direction of a county or local board of health, a board of directors or board of trustees of a corporation, a for-profit or not-for-profit organization, a regional mental health board, tribal organization, or a political subdivision of the state;
 - 2. Enter into a contract developed pursuant to Section 27-50-203, C.R.S. and accept publicly funded individuals.

12.5 Comprehensive Community Behavioral Health Providers

12.5.1 Requirements

- A. Comprehensive community behavioral health providers shall, either directly or through formal agreement with behavioral health providers in the community or region, ensure the provision of all of the following services:
 - 1. Emergency and Crisis Behavioral Health Services in conformity with Chapter 6 of these rules;
 - 2. Mental Health and Substance Use Outpatient Services in conformity with Chapter 4 of these rules;
 - 3. Behavioral Health High-Intensity Outpatient Services in conformity with Chapter 4 of these rules;
 - 4. Care Management pursuant to part 12.5.7 of this Chapter;
 - 5. Outreach, Education, and Engagement Services pursuant to part 12.5.8 of this Chapter;
 - 6. Mental Health and Substance Use Recovery Supports in conformity with Chapter 3 of these rules;
 - 7. Outpatient Competency Restoration pursuant to part 12.5.9 of this Chapter.
 - 8. Screening, assessment, and diagnosis, including risk assessment, crisis planning, and monitoring to key health indicators, in accordance with endorsement specific requirements and part 12.5.3 of this Chapter.
- B. When providing these services directly, the comprehensive community behavioral health provider shall provide the services in conformity with endorsement specific requirements for the services, found in Chapters 3 through 10 of these rules.

- C. When providing these services through formal agreement with another agency, the comprehensive provider shall ensure that the agency providing the services holds the appropriate license(s) and accompanying endorsements in good standing for those services, unless the agency is otherwise exempt from licensure requirements.
- D. Comprehensive community behavioral health providers shall provide services to children and families in conformity with the requirements of Chapter eight (8) of these rules.
- E. In addition to the requirements set forth in the endorsement Chapters three (3) through ten (10), comprehensive community behavioral health providers shall comply with the following requirements:
 - 1. Outpatient requirements
 - a. The comprehensive community behavioral health provider's requirement to provide outpatient services does not include the requirement to provide minor in possession (MIP) services.
 - b. The comprehensive community behavioral health provider shall provide outpatient clinical services during times that ensure accessibility and meet the needs of the individual population to be served, including evening and/or weekend hours.
 - c. As necessary and appropriate for the needs of individuals, comprehensive community behavioral health providers shall provide services in the home and community and shall utilize telehealth methods to deliver care.
 - d. If an individual presents with an emergency or crisis need, appropriate action is taken immediately, and subsequent outpatient follow-up is promptly coordinated and delivered.
 - e. If an individual currently receiving services from a comprehensive community behavioral health provider presents with an urgent need, clinical services, including medication management, are provided within one (1) business day of the time the request is made.
 - f. Comprehensive community behavioral health providers must be designated to provide services to individuals on involuntary outpatient certifications pursuant to part 11.18 of these rules.
 - 2. Crisis/emergency
 - a. The comprehensive community behavioral health provider shall provide crisis management services that are available and accessible twenty-four (24) hours a day. These services may include:
 - (1) Walk-in crisis services; or
 - (2) Mobile crisis services.

12.5.2 Priority Populations

- A. The comprehensive community behavioral health provider shall:
 - 1. Serve all priority populations; and

2. Have personnel with appropriate training and scope of practice to serve all priority populations.

12.5.3 Screening, Triage, and Care Coordination in Alignment with No Refusal Requirements

- A. When an individual attempts to initiate treatment with a comprehensive community behavioral health provider, the comprehensive community behavioral health provider shall complete an initial screening and triage process to determine urgency and appropriateness of care with the comprehensive community behavioral health provider and the service needs of the individual.
- B. Screenings must collect at least the following information from an individual seeking services:
 1. Identifying information;
 2. Primary complaint/reason for seeking services;
 3. Current behavioral health symptoms, including severity, duration, mental status, and changes or impairments in functioning due to symptoms;
 4. Medical concerns/chronic health issues, including pregnancy and postpartum status; and,
 5. Evaluation of imminent risk, including:
 - a. Suicide risk;
 - b. Danger to self or others;
 - c. Urgent or critical medical conditions, including withdrawal or overdose risk; or
 - d. Other immediate risks, including threats from another person.
 6. Health-related social needs and risk factors related to social determinants of health, including but not limited to:
 - a. Food security;
 - b. Housing stability and security;
 - c. Personal safety;
 - d. Access to health services including preventative health care; or
 - e. Physical health concerns for which the individual is not receiving adequate treatment.
- C. The comprehensive community behavioral health provider shall use these standard criteria for determining whether a comprehensive community behavioral health provider clinical scope of practice or treatment capacity are appropriate to meet the needs of the individual, or if the comprehensive community behavioral health provider will instead provide care coordination to support the individual in accessing alternate services in the following circumstances:
 1. The individual presents with the need for a level of care the comprehensive community behavioral health provider does not provide.

2. The comprehensive community behavioral health provider cannot provide services within an appropriate time frame per the individual's needs and the agency's capacity.
- D. In accordance with Section 27-50-301(4), C.R.S., unless it is determined, pursuant to the criteria in part 12.5.3.C of this Chapter, that an individual's needs fall outside the scope and capacity of the comprehensive community behavioral health provider, the comprehensive community behavioral health provider shall not refuse to treat an individual based on the individual's:
1. Insurance coverage, lack of insurance coverage, or ability to pay;
 2. Clinical acuity level related to the individual's behavioral health condition or conditions, including whether the individual has been certified for short-term treatment or long-term care and treatment pursuant to Article 65 of Title 27, C.R.S.;
 3. Readiness to transition out of the Colorado Mental Health Hospital at Pueblo, the Colorado Mental Health Hospital at Fort Logan, or any other mental health institute or licensed facility providing inpatient psychiatric services or acute care hospital providing stabilization because the individual no longer requires inpatient care and treatment;
 4. Involvement in the criminal or juvenile justice system;
 5. Current involvement in the child welfare system;
 6. Co-occurring mental health and substance use disorders, physical disability, or intellectual or developmental disability, irrespective of primary diagnosis, co-occurring conditions, or if an individual requires assistance with activities of daily living or instrumental activities of daily living, as defined in Section 12-270-104(6), C.R.S.;
 - a. Comprehensive community behavioral health providers shall not deny services to individuals who exhibit inappropriate sexual behaviors.
 7. Displays of aggressive behavior, or history of aggressive behavior, as a symptom of a diagnosed mental health disorder or substance use disorder;
 8. Clinical presentation or behavioral presentation in any previous interaction with a provider;
 9. Place of residence; or
 10. Disability, age, race, creed, color, sex, sexual orientation, gender identity, gender expression, marital status, national origin, ancestry, or tribal affiliation.
- E. If the individual's needs exceed the treatment capacity or clinical scope of practice of a comprehensive community behavioral health provider, based on the standard criteria in part 12.5.3.c of this Chapter, the comprehensive community behavioral health provider must ensure that the individual has access to interim behavioral health services until the individual is connected to the most appropriate agency for ongoing care. This may include use of providers within the network of the BHA or its designee, or the regional managed care entity.
- F. The comprehensive community behavioral health provider shall obtain approval from the BHA or its designee under which the agency is operating, or the regional managed care entity for Medicaid individuals, prior to referring a priority population individual to alternative behavioral health treatment services.

1. Only an individual assessed to be experiencing a behavioral health crisis may be referred to external emergency or crisis services without prior approval from the BHA or its designee.
 - a. If an individual is referred to an external provider for crisis or emergency behavioral health services, the agency shall work with the receiving provider to coordinate follow-up care for the individual upon discharge.
- G. If a referral of a priority population individual is approved by the BHA or its designee, the comprehensive behavioral health provider must provide a warm hand off by assisting the client in identifying a new provider, which may involve using the state's care coordination and navigation infrastructure.
- H. For individuals who have health-related social needs that require alternative services outside the scope of the safety net system, such as services for housing, food insecurity, and transportation, the comprehensive community behavioral health provider will connect the individual to appropriate resources to initiate those services. Approval by the BHA or its designee is not required in this instance.
- I. The comprehensive community behavioral health provider shall track the following information for all priority population individuals who were referred to external behavioral health services pursuant to this part 12.5.3 of this Chapter. This information must be maintained in a single report that must be made available upon request by the BHA or its designee. This report shall include:
 1. Individual demographics, including to which priority population the individual belongs;
 2. Standardized descriptions of the needs of the individual that could not be met and require the individual to be referred to another provider;
 3. The outcome and timeliness of referral, i.e., the date of the referral and response from the receiving agency; and
 4. Whether the individual was discharged from a higher level of care to a lower level of care and, if so, what level of care the referring provider was seeking to discharge the individual from.
- J. These processes must apply at the time of initial screening, and any time reassessment indicates the individual's needs have changed and fall outside of the scope of the agency.
 1. When an agency initiates a transition in care for an individual or family under the care of the agency, whether the transition is to an alternate agency or an alternate level of care within the agency, the agency must notify the individual or family face to face, on a telephone call, or two-way video conference and then ensure that appropriate steps are taken to transition the individual or family.
 2. Requirements to not refuse care based on these criteria apply to the comprehensive community behavioral health provider as a whole. Refusal does not include transferring an individual to an alternative level of care within the comprehensive community behavioral health provider or assigning new personnel to support the individual.

12.5.4 Access Plan

- A. Comprehensive community behavioral health providers shall establish an access plan as part of their quality management program.

- B. Access plans must be designed to improve treatment access and/or outcomes for one (1) or more priority populations through an evidenced-based approach.
- C. Comprehensive community behavioral health providers shall implement strategies from the access plan to decrease the disparities in access and outcomes for priority populations.
- D. Development, implementation, and evaluation of the access plan must include the collection and/or analysis of available data related to populations and areas served by the agency to evaluate outcomes for priority populations. Goals and outcome measures should be identified in conjunction with individuals, families, and advocates who represent the identified priority populations. These outcome measures may include but are not limited to:
 - 1. Individual or family-reported measures such as satisfaction, achievement of goals, ability to thrive, or quality of life;
 - 2. System-reported outcomes such as access and engagement in care, preventable hospitalizations and/or hospital readmission, rate of follow-up with individuals and families, level of individual or family engagement, number of substantiated complaints or appeals, and timeliness of transitions to appropriate levels of care; or
 - 3. Utilization measures such as number of individuals or families served, characteristics of individuals who do not engage in services, number of screenings completed, or number of referrals provided.

12.5.5 Governance

- A. Each comprehensive community behavioral health provider shall:
 - 1. Be under the control and direction of a county or local board of health, a board of directors or board of trustees of a corporation, a for-profit or not-for-profit organization, a regional mental health board, tribal organization, or a political subdivision of the state; and
 - 2. Enter into a contract developed pursuant to Section 27-50-203, C.R.S. and accept publicly funded individuals.
- B. Treatment programs of the comprehensive community behavioral health provider must be vested in a director who is a physician or a member of one of the licensed mental health professions. The director is not required to provide oversight or direction for recovery services. If the director is not an authorized practitioner or licensee, the agency shall contract with at least one (1) authorized practitioner or licensee to advise the director on clinical decisions.
- C. The governing board of the comprehensive community behavioral health provider must either:
 - 1. Be composed of at least 51% voting members that have lived experience with accessing services for mental health and/or substance use disorders, which may include parents of children with mental health and/or substance use disorders who have supported their children in accessing services for mental health and/or substance use disorders; or
 - 2. Include at least two (2) voting members that have lived experience with accessing services for mental health and/or substance use disorders, which may include parents of children with mental health and/or substance use disorders who have supported their children in accessing services for mental health and/or substance use disorders.

- a. In addition, the governing body shall demonstrate how it collects, considers, and implements input and feedback from individuals and families currently receiving services in governing body decisions.

12.5.6 Fee Schedule for Services Provided

- A. The comprehensive community behavioral health provider shall waive charges or charge for services on a sliding scale based on income and require that the agency not restrict access or services because of an individual's financial limitations.
- B. The comprehensive community behavioral health provider must ensure no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such service.
 1. Any fees or payments required by the comprehensive community behavioral health providers for such services must be reduced or waived to enable the comprehensive community behavioral health providers if necessary to fulfill this requirement.
- C. The comprehensive community behavioral health provider shall have a published sliding fee discount schedule(s) that includes all services the comprehensive community behavioral health provider proposes to offer pursuant to these criteria. Such fee schedule must be included on the comprehensive community behavioral health provider's website, posted in the comprehensive community behavioral health provider's waiting room, and readily accessible to individuals and families. The sliding fee discount schedule must be communicated in languages/formats and/or communication methods of frequently encountered limited English proficiency (LEP) groups of the comprehensive community behavioral health provider.
- D. The fee schedules, to the extent relevant, conform to federal and state statutory or administrative requirements that may be applicable to existing agencies; absent applicable state or federal requirements, the schedule is based on locally prevailing rates or charges and includes reasonable costs of operation.
- E. The comprehensive community behavioral health provider has written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule. Those policies are applied equally to all individuals seeking services.

12.5.7 Care Management

- A. In addition to the requirements of part 12.3.3, comprehensive community behavioral health providers shall be equipped to provide outreach-focused high intensity supports to individuals who may have complex needs, be involved in multiple systems, and/or require additional support to achieve whole person health.
- B. Care management may include, as necessary to address the assessed needs of an individual, and in alignment with the expressed preferences of the individual:
 1. Convening persons involved in the individual's services, including health care and community-based service providers, family members and other persons identified by the individual, to work collaboratively with the individual for the purpose of service planning and coordination, in order to facilitate wellness, self-management, and recovery of the whole person.

- a. This must occur when the individual is assessed to be at rising risk of adverse outcomes, or when the individual experiences a significant change in status, which may include a behavioral health crisis, change in health or housing status, etc.
 - b. This may include team meetings or other structured discussions.
2. Facilitating access to necessary services and supports identified within the individual's service plan created pursuant to part 12.3.3 of this Chapter through supports including but not limited to:
 - a. Application assistance;
 - b. Community-based outreach to the individual;
 - c. Self-management support including educating the individual about their behavioral health conditions and daily living skills including but not limited to medication use, personal hygiene, transportation use, shopping, and budgeting;
 - d. Accompanying the individual within the community or other setting to access services which the individual may not be able to access independently.
3. Supporting an individual to develop psychiatric advance directives, with the support of appropriate medical and behavioral health professionals, so the individual's preferences for behavioral health treatment and recovery supports are known in the event of a behavioral health crisis.
4. Providing support and outreach during care transitions.
 - a. The agency shall have policies and procedures in place supporting discharge planning and transitions between levels of care, including individuals who have presented to or have been treated at an emergency department (ED) or hospital for behavioral health needs.
 - b. The comprehensive community behavioral health provider shall be proactive in identifying impending care transitions and shall implement these procedures any time that the comprehensive community behavioral health provider is made aware that a care transition is occurring.
 - c. Policies and procedures must address how the comprehensive community behavioral health provider will provide services to individuals and families to support successful care transitions, ensure continuity of services, and minimize the time between discharge and follow-up. These services may include:
 - (1) Peer support;
 - (2) Medication management including completing medication reconciliation and educating individuals, families or persons the individual identifies as their caretaker, about changes to the individual's medications or service plan;
 - (3) Individual education to support self-management, including education regarding warning signs for increasing support needs; and
 - (4) Outreach to promote engagement in follow-up care.

- d. Whenever possible, the comprehensive community behavioral health provider shall work with the discharging facility ahead of discharge to facilitate a seamless transition, in accordance with care coordination requirements in 12.3.3 in this Chapter.
- e. The comprehensive community behavioral health provider shall make and document reasonable attempts to contact individuals who are discharged from a facility within 24 hours of discharge. This may include community-based outreach as applicable to the needs of the individual.
- f. Policies and procedures must address transfer of medical records for services received as permitted by HIPAA, as incorporated by reference in part 1.2 of these rules; 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules; and Section 27-65-101 through -131, C.R.S.

C. Documentation

- 1. Care management provided to an individual pursuant to this part 12.5.7 must be documented in the individual's record.
- 2. The service plan must identify person-centered goals related to mitigating risks and managing assessed needs. The service plan must identify relevant outcome measures and timeframes for assessing progress towards goals.
 - a. The comprehensive community behavioral health provider must document goal progress within the individual's record.

D. Personnel and training

- 1. Comprehensive community behavioral health providers shall have written policies and procedures outlining the initial and ongoing training for personnel delivering the services outlined in this part 12.5.7.
 - a. Training must include training specific to the particular needs of the populations served by the personnel, including the provision of person-centered, trauma-informed, harm reduction-focused, physically and programmatically accessible, and culturally and linguistically appropriate services.
 - b. The training requirements of personnel may vary based on the populations served by that personnel.
 - c. The written policies and procedures must identify the frequency of ongoing training.
- 2. Comprehensive community behavioral health providers shall clearly document trainings in the personnel file and ensure that personnel provide services only to populations for which they are properly trained.
- 3. Personnel providing care coordination must have clearly defined scopes of work that do not exceed their level of training and scope of practice.

12.5.8 Outreach, Education, and Engagement Services

A. General service provisions

1. Comprehensive community behavioral health providers must complete an assessment of the community behavioral health treatment needs of the population they serve.
 2. If the agency is completing, or has completed, a community behavioral health assessment for another government entity or project, or through a third-party, those assessments may be used for the purpose of this part 12.5.8.A.1.
 3. Assessments of community behavioral health treatment needs of applicable service and populations in need by the BHA or a designee of the BHA may be used for the purpose of this part 12.5.8.A.1.
 - a. If using previously completed assessment(s) for the purpose of this part 12.5.8.A.1, community behavioral health needs assessment must not be older than three (3) years.
- B. The community behavioral health treatment needs assessment must include, but is not limited to, the following:
1. Feedback from community stakeholders that address social determinants of health;
 2. Define the community the agency serves by gathering information including, but not limited to, demographics of the community, data on access to care, client grievances and complaints, social determinants of health, and priority population data; and
 3. Assess unmet needs in behavioral health treatment levels of care in the community.
- C. Comprehensive community behavioral health providers must re-assess at least once every three (3) years to adapt to the changing needs of the community they serve.
- D. Comprehensive community behavioral health providers must develop a strategic plan to provide outreach, education, and engagement services. The strategic plan shall include the following:
1. Identified priority population(s) and/or treatment needs,
 2. Plans for outreach, education, and engagement services in the community to meet the priority population demographic. Plans must include:
 - a. How outreach, education, and engagement services will support efforts toward screening, early intervention, and treatment.
 - b. Off-site events and intentional engagement with priority populations, that may involve but is not limited to:
 - (1) Broad community involvement;
 - (2) Community partners that address social determinants of health in serving priority populations in assessed area;
 - (3) Local law enforcement;
 - (4) Local public health departments; and.
 - (5) Cultural centers/organizations.

- c. How planned outreach, education, and engagement services can improve behavioral health outcomes.
 - d. How data will be gathered and analyzed to measure outreach, education, and engagement service outcomes as permitted by HIPAA, as incorporated by reference in part 1.2 of these rules; 42 C.F.R. Part 2, as incorporated by reference in part 1.2 of these rules; and Section 27-65-101 through -131, C.R.S.
- E. Comprehensive community behavioral health providers must engage in outreach, education, and engagement services according to the strategic plan developed pursuant to part 12.5.8.D of this section.
- F. Comprehensive community behavioral health providers must gather, analyze, and interpret data received from efforts to measure outreach, education, and engagement service efforts into an outcome report as permitted by HIPAA, 42 C.F.R. Part 2; and Section 27-65-101, et. Seq.
- G. At the time of license renewal, or at any other additional time requested by the BHA, comprehensive community behavioral health providers must submit the outcomes report and an updated strategic plan for the following licensure year including a summary of outreach, education, and engagement efforts of the previous year and developed goals created from those efforts.

12.5.9 Outpatient Competency Restoration Services

- A. Application process
 - 1. Comprehensive community behavioral health providers must complete the application process with outpatient competency restoration services program within the Office of Civil and Forensic Mental Health (OCFMH) and appear on the OCFMH approved outpatient competency restoration list prior to BHA approval.
- B. Qualification and training
 - 1. Comprehensive community behavioral health providers must ensure that all personnel providing restoration services meet all qualifications as an approved provider of outpatient competency restoration services within OCFMH.
 - 2. Comprehensive community behavioral health providers must meet all training requirements set forth in any contracts between them and OCFMH to provide outpatient competency restoration services and must ensure all personnel providing restoration services attend any additional trainings as required by OCFMH, via contract, and the BHA.
- C. Standards for conducting services
 - 1. Comprehensive community behavioral health providers must provide competency restoration services in an outpatient setting to adult and juvenile individuals that are involved with the criminal justice system and deemed by the court to be incompetent to proceed.
 - 2. An agency must provide care coordination and collaborate with community and state partners when referrals are needed to assist in removing barriers to successful restoration to competency.

3. An agency must provide written notice within a minimum of thirty (30) calendar days in advance to individuals, OCFMH, and the BHA of intention to no longer provide outpatient competency restoration services. Responsibility for continuity of care must remain with the agency currently serving the individual until the transfer is complete.
4. If an agency provider is removed from the approved provider list held by the outpatient competency restoration services program within OCFMH, the BHA may take action to suspend and/or revoke the safety net approval pursuant to part 12.7 of this Chapter.

12.6 Procedures for Approval and BHA Oversight

12.6.1 Initial Approval

- A. Applicants seeking approval as a behavioral health safety net provider will be approved in accordance with the requirements set forth in this section.
- B. The applicant shall initially notify the BHA of their intent to seek approval by submitting a letter of intent. The letter of intent must indicate the provider's intent to seek approval as an essential behavioral health safety net provider and/or comprehensive community behavioral health provider as well as the services the provider intends to provide.
- C. The applicant shall provide the BHA with a complete application including all information and attachments specified in the application form available to access on the BHA's website and any additional information requested by the BHA.
 1. An application may be considered abandoned if the applicant fails to complete the application within twelve (12) months and fails to respond to the BHA. The BHA may administratively close the application process.
 2. After an administrative closure, the applicant may file a new application.
- D. With the submission of an application for approval as a behavioral health safety net provider, or within ten (10) days after a change in ownership or management of a behavioral health safety net provider, each owner and manager shall submit a complete set of the owner's and manager's fingerprints to the Colorado Bureau of Investigation (CBI) for the purpose of conducting a fingerprint-based criminal history record check. The CBI shall forward the fingerprints to the Federal Bureau of Investigation (FBI) for the purpose of conducting fingerprint-based criminal history record checks. Each owner and each manager shall pay the CBI the costs associated with the fingerprint-based criminal history record check. Upon completion of the criminal history record check, the CBI shall forward the results to the BHA. The BHA may acquire a name-based criminal history record check for an applicant who has twice submitted to a fingerprint-based criminal history record check and whose fingerprints are unclassifiable.
 1. An entity that holds a current license to operate from the BHA or CDPHE, and/or is currently recognized as a federally qualified health center are exempt from this requirement.
- E. The applicant shall provide the following information:
 1. Evidence of current licensure in good standing by the Department of Public Health and Environment, Department of Regulatory Agencies, Department of Human Services, or other state agency where applicable, unless otherwise exempt from licensing per applicable state or federal rule or statute.

- a. For applicants, including but not limited to federally qualified health centers, that are exempt from licensure but require federal recognition, the applicant shall provide documentation to demonstrate current recognition.
 - b. Applicants with an existing license from the BHA shall indicate their licensure status within the application. Evidence of licensure by the BHA does not need to be provided by the applicant for approval.
2. The legal name of the applicant and all other names used by it to provide services. The applicant has a continuing duty to submit notification to the BHA for all name changes at least thirty (30) calendar days prior to the effective date of the change.
3. Contact information for the applicant must include a mailing address, telephone number, and e-mail address. If applicable, the applicant's website and facsimile number are to be provided.
4. The identity, address, and telephone number of all persons and business entities with a controlling interest in the applicant, including but not limited to:
 - a. A non-profit corporation shall list the governing body and officers.
 - b. A for-profit corporation shall list the names of the officers and stockholders who directly or indirectly own or control five (5) percent or more of the shares of the corporation.
 - c. A sole proprietor shall include proof of lawful presence in the United States.
 - d. A partnership shall list the names of all partners.
 - e. The chief executive officer of the facility or agency.
 - f. If the addresses and telephone numbers provided above are the same as the contact information for the applicant itself, the applicant shall also provide an alternate address and telephone number for at least one individual for use in the event of an emergency or closure.
5. Proof of professional liability insurance. Behavioral health safety net providers must maintain such coverage for the duration of the approval term and must notify the BHA of any change in the amount, type, or provider of professional liability insurance coverage during the license term.
6. Articles of incorporation, Articles of organization, partnership agreement, or other organizing documents required by the secretary of state to conduct business in Colorado; and by-laws or equivalent documents that govern the rights, duties, and capital contributions of the business entity.
7. The address(es) of the physical location where services are delivered, as well as, if different, where records are stored for BHA review.
8. A copy of any management agreement pertaining to operation of the entity that sets forth the financial and administrative responsibilities of each party.

9. If an applicant leases one (1) or more building(s) to operate under the approval, a copy of the lease or leases must be filed with the license application and show clearly in its context which party to the agreement is to be held responsible for the physical condition of the property.
10. A statement, on the applicant's letterhead, if available, signed and dated, submitted with the application stating whether any of the actions listed in this part 12.6.1.E.10 of these rules have occurred, regardless of whether the action has been stayed in a judicial appeal or otherwise settled between the parties. The actions are to be reported if they occurred within ten (10) years preceding the date of the application for initial approval. The BHA may, based upon information received in the statement, request additional information from the applicant beyond the ten-year (10) time frame.
 - a. For initial approval as a behavioral health safety net provider, whether one (1) or more individuals or entities identified in the response to part 12.6.1.E.4 has a controlling or ownership interest in the business entity and has been the subject or party to any of the following:
 - (1) A civil judgment or criminal conviction resulting from conduct or an offense in the operation, management, or ownership of an agency or other entity related to substandard care or health care fraud. A guilty verdict, a plea of guilty, or a plea of nolo contendere (no contest) accepted by the court is considered a conviction.
 - (2) A disciplinary action imposed by a governmental entity in another state that registers or licenses agencies including but not limited to: a sanction, probation, civil penalty, or a denial, suspension, revocation, or modification of a license or registration.
 - (3) Limitation, denial, revocation, or suspension by any federal, state, or local authorities of any health care related license.
 - (4) The refusal to grant or renew a license for operation of an agency, or contract for participation or certification for Medicaid, Medicare, or other public health or social services payment program.
 - b. For a change of ownership of an agency, whether any of the new owners have been the subject of, or a party to, one (1) of more of the following events:
 - (1) A civil judgment or a criminal conviction in a case brought by the federal, state, or local authorities that resulted from the operation, management, or ownership of an agency or other entity related to substandard care or health care fraud.
 - (2) Limitation, denial, revocation, or suspension of a state license or federal certification by another jurisdiction.
11. Any statement regarding the information requested in part 12.6.1.E.10 of this Chapter must include the following, as applicable:
 - a. If the event is an action by a governmental agency, as described in part 12.6.1.E.10.b: the name of the agency, its jurisdiction, the case name, and the docket proceeding or case number by which the event is designated, and a copy of the consent decree, order, or decision.

- b. If the event is a felony conviction or misdemeanor involving moral turpitude: the court, its jurisdiction, the case name, the case number, a description of the matter or a copy of the indictment or charges, and any plea or verdict entered by the court. For the purposes of this rule, “crimes of moral turpitude” include the following felony, misdemeanor, or municipal offenses or equivalent out-of-state or federal offenses:
 - (1) Any of the offenses against the person set forth in Article 3 of Title 18 of the Colorado Revised Statutes. Examples of such offenses include, but are not limited to, any assault, menacing, or unlawful sexual behavior;
 - (2) Any of the offenses against property set forth in Article 4 of Title 18 of the Colorado Revised Statutes. Examples of such offenses include, but are not limited to, any arson, theft, trespass, or criminal mischief;
 - (3) Any of the offenses involving fraud set forth in Article 5 of Title 18 of the Colorado Revised Statutes;
 - (4) Computer crime as set forth in Article 5.5 of Title 18 of the Colorado Revised Statutes;
 - (5) Any of the offenses involving the family relations set forth in Article 6, Part 4 (wrongs to children), when committed intentionally and knowingly or recklessly; Part 6 (harboring a minor); or Part 8 (domestic violence) of Title 18 of the Colorado Revised Statutes;
 - (6) Any of the offenses constituting wrongs to at-risk adults set forth in, Article 6.5 of Title 18 of the Colorado Revised Statutes;
 - (7) Any of the offenses relating to morals set forth in Article 7 of Title 18 of the Colorado Revised Statutes. Examples of such offenses include, but are not limited to, prostitution, indecent exposure, and criminal invasion of privacy;
 - (8) Any other offense in any jurisdiction whatsoever that is committed intentionally, knowingly, or recklessly, and involves violence, coercion, threats, cruelty, fraud, deception, or deprivation of legally recognized rights; and,
 - (9) Any conspiracy, solicitation, or criminal attempt to commit any of the above offenses, or participation as an accessory to any of the above offenses.
 - c. If the event is a civil action or arbitration proceeding: the court or arbiter, the jurisdiction, the case name, the case number, a description of the matter or a copy of the complaint, and a copy of the verdict of the court or arbitration decision.
- F. Each application must be signed under penalty of perjury by an authorized corporate officer, general partner, or sole proprietor of the agency as appropriate.
- G. BHA shall conduct a preliminary assessment of the application and notify the applicant of any application defects.

1. The applicant shall respond within fourteen (14) calendar days to written notice of any application defect.
- H. BHA will provide written notice to the applicant within thirty (30) calendar days of receipt of a complete application.
- I. BHA will act on an application within ninety (90) calendar days of receipt of the completed application.
- J. The duration of the initial approval will be two (2) years from the date of issuance.
 1. BHA may conduct annual inspections during the two (2) year approval duration, in addition to any other inspections indicated in Section 12.6.6.G.

12.6.2 Provisional Approval

- A. Where an applicant for an initial approval fails to fully conform to the applicable statutes and regulations but the BHA determines the applicant is in substantial compliance with these rules and regulations and is temporarily unable to conform to all the minimum standards, a provisional approval may be granted. No provisional approval may be issued to an applicant if the operations may adversely affect individual health, safety, or welfare.
 1. A provisional approval will be valid for ninety (90) days.
 2. A second provisional approval, for another ninety (90) days, may be issued if the BHA determines that it is likely that compliance can be achieved by the date of expiration of the second provisional approval.
 3. The second provisional approval may be issued for the same duration as the first. The BHA may not issue a third or subsequent provisional approval to the entity.
 4. During the term of the provisional approval, the BHA shall conduct any review it deems necessary to determine if the agency meets the requirements for a regular approval.
 5. If the BHA determines, prior to expiration of the provisional approval, that the agency is in compliance with all applicable rules, it may issue a regular approval. The regular approval will be valid for one (1) year from the date of issuance of the regular approval, unless otherwise acted upon pursuant to part 12.7 of this Chapter.

12.6.3 Renewal of Approval

- A. An agency seeking renewal must provide the BHA with a renewal application, signed under penalty of perjury by an authorized corporate officer, general partner, or sole proprietor of the agency as appropriate at least sixty (60) calendar days prior to the expiration of the existing approval. Renewal applications shall contain the information required in part 12.6.1.E of this Chapter unless the information has been previously submitted and no changes have been made to the information currently held by the BHA.
- B. Failure of the agency to accurately answer or report any of the information requested by the BHA will be considered good cause to deny the renewal application.
- C. The BHA shall conduct a preliminary assessment of the renewal application and notify the agency of any application defects.

1. The agency shall respond within fourteen (14) calendar days to written notice of any application defect.
- D. The duration of the renewal approval will be two (2) years from the date of issuance.
 1. The BHA may conduct annual inspections during the two (2) year approval duration, in addition to any other inspections indicated in section 12.6.6.G.

12.6.4 Change of Ownership/Management

- A. If an agency undergoes a change in ownership without following the procedures outlined in this part 12.6.4, their existing approval will be terminated. Termination of the approval may not occur until after a hearing and in compliance with the provisions and procedures specified in Section 24-4-101 through -109, C.R.S.
- B. When an agency initiates a change of ownership, the agency must submit notification to inform the BHA of the change.
- C. Each agency undergoing a change of ownership shall submit an application, as prescribed in part 12.6.1 of this Chapter at least thirty (30) calendar days before a change of ownership.
 1. The application must include supporting documentation for change of ownership.
- D. The BHA will consider the following criteria in determining whether there is a change of ownership of an agency that requires a new approval. The transfer of fifty percent (50%) of the ownership interest referred to in this part 12.6.4.D may occur during the course of one (1) transaction or during a series of transactions occurring over a five (5) year period.
 1. Sole proprietors:
 - a. The transfer of at least fifty percent (50%) of the ownership interest in an agency from a sole proprietor to another individual, whether or not the transaction affects the Title to real property, shall be considered a change of ownership.
 - b. Change of ownership does not include forming a corporation from the sole proprietorship with the proprietor as the sole shareholder or forming a limited liability company from sole proprietorship.
 2. Partnerships:
 - a. Dissolution of the partnership and conversion into any other legal structure shall be considered a change of ownership if the conversion also includes a transfer of at least fifty percent (50%) of the ownership to one (1) or more new owners.
 - b. Change of ownership does not include dissolution of the partnership to form a corporation with the same persons retaining ownership in the new corporation.
 3. Corporations:
 - a. Merger of two (2) or more corporations resulting in the creation of a new corporate entity will be considered a change of ownership if the consolidation includes a transfer of at least fifty percent (50%) of the ownership to one or more new owners.

- b. Formation of a corporation from a partnership, a sole proprietorship, or a limited liability company will be considered a change of ownership if the change includes a transfer of at least fifty percent (50%) of the ownership to one (1) or more new owners.
 - c. The transfer, purchase, or sale of shares in the corporation such that at least fifty percent (50%) of the ownership of the corporation is shifted to one (1) or more new owners will be considered a change of ownership.
 - 4. Limited liability companies:
 - a. The transfer of at least fifty percent (50%) of the ownership interest in the company will be considered a change of ownership.
 - b. The termination or dissolution of the company and the conversion thereof into any other entity will be considered a change of ownership if the conversion also includes a transfer of at least fifty percent (50%) of the ownership to one (1) or more new owners.
 - c. Change of ownership does not include transfers of ownership interest between existing members if the transaction does not involve the acquisition of ownership interest by a new member. For the purposes of this part.
 - 5. Non-profits:
 - a. The transfer of at least fifty percent (50%) of the controlling interest in the nonprofit is considered a change of ownership.
 - 6. Management contracts, leases, or other operational arrangements:
 - a. If the agency enters into a lease arrangement or management agreement whereby the owner retains no authority or responsibility for the operation and management of the agency, the action will be considered a change of ownership that requires a new approval.
 - 7. Legal structures:
 - a. The conversion of an agency's legal structure, or the legal structure of a business entity that has an ownership interest in the agency is a change of ownership if the conversion also includes a transfer of at least fifty percent (50%) of the agency's ownership interest to one (1) or more new owners.
- E. The existing agency is responsible for correcting all rule violations and deficiencies in any current plan of action before the change of ownership becomes effective. In the event that such corrective actions cannot be accomplished in the time frame specified, the prospective agency shall be responsible for all uncorrected rule violations and deficiencies including any current plan of action submitted by the previous agency unless the prospective agency submits a revised plan of action, approved by the BHA, before the change of ownership becomes effective.
- F. When the BHA issues an approval to the new owner, the previous owner must return its approval to the BHA within five (5) calendar days of the new owner's receipt of its approval.

12.6.5 Rule Waivers

- A. Any agency or applicant that has applied for or been approved as a behavioral health safety net provider has the right to apply for a waiver of any rule or standard set forth in these rules which, in their opinion, poses an undue hardship on the applicant, agency, or community.
- B. Nothing contained in these provisions abrogates the agency's obligation to meet minimum requirements under local safety, fire, electrical, building, zoning, and similar codes.
- C. Nothing herein authorizes a waiver of any statutory requirement under state or federal law, except to the extent permitted therein.
- D. Upon application to the BHA, a waiver may be granted in accordance with this part 12.6.5. Absent the existence of a current waiver issued pursuant to this part, behavioral health safety net providers are expected to comply at all times with all applicable regulations except in instances where they are granted a provisional approval in accordance with part 12.6.2 of this Chapter.
- E. Waiver applications must be submitted to the BHA in writing.
 - 1. The BHA will only consider one (1) regulation per waiver application.
 - 2. The waiver application must provide the BHA information related to:
 - a. The regulation the agency or applicant is requesting to waive;
 - b. The reason why the waiver is being requested;
 - c. A proposed alternate compliance plan;
 - d. Any other information relevant to the waiver request that would inform the BHA's decision in either granting or denying the waiver.
 - 3. The waiver application must be signed by an authorized representative of the agency or applicant, who is the primary contact person and the person responsible for ensuring that accurate and complete information is provided to the BHA.
- F. In making its determination, the BHA may consider any information it deems relevant, including but not limited to:
 - 1. Critical incident and complaint investigation reports, licensure or certification survey reports, anticipated impact of the waiver on individual safety and quality of care if any, and findings of these reports related to the agency and/or the operator or owner thereof.
 - 2. When determining whether a waiver should be granted, the BHA shall prioritize the impact of the waiver on the health, safety, and welfare of individuals over any alleged undue hardship.
- G. The BHA shall act on a waiver application within ninety (90) calendar days of receipt of the completed application. An application will not be deemed complete until the applicant has provided all information and documentation requested by the BHA.
- H. The BHA may specify terms and conditions under which any waiver is granted, including which terms and conditions must be met in order for the waiver to remain effective. The term for which each waiver granted will remain effective must be specified at the time of issuance but may not exceed the term of the current approval.

1. At any time, upon reasonable cause, the BHA may inspect an agency with an active waiver to ensure that the terms and conditions of the waiver are being observed, and/or that the continued existence of the waiver is otherwise appropriate.
 2. Within thirty (30) calendar days of the termination, expiration, or revocation of a waiver, the agency shall submit to the BHA an attestation of compliance with the regulation to which the waiver pertained.
- I. The BHA will institute termination of a waiver upon a change of ownership of the agency, as defined in part 12.7.4. However, to prevent such termination, the prospective new owner may submit a waiver application to the BHA prior to the effective date of the change of ownership. Provided the BHA receives the new application by prior to the effective date of the change of ownership, the waiver will be deemed to remain effective until such time as the BHA acts on the application. Termination of the waiver may not occur until after a hearing and in compliance with the provisions and procedures specified in Section 24-4-101 through -109, C.R.S.
1. Except as otherwise provided in this part 12.6.5, a waiver may not be granted for a term that exceeds the current approval term.
 2. If an agency wishes to maintain a waiver beyond the stated term, it must submit a new waiver application to the BHA not less than ninety (90) calendar days prior to the expiration of the current term of the waiver or with an approval renewal.
- J. Notwithstanding anything in this part 12.6.5 to the contrary, the BHA may revoke a waiver if it determines that:
1. The waiver's continuation jeopardizes the health, safety, or welfare of individuals served by the agency;
 2. The waiver application contained false or misleading information;
 3. The terms and conditions of the waiver have not been complied with;
 4. The conditions under which a waiver was granted no longer exist or have changed materially; or,
 5. A change in a federal or state statute or regulation prohibits, or is inconsistent with, the continuation of the waiver.
- K. Notice of the revocation of a waiver must be provided to the agency in accordance with the Colorado Administrative Procedures Act and will not be effective until after a hearing in compliance with the provisions and procedures specified in Section 24-4-101 through -109, C.R.S.

12.6.6 Continuing Obligations and BHA Oversight

- A. Each agency must have and maintain electronic business communication tools, including but not limited to, internet access and a valid e-mail address. The agency must use these tools to receive and submit information.
- B. The approval is only valid while in the possession of the agency to whom it is issued and may not be subject to sale, assignment, or other transfer, voluntary or involuntary.
- C. The agency must provide accurate and truthful information to the BHA during inspections, investigations, applications, and oversight activities.

- D. When an agency is subject to inspection, certification, or review by other agencies, accrediting organizations, or inspecting companies, the agency shall provide and/or release to the BHA, upon request, any correspondence, reports, or recommendations concerning the agency that were prepared by such organizations.
- E. Each agency must submit notification to the BHA regarding any change in the information required by part 12.6.1.E of this Chapter from what was contained in the last submitted approval application.
 - 1. Changes to the operation of the agency may not be implemented without prior approval from the BHA. An agency shall, at least thirty (30) calendar days in advance, submit notification to the BHA regarding any of the following proposed changes.
 - a. Change in license category or classification.
 - b. Change in the scope of services, including the addition or removal of an endorsement, a service, or a physical location.
 - c. Change in legal name of the agency and all other names used by it to provide services.
- F. The BHA and any duly authorized representatives thereof have the right to enter upon and into the premises of any approved agency or applicant for an agency approval in order to determine the state of compliance with the statutes and regulations and must initially identify themselves to the person in charge of the agency at the time.
- G. The BHA may use the following measures to ensure an agency's full compliance with the applicable statutory and regulatory criteria.
 - 1. The BHA may conduct an unscheduled or unannounced review of a current agency based upon, but not limited to, the following criteria:
 - a. Routine compliance inspection,
 - b. Reason exists to question the agency's continued fitness to conduct or maintain operations in accordance with the approval requirements,
 - c. A complaint alleging non-compliance with approval requirements,
 - d. Discovery of previously undisclosed information regarding an agency or any of its owners, officers, managers, or other employees if such information affects or has the potential to affect the agency's provision of services, or
 - e. The omission of relevant information from documents requested by the BHA or indication of false information submitted to the BHA.
 - 2. Plan of action
 - a. If after review or pursuant to a complaint, it is determined that an agency is not in compliance with these rules, the agency shall be notified in writing, within thirty (30) business days of the specific deficiency/deficiencies.
 - b. After any review, the BHA may request a plan of action from an agency or require an agency's compliance with a BHA directed plan of action.

- c. If the agency does not agree with any or all of the findings regarding non-compliance, the agency has ten (10) business days from the receipt of non-compliance notice to dispute the findings by submitting evidence to the BHA.
- d. The agency shall receive a written response within thirty (30) business days of the review of submitted evidence.
- e. If the submitted information is sufficient, the agency shall be determined in compliance with these rules.
- f. If the agency continues to be found out of compliance with these rules, the agency shall have thirty (30) business days from the date of receipt of the review findings to submit a plan of action.
- g. The plan of action must be in the format prescribed by the BHA and included, but not be limited to, the following:
 - (1) A description of how the agency will correct each identified deficiency.
 - (a) If deficient practice was cited for specific personnel, the description shall include the measures that will be put in place or systemic changes made to ensure that the deficient practice will not reoccur for the affected individuals and/or other individuals having the potential to be affected.
 - (2) A description of how the agency will monitor the corrective action to ensure each deficiency is remedied and will not reoccur, and
 - (3) A completion date that is no later than ninety (90) calendar days from the issuance of the deficiency list, unless otherwise required or approved by the BHA. The completion date is the date that the entity deems it can achieve compliance.
- h. A completed plan of action must be:
 - (1) Signed by the agency's director, administrator, or manager, and
 - (2) Submitted to the BHA within thirty (30) calendar days after the date of the BHA's written notice of deficiencies.
 - (a) If an extension of time is needed to complete the plan of action, the agency shall request an extension in writing from the BHA prior to the plan of action due date. The BHA may grant an extension of time.
- i. The BHA has discretion to approve, impose, modify, or reject a plan of action.
 - (1) If the plan of action is accepted, the BHA shall notify the agency by issuing a written notice of acceptance, served either in-person or by first-class mail.
 - (2) If the plan of action is unacceptable, the BHA shall notify the agency in writing, and the agency shall re-submit the changes within the time frame prescribed by the BHA in the notice.

- (3) If the agency fails to comply with the requirements or deadlines for submission of a plan or fails to submit requested changes to the plan, the BHA may reject the plan of action and impose disciplinary sanctions as set forth in part 12.7 of this Chapter.
 - (4) If the agency fails to implement the actions agreed to by the action date in the approved plan of action, the BHA may impose enforcement sanctions as set forth below in part 12.7.
- H. The agency must provide, upon request, access to or copies of the following to the BHA for the performance of its regulatory oversight responsibilities:
 - 1. Individual records.
 - 2. Reports and information including but not limited to, staffing reports, census data, statistical information, and other records, as determined by the BHA.
- I. Oversight and enforcement activities may include review of endorsements and/or separate physical locations as necessary for the BHA to ensure the health, safety, and welfare of individuals.

12.7 Enforcement and Adverse Actions

12.7.1 Denial

- A. The BHA may deny an agency's approval as a behavioral health safety net provider for reasons including but not limited to, the following:
 - 1. The agency has not fully complied with all local, state, and federal laws and regulations applicable to the approval;
 - 2. The application or its accompanying documents contain a false statement of material fact;
 - 3. The agency fails to respond to BHA requests for additional information in the time frame indicated in the request;
 - 4. The agency refuses any part of an inspection;
 - 5. The agency fails to comply with federal financial participation requirements;
 - 6. The agency fails to comply with state and federal data and financial reporting requirements;
 - 7. The agency has failed to cooperate with the investigation of any local, state, or federal regulatory body or law enforcement agency; or
 - 8. The agency is not in compliance with regulatory requirements or has a documented pattern of non-compliance that has harmed or has the potential to harm the health or safety of the individual(s) served.
- B. If the BHA denies an application for approval, it shall provide the agency with a written notice, served either in-person or by first-class mail, explaining the basis for the denial and affording the agency the opportunity to respond and request a hearing.

- C. Appeals of denials must be conducted in accordance with the State Administrative Procedure Act, Section 24-4-101 through -109, C.R.S.

12.7.2 Revocation of Approval

- A. The BHA may revoke an existing approval if an agency fails or refuses to comply with the statutory and/or regulatory requirements applicable to its approval. Failures to comply include:
1. Making a false statement of material fact about individuals served by the agency, its personnel, capacity, or other operational components verbally or in any public document, or in a matter under investigation by the BHA or another governmental entity,
 2. Preventing, interfering with, or attempting to impede in any way the work of a representative or agent of the BHA in investigating or enforcing the applicable statutes or regulations,
 3. Falsely advertising or in any way misrepresenting the agency's ability to provide services for the individuals served based on its license type or status,
 4. Failing to provide reports and documents required by regulation or statute in a timely and complete fashion,
 5. Failing to comply with or complete a plan of action in the time or manner specified,
 6. Falsifying records or documents,
 7. Knowingly using or disseminating misleading, deceptive, or false information,
 8. Accepting commissions, rebates, or other forms of remuneration for referrals or other treatment decisions, or
 9. Exercising undue influence or coercion over an individual to obtain certain decisions or actions or for financial or personal gain. A relationship other than a professional relationship, including but not limited to a relationship of a sexual nature, between an owner, director, manager, administrator, or other personnel and an individual.
- B. Revocation must not occur until after a hearing and in compliance with the provisions and procedures specified in Article 4 of Title 24 and in Section 27-50-505, C.R.S.

12.7.3 Intermediate Restrictions

- A. The BHA may impose the following intermediate restrictions or conditions on an agency that has sought enhanced service payments in accordance with Section 27-50-505(3), C.R.S.:
1. Retaining a consultant to address corrective measures including deficient practice resulting from systemic failure;
 2. Monitoring by the BHA for a specific period;
 3. Providing additional training to personnel, owners, or operators of the agency;
 4. Complying with a directed written plan to correct the violation; or
 5. Paying a civil fine not to exceed two thousand dollars (\$2,000) in a calendar year.

- B. The agency may appeal any intermediate restriction or condition to the BHA in accordance with the Colorado Administrative Procedures Act Section 24-4-101, et seq., C.R.S.

12.7.4 Right to Appeal

- A. Any agency adversely affected or aggrieved by these rules or by the BHA's decisions in regard to implementation of these rules, has the right to appeal to the Colorado Department of Personnel and Administration, Office of Administrative Courts, and may subsequently seek judicial review of the BHA's action in accordance with Section 24-4-101 through -109, C.R.S.
- B. The following actions may be submitted to an administrative law judge for an evidentiary hearing: denial or revocation of an approval.
- C. After written notification from the BHA of intended action, the agency has twenty-one (21) calendar days to submit a written appeal. The appeal must be received by the BHA within twenty-one (21) days from the date the written notification of action letter was sent by the BHA.
- D. In all cases except waiver denials, the BHA will file a notice of charges with the Office of Administrative Courts to begin the administrative process. In waiver denials, if the applicant for the waiver requests an appeal, the request for appeal must be forwarded to the Office of Administrative Courts. Once the appellant's request is forwarded to the office of administrative courts, the BHA may file a notice of charges.
- E. Subsequent to an evidentiary hearing at the Office of the Administrative Courts and the issuance of a final agency decision, a party may seek to appeal the final agency decision through judicial review in accordance with Section 24-4-106, C.R.S.

The following sections 21.000 through 21.290.58 and sections 21.400 through 21.400.6 of these rules are applicable to agencies approved or designated by the BHA prior to January 1, 2024, pursuant to Section 27-81-106, C.R.S.; Sections 27-50-101 through 27-50-903; Sections 27-65-101 through 27-65-131; or Sections 27-66-101 through 27-66-110, C.R.S. until such time that such agencies' approval or designation expires and/or is up for renewal. Upon renewal, Chapters 1 - 11 above shall apply.

Chapter 13: Controlled Substance Services

13.1 Definitions

“Administer” means the direct application of a controlled substance, whether by injection, inhalation, ingestion, or any other means to the body of an individual.

“Approved Private Treatment Facility” means a private agency meeting the definition set forth in Section 27-81-102(2), C.R.S., and standards prescribed and approved under Section 27-81-106, C.R.S., and shall be referred to as “approved treatment facility”.

“Approved Public Treatment Facility” means an agency operating under the direction and control of or approved by BHA and meeting the definition set forth in Section 27-81-102(3), C.R.S., and standards prescribed and approved under Section 27-81-106, C.R.S., and shall be referred to as “approved treatment facility.”

“Compound” means to produce or create by combining two or more substances.

“Controlled Substance” means a drug whose general availability is restricted or any substance that is strictly regulated or outlawed because of its potential for abuse or dependence. Controlled substances include narcotics, stimulants, depressants, hallucinogens, and cannabis.

“Corrective Action” means a time limited remedial measure applied to agencies that are out of compliance during a one (1) year licensing period.

“Diversion” means the transfer of any controlled substance from a licit to an illicit channel of distribution or use.

“Maintenance Treatment” means the dispensing of a controlled substance, such as methadone or buprenorphine, at stable dosage levels for a period in excess of twenty-one (21) days in the supervised treatment of an individual for opioid use disorder.

“Medically Supervised Withdrawal” means the process through which an individual who is physically dependent on alcohol, illicit drugs, prescription medications, or a combination of these substances is over a period of time withdrawn from the substances of dependence and the process may include the use of controlled substances to manage the symptoms of withdrawal under the supervision of a qualified practitioner.

“Office-based opioid treatment” or “OBOT” means the prescribing of medications for the treatment of opioid use disorders by a federally authorized primary care or general health care provider outside of programs required to be licensed pursuant to Section 27-80-201 et seq., C.R.S.

“Physical dependence” means a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

“Practitioner” means:

- A. A physician or other person licensed, registered or otherwise permitted to distribute, dispense, or to administer a controlled substance in the course of professional practice.
- B. A pharmacy, hospital or other institution licensed, registered, or otherwise permitted to distribute, dispense, or to administer a controlled substance in the course of its professional practice in this state.

13.2 Authority and Applicability

- A. These rules are established to create standards for agencies seeking a controlled substance license.
- B. All agencies providing controlled substance licensed services as defined within 13.3 shall meet the standards in this Chapter 13. Controlled substance licensed agencies shall require a BHE license, and the agency shall comply with Chapter 2 and corresponding Chapters of these rules applicable to levels of care provided.

13.3 Controlled Substance License Requirements

- A. Agencies shall apply for and obtain a controlled substance license if they dispense, compound, or administer (pursuant to Section 27-80-204, C.R.S.) a controlled substance in order to treat a substance use disorder or to manage the withdrawal symptoms of a substance use disorder, from stock medication. All applicants for a controlled substance license must demonstrate compliance with these rules and all applicable state and federal statutes and regulations, including but not limited to the 72-hour emergency rule and others pertaining to controlled substances. The 72-hour emergency rule means the regulation issued by the Drug Enforcement Administration (DEA) found at 21 C.F.R. § 1306.07 (Apr. 2024), which is hereby incorporated by reference, no later editions or amendments are incorporated. This regulation is available at no cost from the DEA at 8701 Morrisette Drive, Springfield, VA 22152 or at <https://www.ecfr.gov/current/title-21>. This regulation is also available for public inspection at the Colorado Department of Human Services, Behavioral Health Administration, 710 S. Ash st, Suite C140, Denver, CO 80246, during regular business hours.
- B. An office-based opioid treatment (OBOT) provider that does not dispense, compound, or administer a controlled substance from stock medication on-site is not required to obtain a controlled substance license pursuant to this part 13.3.
- C. In accordance with 21 C.F.R. § 1306.07(c), as incorporated by reference in Section 13.3.a. administering or dispensing of narcotic drugs: BHA CSL rules are not intended to impose limitations on a physician or authorized hospital staff to administer or dispense narcotic drugs in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction, or to administer or dispense narcotic drugs to persons with intractable pain in which no relief or cure is possible or none has been found after reasonable efforts.

13.3.1 Licensing Procedures

- A. Treatment facilities meeting all the requirements of Colorado Revised Statutes Part 1 of Article 280 of Title 12; Part 3 of Article 18 of Title 18; Section 27-81-106, C.R.S.; the requirements of the controlled substance license rules; and all applicable state and federal regulations including those that apply to controlled substances shall be issued a controlled substance license.
- B. A controlled substance license issued by BHA shall be obtained annually for each approved treatment facility that dispenses, compounds, or administers a controlled substance to treat substance use disorders or the withdrawal symptoms of a substance use disorder.
- C. A separate controlled substance license is required for each approved treatment facility site where controlled substances are dispensed, compounded, or administered, in order to treat substance use disorders or the withdrawal symptoms of a substance use disorder.

- D. Any approved treatment facility that receives a controlled substance license may dispense, compound, or administer controlled substances only to the extent authorized by their license and in conformity with Colorado Revised Statutes Part 1 of Article 280 of Title 12, and Article 18 of Title 18.
- E. Routine Monitoring: Controlled substance licensing visits shall be scheduled and conducted by BHA during the approved agencies' normal business hours to the extent possible.
- F. BHA shall conduct unscheduled site visits for specific monitoring purposes and investigation of complaints or critical incidents involving approved agencies that have a controlled substance license. These unscheduled visits shall be in accordance with the:
 - 1. Controlled Substance License Rules;
 - 2. BHA policies and procedures;
 - 3. Department substance use disorder BHA Rules; and
 - 4. Any statutes and regulations that protect the confidentiality of individual identifying information.
- G. BHA shall have access to all individual, agency, and personnel records and any other relevant documentation required to determine compliance with these rules and to coordinate individual placement and care.
- H. A controlled substance license shall not be granted to an agency unless there is documentation that the medical director or qualified practitioner dispensing, compounding or administering controlled substances has not been convicted within the last two (2) years of a willful violation of Part 1 of Article 180 of Title 12 of the Colorado Revised Statutes or any other state or federal law regulating controlled substances

13.3.2 Initial License

- A. Applicants for an initial controlled substance license to dispense, compound, or administer controlled substances to treat a substance use disorder or to manage the withdrawal symptoms of a substance use disorder shall submit a controlled substance license application that has been affirmed and signed by a qualified practitioner, a copy of current policies and procedures addressing the use of controlled substances to treat substance use disorders or withdrawal symptoms of a substance use disorder, and the application fee of five hundred dollars (\$500).
- B. No approved treatment facility that is required to be licensed shall engage in any activity for which a controlled substance license is required until the facility's application is granted, and a license is issued to the facility by BHA.
- C. Initial controlled substance license applications received by BHA that are not completed according to instructions, do not include the application fee, or do not include the required policies and procedures shall be returned to the applicant by certified mail with the submitted application fee and a written explanation as to why their application is being returned.

- D. BHA shall review complete initial applications that have the required fee and appropriate policies and procedures and BHA shall conduct an on-site inspection to determine that the applicant is in compliance with these controlled substance license rules, treatment rules, and all state and federal statutes and regulations. If the Governor or local government declares an emergency or disaster BHA has discretion to modify the requirement for on-site inspections. If BHA modifies the requirement for on-site inspections, the requirement shall only be modified as necessary because of circumstances related to the disaster or emergency.
- E. Initial applicants that have submitted satisfactory policies and procedures and other required documentation shall be granted a one hundred and eighty (180) day provisional license.
- F. BHA may conduct a site visit to determine that the provisionally licensed agency is in compliance with these controlled substance license rules, treatment rules, and all state and federal statutes and regulations. If, after the first provisional license, an agency has not demonstrated full compliance, a second one hundred and eighty (180) day provisional license may be granted if substantial progress continues to be made, and it is likely compliance can be achieved by the date of expiration of the second provisional license. If, at the end of the first provisional license, an agency demonstrates compliance, a full controlled substance license shall be issued. BHA will not issue a third or subsequent provisional license to the applicant.
- G. BHA shall conduct a site visit to determine compliance with all applicable state and federal laws and regulations at the end of the second provisional license period. If at the end of the second provisional license an agency demonstrates compliance, a full controlled substance license shall be issued.
- H. An applicant for licensure pursuant to these rules and regulations shall also be considered an applicant for registration pursuant to Section 18-18-302, C.R.S.
- I. Initial applicants that are found not to be in full compliance shall have their license applications returned by certified mail with a written explanation as to why their application is being returned and notification that their controlled substance license application has been denied as of ten (10) days from the date the denial letter was mailed. Application fees shall not be refunded. If an applicant disagrees with the decision, they may appeal (Part 2.24.5 of these Rules); or upon remedying the noted deficiencies, may re-apply for an initial license in accordance with Chapter 13 of these rules.

13.3.3 License Renewal

- A. A controlled substance license shall expire one (1) year from the date the license is granted. A term shorter than one (1) year may be issued if agreed upon between the agency and BHA.
 - 1. If a term shorter than one (1) year is issued, fees may be prorated to reflect the time period of the license term.
- B. Agencies wishing to continue their controlled substance license shall submit a license renewal application to BHA thirty (30) days prior to the expiration date of their current controlled substance license along with the required fee of five hundred dollars (\$500). A copy of the agency's DEA narcotic treatment program registration and SAMHSA accreditation or certification as applicable shall also be submitted with each annual renewal application for this program type.
- C. Any treatment facility that currently has a controlled substance license issued by BHA may not apply for renewal more than sixty (60) days before the expiration date of the current controlled substance license.

- D. A controlled substance license renewal application that is received by BHA fewer than thirty (30) calendar days prior to the expiration of their existing license may fail to receive their new license prior to the expiration of their existing license. An agency that submits its renewal application fewer than thirty (30) days prior to the expiration of the current license and does not receive a new license prior to the current license expiration may reapply for an initial license in accordance with Chapter 13 of these rules.
- E. A controlled substance license renewal application that is received by BHA after the current license expiration date shall be returned by certified mail with written notification that the license is no longer in effect. Applicants may reapply for an initial license in accordance with Chapter 13 of these rules.
- F. If the governor or local government declares an emergency or disaster BHA has discretion to modify the requirement for on-site inspections. If BHA modifies the requirement for on-site inspections, the requirement shall only be modified as necessary because of circumstances related to the disaster or emergency.
- G. An agency that is in full compliance shall be granted renewal of their annual controlled substance license that shall be effective for one (1) year from the prior license's expiration date.

13.3.4 Probationary License

- A. At BHA's discretion, a probationary license may be issued to an agency out of compliance with applicable BHA, state, or federal regulations prior to issuance of a renewal license or during a current license term. The agency will be notified in writing of non-compliance areas and the need for a plan of action (see Part 2.24.3 of these rules).
- B. A probationary license will replace the current license for a period not to exceed ninety (90) calendar days.
- C. Administrative and treatment activities may be limited by a probationary license while the agency addresses corrective actions.
- D. A second probationary license may be issued for a period not to exceed ninety (90) calendar days if substantial progress continues to be made and it is likely that compliance can be achieved by the date of expiration of the second probationary license.
- E. If the agency fails to comply with or complete a plan of action in the time or manner specified, or is unwilling to consent to the probationary license, BHA shall revoke the license and the agency shall be notified by certified mail that the agency's license is revoked as of ten (10) days from the date the letter was mailed. If an agency disagrees with the decision, the agency may appeal (see Part 2.24.5 of these rules).
- F. Upon remedying the noted deficiencies, an agency may re-apply for an initial license in accordance with Part 13.5 of these rules.

13.3.5 License Denial, Revocation, Or Suspension

- A. A controlled substance license may be denied, suspended, or revoked in accordance with Part 2.24 of these rules and upon finding that the agency:
 - 1. Is not in compliance with the controlled substance license rules;
 - 2. Has violated any provision of Part 1 of Article 280 of Title 12, And Article 18 of Title 18 of the Colorado Revised Statutes;

3. Has failed to implement BHA imposed corrective actions;
 4. Has been negligent resulting in risk to individual and/or personnel health or safety;
 5. Has failed to provide for adequate supervision of treatment personnel as outlined in Part 2.5.1 of these rules and defined by the supervisor's professional practice board;
 6. Has furnished false or fraudulent information in an application;
 7. Has, as a practitioner, been convicted of, or has had accepted by a court a plea of guilty or *nolo contendere* to a felony under any state or federal law relating to a controlled substance; or
 8. Has had their federal registration to manufacture, conduct research on, distribute, or dispense a controlled substance suspended or revoked.
- B. BHA may limit revocation or suspension of a controlled substance license to the particular controlled substance, which was the basis for revocation or suspension.
- C. If BHA denies, suspends, or revokes a controlled substance license, all controlled substances owned or possessed by the agency at the time of the denial or suspension or on the effective date of the revocation order must be placed under seal. No disposition may be made of substances under seal until the time for making an appeal has elapsed or until all appeals have concluded, unless a court orders otherwise or orders the sale of any perishable controlled substances and the deposit of the proceeds with the court, or if BHA orders otherwise. Upon a revocation order becoming final, all controlled substances may be forfeited to the state.
- D. BHA shall promptly notify the Drug Enforcement Administration and the appropriate professional licensing agencies, if any, of all charges and the final disposition thereof and of all forfeitures of a controlled substance.

13.4 Treatment Provisions Under A Controlled Substance License

13.4.1 Agency Policies And Procedures

- A. Agencies shall develop and implement policies and procedures, as defined in this Part 13.4.1, that address the use of controlled substances in the treatment of substance use disorders or the withdrawal symptoms of a substance use disorder. These policies shall include, but are not limited to, how individuals are assessed to be appropriate to receive a controlled substance to treat their substance use disorder or the withdrawal symptoms of a substance use disorder. These policies shall meet the requirements of all federal, state, and local laws pertaining to controlled substances.
- B. Medication assisted treatment using a controlled substance shall be provided to individuals with a substance use disorder who are seeking treatment to manage symptoms of physical and psychological withdrawal and cravings, and to reduce risk associated with drug use, including overdose, death, and the spread of infectious diseases.
- C. Approved agencies must only dispense, compound, or administer, controlled substances by or on the order of a qualified practitioner who currently possesses and maintains a license to practice medicine in the State of Colorado as provided by Article 240, of Title 12, C.R.S. The qualified practitioner's medical order must be documented in the individual's treatment record.

- D. Approved agencies that dispense, compound, or administer controlled substances must also have a current registration from the Drug Enforcement Administration for the state in which they are licensed.
- E. All controlled substances must be dispensed, compounded, or administered according to applicable state and federal statutes, regulations and rules, controlled substance license rules, and BHA rules.
- F. Controlled substances must be dispensed, compounded, or administered in accordance with the manufacturer's specifications found on product labels and/or in printed instructions accompanying the product.
- G. Agencies shall maintain an individual dispensing record on each individual that receives controlled substances at their facility. The dispensing record shall include:
 - 1. Complete name of individual receiving the controlled substance;
 - 2. Name of the controlled substance, strength, and dosage form;
 - 3. Amount consumed;
 - 4. Amount dispensed;
 - 5. Date dispensed;
 - 6. Amount and dosage form taken home by individual (if applicable); and
 - 7. First initial and last name and the credentials of the individual who dispensed the controlled substance medication.
- H. Agencies shall ensure that all personnel are working within their scope of practice and shall only allow licensed medical personnel to dispense, compound, or administer controlled substances.
- I. Each approved treatment facility shall provide formal training and testing on an annual basis to all personnel for the following:
 - 1. State and federal requirements regarding controlled substances and confidentiality, including BHA rules; and
 - 2. Pharmacology of controlled substances dispensed, including but not limited to loss of tolerance, dangerous drug or alcohol interactions, signs and symptoms of overdose, purpose of its use.

13.4.2 Critical Incident Reporting

- A. In addition to the provisions of Part 2.16 of these rules, theft, loss, misuse, diversion, or illicit distribution of agency-dispensed or prescribed controlled substance medication shall also be considered a critical incident and BHA critical incident reporting policy shall be followed. Critical incidents must be reported to BHA within one (1) business day of when the agency determines that a reportable incident has occurred or upon BHA request.

13.4.3 Medical Evaluations

- A. Individuals who wish to receive medication assisted treatment shall have medical evaluations conducted by a qualified practitioner to determine physical dependence and to determine that such individuals are appropriate for treatment with a controlled substance. Evaluations shall include, but are not limited to:
 - 1. A medical history that includes a detailed and comprehensive account of substance use history, which includes all substances of misuse;
 - 2. Evidence of current physical dependence (for OTPS, see Part 13.8.1.C.2); and
 - 3. A pregnancy screen for females and pregnancy-capable individuals of childbearing age.

13.4.4 Informed Consent to Receive a Controlled Substance

- A. All individuals receiving medication assisted treatment shall sign informed consent indicating they are voluntarily agreeing to treatment with a controlled substance. The individual shall be informed of what controlled substance they are receiving and the expected benefits and risks of medication assisted treatment. All individuals receiving controlled substances must also be informed of the risks of using other substances in combination with a controlled substance. Should an individual change controlled substance medications over the course of treatment, the individual must sign a new informed consent specific to each controlled substance they are receiving under the care of the controlled substance license.

13.4.5 Security Controls and Operating Procedures

- A. All agencies must follow the standards of physical security controls and operating procedures required by the Federal Drug Enforcement Administration necessary to prevent diversion as outlined in Title 21, Food and Drugs, Chapter II, Code of Federal Regulations, Sections 1301.71 through 1301.77 (September 2022), which are hereby incorporated by reference. No later editions or amendments are incorporated. These regulations are available at no cost from the U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, 2401 Jefferson Davis Highway, Alexandria, VA 22301; or, the Colorado Department of Human Services, Behavioral Health Administration, 710 S. Ash St. Suite C140, Denver, CO 80246; or at any state publications depository library, during regular business hours.

13.4.6 Record Keeping

- A. Agencies must follow the record keeping requirements of the Federal Drug Enforcement Administration, Code of Federal Regulations (Title 21, Food and Drugs, Part 1304) to ensure compliance with the requirements in Part 1 of Article 280 of Title 12, C.R.S. (September 2021), which are hereby incorporated by reference. No later editions or amendments are incorporated. These regulations are available at no cost from the U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, 2401 Jefferson Davis Highway, Alexandria, VA 22301; or the Colorado Department of Human Services, Behavioral Health Administration, 710 S. Ash St. Suite C140, Denver, CO 80246; or at any state publications depository library, during regular business hours.
- B. Agencies must also keep inventories, records, and reports that are required by any other state or federal law or standard regulating controlled substances.

13.4.7 Handling and Storage

- A. All agencies shall have adequate and proper facilities for the handling and storage of controlled substances. All agencies must maintain proper control over such controlled substances to ensure against their being illegally dispensed or distributed. Access to the storage area shall be restricted to personnel specifically authorized to handle controlled substances. This includes restricting the number and accessibility of keys or passwords.
- B. Agencies shall also develop and implement policies on how controlled substances will be obtained, stored, and accounted for. These policies shall include, but are not limited to:
 - 1. What controlled substance the agency will be using for the substance use disorder they are treating and how these controlled substances will be dispensed, compounded, or administered, as well as who will be responsible for ordering the controlled substances;
 - 2. Where the controlled substances will be stored;
 - 3. How the controlled substances will be accounted for; and
 - 4. Who will have access to the controlled substances.

13.4.8 Toxicology Screening Requirements

- A. Agencies shall develop and implement toxicology screen policies and procedures that specify a random sample collection protocol and these policies must include, but are not limited to:
 - 1. How appropriate and approved samples for drug testing shall be collected and analyzed in accordance with applicable state and federal statutes and regulations;
 - 2. How toxicology screens shall be used to detect the presence of the approved controlled substance, that is being dispensed, and its metabolite, for which laboratory analyses are available;
 - 3. How all individuals entering medication assisted treatment shall provide a toxicology screen at time of admission and then as clinically indicated throughout the treatment episode;
 - 4. How an agency shall address an individual having illicit substances in a toxicology screen, including unauthorized prescription medication; and
 - 5. How the agency incorporates harm reduction, trauma-informed practices, and respect for the gender identity of the individuals being screened.

13.5 Opioid Treatment Programs (OTP)

- A. These parts 13.5 through 13.8 are applicable to agencies licensed as an Opioid Treatment Program (OTP).
- B. Agencies shall follow all federal requirements in accordance with 42 C.F.R. Part 8 (2024), which are hereby incorporated by reference. No later editions or amendments are incorporated. These regulations are available at no cost from the U.S. Department of Health & Human Services, Substance Abuse & Mental Health Services Administration, Office of Communications, 5600 Fishers Lane, Rockville, MD 20857, or at <https://www.ecfr.gov/>. These regulations are also available for public inspection and copying at the Colorado Department of Human Services, Behavioral Health Administration, 710 S. Ash St. Suite C140, Denver, CO 80246, during regular business hours.

13.5.1 Definitions

“21 C.F.R. Part 1300, 1301, and 1304” means the federal regulations issued by the Drug Enforcement Administration of the U.S. Department of Justice found at 21 C.F.R. Part 1301, 1302, and 1304 (Oct. 2021), which are hereby incorporated by reference. No later editions or amendments are incorporated. These regulations are available at no cost from the U.S. Department of Justice, Drug Enforcement Administration, Liaison and Policy Section, 8701 Morrisette Drive, Springfield, VA 22152 or at <https://www.ecfr.gov/>. These regulations are also available for public inspection and copying at the Colorado Department of Human Services, Behavioral Health Administration, 710 S. Ash St. Suite C140, Denver, CO 80246, during regular business hours.

“42 C.F.R. PART 8” means the federal regulations issued by the United States Secretary of Health and Human Services found at 42 C.F.R. Part 8 (Apr. 2024), as incorporated by reference in Section 13.5.B.

“Administrative Discharge” means a process whereby an OTP has determined immediate treatment discharge is the most appropriate pathway for an individual for causes such as safety concerns for the individual or others, incarceration or other confinement which does not permit the individual’s treatment continuation, or for non-payment of fees. The timeframe for this typically involves a treatment transfer and/or taper at a rate set forth by the program.

“Administrative Transfer” means a process whereby an OTP has determined treatment continuation for an individual is unsafe for the individual receiving treatment or others and a program decides to transfer care to another clinic of the individual’s choice. To avoid unnecessary medication taper, this individual is to be transferred at a time frame that is determined by agreement with the receiving OTP.

“Comprehensive Metabolic Panel” means a blood test that measures proteins, enzymes, electrolytes, minerals and other substances in the body. A qualified practitioner can use the results to diagnose, screen for or monitor health conditions or side effects of medications, and make appropriate medical referrals.

“Dilute urinalysis” for the purposes of these rules means a creatinine level less than twenty (20) milligrams.

“Diversion Control Plan” or “DCP” means a written document that contains specific measures to reduce theft, loss, misuse, or illicit distribution of agency-dispensed or prescribed controlled substance medication.

“Guest Dosing” means a process where an individual in an OTP may be able to dose at another clinic, either in the state or out of state, to maintain the continuity of care for their OTP.

“History Of Present Illness” means a chronological description of the development of the individual’s present illness from the first sign and/or symptom or from the previous encounter to the present. It shall include the following elements: location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms as applicable.

“Lock In” means a process where a program, along with the State authority, determines that an individual is best served clinically at one (1) program. This determines where the individual is to go for their OTP.

“Lock Out” means a process where a program, along with the State authority, determines that it is in an individual’s best interest to be locked out of a program due to concerns of this individual not being safe to themselves or others in a program and/or could be a threat to that program due to diversion or other items.

“Medical Director” means a physician licensed to practice medicine in the jurisdiction in which the OTP is located and shall assume responsibility for all medical and behavioral health services performed by the OTP, including their administration in accordance with 42 C.F.R. § 8.2., as incorporated by reference in Section 13.5.

“Medication Unit” means an entity that is established as part of, but geographically separate from, an OTP from which qualified practitioners, contractors working on behalf of the OTP, or community pharmacists may dispense or administer medications for opioid use disorder (MOUD), collect samples for drug testing or analysis, or provide other OTP services. Medication units can provide the same services as an OTP, as used in 42 C.F.R. Part 8, as incorporated by reference in Section 13.5.

“Mobile Opioid Treatment Unit” for the purpose of this Chapter 13 has the same meaning as “Mobile Narcotic Treatment Program” as used in 21 C.F.R. Part 1300.01, as incorporated by reference in this Section 13.5.1. An OTP operating from a motor vehicle that serves as a mobile component (conveyance) and is operating under the registration of the OTP and engages in maintenance and/or detoxification treatment with narcotic drugs in schedules II-V, at a location or locations remote from, but within the same state as, its registered location. Operating a mobile OTP is a coincident activity of an existing OTP, as listed in § 1301.13(E).

“Motor Vehicle” means a vehicle propelled under its own motive power and lawfully used on public streets, roads, or highways with more than three (3) wheels in contact with the ground. This term does not include a trailer, as used in 21 C.F.R. Part 1300.01.

“OTP” means opioid treatment program.

“Review Of Systems” means an inventory of body systems obtained through a series of questions to identify signs and/or symptoms the individual may be experiencing or has experienced.

“Special Exception Requests” are requests for take-home doses beyond what is allowed for an individual who is prescribed a controlled substance at the time of the request. Requests must be sent to the state authority for final approval.

“Split Dosing” means, in accordance with SAMHSA, the dispensing of a single dose of MOUD as separate portions to be taken within a twenty-four (24) hour period. Split dosing is indicated among, but not limited to, those individuals who: possess a genetic variant which increases methadone metabolism; concurrently take other medications or drink alcohol that also induce hepatic enzymes leading to more rapid metabolism of methadone; who are pregnant; or for whom methadone or buprenorphine are being used to treat a concurrent pain indication in addition to the diagnosis of Opioid Use Disorder (OUD). This leads to more stable, steady-state medication levels.

“Take-Home Dose” is a prescription of individually labeled bottles or containers of methadone and other controlled substances, dose and quantity determined by prescribing qualified practitioner, and dispensed to the individual. Each bottle or container is labeled with proper required DEA information.

“Take-Home Dose Callback” means a measure of dispensed controlled substance diversion control wherein the OTP contacts and requests the individual to report back to the OTP within a reasonable period (e.g., 24 to 36 hours) with all take-home doses dispensed by the OTP. This practice may be a result of randomized individual selection or for-cause (when concerns of diversion are present) in nature. The number of take-home doses remaining must correspond to the number expected based on prescribed ingestion.

“Taper” refers to when an individual is being reduced on their dose for any reason, either of their own accord or due to concerns that the medical director raises. Tapers are started with a medical order and monitored by the medical personnel.

“Torsades de Pointes” or simply *Torsades*, is a French term that literally means “twisting of the spikes.” It refers to a specific, rare variety of ventricular tachycardia that exhibits distinct characteristics on the electrocardiogram (ECG).

“Transfer” is when an individual transfers from one program to another without a break in treatment.

13.6 Opioid Treatment Program General Provisions

- A. Opioid Treatment Programs (OTP) must provide treatment to individuals meeting criteria for opioid use disorder according to the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR) (2022)
- B. Agencies applying to be licensed as an OTP must have the following:
 - 1. Controlled substance license;
 - 2. Drug Enforcement Administration (DEA) registration;
 - 3. Substance Use and Mental Health Services Administration (SAMHSA) certification; and
 - 4. Federal accreditation, when applicable.
- C. In addition to OTP provisions beginning with 13.6., OTPs shall adhere to requirements listed within 13.1 through 13.8.5.

13.6.1 Services for Pregnant and Postpartum Individuals

- A. When prospective or currently enrolled individuals are pregnant or postpartum, the following considerations shall be cared for through policies, procedures, and clinical documentation:
 - 1. Agencies must provide admission to pregnant individuals within forty-eight (48) hours of request for services or provide interim services until an admit date is available;
 - 2. Confirmation of pregnancy for pregnancy-capable individuals upon OTP enrollment;
 - 3. Agencies must not medically withdraw pregnant individuals receiving methadone or other approved controlled substances without the approval of the Behavioral Health Administration;
 - 4. Prenatal care and other sex-specific services, including reproductive health services, for pregnant and postpartum individuals shall be provided and documented either by the OTP or by referral to appropriate healthcare practitioners; and
 - 5. Evidence-based treatment protocols for the pregnant individual, such as split dosing regimens, may be instituted after assessment by a qualified practitioner operating within the OTP.

13.6.2 Admission Criteria

- A. Agencies must follow all federal requirements in accordance with 42 C.F.R. Part 8 (2024), as incorporated by reference in Section 13.5.B.
- B. OTPS offering short-term or long-term detoxification treatment shall follow all applicable state and federal laws, rules, and regulations regarding admission criteria.

- C. At time of admission, individuals shall be oriented to OTP policies and procedures, including, but not limited to:
1. Benefits and risks of medication for Opioid Use Disorder;
 2. Fee structure and payment options. This policy must include written acknowledgement of understanding from the individual. The individual will be provided with a copy of this document and a copy will be placed in the clinical record;
 3. Conditions for dosing, counseling and toxicology sample collection. The policy must include provisions for holding doses, evaluation of the "impaired" individual, treatment stipulations and agreements, "refusal" or "inability" to provide specimens for toxicology testing and unacceptable/unsafe behavior that limits the individual's ability to participate in OTP;
 4. Take-home treatment structure established by the OTP;
 5. Special exception requests;
 6. Consequences for violating policies; and
 7. Written procedures and signed acknowledgements around the following shall include, but not be limited to:
 - a. Behavioral agreements;
 - b. Office treatment lock-in;
 - c. Office treatment lock-out;
 - d. Reduction in take-home doses;
 - e. Administrative discharges;
 - f. Administrative transfers;
 - g. Guest dosing;
 - h. OTP transfer policy;
 - i. Taper protocol for any and all circumstances, including inability to pay;
 - j. Hospitalization while in OTP instructions, including clinic after-hours information;
 - k. Emergency procedures in case of a natural disaster, human-induced disaster, or emergent closing of the clinic;
 - l. Use of prescription drug monitoring program in treatment;
 - m. Use of other prescription medications in treatment; and
 - n. Provisions around conditions for dosing.

- D. OTPs shall provide alternatives to admission denial due to lack of government-issued photo identification. This is including, but not limited to, accepting various forms of suitable identification, coordinating with BHA to establish a unique treatment identifier within the central registry system, and direct referral to alternative MOUD (medications for opioid use disorder) treatment options.
- E. Individuals re-admitted to treatment following treatment absences of six (6) months or more must undergo medical evaluations, physical examinations, and/or laboratory tests as deemed appropriate by an OTP medical director or qualified practitioner.

13.6.3 Prescribing, Dispensing, And Administering Approved Controlled Substances

- A. An OTP medical director or a qualified practitioner shall order approved controlled substances and document orders in individual records.
- B. Exceptions to dosing regimens outlined in federal regulations shall require approval by BHA prior to dosing.
- C. Approved controlled substances must be administered by OTPs according to manufacturer's specifications found on product labels and/or in printed instructions accompanying the product.
- D. In circumstances where individuals must be administratively discharged from the agency OTP or MOUD services, OTPs shall make a good faith documented effort to obtain appropriate consents and coordinate transition of care to nearby MOUD treatment and other applicable services to reduce the risk of opioid withdrawal and harm. When transfer effort is unsuccessful, OTPs shall notify and coordinate with BHA before providing a safe medical taper due to inability or unwillingness to pay. Pregnant individuals shall have the option to defer payment for treatment and continue to receive MOUD.
- E. OTP medical directors and leadership shall develop a medication induction protocol which considers, on an individualized basis and among other factors, rate of dose adjustment and when initiation of take-home dose protocol would be safe for the individual and community.
- F. In an effort to prevent medication disruption, OTPs shall make a good faith effort to provide or coordinate services for treatment-enrolled individuals in treatment settings outside of the agency, including carceral settings.

13.6.4 Take-Home Dose Guidance

- A. In accordance with 42 C.F.R. § 8.12(i)(2)(i-vi), as incorporated by reference in Section 13.5.B of these rules, OTP decisions on dispensing MOUD to individuals for unsupervised use shall be determined by an appropriately licensed OTP medical practitioner or the medical director. In determining which individuals may receive unsupervised medication doses, the medical director or program medical practitioner shall consider, among other pertinent factors that indicate that the therapeutic benefits of unsupervised doses outweigh the risks, the following criteria:
 - 1. Absence of active substance use disorders, other physical or behavioral health conditions that increase the risk of individual harm as it relates to the potential for overdose, or the ability to function safely;
 - 2. Regularity of attendance for supervised medication administration;
 - 3. Absence of serious behavioral problems that endanger the individual, the public, or others;
 - 4. Absence of known recent diversion activities;

5. Whether take-home medication can be safely transported and stored; and
 6. Any other criteria that the medical director or medical practitioner considers relevant to the individual's safety and the public's health.
- B. Buprenorphine products that are dispensed, compounded, and administered by an OTP do not require time in treatment requirements as listed in this Part 13.6.4.A.1. However, an OTP is still responsible for including all controlled substances dispensed, compounded, and administered in their division control plan, including OTP directed buprenorphine take-home doses.
- C. In accordance with 42 C.F.R. § 8.12(l)(3)(I-III), as incorporated by reference in Section 13.5.B, such determinations and the basis for such determinations consistent with the criteria outlined in 13.6.4 of this section shall be documented in the individual's medical record. If it is determined that an individual is safely able to manage unsupervised doses of MOUD, the dispensing restrictions set forth in D.1 through D.3 of this section apply. The dispensing restrictions set forth in paragraphs D.1 through D.3 of this section do not apply to buprenorphine and buprenorphine products.
1. During the first fourteen (14) calendar days of treatment, take-home doses are limited to a seven (7) day supply. It remains within the discretion of the qualified practitioner operating within the OTP to determine the number of take-home doses up to seven (7) days, but decisions must be based on the criteria listed in A.1-6. The rationale underlying the decision to provide unsupervised doses of methadone must be documented in the individual's clinical record.
 2. From fifteen (15) calendar days of treatment, take-home doses are limited to a fourteen (14) day supply. It remains within the discretion of the qualified practitioner operating within the OTP to determine the number of take-home doses up to fourteen (14) calendar days, but decisions must be based on the criteria listed in a.1-6. The rationale underlying the decision to provide unsupervised doses of methadone must be documented in the individual's clinical record.
 3. From thirty-one (31) calendar days of treatment, take-home doses provided to an individual are not to exceed a twenty-eight (28) day supply. It remains within the discretion of the qualified practitioner operating within the OTP to determine the number of take-home doses up to twenty-eight (28) days, but decisions must be based on the criteria listed in A.1-6. The rationale underlying the decision to provide unsupervised doses of methadone must be documented in the individual's clinical record.
- D. In determining a safe amount of take-home doses for individuals transferring from one Colorado OTP to another Colorado OTP, the receiving OTP shall determine and document the amount of take-home doses provided by the previous OTP.
- E. Individuals transferring from out of state must meet the Colorado state requirements for the take-home doses they are requesting.
- F. OTPs shall seek BHA and SAMHSA approval prior to providing take-home doses beyond limits defined by 13.6.4 of this ruleset and 42 C.F.R. § 8.12(l)(3)(I-III) as incorporated by reference in Section 13.5.
- G. Take-home doses may be approved by OTPs for days clinics are closed, including Sundays and state and federal holidays.
- H. Take-home doses shall not be approved for individuals undergoing short-term supervised withdrawal.

- I. Written agreements shall be developed and implemented for individuals approved for take-home doses. Agreements must be part of the service plan and shall explain the rationale for approving take-home medication, stipulate dose amounts, and set consequences for violating agreement conditions.
- J. Take-home doses shall be dispensed in medication containers that conform to state and federal poison prevention packaging requirements, including childproof lids.
- K. Labels must be affixed to containers with the following information:
 - 1. OTP names, addresses, and telephone numbers;
 - 2. Individual names;
 - 3. Drug types;
 - 4. Dose amounts, if not OTP medical director-authorized blind doses; and
 - 5. Directions for use.
- L. Take-home doses numbering six (6) or less shall be transported in a discrete and secure manner agreed upon by OTPs and individuals.
- M. Take-home doses numbering seven (7) or more shall be transported in locked, well-constructed containers that resist tampering.
- N. Take-home doses shall be securely and discretely stored in a manner that reduces the risk for access by children and unauthorized persons.
- O. OTPs must submit and obtain BHA approval for the following:
 - 1. Take-home doses for individual supervised withdrawal lasting less than thirty (30) consecutive calendar days
 - 2. Take-home doses that do not conform to take-home dose requirements; and
 - 3. Take-home doses for OTP individuals admitted to extended health care agencies, licensed residential substance use disorder agencies, or carceral settings.
- P. OTPs shall have policies and procedures for transporting methadone or other approved controlled substances to individuals in residential treatment, carceral settings, or recovery agencies, that include chain-of-custody documentation retained by the OTP and a secure plan for OTP enroll storage from the facility.
- Q. In the event of take-home medication theft, loss, or diversion, take-home dose replacement shall not be provided until documented review and approval is given by a qualified practitioner within the OTP. In-person dosing shall be continued in the event of take-home medication theft, loss, misuse, or diversion.
- R. OTPs shall offer either directly or through prescription, opioid antagonists for all individuals receiving MOUD take-home doses.

13.6.5 Prescription Drug Monitoring Program (PDMP)

- A. Medical directors and other qualified health care professionals within the OTP shall utilize the information obtained from the Colorado State Board of Pharmacy's Electronic Prescription Drug Monitoring program (PDMP), developed pursuant to Section 12-280-403, C.R.S. The PDMP shall be utilized at key decision-making points, including at intake and take-home dose consideration. Documentation should include relevant recent prescription history and/or copy of results uploaded to the clinical chart.

13.6.6 Diversion Control and Central Registry

- A. OTPs shall maintain a current diversion control plan, which assigns responsibility to OTP medical and administrative leadership and personnel for developing, performing, and monitoring measures and functions described in OTP's diversion control plan.
- B. The diversion control plan shall include, at minimum, the following categories:
1. Program environment;
 2. Dosing;
 3. Take-home doses;
 4. Take-home dose callbacks;
 5. Prevention of multiple program enrollment; and
 6. Misuse of prescription medication as outlined in SAMHSA federal OTP guidelines;
- C. As a core function of diversion control, the following must occur:
1. Randomized take-home dose callbacks shall be performed and documented at a minimum of two (2) per year for individuals whose take-home doses equal seven (7) or greater and may coincide with random toxicology screens.
 2. For-cause take-home dose callbacks shall be performed whenever take-home dose diversion or misuse is suspected and OTPs shall develop written protocol to determine consistently under which circumstances and how those take-home callbacks will be conducted and documented.
- D. OTPs shall prevent simultaneous enrollment of individuals in more than one (1) clinic by fully participating in the behavioral health administration central registry, developed pursuant to Section 27-80-215, C.R.S.
1. Prior to admitting applicants to treatment, OTPs shall initiate a clearance inquiry to BHA's central registry of OTP-enrolled individuals by submitting applicant information in BHA-prescribed formats.
 2. Applicant information must include:
 - a. Name;
 - b. Date of birth;
 - c. Proposed date of admission; and
 - d. Other information required by the individual clearance procedure.

3. Applicants shall not be admitted to treatment when BHA's central registry shows them as currently enrolled in another OTP.
 4. In the event that the central registry is inaccessible, not functioning, or BHA is closed, an OTP shall contact another OTP within their geographic area to verify an individual's enrollment status.
 5. OTPs must report clinic discharges to BHA's central registry within three (3) business days or immediately upon transfer.
- E. By definition, mobile opioid treatment units and medication units operate under the license of an OTP and therefore do not require a central registry account separate from the home OTP. Individuals receiving services at either mobile or med units must be enrolled in the primary OTP's central registry. It is the OTP's responsibility to prevent medication error and diversion across that spectrum of service delivery.

13.6.7 Mobile Opioid Treatment Units and Medication Units

- A. OTPs utilizing mobile opioid treatment units or medication units shall follow all applicable state and federal regulations, including these BHA OTP rules as incorporated by reference in Part 13.5.1 of these rules.
- B. OTPs are not required to obtain a separate behavioral health entity license or controlled substance license for medication units or mobile opioid treatment units.
- C. OTPs shall develop the following plans for mobile opioid treatment units or medication units:
1. Staffing plan;
 2. Security plan;
 3. Adequate handling and storage plan of controlled substances;
 4. Contingency plans for mobile opioid treatment unit closure, including but not limited to, adverse weather events, human-induced disasters, and unit breakdown for mobile medication units only; and
 5. Vehicle maintenance plan for mobile medication units only.
- D. Mobile opioid treatment units and medication units shall comply with reporting requirements determined by BHA pursuant to Part 2.16 of these rules.
- E. OTPs shall submit current schedule of planned dosing stops for mobile medication units to BHA prior to initiating care at those stops.

13.7 Personnel

13.7.1 OTP Medical Directors

- A. An OTP must have a designated medical director who shall authorize and oversee other qualified practitioners, other appropriately licensed and/or certified medical personnel and all medical services provided.
- B. The medical director must be available to the OTP for service provision or consultation.

- C. The medical director, qualified practitioners, and all other medical healthcare providers shall currently possess and maintain licenses to practice medicine/nursing in compliance with the credentialing requirements of their own profession in Colorado as provided by Article 240, Title 12, C.R.S. OTP medical directors shall assure appropriate credentials and training for other OTP physicians and other qualified health care providers to dispense, compound or administer a controlled substance in an OTP.
- D. The medical director must complete an annual review of federal and state guidelines and rules to ensure that the OTP agency is in compliance with all state and federal rules and regulations regarding medical treatment for opioid use disorder.
- E. The medical director shall sign an acknowledgment of review of all BHA-issued BHE and controlled substance licensing violations and recommendations connected to the OTP.
- F. OTPs utilizing a qualified practitioner shall have a plan that at minimum:
 - 1. Identifies all qualified practitioners with prescriptive authority;
 - 2. Identifies the number of hours practitioners with prescriptive authority are onsite weekly;
 - 3. Establishes qualified practitioner supervision requirements, including review and documentation of all medication orders for approved controlled substances and other medications, which also includes subsequent dose adjustments and changes to take-home doses; and
 - 4. Addresses consultation requirements for when medical directors are not onsite.
- G. OTP medical directors and qualified practitioners must ensure the following:
 - 1. Medical evaluations are completed, including evidence of current physical dependence and/or history of opioid use or exceptions to admission criteria that are documented prior to initial dosing;
 - 2. These medical evaluations are done at admission prior to initial dose;
 - 3. The physical examinations and all appropriate laboratory tests are performed and reviewed within fourteen (14) calendar days following treatment admission;
 - 4. All medical professionals must educate individuals regarding risks and benefits of OTP and document that individuals are entering voluntarily;
 - 5. Other medical concerns shall be addressed by OTPs or referred to other medical agencies when appropriate, as determined by an OTP medical director or a qualified practitioner; and
 - 6. All medical orders are properly signed or countersigned, including initial orders for approved controlled substances and other medications, subsequent dose increases or decreases, changes in take-home doses, emergency situations, and other special circumstances by a qualified practitioner in an OTP, operating within scope of their license.
- H. Medical directors shall ensure that OTPs make documented efforts to outreach individuals actively enrolled at the OTP who have missed three (3) or more consecutive doses.

13.7.2 OTP Sponsors

- A. OTP sponsors are responsible for the following:
 - 1. Overall operation of the program, including, but not limited to:
 - a. Compliance with all applicable state and federal laws, rules, and regulations;
 - b. Medical and counseling personnel are qualified to provide opioid replacement treatment;
 - c. Ensures an active medical director is assigned to the OTP and available for supervision;
 - d. Individuals are enrolled on their own volition;
 - e. Full disclosure is made to individuals about opioids and their use in treatment
 - f. Written, informed consents for opioid replacement treatment are signed by individuals eighteen (18) years of age and older;
 - g. Written, informed consents for all aspects of opioid replacement treatment are signed by parents, legal guardians or other responsible adults designated by appropriate state authorities for individuals under age eighteen (18) years old;
 - h. Written (OTP) policies and procedures are developed, implemented, and maintained that are based on and in compliance with BHA rules;
 - i. All reasonable and clinically indicated efforts are made to coordinate treatment with other healthcare and behavioral health providers. Documentation includes obtaining individuals' consent to release information to communicate with those practitioners;
 - j. Methadone and other controlled substances are disposed of in accordance with the federal regulations; and
 - k. Printed acknowledgements are signed by individuals and kept in individual records stating that they have been informed of the United States Department of Transportation regulation against the use of OTP prescribed methadone by commercial drivers and the possible loss of commercial driver's license if taking methadone for an opioid use disorder is discovered.

13.7.3 Personnel Training

- A. Training for new OTP personnel is documented in personnel records, including, but not limited to, provisions of part 2.5.I of these rules and the following:
 - 1. Federal OTP laws and regulations;
 - 2. State OTP laws and regulations;
 - 3. Agency OTP policies and procedures;
 - 4. Clinical practices including, but not limited to:
 - a. Protocols around special exception requests;

- b. Take-home dose adjustment requests; and
 - c. Any take-home protocol such as holiday dosing, weekend dosing, hold doses, hospitalization of individuals, incarceration, nursing home stays, and guest dosing.
- 5. Pharmacology of methadone and other controlled substances, including, but not limited to, loss of tolerance to opioids, dangerous drug or alcohol interactions, signs and symptoms of overdose, and purpose of its use.
- B. Annual training for OTP personnel, including, but not limited to:
 - 1. Most current pharmacology of medications used, and clinical practices applicable to OTP, including problems with interactions of medications ;
 - 2. Review of federal and state regulations and rules;
 - 3. Review of current agency OTP policies and procedures; and
 - 4. Infectious disease risks and screening.

13.8 Service Delivery

13.8.1 Medical Evaluations

- A. Individuals admitted to OTPs shall have medical evaluations conducted by a medical director or qualified practitioner prior to the first dose.
- B. In accordance with 42 C.F.R. § 8.12(F)(2)(B)(II), as incorporated by reference in Section 13.5, if the practitioner is not a qualified practitioner operating within the OTP, the medical evaluation must be completed no more than seven (7) days prior to OTP admission. Where the evaluation is performed outside of the OTP, the written results and narrative of the examination, as well as available lab testing results, must be transmitted, consistent with applicable privacy laws, to the OTP, and verified by a qualified practitioner operating within the OTP.
- C. Medical evaluations must include, at minimum, the following:
 - 1. Past medical history, past substance use history, including required chronologies of opioid use and dependence, choice of opioid, and route of administration;
 - 2. Confirmation of evidence of current physical dependence, or diagnostic criteria for active moderate to severe opioid use disorder (OUD), or OUD remission, or are at high risk for disease recurrence or overdose;
 - 3. Cardiovascular assessment for the risk of *torsades de pointes*; and
 - 4. Other co-occurring conditions.

13.8.2 Physical Examinations

- A. Physical examinations, informed by the results of history of present illness and comprehensive review of systems, shall be conducted, evaluated, and documented in individual records by medical directors or authorized OTP practitioners practicing within their scope, within fourteen (14) consecutive calendar days following treatment admission and annually from date of admission.

- B. In accordance with 42 C.F.R. § 8.12(F)(2)(B)(III), as incorporated by reference in part 13.5 of these rules. The full exam can be completed by a qualified practitioner operating outside of the OTP, if the exam is verified by a qualified practitioner operating within the OTP as being true and accurate and transmitted in accordance with applicable privacy laws.
- C. At a minimum, physical examinations shall consist of:
 - 1. History of present illness;
 - 2. Comprehensive review of systems; and
 - 3. Vital signs (temperature, pulse, blood pressure, and respiratory).
- D. When exam results indicate further testing or medical follow-up, the OTP shall make documented efforts to educate the individual and make referrals to appropriate medical care.

13.8.3 Laboratory Tests

- A. Admission laboratory tests shall be conducted either on-site or through referral, and results shall be evaluated and documented in individual records within fourteen (14) consecutive calendar days following treatment admission. When utilizing laboratory tests performed outside of the OTP to comply with rule, the OTP must ensure tests are drawn not more than thirty (30) days prior to admission to the OTP.
- B. Screening for the following shall be documented and the following laboratory tests shall be completed when clinically indicated:
 - 1. Urine toxicology or other tests to determine current substance use;
 - 2. Viral hepatitis, syphilis, tuberculosis, HIV/AIDS, sexually transmitted infections, and other infectious diseases;
 - 3. Complete blood count and differential;
 - 4. Routine and microscopic urinalysis; and
 - 5. Comprehensive metabolic panel (CMP).
- C. The following laboratory tests shall be conducted with consent, every two (2) consecutive years from date of admission when clinically indicated:
 - 1. Viral hepatitis, syphilis, tuberculosis, HIV/AIDS, sexually transmitted infections, and other infectious diseases; and
 - 2. Complete blood count and differential;
 - 3. Comprehensive metabolic panel (CMP).
- D. When laboratory test results indicate further testing or medical follow-up, the OTP shall make documented efforts to educate the individual and make referrals to appropriate medical care.
- E. In accordance with 42 C.F.R. § 8.12 (f)(2)(b)(iii), as incorporated by reference in part 13.5 of these rules, an individual's refusal to undergo lab testing for co-occurring physical health conditions should not preclude them from access to treatment, provided such refusal does not have potential to negatively impact treatment with medications.

13.8.4 Toxicology Screens/Urine Drug Screens

- A. OTPs shall develop and implement policies and procedures that ensure a random sample collection protocol that minimizes falsification and respectfully limits refusal to provide specimens for testing, including offering alternative methods for testing.
 - 1. Individuals shall have no notification prior to the day they are required to give a sample.
 - 2. Individuals shall not be allowed to give a sample on days they normally attend the clinic unless those days are coincidentally randomly assigned sample days.
- B. OTPs shall develop and implement policies and procedures that establish treatment responses to the following:
 - 1. Evidence of unauthorized drugs in toxicology screens, including prescription medications;
 - 2. Lack of all OTP-administered controlled substances in toxicology screens;
 - 3. Dilute urine analysis;
 - 4. Use of the prescription drug monitoring program; and
 - 5. How the agency incorporates harm reduction and trauma-informed practices, and respect for the gender identity of the individuals being screened.
- C. Toxicology screens shall occur with the following frequencies:
 - 1. One (1) toxicology screen at admission;
 - 2. Eight (8) annual random toxicology screens;
 - 3. An initial toxicology screen for individuals undergoing short-term supervised withdrawal;
 - 4. An initial toxicology screen and at least one (1) random toxicology screen per month for individuals undergoing long-term supervised withdrawal;
 - 5. At least one (1) random toxicology screen during thirty (30) day reduction in take-home doses due to diversion or other factors as indicated in 13.6.4 of this Chapter; and
 - 6. If toxicology screening frequency is above standards listed in 13.8.4.C 1-5, the OTP shall document medical or clinical necessity.
- D. Refusal to provide samples for toxicology screens shall be considered to be positive toxicology screens.
- E. Dilute urinalysis will be reviewed and assessed.
- F. The state authority will monitor drug trends and may require testing for additional substances that pose a risk to health and safety of individuals receiving OTP services.
- G. Results of OTP drug screening shall be utilized as a clinical tool for monitoring an individual's substance use patterns before and during treatment. The agency's medical director shall ensure that drug screen results are not to be utilized as the sole factor in the administrative discharge of an individual from treatment in cases that do not involve negative drug screens for methadone metabolite.

13.8.5 Counseling Services

- A. In accordance with 42 C.F.R. § 8.12(F)(5)(I)(II) & (III), as incorporated by reference in Part 13.5.1 of these rules, OTPs operating in Colorado shall follow the following standards of counseling care:
1. OTPs must provide adequate substance use disorder counseling and psychoeducation to each individual as clinically necessary and mutually agreed-upon, including harm reduction education and recovery-oriented counseling. This counseling shall be provided by a program counselor, qualified by education, training, or experience, to assess the psychological and sociological background of individuals, and engage with individuals, to contribute to the appropriate care plan for the individual and to monitor and update individual progress;
 2. OTPs must provide counseling on preventing exposure to, and the transmission of, human immunodeficiency virus (HIV), viral hepatitis, and sexually transmitted infections (STIs) and either directly provide services and treatments or actively link to treatment each individual admitted or readmitted to treatment who has received positive test results for these conditions from initial and/or periodic medical examinations;
 3. OTPs must provide directly, or through referral to adequate and reasonably accessible community resources, vocational training, education, and employment services for individuals who request such services or for whom these needs have been identified and mutually agreed-upon as beneficial by the individual and program staff;
 4. Individual refusal of counseling shall not preclude them from receiving MOUD. OTPs shall perform re-assessment of individual's interest in counseling services at least every one hundred and eighty (180) days and document as necessary in the individual's service plan; and
 5. As part of quality improvement planning, OTPs shall track, in addition to requirements outlined in Chapter 2.17, OTP discharges, reasons for discharge, and progress to retention improvement efforts.

Chapter 14: Recovery Support Services Organizations

14.1 Authority and Applicability

- A. House Bill 21-1021 provides that it is in the best interest of the state to support the peer support professional workforce through the creation of peer-run recovery support services organizations.
- B. The general assembly authorized the Colorado Department of Human Services, in collaboration with the Department of Health Care Policy and Financing, to promulgate rules establishing minimum standards that recovery support services organizations must meet. § 27-60-108(3)(A), (C) C.R.S.

14.2 Definitions

"Licensed Mental Health Provider" means:

- A. A mental health professional licensed or certified pursuant to Section 12-245-203(2), C.R.S., except for unlicensed psychotherapists pursuant to Section 12-245, C.R.S.
- B. Advanced practice registered nurse registered pursuant to Section 12-255-111, C.R.S. with training in substance use disorders or mental health.

- C. Physician assistant licensed pursuant to Section 12-240-113, C.R.S. with specific training in substance use disorders or mental health.
- D. Psychiatric technician licensed pursuant to Section 12-295-103(4), C.R.S.
- E. Medical doctor or doctor of osteopathy licensed pursuant to Section 12-240-107, C.R.S.

14.3 License Requirement

- A. Organizations shall apply for and obtain a recovery support services organization license if:
 - 1. They are a peer-run organization providing peer support to individuals with behavioral health disorder; and
 - 2. The organization is seeking reimbursement through Medicaid.
- B. All applicants for a recovery support services organization license shall demonstrate compliance with these rules and all applicable state and federal regulations and statutes.

14.4 Annual License

- A. Each approved recovery support services organization that provides peer support and seeks reimbursement through Medicaid shall obtain a BHA-issued recovery support services organization license annually.
- B. Peer-run service providers are not required to seek RSSO licensure to provide services unless they seek Medicaid reimbursement for peer support services rendered under a peer-run service provider.

14.5 General Provisions

14.5.1 Service Provisions

- A. Recovery support services organizations may provide a variety of nonclinical, recovery-focused services and supports. These services shall include engaging individuals in peer-to-peer relationships that support healing, personal growth, life skills development, self-care, and crisis-strategy development to help achieve recovery, wellness, and life goals. These services may include, but are not limited to:
 - 1. Peer-run drop in centers;
 - 2. Recovery and wellness centers;
 - 3. Employment services;
 - 4. Prevention and early intervention activities;
 - 5. Peer mentoring for children and adolescents;
 - 6. Warm lines; or
 - 7. Advocacy services.
- B. A peer support professional may provide services on behalf of a recovery support services organization in a variety of clinical and nonclinical settings that may include, but are not limited to:

1. Justice-involved settings;
 2. Physical health settings, such as pediatrician or obstetric and gynecological health care offices;
 3. Emergency departments;
 4. Services delivered via telehealth;
 5. Agencies serving homeless communities;
 6. Peer respite homes;
 7. School-based health centers; or
 8. Home and community-based settings.
- C. Recovery support services organizations must have an established process by which the organization coordinates its services with those rendered by other agencies, including treatment agencies, to ensure an uninterrupted continuum of care to persons with behavioral health disorders.

14.5.2 Staff Requirements and Training

- A. Recovery support services organizations must employ or contract with a licensed mental health provider pursuant to Section 12-245-203(2), C.R.S. to administer on-going supervision of peer support professionals employed or contracted by recovery support services organizations. The licensed mental health provider must be in good standing with their credentialing body and must demonstrate in a manner determined by the behavioral health commissioner having received formal training specific to:
1. Provision of peer support services;
 2. Supervision of peer support professionals; and
 3. Role of peer support professionals.
- B. For peer support professionals with less than twelve (12) months experience, individual supervision by the licensed mental health provider of sufficient length to address needs for a minimum of thirty (30) minutes, two (2) times per month is required. For peer support professionals with more than twelve (12) months experience, individual supervision by the licensed mental health provider of sufficient length to address needs for a minimum of thirty (30) minutes, once per month is required. Supervisors shall maintain documentation of all supervisory sessions.
- C. Recovery support services organizations must employ or contract with peer support professionals who have successfully completed formal training covering all content areas outlined in "core competencies for peer workers in behavioral health services – 2018" established by United States Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) and does not include any later amendments or editions. These regulations are available at no cost at <https://www.samhsa.gov/> and are also available for public inspection and copying at the Colorado Department of Human Services, Behavioral Health Administration, 710 S. Ash St, Suite C410, Denver, CO 80246 during regular business hours.

- D. Peer support professionals must obtain a certification as a peer support professional and be in good standing with their certifying body.
- E. All staff employed or contracted by a recovery support services organization must comply with background checks and employment verification processes outlined in 2 CCR 502-1 Part 2.5 and be verified at least annually.

14.5.3 Documentation Requirements

- A. Recovery support services organizations shall comply with release of information requirements pursuant to 2 CCR 502-1 Part 2.7.13.
- B. Recovery support services organizations shall comply with consent requirements pursuant to 2 CCR 502-1 Part 2.7.a.7.
- C. Recovery support services organizations shall maintain records of the services provided to individuals by the RSSOs. The record shall be shared with BHA pursuant to a procedure determined by the behavioral health commissioner. For each encounter in which services are provided, the record shall contain:
 - 1. Date of service;
 - 2. Total contact time with person;
 - 3. Session setting/place of service;
 - 4. Reason for the encounter and description of services provided; and
 - 5. Provider's dated signature and relevant qualifying credential.
- D. Recovery support services organizations shall have policies and procedures that address at a minimum:
 - 1. Experience and hiring requirements for peer support professionals and licensed mental health providers;
 - 2. The program's standards of practice and code of ethics;
 - 3. Training for peer support professionals related to providing support services;
 - 4. Training for licensed mental health providers related to the supervision of peers;
 - 5. A description of each aspect of the program, including staff roles and responsibilities and how the organization meets the description of "peer run";
 - 6. The program's care coordination policy, including referral procedures;
 - 7. The handling of grievances and complaints by individuals receiving services;
 - 8. Reporting and reviewing critical incidents in accordance with 2 CCR 502-1 Part 2.16;
 - 9. Compliance with confidentiality, HIPAA, and 42 C.F.R. Part 2; and
 - 10. Methods for recording information required by 2 CCR 502-1 Part 14.5.3.

14.5.4 Site Visits

- A. Routine monitoring: recovery support services organization licensing visits shall be scheduled and conducted by BHA during the RSSO's normal business hours to the extent possible.
- B. BHA shall conduct unscheduled site visits for specific monitoring purposes and investigation of complaints or critical incidents involving approved organizations that have a recovery support services organization license. These unscheduled visits shall be in accordance with the:
 - 1. Recovery support services organization license rules;
 - 2. BHA policies and procedures; and
 - 3. Any statutes and regulations that protect the confidentiality of individual identifying information, including HIPAA and 42 C.F.R. Part 2 as incorporated by reference in Part 1.2 of these rules.
- C. BHA shall have access to all individual, organization, and staff records and any other relevant documentation required to determine compliance with these rules and to coordinate individual services.
- D. Site inspection may be required at the sole discretion of BHA.

14.6 Ethical Standard

- A. Recovery support services organizations shall ensure that peer support professionals adhere to ethical standards. Violations of ethical standards include:
 - 1. Performing duties outside of the scope of practice of a peer support professional;
 - 2. Any breach of professional boundaries between a peer support professional and an individual receiving services, including relationships of a sexual or romantic nature between the peer support professional and individual receiving services;
 - 3. Fraudulent activity, including but not limited to misrepresenting credentials and falsifying records;
 - 4. Failure to meet generally accepted standards of peer support professional practice; or
 - 5. Any conduct described in 2 CCR 502-1 Part 2.24.

14.7 Critical Incident Reporting

- A. Critical incident reporting shall occur in accordance with 2 CCR 502-1 Part 2.16.

14.8 Licensing Procedures

14.8.1 Initial Licenses

- A. Applications for initial licenses for RSSOs shall be submitted and processed according to procedures outlined in 2 CCR 502-1 Part 2.18.
- B. The application fee for an RSSO license shall be two hundred dollars (\$200).
- C. No initial license shall issue prior to BHA inspection per 2 CCR Part 2.18.

14.8.2 Provisional Licenses

- A. Provisional licenses may be granted under the circumstances and through the processes described in 2 CCR Part 2.19.

14.8.3 License Renewal

- A. License renewal shall be conducted according to processes outlined in 2 CCR 502-1 Part 2.20.

14.8.4 Conditional License

- A. Conditional licenses may be granted under the circumstances and through the processes described in 2 CCR 502-1 Part 2.24.3.

14.8.5 License Revocation, Denial, Suspension, Limitation, or Modification

- A. A license may be revoked, denied, suspended, limited, or modified according to 2 CCR Part 2.24.2.
- B. A license may be revoked, denied, suspended, limited, or modified if an individual providing services under the organization's auspices violates ethical standards outlined in 2 CCR 502-1 Part 2.24.2.a.
- C. A recovery support services organization that has a limited, suspended, or modified license will maintain that licensure status even if the recovery support services organization changes its name but retains the same supervising licensed mental health provider.

14.8.6 Inactivation or Surrender of a License

- A. No recovery support services organization license shall be inactivated except with BHA's approval. A recovery support services organization may request inactivation at any time. Approval to inactivate a license will not be unreasonably denied. Inactivation or surrender of a license will not avoid discipline if otherwise justified.

14.9 Appeal

- A. Any recovery support services organization adversely affected or aggrieved by these rules or by BHA's decisions in regard to implementation of these rules has the right to appeal a BHA action in accordance with 2 CCR 502-1 Part 2.24.5.

21.000 BEHAVIORAL HEALTH

21.100 DEFINITIONS

“42 C.F.R. Part 2” means the federal regulations issued by the Substance Abuse & Mental Health Services Administration of the U.S. Department of Health & Human Services found at 42 C.F.R. Part 2 (Feb. 2018), which are hereby incorporated by reference. No later editions or amendments are incorporated. These regulations are available at no cost from the U.S. Department of Health & Human Services, Substance Abuse & Mental Health Services Administration, Office of Communications, 5600 Fishers Lane, Rockville, MD 20857 or at <https://www.ecfr.gov/>. These regulations are also available for public inspection and copying at the Colorado Department of Human Services, Office of Behavioral Health, 3824 West Princeton Circle, Denver, Colorado 80236, during regular business hours.

“Acute Treatment Unit” (ATU) means a designated facility or a distinct part of a facility for short-term psychiatric care, which may include substance use disorder treatment. An ATU provides a twenty-four (24) hour, therapeutically planned and professionally staffed environment for individuals who do not require inpatient hospitalization but need more intense and individualized services, such as crisis management and stabilization services, than are available on an outpatient basis, as defined in 27-65-102(1), C.R.S.

“Aggrieved” means having suffered actual loss or injury or being exposed to potential loss or injury to legitimate interests as defined in 24-4-102 (3.5), C.R.S.

“Behavioral Health” for the purposes of these rules, behavioral health includes substance use and mental health. “Department” is the Colorado Department of Human Services.

“Community Mental Health Clinic” means a health institution planned, organized, operated, and maintained to provide basic community services for the prevention, diagnosis, and treatment of emotional or mental disorders, such services being rendered primarily on an outpatient and consultative basis.

“Counselor-in-training” means an individual currently in the process of obtaining a professional credential pursuant to Part 8 of Article 245 of Title 12, C.R.S. “Counselor-in-training” does not include a psychologist candidate; a clinical social worker candidate; a marriage and family therapist candidate; a licensed professional counselor candidate; or an addiction counselor candidate.

“Designated Facility” means an agency has applied for and been approved by the department under these rules to provide mental health services.

“Designated Managed Service Organization” means an organization approved and authorized by the Department to manage oversight, quality assurance, and contract compliance of substance use disorder treatment providers within one or more of the seven established geographic sub-state planning areas.

“Disaster” means the occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property resulting from any natural cause or cause of human origin, including but not limited to fire, flood, earthquake, wind, storm, wave action, hazardous substance incident, oil spill or other water contamination requiring emergency action to avert danger or damage, volcanic activity, epidemic, air pollution, blight, drought, infestation, explosion, civil disturbance, hostile military or paramilitary action, or a condition of riot, insurrection, or invasion existing in the state or in any county, city, town, or district in the state as defined in Section 24-33.5-703(3), C.R.S..

“Emergency” means an unexpected event that places life or property in danger and requires an immediate response through the use of state and community resources and procedures Section 24-33.5-703(3.5), C.R.S.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, pub. l. no. 104-191, 110 stat. 1936 (1996), codified at 42 U.S.C. § 300GG (2012) and 29 U.S.C. § 1181 et seq. (2012) and 42 U.S.C. § 1320D et seq. (2012) and the federal regulations issued by the U.S. Department of Health & Human Services found at 45 C.F.R. Part 160 (2017); 45 C.F.R. Part 162 (2017); and, 45 C.F.R. Part 164 (2017), which are hereby incorporated by reference. No later editions or amendments are incorporated. These statutes are available for public inspection and copying from the Tenth Circuit Court of Appeals Library, Room 430 Byron Rogers Courthouse, 1929 Stout Street, Denver, Colorado 80294, from the hours of 8 A.M. TO 4:30 P.M. or at <http://uscode.house.gov/>. These statutes are also available for public inspection and copying at the Colorado Department of Human Services, Office of Behavioral Health, 3824 West Princeton Circle, Denver, Colorado 80236, during regular business hours. These regulations are available at no cost from the U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or at <https://www.ecfr.gov/>. These regulations are also available for public inspection and copying at the Colorado Department of Human Services, Office of Behavioral Health, 3824 West Princeton Circle, Denver, Colorado 80236 during regular business hours.

“Individual” means a person seeking or receiving services.

“Inpatient” refers to inpatient hospitalization as well as twenty-four (24) hour residential levels of care.

“Inspection” means a process of review to ensure licensed or designated entities are operating in substantial conformity with applicable licensing and/or designation rules. Inspections may be conducted remotely for licensure or designation renewals if the entity has received an on-site visit within three (3) years or for entities providing telehealth-only services.

“Legal Guardian” is an individual appointed by the court, or by will, to make decisions concerning an incapacitated individual's or minor's care, health, and welfare.

“Legal Representative” means one of the following:

- A. The legal guardian of the individual, where proof is offered that such guardian has been duly appointed by a court of law, acting within the scope of such guardianship;
- B. An individual named as the agent in a Power of Attorney (POA) that authorizes the individual to act on the individual's behalf, as enumerated in the POA;
- C. An individual selected as a proxy decision-maker pursuant to Section 15-18.5-101, et seq., C.R.S., to make medical treatment decisions. For the purposes of these rules, the proxy decision-maker serves as the individual's legal representative for the purposes of medical treatment decisions only; or,
- D. A conservator, where proof is offered that such conservator has been duly appointed by a court of law, acting with the scope of such conservatorship.

“Licensed Agency” means an agency approved and licensed under these rules by the Department to provide substance use disorder treatment.

“Medication formulary” means the *Required Formulary Psychotropic Medications: 2018*, which is hereby incorporated by reference. No later editions or amendments are incorporated. The medication formulary is available at no cost from the Colorado Department of Human Services at <https://www.colorado.gov/pacific/cdhs/behavioral-health-laws-rules>. The medication formulary is also available for public inspection and copying at the Colorado Department of Human Services, Office of Behavioral Health, 3824 West Princeton Circle, Denver, CO 80236, during regular business hours.

The medication formulary is a list of minimum medications, established pursuant to 27-70-103, C.R.S., that may be used by service providers to increase the likelihood that a broad spectrum of effective medications are available to individuals to treat behavioral health disorders, regardless of the setting or service provider. The medication formulary may not contain a complete list of medications, and providers may prescribe and/or carry any additional medications they deem necessary.

“Office” is the Office of Behavioral Health within the Colorado Department of Human Services.

“Plan of Action” is a description of how an agency plans to bring into compliance any standards identified as out of compliance within a specified time period.

“Placement facility” means a public or private facility that has a written agreement with a designated facility to provide care and treatment to any individual undergoing mental health evaluation or treatment by the designated facility. A placement facility may be a general hospital, nursing care facility, or licensed residential child care facility.

“RCCF” means a residential child care facility licensed pursuant to 12 CCR 2509-8, Section 7.705, et seq., by the Colorado Department of Human Services, Division of Child Welfare.

“Short-Term” psychiatric care means the average lengths of services are from three (3) to seven (7) days.

“The ASAM Criteria” means the publication from the American Society of Addiction Medicine, Mee-Lee, D., Shulman, G.D., Fishman, M.J., Gastfriend, D.R., Miller, M.M., EDS. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd ed. Carson City, NV: The Change Companies®; 2013, which is hereby incorporated by reference. No later editions or amendments are incorporated. Mee-Lee, D., Shulman, G.D., Fishman, M.J., Gastfriend, D.R., Miller, M.M., EDS. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd ed. Carson City, NV: The Change Companies®; 2013, is available for a reasonable charge at <http://www.asam.org/resources/the-asam-criteria>. Mee-Lee, D., Shulman, G.D., Fishman, M.J., Gastfriend, D.R., Miller, M.M., EDS. The ASAM Criteria: Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions, 3rd ed. Carson City, NV: The Change Companies®; 2013, is also available for public inspection at the Colorado Department of Human Services, Office of Behavioral Health, 3824 West Princeton Circle, Denver, Colorado 80236, during regular business hours.

21.105 RIGHT TO APPEAL [Eff. 5/1/16]

Any licensee or designee adversely affected or aggrieved by these rules or by the Department’s decisions in regard to implementation of these rules, has the right to appeal to the Colorado Department of Personnel and Administration, Office of Administrative Courts, and may subsequently seek judicial review of the Department’s action in accordance with Section 24-4-101, et seq., C.R.S.

- A. The following actions may be submitted to an Administrative Law Judge for an evidentiary hearing: denial of a license or designation, provisional license, probationary license, revocation, denial of a waiver, limitation of a license, denial of a modification.
- B. After written notification from the Department of intended action, the licensee or designee has twenty one (21) calendar days to submit a written appeal. The appeal must be received by the Division of Behavioral Health within twenty one (21) days from the date the written notification of action letter was sent by the Department.
- C. In all cases except waiver denials, the Department will file a notice of charges with the Office of Administrative Courts to begin the administrative process. In waiver denials, the Appellant’s request for appeal shall be forwarded to the Office of Administrative Courts. Once the appellant’s request is forwarded to the Office of Administrative Courts, the Department may file a notice of charges.

- D. An answer to the notice of charges shall be due twenty one (21) calendar days after the date of mailing of the notice of charges.
- E. The Office of Administrative Courts shall send out a procedural order directing the course of the proceedings and setting the matter for hearing.
- F. Subsequent to an evidentiary hearing at the Office of the Administrative Courts and the issuance of a final agency decision, a party may seek to appeal the final agency decision through judicial review in accordance with Section 24-4-106, C.R.S.

21.110 GOVERNANCE [Eff. 11/1/13]

- A. Licensed and or designated entities by the Department shall be recognized by and allowed to do business in Colorado.
- B. Governance shall provide for and maintain at minimum:
 - 1. Compliance with these rules and applicable federal and state regulations;
 - 2. Agency operating policies and procedures based on these rules, Department policies and procedures, and applicable state and federal regulations;
 - 3. Organizational structures that clearly delineate staff positions, and lines of authority, and supervision;
 - 4. Adequate financial resources to maintain agency personnel, physical facilities, and operations;
 - 5. Physical facilities that meet all current and applicable local and state health, safety, building, plumbing and fire codes and zoning ordinances;
 - 6. Property liability insurance;
 - 7. Professional liability (malpractice) insurance;
 - 8. Accurate, up-to-date individual attendance and payment records; and,
 - 9. A written emergency plan and procedures that address provisions for dealing with medical or natural emergencies. Maps of emergency exits shall be conspicuously posted in each site.

21.120 BEHAVIORAL HEALTH LICENSURE AND DESIGNATION

21.120.1 General Provisions

- A. Any agency licensed and/or designated by the Department shall comply with Sections 21.100 through 21.190 and all rules applicable to the specific behavioral health services for which it is licensed or designated.
- B. The Department will review compliance, at a minimum:
 - 1. Licensed agencies once every two (2) years;
 - 2. Facilities designated to provide mental health services per Title 27, Article 65, C.R.S., annually and all other designated agencies at least once every two (2) years; and,

3. When there is reasonable cause to question the agency's fitness to conduct or maintain a license or designation.
- C. Compliance review of sub-contractors and affiliate agencies shall be at the discretion of the Department. Review will be limited to those services that are provided pursuant to contract or affiliation agreement with the licensed or designated agency.
- D. Based on compliance issues identified through application review and inspection, the agency may be issued a provisional or probationary license or designation.
- E. Applicants that are in full compliance shall be granted a Department license to provide substance use disorder services and/or designated to provide mental health services for up to two (2) consecutive years from the date granted.
- F. Licenses and designations shall be displayed in a prominent, publicly accessible place within each agency and or site.
- G. Current licenses and designations shall remain in effect during the approval process when completed license and designation applications are received by the Department sixty (60) calendar days prior to the existing license or designation expiration date.
- H. An agency whose license or designation is not current shall not indicate in any form or manner that it is licensed or designated and shall not provide behavioral health services requiring a license or designation.
- I. Any agency site that has not provided behavioral health services specific to its license or designation status for two (2) years shall be reviewed for termination of licensure or designation.
- J. Applicants may appeal licensing decisions in accordance with the state Administrative Procedure Act, as found in Section 24-4-101, et seq., C.R.S.

21.120.2 LICENSING PROCEDURES FOR AGENCIES PROVIDING SUBSTANCE USE DISORDER SERVICES

21.120.21 Criteria [Eff. 11/1/13]

- A. Providers shall obtain a license if:
 1. Required by statute to be licensed by the Department;
 2. They receive public funds to provide substance use disorder treatment or substance use disorder education;
 3. They provide such treatment to individual populations whose referral sources require them to be treated in agencies licensed by the Department; or,
 4. They are acquiring existing agencies or sites licensed by the Department.
- B. Licenses for treatment and education services and levels of care are required for each physical site.
- C. A license is not transferable from one licensed agency to another, from one treatment site to another, or from a licensed agency to an unlicensed organization or individual.

- D. Hours of education and treatment provided by agencies whose license is not currently in effect may not count toward fulfilling individual obligations to courts; probation; parole; Colorado Department of Revenue, Motor Vehicle Division; and, other referral sources.
- E. Agencies funded by the Department or a by a designated Managed Service Organization shall be licensed to treat individuals involuntarily committed to treatment in accordance with Section 21.270.

21.120.22 Initial Licenses

- A. Applicants for an initial license to provide substance use disorder services shall submit a completed application with required documentation and fees.
- B. An agency may be approved for licensure, granted provisional approval, or have its application denied. The applicant shall be advised of the decision in writing within sixty (60) business days of the initial inspection.
- C. An applicant not in compliance may have its license application returned by certified mail with written summaries of deficiencies and notification that the license application is denied. If an applicant disagrees with the decision, s/he may appeal (see Section 21.105); or upon remedying the noted deficiencies, may re-apply for an initial license in accordance with Section 21.120.2 of these rules. Application fees may not be refunded.

21.120.23 Provisional Licenses

- A. A provisional license may be granted for a period not to exceed ninety (90) calendar days if after initial inspection and review:
 - 1. The provider is in substantial compliance with these rules and regulations and is temporarily unable to conform to all the minimum standards required under these rules. No provisional license shall be issued to a provider if the operations may adversely affect individual health, safety, or welfare;
 - 2. Compliance will be achieved within a reasonable period of time;
 - 3. The provider has a reasonable written plan or schedule for achieving compliance; and,
 - 4. The provider shall provide proof that attempts are being made to conform and comply with applicable rules.
- B. A second provisional license for a period not to exceed ninety (90) calendar days may be granted if substantial progress continues to be made, and it is likely compliance can be achieved by the date of expiration of the second provisional license.
- C. During the term of the provisional license, reviews and inspections may be conducted to determine if the applicant is in compliance and meets the requirements for a license.
- D. Initial applicants who have completed all provisions and are found to be in compliance prior to the expiration of the provisional license shall be granted a license for up to two (2) consecutive years from the date the original provisional license was issued.

- E. If the applicant does not come into compliance during the provisional licensing period, the application for a two (2) year license shall be denied. A denied application shall be returned by certified mail with written summaries of deficiencies and notification that the provisional license is no longer in effect as of ten (10) days from the date the letter was mailed. Original application fees shall not be refunded. If an applicant disagrees with the decision, s/he may appeal (see Section 21.105); or upon remedying the noted deficiencies, may re-apply for an initial license in accordance with Section 21.120.2 of these rules.

21.120.24 License Renewal

- A. An agency seeking renewal shall provide the Department with a completed license application and the applicable fee at least sixty (60) calendar days prior to the expiration of the existing license.
- B. License renewal applications received by the Department after the current license expiration date shall be returned by certified mail with written notification that the license is no longer in effect. Applicants may reapply for an initial license in accordance with Section 21.120.2 of these rules.
- C. License renewal applications that are received by the Department fewer than sixty (60) calendar days prior to the expiration of their existing license may fail to receive their new license prior to the expiration of their old license. An agency that submits its renewal application fewer than sixty (60) days prior to the expiration of the current license and does not receive a new license prior to that date may reapply for an initial license in accordance with Section 21.120.2 of these rules.
- D. Failure of a licensee to accurately answer or report any of the information requested by the Department shall be considered good cause to deny the license renewal application.
- E. The agency licensee shall be notified in writing of non-compliance areas and the need for a plan of action as outlined in Section 21.120.6. A probationary license may be granted.
- F. An agency in compliance with the applicable Department rules and state and federal regulations shall be granted a license renewal effective as of the expiration dates of the current license.

21.120.25 Probationary License [Eff. 11/1/13]

- A. At the Department's discretion, a probationary license may be granted to an agency out of compliance with applicable Department, state or federal regulations prior to issuance of a renewal license or during a current license term. The agency will be notified in writing of non-compliance areas and the need for a plan of action (see Section 21.120.6).
- B. A probationary license will replace the current license for a period not to exceed ninety (90) calendar days.
- C. Administrative and treatment activities may be limited by a probationary license while the agency addresses corrective actions.
- D. A probationary license may be re-issued for a period not to exceed ninety (90) calendar days if substantial progress continues to be made and it is likely that compliance can be achieved by the date of expiration of the second probationary license.

- E. If the licensee fails to comply with or complete a plan of action in the time or manner specified, or is unwilling to consent to the probationary license, the modification to a probationary license shall be treated as a revocation of the licensee and s/he shall be notified by certified mail that the probationary license is no longer in effect as of ten (10) days from the date the letter was mailed. If an applicant disagrees with the decision, s/he may appeal (see Section 21.105); or upon remedying the noted deficiencies, may re-apply for an initial license in accordance with Section 21.120.2 of these rules.

21.120.26 License Modifications

- A. An agency shall submit a license modification application and written documentation demonstrating compliance with all applicable Department rules, policies and procedures, a minimum of thirty (30) calendar days prior, in the following circumstances:
1. Adding, selling, moving or closing agencies, sites, services, or levels of care;
 2. Changing the agency name;
 3. Changing agency governance.
- B. Failure to submit license modification applications and required documentation within thirty (30) calendar days may result in the agency, specific sites, and or levels of care not being licensed.
- C. Application fees for a license modification are not required.
- D. Emergency license modification request
1. An agency may submit a request to the department for an emergency or disaster modification to their license during the timeframe services are disrupted due to a statewide emergency or disaster.
 2. An agency shall provide the department information including but not limited to:
 - a. An explanation for the need for an emergency or disaster license modification; and,
 - b. An explanation or demonstration of compliance with all applicable department rules, policies and procedures.
 3. At the department's discretion, an emergency or disaster license modification may be granted to an agency without an on-site inspection by the department.
 4. Upon receiving confirmation of an emergency or disaster license modification, an agency may provide services immediately and continue to operate under the modified license for up to sixty (60) days after the disaster or emergency has ceased.
 5. To continue to operate beyond sixty (60) days after the emergency or disaster has ceased, an agency shall submit a permanent license modification pursuant to 21.120.26.a.

21.120.27 Limited License [Eff. 11/1/13]

- A. At the Department's discretion, a limited license may be issued to an agency to prevent or address a perceived conflict of interest and/or a dual relationship within the agency that may negatively impact persons receiving services.

The following include, but are not limited to, circumstances where there may be a perceived conflict of interest and/or a dual relationship exists within an agency:

1. The sharing of information across systems that could negatively impact the individual; or,
 2. A financial interest of the agency that may have negative treatment and/or referral implications pertaining to the individual; or,
 3. The combining of professional roles within the agency that is incompatible to the best interests of the individual(s) receiving treatment.
- B. Limitation of the license may include, but is not limited to:
1. Limiting the specific clientele an agency may serve;
 2. Limiting the specific location(s) where an agency may or may not offer services; or,
 3. Limiting the specific level of care that may be provided pursuant to the license.
- C. If an applicant is unwilling to consent to the limitation on the license, the limitation shall be treated as a denial and s/he may appeal (see Section 21.105); or upon remedying the noted perceived conflict of interest and/or a dual relationship, may re-apply for an initial license in accordance with Section 21.120.2 of these rules.

21.120.3 FACILITIES DESIGNATED TO PROVIDE MENTAL HEALTH SERVICES [Eff. 11/1/16]

Facilities designated to provide mental health services may be:

- A. A general or psychiatric hospital licensed or certified by the Colorado Department of Public Health and Environment;
- B. A community mental health center Licensed by the Colorado Department of Public Health and Environment or a community mental health clinic;
- C. An acute treatment unit licensed by the Colorado Department of Public Health and Environment;
- D. A crisis stabilization unit, licensed as an acute treatment unit or as a community clinic by the Colorado Department of Public Health and Environment; or,
- E. A residential child care facility licensed by the Colorado Department of Human Services, Division of Child Welfare.

Applicant facilities shall identify any parent organization ultimately responsible for their operation.

21.120.31 Application of Rules [Eff. 11/1/16]

- A. Designated facilities that are hospitals, acute treatment units, or crisis stabilization units shall comply with all applicable rules including provisions contained in Section 21.280.
- B. Designated facilities that are community mental health centers pursuant to Section 27-66-101, C.R.S., shall comply with Sections 21.130 through 21.200.15, where applicable, and Section 21.280. Treatment provisions, as contained in Sections 21.280.3 through 21.280.9 shall apply to only those individual being treated involuntarily pursuant to Title 27, Article 65, C.R.S.

- C. Designated facilities that are community mental health clinics shall comply with Sections 21.130 through 21.200.15 and Sections 21.280.21 through 21.280.22.
- D. Designated facilities that are residential child care facilities (RCCF) shall follow Section 21.120.3 through 21.120.44 and 21.200 through 21.200.15, where applicable. RCCFs designated to provide mental health services pursuant to Title 27, Article 65, C.R.S. shall follow Sections 21.200, where applicable, and Section 21.280.
- E. Designated managed service organizations (DMSO) shall only comply with 21.120.5 and 21.120.8.

21.120.32 Mental Health Services Pursuant to Title 27, Article 65, C.R.S., Care and Treatment of Persons with Mental Illness Designations [Eff. 5/1/16]

- A. A facility meeting the criteria in Section 21.120.3, excluding community mental health clinics, may apply to the Department to become designated to provide any or all of the following services:
 - 1. Seventy-two (72) hour treatment and evaluation;
 - 2. Short-term treatment; or,
 - 3. Long-term treatment.
- B. Facilities designated for seventy-two (72) hour treatment and evaluation, short-term, or long-term treatment shall have a person who is licensed in Colorado to practice medicine or a certified Colorado psychologist, either employed or under contract, who is responsible for the evaluation and treatment of each individual. Hospital staff privileges shall be an acceptable form of contractual arrangement. The professional person licensed in Colorado to practice medicine or a certified Colorado psychologist may delegate part of his/her duties, except as limited by licensing statutes or these rules, but s/he shall remain responsible at all times for the mental health treatment administered.

21.120.33 Seventy-Two (72) Hour Treatment and Evaluation Facilities [Eff. 5/1/16]

- A. Facilities that are designated as seventy-two (72) hour treatment and evaluation facilities may detain on an involuntary basis persons placed on a seventy-two (72) hour hold for the purpose of evaluation and treatment.
- B. Exclusion of Saturdays, Sundays, and Holidays

Evaluation shall be completed as soon as possible after admission. The designated treatment and evaluation facility may detain a person for seventy-two (72) hour evaluation and treatment for a period not to exceed seventy-two (72) hours, excluding Saturdays, Sundays and holidays if evaluation and treatment services are not available on those days. For the purposes of these rules, evaluation and treatment services are not deemed to be available merely because a professional person licensed in Colorado to practice medicine or a certified Colorado psychologist is on call during weekends and holidays.

21.120.34 Short-Term and Long-Term Treatment Facilities [Eff. 5/1/16]

- A. Facilities that are designated as short-term treatment facilities may involuntarily detain individuals for short-term (a period of not more than three months) or extended short-term care and treatment (a period of not more than an additional three months).

- B. Facilities that are designated as long-term treatment facilities may involuntarily detain individual for long-term care and treatment (a period not to exceed six months) or extended long-term treatment (a period of not more than additional six months).
- C. Every person receiving treatment for a mental health disorder by a designated short-term or long-term facility shall upon admission be placed under the care of a person who is licensed in Colorado to practice medicine or a certified Colorado psychologist and employed by or under contract with the designated facility.

21.120.35 Mental Health Centers and Community Mental Health Clinics [Eff. 5/1/16]

- A. Mental health centers and community mental health clinics shall use membership on the governing board or equivalent for soliciting input regarding issues which impact persons receiving care. Input shall be solicited from adults, children and adolescents receiving services, and their parents or guardians. The input shall be taken into consideration by management or the governing board during decision-making processes.
- B. Emergency/crisis services and evaluation under Sections 27-65-105 and 106, C.R.S., shall be provided twenty-four (24) hours per day including Saturdays, Sundays and holidays. Initial responses to emergencies shall occur either by telephone within fifteen (15) minutes of the call, within one (1) hour of contact in urban and suburban areas, or within two (2) hours of contact in rural and frontier areas.

21.120.36 Medication Consistency in Designated Facilities

- A. Designated facilities shall ensure all clinical staff are aware of and have access to the medication formulary.
- B. Designated facilities shall ensure their providers have access to the medications on the medication formulary when prescribing medications to treat behavioral health disorders.

21.120.4 DESIGNATION PROCEDURE

- A. Facilities applying for designation shall submit an application to the Department on a state approved form.
- B. Facilities providing twenty-four (24) hour inpatient or acute crisis care, must apply for a separate designation based on the unique physical address of each site.
- C. Except in emergency circumstances affecting the facility's ability to provide evaluation and treatment services, a facility seeking to exclude Saturdays, Sundays and holidays from the seventy-two (72) hour limitation on detaining persons for evaluation and treatment must supply in its application for designation or re-designation documentation to establish that it does not have evaluation services available on these days due to the limited availability of a professional person licensed in Colorado to practice medicine or a certified Colorado psychologist.
- D. Receipt of the application shall be acknowledged in writing and state what additional information or documents, if any, are required for review prior to an inspection.
- E. For initial designation applications, the applicant shall be advised in writing within sixty (60) calendar days of initial inspection of the decision of the Department. The facility may be approved for designation, granted provisional approval, or the application may be denied.
- F. A facility that is found to be in compliance with these rules shall be approved as a facility designated to provide mental health services effective for up to a two (2) year period.

- G. Designations shall be automatically revoked or deemed lapsed for any facility whose license to operate as a health care or residential child care facility has been withdrawn, revoked or allowed to lapse.
- H. If the application for designation is denied, the reason(s) for denial shall be provided in a certified letter. If an applicant disagrees with the decision, s/he may appeal (see Section 21.105); or upon remedying the noted deficiencies, may re-apply for designation in accordance with Sections 21.120.3 and 21.120.4 of these rules.

21.120.41 Provisional Designation [Eff. 11/1/13]

- A. Provisional approval may be granted for a period not to exceed ninety (90) calendar days if, after initial inspection and review of a facility:
 - 1. The facility is in substantial compliance with these rules, and is temporarily unable to conform to all the minimum standards required under these rules. No provisional designation shall be issued to a facility if the operation of the facility may adversely affect individual health, safety, or welfare;
 - 2. Compliance will be achieved within a reasonable period of time; and,
 - 3. The facility has a reasonable plan or schedule in writing for achieving compliance.
- B. The facility shall provide proof that attempts are being made to conform and comply with applicable rules.
- C. A second provisional approval for a period not to exceed ninety (90) calendar days may be granted under the same criteria if necessary to achieve compliance.
- D. If the facility is not able to come into compliance within one hundred and eighty (180) calendar days from date initial provisional license granted, the application may be denied.

21.120.42 Re-Designation

- A. A facility seeking designation renewal shall provide the department with a completed designation application at least sixty (60) calendar days prior to the expiration of the existing designation.
- B. Designation renewal applications received by the Department after the current designation expiration date shall be returned by certified mail with written notification that the designation is no longer in effect. Applicants may reapply for an initial designation in accordance with Section 21.120.4 of these rules.
- C. Designation renewal applications that are received by the Department fewer than sixty (60) calendar days prior to the expiration of their existing designation may fail to receive their new designation prior to the expiration of their old designation. An agency that submits its renewal application fewer than sixty (60) days prior to the expiration of the current designation and does not receive a new designation prior to that date may reapply for an initial designation in accordance with section 21.120.2 of these rules.
- D. Failure of a designee to accurately answer or report any of the information requested by the Department shall be considered good cause to deny the designation renewal application.
- E. Facilities designated to provide care and treatment to persons with mental health disorders pursuant to Section 27-65-101, et seq., C.R.S., shall receive an annual review for compliance. All other designated facilities shall be reviewed on-site at least every two (2) years.

- F. Facilities shall be notified in writing of non-compliance areas and the need for a plan of action as outlined in Section 21.120.6. A probationary designation may be granted.
- G. A facility in compliance with applicable Department rules and state and federal regulations shall be granted designation effective as of the expiration date for a period not to exceed two (2) years.

21.120.43 Probationary Designation [Eff. 11/1/13]

- A. A probationary designation may be granted to a licensee out of compliance with applicable Department or state and federal regulations prior to issuance of a renewal designation or during a current designation period. The facility will be notified in writing of non-compliance areas and the need for a plan of action (see Section 21.120.6).
- B. A probationary designation will replace the current designation for a period not to exceed ninety (90) calendar days.
- C. Administrative and treatment activities may be limited by a probationary designation while the facility addresses corrective actions.
- D. A probationary designation may be re-issued for a period not to exceed ninety (90) calendar days if substantial progress continues to be made and it is likely that compliance can be achieved by the date of expiration of the second probationary license.
- E. If the facility fails to comply with or complete a plan of action in the time or manner specified, or is unwilling to consent to the probationary designation, the modification to a probationary designation shall be treated as a revocation of the designation and the facility shall be notified by certified mail of the deficiencies, reason for action, and that the probationary designation is no longer in effect as of ten (10) days from the date the letter was mailed. If the facility disagrees with the decision, it may appeal (see Section 21.105); or upon remedying the noted deficiencies, may re-apply for a designation in accordance with Sections 21.120.3 and 21.120.4 of these rules.

21.120.44 Change in Designation [Eff. 11/1/13]

If a facility makes a change in its designation status or decides to drop its designation, it shall notify the Department in writing not later than thirty (30) calendar days prior to the desired effective date. The facility shall submit a written plan for the transfer of care for the individuals with mental health disorders if the facility will no longer treat those individuals. This plan shall be submitted no later than ten (10) business days prior to the effective date.

21.120.5 DESIGNATED MANAGED SERVICE ORGANIZATION (DMSO) [Eff. 11/1/13]

- A. The Office of Behavioral Health, within the Department, has the authority pursuant to Section 27-80-107, C.R.S., to designate a Managed Service Organization (MSO) responsible for service delivery to eligible persons, as described in the annual federal Substance Abuse Prevention and Treatment Block Grant application, residing in each of the seven (7) defined geographic regions.
- B. Once designated, each managed service organization shall be reviewed annually for compliance pursuant to Section 27-80-107, C.R.S., and Department rules and contract.
- C. MSO's shall follow all applicable Department rules.

21.120.51 Role of Designated Managed Service Organizations (DMSO) [Eff. 11/1/13]

- A. Each DMSO will oversee the expenditure of Department funds in providing effective population-specific substance use disorder treatment and related services to the priority populations identified in each applicable contract.
- B. Each DMSO will develop and monitor a network of licensed providers of substance use disorder services to deliver a full continuum of care as defined in the Department contract within the designated geographic regions of the state.
- C. Each DMSO will ensure the delivery of population-specific services to priority populations as defined in the Department contract, to include individuals and families in need of substance use disorder treatment and related services.

21.120.52 Reporting Requirements [Eff. 11/1/13]

- A. Each DMSO must maintain a fiscal reporting system that complies with state and federal requirements.
- B. Each DMSO must maintain an individual-services reporting system that complies with state and federal requirements.

21.120.53 Service Provision [Eff. 11/1/13]

When a DMSO provides substance use disorder treatment or a related service to any individual, it must be licensed by the Department and demonstrate compliance with all applicable rules.

21.120.54 Monitoring and Quality Improvement [Eff. 11/1/13]

- A. Each DMSO must demonstrate ethical, legal, and solvent fiscal practices, and must maintain a system for periodic review of its contracts, billing and coding procedures, billing records, contractual requirements, and legal requirements.
- B. Each DMSO must maintain a system for periodic review of its contractors to identify any intentional or unintentional wrongdoing and to ensure that they are exercising ethical, legal, and solvent fiscal practices.

21.120.55 Revocation [Eff. 11/1/13]

- A. Designation shall be revoked for reasons including but not limited to those in Section 21.120.8.
- B. Prior to starting a revocation process, the DMSO shall be notified of the facts or conduct that may warrant such action. A plan of action may be required (see Section 21.120.6).
- C. Where there are grounds to find that the DMSO has engaged in deliberate and willful violation or that the public health, safety, or welfare requires emergency action, the Department may summarily suspend the designation pending proceedings for suspension or revocation.
- D. Written notification of action to revoke a designation shall be sent to the DMSO. Except in cases of deliberate and willful violation or of substantial danger to the public health and safety, such notice shall be sent at least ten (10) working days before the date such action goes into effect, and shall include reasons for the action and rights to the appeal process specified in the State Administrative Procedure Act, pursuant to Sections 24-4-105 through 107, C.R.S.

21.120.6 LICENSE AND DESIGNATION REVIEW PROCESS AND PLANS OF ACTION [Eff. 11/1/13]

- A. If after review or pursuant to a complaint, that a licensed or designated agency, contractor, or affiliate is not in compliance with these rules, the organization shall be notified in writing, within thirty (30) business days, of the specific items found to have been out of compliance.
- B. If the agency does not agree with any or all of the findings regarding non-compliance, the agency has ten (10) business days from the receipt of non-compliance notice to dispute the findings by submitting evidence to the Department.

The agency shall receive a written response within thirty (30) business days of the review of submitted evidence.

If the submitted information is sufficient, the agency shall be determined in compliance with these rules.

If the agency continues to be found out of compliance with these rules, the agency shall have thirty (30) business days from the date of receipt of the review findings to submit a plan of action. The plan shall include anticipated dates for achieving full compliance.

- C. If the agency does not dispute the findings, it shall have thirty (30) business days from the receipt of the notice of non-compliance to submit a written plan of action addressing the compliance issues. The plan shall include anticipated dates for achieving full compliance within ninety (90) business days of the submitted plan.
- D. After reviewing the agency's plan of action, the Department may take action as follows:
 - 1. Approve the proposed plan and schedule for achieving full compliance; or,
 - 2. Approve a modified plan and schedule for achieving full compliance; or,
 - 3. Initiate action to revoke, suspend, make probationary, limit, or modify the license or designation of the agency as provided in Section 24-4-104, C.R.S.; and,
 - 4. In cases where a plan of action has been approved, the agency shall remain licensed or designated subject to the achievement of the plan of action.

21.120.7 WAIVERS [Eff. 11/1/13]

Every licensed and designated agency shall comply in all respects with applicable rules. Upon application to the Department, a waiver of the specific requirements of these rules may be granted in accordance with this section, unless the requirements are otherwise required by state or federal law, and individual rights shall not be waived.

- A. Time Period

A waiver of a specific rule may be granted to a licensed or designated agency, or an agency seeking initial application, for a period not to exceed the two year licensing or designation period. The waiver may be renewed at the time of re-licensing or designation.

B. Compliance with all Other Regulations

Agencies applying for or granted a waiver shall be in compliance with local, state and federal regulations, shall not have outstanding findings with regulatory authorities, and be in good standing with meeting any and all contractual requirements related to providing behavioral health services.

C. Grounds for a Waiver

A waiver may be granted upon a finding that:

1. The waiver would not adversely affect the health, safety and welfare of the individuals; and/or,
2. Either it would improve care or application of the particular rule would create a demonstrated financial hardship on the organization seeking the waiver.

D. Burden of Proof

The agency seeking the waiver has the burden of proof. Consideration shall be given as to whether the intent of the specific rule has been met.

E. Placement Facilities

When a designated agency provides mental health services through a placement facility and a waiver is sought for such services, the designated agency and not the placement facility shall request the waiver.

F. Requests for Waivers

Requests for waivers shall be submitted to the Department on the state prescribed form. The request shall include:

1. A detailed description of the behavioral health services provided by the agency;
2. The rule section proposed to be waived and the waiver's effect on the health, safety and welfare of the individuals served;
3. The expected improvement in the care of individuals;
4. If there would be undue financial hardship on the agency, and to what degree; and,
5. Signature of the Board President, Director of the agency, or designee.

G. Decision Process

Unless additional time is required to make inspections or obtain additional information from the agency, the agency shall be notified in writing of the decision within thirty (30) calendar days following the date of receipt of the completed waiver application.

H. Appeal Rights

An agency may appeal the decision of the Department regarding a waiver application as provided by the Colorado Administrative Procedure Act, Sections 24-4-104 and 24-4-105, C.R.S.

21.120.8 LICENSE AND DESIGNATION REVOCATION, DENIAL, SUSPENSION, LIMITATION OR MODIFICATION [Eff. 11/1/13]

- A. At the Department's discretion, a license or designation may be revoked, denied, suspended, modified or have limited licenses or designation. Written notification of the basis for action shall be sent by certified mail to the last known address of the agency, and is effective ten (10) days from the date the letter was mailed. If the affected agency disagrees with the decision, it may appeal per Section 21.105.
- B. A license or designation may be summarily suspended pending proceedings for suspension or revocation in cases of deliberate or willful violation of applicable statutes and regulations or where the public health, safety, or welfare requires emergency action.
- C. A license or designation may be revoked, denied, suspended, modified, or limited for reasons including, but not limited to, the following:
 - 1. Non-compliance with these rules, applicable federal and state laws and regulations, or contracting requirements.
 - 2. Negligence resulting in risk to individuals, staff, public health or safety;
 - 3. Knowingly using or disseminating misleading, deceptive, or false information about other agencies including, but not limited to, advertising;
 - 4. Exercising undue influence on or otherwise exploiting individuals to obtain or sell services, goods, property, or drugs for financial or personal gain;
 - 5. Accepting commissions, rebates, or other forms of remuneration for referring persons to or by the licensed or designated agency;
 - 6. Evidence of agency fraud or misrepresentation;
 - 7. Failure to provide persons with information required by these rules and applicable state and federal statutes, rules, and regulations;
 - 8. Failure to submit required data in an accurate and timely manner to the Department or its authorized representatives;
 - 9. Withholding access to clinical, staff, or fiscal records, or administrative information when requested by the Department;
 - 10. Sale, use or distribution of alcohol or illicit drugs, or unauthorized sale or distribution of prescription or over-the-counter drugs on treatment premises or during treatment activities off premises;
 - 11. Knowingly using, and/or disseminating false information about these rules, Department rules and state or federal regulations, or other information essential to interpreting or managing an individual's status, case management or interagency coordination.
 - 12. Commits a fraudulent insurance act as defined in Section 10-1-128, C.R.S.
 - 13. Failure to comply with a written plan of action.

21.130 DATA REQUIREMENTS [Eff. 11/1/13]

Licensed and designated organizations shall provide accurate and timely submission of required data to the Department identified data collection systems or its authorized representatives and retain a copy in treatment record.

21.140 CRITICAL INCIDENT REPORTING

A critical incident is any significant event or condition that must be reported within twenty-four (24) hours to the Department that is of public concern and/or has jeopardized the health, safety and/or welfare of individuals or staff.

- A. The Department may conduct scheduled or unscheduled site reviews for specific monitoring purposes and investigation of critical incidents reports in accordance with:
 - 1. CDHS policies and procedures;
 - 2. Regulations that protect the confidentiality and individual rights in accordance with Sections 27-65-101, et seq., C.R.S.; HIPAA; AND, 42 C.F.R. Part 2.
 - 3. Controlled substance licensing, Title 27, Article 82, C.R.S.; Section 27-80-212, C.R.S., and Section 18-18-503, C.R.S.
- B. The Department shall have access to relevant documentation required to determine compliance with these rules.
- C. The agency shall:
 - 1. Establish written policies and procedures for reporting and reviewing all critical incidents occurring at the facility;
 - 2. Submit Critical Incidents reports to the Department according to state prescribed forms. This is not in lieu of other reporting mandated by state statute or federal guidelines;
 - 3. Make available a report with the investigation findings for review by the Department, upon request; and,
 - 4. Maintain critical incidents reports for a minimum of three years following the incident.
- D. Nothing in this section shall be construed to limit or modify any statutory or common law right, privilege, confidentiality or immunity.

21.150 QUALITY IMPROVEMENT [Eff. 11/1/13]

- A. The agencies and programs that the Department contracts with, licenses, or designates, shall have a quality improvement program designed to monitor, evaluate, and initiate activities to improve the quality and effectiveness of administrative and behavioral health services.
- B. The agency shall adopt and implement a written quality improvement plan that includes, at a minimum the following processes:
 - 1. Clinical quality measurement of performance.

2. Determine the appropriateness and effectiveness of treatment through a clinical review of a representative sample of open and closed records at a minimum of every six (6) months.
3. Identify and respond to trends concerning significant events, risks, emergency procedures, critical incidents as defined in Section 21.140, and grievances as defined in Section 21.180.
4. Incorporate documented quality improvement findings into clinical and organizational planning, decision making, and to develop staff and individual educational programs.
5. Evaluate annually and update the quality improvement plan as necessary. A copy of the annual findings and report shall be available for review.

21.160 PERSONNEL

21.160.1 GENERAL PROVISIONS

- A. The organization shall have written personnel policies and procedures that include:
1. Personnel (including contracted staff, interns, and volunteers) shall have access to and be knowledgeable about the organization's policies, procedures, and state and federal laws and regulations relevant to their respective duties.
 2. Personnel are assigned duties that are commensurate with documented education, training, work experience, and professional licenses and certifications. Licensed or certified staff shall perform duties in accordance with applicable statutes, rules and regulations.
 3. Training
 - a. The organization shall document the evaluation of applicable previous related experience for volunteers and for staff, and ensure that these personnel have all of the training, including on-the-job training, required in this section.
 - b. All staff shall be given on-the-job training or have related experience in the job assigned to them. They shall be supervised until they have completed on-the-job training appropriate to their duties and responsibilities, or have had previous related experience evaluated.
 - c. The organization shall maintain records documenting completion of all required training, or review of evaluation of previous related experience.
 - d. Volunteers having direct individual contact shall receive training appropriate to their duties and responsibilities.
 - e. Personnel shall receive the following training when first hired and on a periodic basis:
 - 1) Training specific to the particular needs of the populations served;
 - 2) Orientation of the physical plant;
 - 3) Emergency preparedness;

- 4) Individual rights of the population served;
 - 5) Confidentiality (individual privacy and records privacy and security); and,
 - 6) Training on needs identified through the quality improvement program.
- 4. Personnel (including contracted staff, interns, and volunteers) shall not engage in prohibited activities outlined in Section 12-245-224, C.R.S.
- B. Documentation of training, including topics and attendance, shall be maintained in personnel files or organization training log.
- C. Personnel files for each staff shall be maintained by the organization.
 - 1. Files of current staff shall be available onsite for review by the Department.
 - 2. Files shall include documentation of:
 - a. Job description that shall detail minimum qualifications, core competencies, duties, and supervisory structure;
 - b. Education and work experience; and
 - c. Background investigations as described in Section 21.160.2.

21.160.2 BACKGROUND CHECKS AND EMPLOYEE VERIFICATION

- A. Pre-employment background investigations:
 - 1. Shall be required for all staff, interns and volunteers who have direct contact with individuals receiving services.
 - 2. Take place at submission of an initial Office of Behavioral Health license or designation application or take place at pre-employment.
 - 3. Consist of at least a criminal background check performed by the Colorado Bureau of Investigation.
- B. Pre-employment inquiries:
 - 1. The agency shall verify license, certification, and a check of disciplinary action through the Colorado Department of Regulatory Agencies; and,
 - 2. Complete a reference check.
- C. Organizations shall maintain evidence of background investigations and employee verification in personnel files.
- D. The organization shall have written criteria for evaluating which convictions or complaints make an applicant unacceptable for hire or a staff unacceptable for retention.
- E. The organization shall incur the costs of obtaining a criminal history and background check of potential employees.
- F. The organization shall develop and implement written criteria for:

1. Routine monitoring of employee credentials and disciplinary actions; and,
2. Reporting requirements of investigations, indictments, or convictions that may affect employee's ability to carry out his/her duties or functions of job.

21.170 RECORDS CARE AND RETENTION

21.170.1 GENERAL PROVISIONS

- A. Agencies shall assure that all paper and electronic records are maintained to prevent unauthorized access in accordance with 42 C.F.R. Part 2 and HIPAA.
- B. For outpatient agencies:
 1. Individual records for adults shall be retained for seven (7) years from date of discharge from agency.
 2. For individuals who are under eighteen (18) years of age when admitted to the agency, records shall be retained until the individual is twenty five (25) years of age.
- C. For inpatient agencies:
 1. Individual records for adults shall be retained for ten (10) years from date of discharge from agency.
 2. For individuals who are under eighteen (18) years of age when admitted to the agency, records shall be retained until the individual is twenty eight (28) years of age.
- D. All records are to be disposed in accordance with State and Federal confidentiality statutes and regulations.
- E. Disposal services commissioned by an agency to dispose of individual records shall sign Qualified Service Organization Agreements or Business Associate Agreements.
- F. Staff having access to individual records shall be knowledgeable of state and federal statutes, policies, and procedures which protect individual identity and service information from unauthorized access and disclosure.
- G. Agencies shall develop policies and procedures that protect individual identity and treatment information when transporting electronic and written records.
- H. Agencies shall establish guidelines for reporting breach or potential loss of individual identity and service information in accordance with state and federal confidentiality statutes and regulations.
- I. Records shall be accessible to agency staff and the Department.
- J. Agencies that are closing or acquired by another agency shall protect individual identity per state and federal regulations.

21.170.2 CONFIDENTIALITY [Eff. 11/1/13]

- A. The confidentiality of the individual record, including all medical, mental health, substance use, psychological and demographic information shall be protected at all times, in accordance with all applicable state and federal laws and regulations.

- B. The information in this section shall not be construed to limit the access of duly authorized representatives of the Department to confidential material for purposes of assuring compliance with these rules. Such duly authorized representatives of the Department are obligated to protect the confidentiality of any individual information reviewed.

21.170.3 RELEASE OF INFORMATION

- A. An agency that is licensed or designated by the Department must comply with release of information regulations Pursuant to 42 C.F.R. Part 2 and HIPAA.
- B. The signed release of information shall state, at a minimum:
1. Persons who shall receive the information;
 2. For what purpose;
 3. The information to be released;
 4. That it may be revoked by the individual, parent, or legal guardian at any time;
 5. That the release of information shall be time limited up to two (2) years.
- C. Records shall be released to the staff of the governor's designated Protection and Advocacy System for Individuals with Mental Illness, per Section 27-65-121(1)(i), C.R.S., under the following guidelines for all records of:
1. Any individual who is an individual of the system or the legal guardian, conservator, or other legal representative of such individual has authorized the system to have access;
 2. Any individual with a mental health disorder, who has a legal guardian, conservator, or other legal representative, with respect to whom a complaint has been received by the system or with respect to whom there is probable cause to believe the health or safety of the individual is in serious and immediate jeopardy, whenever:
 - a. Such representative has been contacted by such system upon receipt of the name and address of such representative;
 - b. Such system has offered assistance to such representative to resolve the situation;
 - c. Such representative has failed or refused to act on behalf of the individual.
- D. Whenever a family member or other party requesting information, not including the agency, requests that information revealed to treating personnel remain confidential, such information shall not be released unless otherwise provided by law or court order.
1. Whenever confidential information provided by a family member or other party providing information is ordered released, attempts shall be made to notify the family member or informant of the release of information by the individual who has obtained the court order.
 2. The fact that confidential information is being withheld may be disclosed to individuals requesting the information, but if the individual's attorney has requested the information, the fact that confidential information is being withheld shall be disclosed.

21.170.4 CONSENTS

- A. A written agreement shall be executed between the agency and the individual or the individual's legal representative at the time of admission. The parties may amend the agreement provided such amendment is evidenced by the written consent of both parties. No agreement shall be construed to relieve the organization of any requirement or obligation imposed by law or regulation.
- B. Individual consents shall include consent to treatment.
- C. Services shall involve families and significant others with written individual consent, unless clinically contraindicated.
- D. For minor's consent, please review Care of Children, Youth, and Families in Section 21.200.13.
- E. For opioid medication assisted treatment consent, see Section 21.320.
- F. If the Governor or local government declares an emergency or disaster an agency may obtain documented oral agreements or consents in place of written agreements or consents. Documented oral agreements and consents shall only be used as necessary because of circumstances related to the emergency or disaster. Agencies shall send a hard copy or electronic copy of the documented agreement or consent to the individual within two (2) business days of the oral agreement or consent.

21.180 GRIEVANCE [Eff. 11/1/13]

- A. The agency shall establish a uniform procedure for prompt management of grievances brought by individuals accessing, receiving or being evaluated for services and their family members. The organization shall develop policies and procedures for handling grievances. A grievance shall mean any expression of dissatisfaction about any matter related to provided services, and shall be accepted verbally or in writing.
- B. The agency shall provide a fair and accessible grievance resolution process, which shall provide the individual with a resolution no later than fifteen (15) business days from submission of the grievance. If the grievance is received verbally the representative shall create a written documentation of the grievance.
- C. The agency shall designate a representative, who shall be available to assist individuals in resolving grievances, and who shall have no involvement in the clinical or regular care of the individual.
- D. The agency shall educate service recipients and their representatives about the mechanisms in place for filing grievances. This education shall include rights, and internal grievance process and procedures, and the name, contact information, and responsibilities of the designated representative within the agency. Appropriate contacts for external appeal shall also be provided, which may include, but are not limited to, the following: the Colorado Department of Regulatory Agencies, the Colorado Department of Public Health and Environment, the Colorado Department of Health Care Policy and Financing, or the governor's designated Protection and Advocacy System for Individuals with Mental Illness. Documentation in the records shall include dated signature of the individual receiving the information.
- E. A notice of rights, grievance procedure, the representative's name, office location, responsibilities, and telephone number shall be posted within the agency in prominent locations where persons access, receive or are evaluated for services.

- F. The agency shall maintain a record of submitted grievances, separate from the individual records that include the date, the type of grievance, and the outcome of investigation. Data shall be reported annually to the Department.

21.190 DOCUMENTATION IN INDIVIDUAL RECORDS

21.190.1 DEFINITIONS [Eff. 5/1/16]

“Admission Summary” is a brief review of assessments and other relevant intake data, including screenings, which summarizes the current status and provides a basis for individualized service planning.

“Assessment” is a formal and continuous process of collecting and evaluating information about an individual for service planning, treatment and referral. This information establishes justification for services.

“Best Practices” are interventions, techniques, and treatment approaches that have some quantitative data showing positive treatment outcomes over a period of time, but may not have enough research or replication to be considered an evidence-based approach.

“Case Management” means activities that are intended to help individuals gain access to behavioral health and supportive services (including social, educational, and medical) that are coordinated and appropriate to the changing needs and stated desires of the individual over time. Activities include, but are not limited to: service planning, referral, monitoring, follow-up, advocacy, and crisis management.

“Chief Complaint/Presenting Problem” means the reason/concern/motivation that prompts the client to seek services or that their referral source identifies as the issue, which requires intervention, usually in the person’s own words. It also includes onset, duration, other symptoms noted, progression of the problem, solutions attempted at alleviating the problem, how the person’s life has been impacted, and how the person views responsibility for the problem. It can be information from a referral, family or other professional.

“Culture” means the shared patterns of behaviors and interactions, cognitive constructs, and affective understanding learned through a process of socialization. These shared patterns identify the members of a culture group while also distinguishing those of another group. People within a culture usually interpret the meaning of symbols, artifacts, and behaviors in the same or similar ways. Culture includes, but is not limited to: race, ethnicity, religion, spirituality, gender, sexual orientation, language and disabilities.

“Cultural Assessment” means identifying and understanding aspects of an individual’s culture and linguistic needs in order to incorporate the information into service planning and service delivery. It is necessary to incorporate cultural considerations into service delivery in order to best understand and address ways in which culture influences an individual’s behavioral health issues.

“Discharge” means the termination of treatment obligations and service between the individual and the agency.

“Evidence-Based” practices, principles, and programming are interventions, techniques, and treatment methods that have been tested using scientific methodology and proven to be effective in improving outcomes for a specific population.

“Screening” is a brief process used to determine the identification of current behavioral health or health needs and is typically documented through the use of a standardized instrument. Screening is used to determine the need for further assessment, referral, or immediate intervention services.

21.190.2 CONTENT OF RECORDS [Eff. 5/1/16]

- A. A confidential record shall be maintained for each individual. Records shall be dated and legibly recorded in ink or in electronic format.
- B. Documents shall include, where applicable:
 - 1. Consent to treatment;
 - 2. Consent to release confidential information;
 - 3. Assessments and screenings;
 - 4. Admission summary;
 - 5. Service plan;
 - 6. Re-assessment(s);
 - 7. Progress notes;
 - 8. Medication administration or monitoring record;
 - 9. Physician's orders;
 - 10. Documentation of on-going services provided by external services providers;
 - 11. Advance directives;
 - 12. Acknowledgements and disclosures;
 - 13. Legal and court paperwork; and,
 - 14. Discharge summaries.
- C. See specific program areas for additional content of record requirements.

21.190.3 ASSESSMENT [Eff. 5/1/16]

- A. A comprehensive best practices assessment shall be completed as soon as is reasonable upon admission and no later than seven (7) business days of admission into services with the noted exceptions:
 - 1. Acute Treatment Unit: within twenty-four (24) hours of admission.
 - 2. Withdrawal Management units, inpatient hospitalization: within seventy-two (72) hours of admission.
- B. Assessment shall continue throughout the course of treatment and shall be reviewed and updated when there is a change in the person's level of care or functioning, or, must occur at minimum, every six months.
- C. All methods and procedures used to assess and evaluate an individual shall be developmentally and age appropriate, culturally responsive, and conducted in the individual's preferred language and/or mode of communication.

- D. The assessment shall be documented in the individual record and, at minimum, include the following where information is available and applicable:
1. Identification and demographic data;
 2. Chief complaint/presenting problem;
 3. Mental health history;
 4. Substance use;
 5. Physical and dental health status;
 6. A diagnosis with sufficient supporting criteria and any subsequent changes in diagnosis;
 7. A mental status examination for each individual who is given a diagnosis;
 8. History of involuntary treatment;
 9. Advance directives.
 10. Capacity for self-sufficiency and daily functioning;
 11. Cultural factors that may impact treatment, including age, ethnicity, linguistic/communication needs, gender, sexual orientation, relational roles, spiritual beliefs, socio-economic status, personal values, level of acculturation and/or assimilation, and coping skills;
 12. Education, vocational training, and military service;
 13. Family and social relationships;
 14. Trauma;
 15. Physical/sexual abuse or perpetration and current risk;
 16. Legal issues;
 17. Issues specific to older adults such as hearing loss, vision loss, strength; mobility and other aging issues;
 18. Issues specific to children/adolescents such as growth and development, daily activities, legal guardians and need for family involvement and engagement in the child's treatment;
 19. Strengths, abilities, skills, and interests; and,
 20. Barriers to treatment.
- E. See specific program areas for additional assessment requirements.

21.190.4 SERVICE PLANNING AND REVIEWS

21.190.41 Service Planning Requirements [Eff. 5/1/16]

- A. An individualized, integrated, comprehensive, written service plan will be:

1. Collaboratively developed between the individual and service provider or treatment team;
 2. Goal focused;
 3. Written in a manner that fosters an individual's highest possible level of independent functioning; and,
 4. Ongoing throughout treatment.
- B. Service planning shall be developed with the individual following an identified assessment(s) and shall apply intervention, treatment, recovery oriented services and continuing care strategies to the degree indicated by the findings of the assessment(s).
- C. An initial service plan shall be formulated to address the immediate needs of the individual within twenty-four (24) hours of assessment.
- D. The service plan shall be developed, by a multidisciplinary team when applicable, as soon as is reasonable after admission and no later than:
1. Acute Treatment Units (ATU): twenty-four (24) hours of admission;
 2. Withdrawal Management: seventy-two (72) hours of admission;
 3. Inpatient Hospitalization: seventy-two (72) hours of admission;
 4. Residential Treatment Facility: ten (10) business days after assessment;
 5. Partial Hospitalization: seven (7) business days after assessment; or,
 6. Outpatient: fourteen (14) business days after assessment.
- E. In addition, services plans shall:
1. Specify goals based on the assessment;
 2. Be strength-based, gender appropriate, and individually directed;
 3. Reflect findings of a cultural assessment, to include, but not limited to: gender, sexual orientation, socio-economic status, ethnicity, personal values, level of acculturation and/or assimilation, spirituality, linguistics, age, family systems, interpretation of trauma and coping skills;
 4. Contain specific, measurable, attainable objectives that relate to the goals and have realistic expected date(s) of achievement;
 5. Goals and objectives written in a manner understandable to the individual;
 6. Identify the type, frequency and duration of services;
 7. Be developmentally and/or age appropriate; and,
 8. Include involvement of other identified family and supportive individuals, when appropriate.

- F. All parties (the individual, legal guardian, multidisciplinary team members) who participate in the development of the plan shall sign the plan. The record shall contain documentation whenever a plan is not signed by the individual or participating parties.
- G. There shall be documentation that the individual was offered a copy of the plan.

21.190.42 Service Plan Revisions and Reviews [Eff. 5/1/16]

- A. Unless otherwise indicated, reviews and any service plan revisions shall be completed and documented when there is a change in the individuals' level of functioning or service needs and no later than:
 - 1. Acute Treatment Units (ATU) and Withdrawal Management: three (3) calendar days;
 - 2. Inpatient Hospitalization: every seven (7) calendar days for four (4) weeks; after four (4) weeks: monthly; and, after six (6) months: quarterly;
 - 3. Residential Treatment Facility: monthly for six (6) months and quarterly after six (6) months;
 - 4. Partial Hospitalization: every fourteen (14) calendar days;
 - 5. Opioid Medication Assisted Treatment: every three (3) months; or,
 - 6. Outpatient: every six (6) months, unless individuals receive medication/psychiatric services only as described in Section 21.190.7.
- B. The service plan review shall include documentation of:
 - 1. Progress made in relation to planned treatment outcomes;
 - 2. Any changes in the individual's treatment focus; and,
 - 3. Adjustments to the plan concerning individual lengths of stay as indicated by on-going assessments.
- C. Reviews shall be conducted collaboratively by clinician and individual.
- D. The record shall contain documentation whenever the individual or participating parties do not sign a revised plan.
- E. There shall be documentation that the individual was offered a copy of the plan.

21.190.5 TREATMENT PROGRESS DOCUMENTATION REQUIREMENTS [Eff. 5/1/16]

- A. Progress notes are a written chronological record of an individual's progress in relation to planned outcomes of services.
- B. Progress notes shall contain the following information unless otherwise noted in specific service population sections of these rules:
 - 1. Ongoing progress including dates and types of service, adhering to program-specific frequency requirements;

2. A summary of the activity for the session and progress toward specific treatment goals to be completed with minimum frequency of:
 - a. One (1) note per session for outpatient and intensive outpatient,
 - b. Daily for inpatient and intensive residential services,
 - c. Weekly for partial hospitalization and all other levels of residential treatment;
 3. The individual's response to treatment approaches and information about progress toward achieving service plan goals and objectives;
 4. Changes in the service plan with reasons for such changes;
 5. Information regarding support and ancillary services recommended and provided;
 6. Any significant change in physical, behavioral, cognitive and functional condition and action taken by staff to address the individual's changing needs; and,
 7. Case management notes reflecting the content of each contact, including ancillary and collateral contacts.
- C. Treatment notes shall not include protected health information pertaining to other individuals receiving services.
- D. Treatment entries shall be signed and dated by the author at the time they are written, with at least first initial, last name, degree and or professional credentials. Telephone orders shall be written at the time they are given and authenticated at a later time.

21.190.6 DISCHARGE PLANNING AND SUMMARIES

21.190.61 Discharge Planning Requirements [Eff. 5/1/16]

- A. Discharge planning begins at the time of admission, is updated during the course of services, and engages the individual and support systems s/he identifies in the planning process.
- B. Discharge policies and procedures shall include criteria outlining the requirements for an individual's discharge from treatment.
- C. Discharge plans shall be concise, complete, and comprehensive to facilitate transition to the next level of care when applicable.
- D. Persons receiving services on a voluntary basis shall be discharged from treatment immediately at their request unless emergency commitments or emergency mental health holds are in effect.
- E. Documentation of discharge information provided to the individual, where applicable, shall include:
 1. Medications at discharge including, dosages and instructions for follow-up;
 2. Legal status and any other legal restrictions placed upon the individual;
 3. Referrals with details; and,
 4. Information if the discharge is being made against advice of provider.

21.190.62 Discharge Summary [Eff. 5/1/16]

Discharge summaries shall be completed as soon as possible, no later than thirty (30) calendar days after discharge. The agency's policy and procedures shall determine the minimum timeframe for completion. Records shall contain a written discharge summary to include, but not limited to, the following information, where applicable:

- A. Reason for admission;
- B. Reason for discharge;
- C. Primary and significant issues identified during course of services;
- D. Diagnoses;
- E. Summary of services, progress made, and outstanding concerns;
- F. Coordination of care with other service providers;
- G. Advance directives developed or initiated during course of services.
- H. Summary of medications prescribed during treatment, including the individual's responses to medications;
- I. Medications recommended and prescribed at discharge;
- J. Summary of legal status throughout the course of services and at time of discharge;
- K. Documentation of referrals and recommendations for follow up care;
- L. Documentation of the individual's and/or family's response and attitude regarding discharge; and,
- M. Information regarding the death of the individual.

21.190.7 MEDICATION/PSYCHIATRIC SERVICES ONLY AT MENTAL HEALTH CENTERS AND CLINICS [Eff. 11/1/13]

- A. A person qualifies to be classified as receiving medication/psychiatric services only when the agency provides a maximum of three (3) services, in addition to services related to medications, within a six (6) month period of time.
- B. At least annually, a licensed behavioral health professional shall complete and document in the clinical record:
 - 1. Clinical rationale supporting a medication/psychiatric services only status;
 - 2. An updated assessment;
 - 3. An updated service plan; and,
 - 4. A Colorado Client Assessment Record (CCAR).

21.200 CARE AND TREATMENT OF CHILDREN, YOUTH AND FAMILIES

21.200.1 BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND YOUTH

21.200.11 Definitions

- A. "Psychotherapy" or "psychotherapy services" as defined in Section 12-245-202(14), C.R.S., means the treatment, diagnosis, testing, assessment, or counseling in a professional relationship to assist individuals or groups to alleviate behavioral and mental health disorders, understand unconscious or conscious motivation, resolve emotional, relationship, or attitudinal conflicts, or modify behaviors that interfere with effective emotional, social, or intellectual functioning. Psychotherapy follows a planned procedure of intervention that takes place on a regular basis, over a period of time, or in the cases of testing, assessment, and brief psychotherapy, psychotherapy can be a single intervention.
- B. "Youth" in this section means, under the age of twenty-one (21), unless otherwise noted.

21.200.12 General Provisions

- A. In addition to these rules, programs providing behavioral health services to children and adolescents must follow provisions made in Sections 21.110 through 21.190.
- B. Residential child care facilities licensed by the Colorado Department of Human Services, Division of Child Welfare, shall follow Sections 21.120 and 21.200, where applicable.

21.200.13 Rights of Children and Adolescents

These provisions shall not apply to any youth admitted to a facility designated under Title 27, Article 65, C.R.S., Care and Treatment of Persons with Mental Illness, for behavioral health purposes pursuant to the Children's Code, Title 19, C.R.S., when there have been judicial proceedings authorizing the placement of the youth into a facility.

- A. In addition to the individual rights in Section 21.280.26 for adults, youth who are fifteen (15) years of age or older, with or without the consent of a parent or legal guardian, have the right to:
 - 1. Consent to receive behavioral health services from an agency or a professional person;
 - 2. Consent to voluntary hospitalization;
 - 3. Object to hospitalization and to have that objection reviewed by the court under the provision of Section 27-65-103, C.R.S.; and
 - 4. Consent to release of information.
- B. Parents or legal guardians shall be contacted without the youth's written or verbal consent if:
 - 1. The individual presents as a danger to self or others; or,
 - 2. Essential medical information is necessary for parents or legal guardians to make informed medical decisions on behalf of youth.
- C. Behavioral health facilities must obtain parental or legal guardian consent for youth under fifteen (15) years of age, with the following exception:

1. Section 12-245-203.5(2), C.R.S. allows psychotherapy services, as defined in Section 12-245-202(14)(a), C.R.S., to be provided to a youth who is twelve (12) years of age or older, with or without the consent of the youth's parent or legal guardian if the youth is knowingly and voluntarily seeking such services and the provision of psychotherapy services is clinically indicated and necessary to the youth's well-being. The following mental health professionals are the only professionals allowed to provide outpatient psychotherapy services in an outpatient setting, to a youth who is twelve (12) years of age or older, with or without the consent of the youth's parent or legal guardian:
 - a. A professional person as defined in Section 27-65-102(17), C.R.S., which means a person licensed to practice medicine in this state, a psychologist certified to practice in this state, or a person licensed and in good standing to practice medicine in another state or a psychologist certified to practice and in good standing in another state who is providing medical or clinical services at a treatment facility in this state that is operated by the armed forces of the united states, the united states public health service, or the united states department of veterans affairs;
 - b. A mental health professional licensed pursuant to Article 245, of Title 12, C.R.S., which in accordance with Section 12-245-203.5, C.R.S., includes:
 - 1) A psychologist licensed pursuant to Part 3 of Article 245, of Title 12, C.R.S. or a psychologist candidate pursuant to Part 3 of Article 245, of Title 12, C.R.S.;
 - 2) A social worker licensed pursuant to Part 4 of Article 245, of Title 12, C.R.S.;
 - 3) A marriage and family therapist licensed pursuant Part 5 of Article 245, of Title 12, C.R.S.;
 - 4) A professional counselor licensed pursuant to Part 6 of Article 245, of Title 12, C.R.S. or a licensed professional counselor candidate pursuant to Part 6 of Article 245, of Title 12, C.R.S.;
 - 5) An addiction counselor licensed pursuant to Part 8 of Article 245, of Title 12, C.R.S.; or
 - c. A school social worker licensed by the Department of Education.
- D. Youth who are under the age of fifteen (15) have the right to object to hospitalization and to have a guardian ad litem appointed pursuant to Section 27-65-103, C.R.S.
- E. Appropriate educational programs shall be available for all school age youth who are residents of the designated facility in excess of fourteen (14) calendar days. These educational programs may be provided by either the local school district or by the designated facility. If provided by the designated facility, the educational program shall be approved by the Colorado Department of Education.

21.200.14 Assessment of Children and Adolescents [Eff. 5/1/16]

Agencies shall follow Section 21.190.3 and the following:

- A. Assessments must include an evaluation of the family's, or other supportive adult's, social and environmental challenges and strengths that may pertain to the youth's treatment. If family or other supportive adults support needs are identified, this shall be addressed in the service plan.
- B. The assessment must explore how the identified family members, supportive individuals or significant others will be involved in behavioral health services. In the event that any individual's involvement is contraindicated, the clinical rationale must be documented.
- C. An assessment shall address any needs of a youth at least seventeen (17) years of age who is expected to require behavioral health services and supports beyond the age of eighteen (18).

21.200.15 Service Planning for Children and Adolescents [Eff. 5/1/16]

Agencies shall follow Section 21.190.4, service planning and reviews, and the following:

- A. The service plan shall be developed in collaboration with the youth's parent or legal guardian and be signed by both. In the event that involvement of the parent or legal guardian is contraindicated, the rationale shall be documented.
- B. A copy of the service plan shall be provided to the individual and parent or legal guardian, unless contraindicated.
- C. The service plan shall include goals and objectives that address family support needs as identified in the assessment.

21.200.2 LICENSED SUBSTANCE USE DISORDER AGENCIES TREATING YOUTH [Eff. 5/1/16]

- A. Agencies providing substance use disorder treatment services to youth shall be licensed by the Department to treat youth and comply with Section 21.210.
- B. Agencies shall implement evidence-based screening, assessment instruments, and curricula, designed and developed for youth.
- C. Agencies shall provide recovery-oriented services appropriate for youth, when indicated.
- D. Youth shall be informed that non-compliance with treatment programs to which they are sentenced shall be reported by the agency to referring courts and/or their agents.

21.200.3 Minor in Possession: Education and Treatment [Eff. 5/1/16]

For the purposes of this section "Minor in Possession" (MIP) is the legal terminology used for an offense that is issued to individuals age twenty (20) and younger for underage drinking or possession. MIP may result in a revocation of a driver's license, a substance use disorder assessment, and/or alcohol education and treatment classes per Section 18-13-122, C.R.S.

21.200.31 General Provisions [Eff. 5/1/16]

- A. Agencies providing MIP services shall comply with Section 21.200.2.
- B. Agencies shall not place a youth with a MIP citation in DUI/DWAI education or therapy groups unless the youth also has a DUI/DWAI offense.
- C. All agency education and treatment staff shall have documented training, supervision and experience in adolescent development and prevention, intervention and treatment approaches.

- D. When possible, minors sixteen (16) years of age and under should be treated in separate groups than those that are provided to individuals seventeen (17) to twenty (20) years old.
- E. Agencies shall conduct ongoing assessment of progress in education and/or treatment level of care to determine if youth are in the appropriate service level.

21.200.32 Minor in Possession: First Offense Education and Intervention [Eff. 5/1/16]

- A. MIP education is for youth who have received their first MIP citation and shall be conducted in an outpatient setting.
- B. MIP education shall be at least eight (8) hours, completed over no less than a two (2) day period with no more than four (4) hours of education per day.
- C. Education topics shall include:
 - 1. Current legal consequences for additional MIP citations;
 - 2. Resources or referrals for treatment level services, when indicated;
 - 3. Developmental impact of early onset substance use and subsequent impact on developing brain;
 - 4. Physiological effect of alcohol and other drug use;
 - 5. Refusal skills; and,
 - 6. Avoidance of high risk situations.
- D. For youth seventeen (17) years old and younger, agencies shall include and document a minimum of two (2) hours of parental involvement, unless contraindicated.

21.200.33 Minor in Possession: Second and Subsequent Offense Treatment [Eff. 5/1/16]

- A. Second Minor in Possession Offense
 - 1. Second offense MIP therapy shall be conducted in an outpatient setting, shall be a minimum of twelve (12) hours in duration over eight (8) weeks, and shall not exceed ninety (90) minute sessions, excluding breaks and administrative procedures.
 - 2. Agencies shall complete an individualized service plan, with each youth in accordance with Sections 21.190.4 and 21.200.15 of these rules.
 - 3. For youth seventeen (17) years old and younger, agencies shall include and document a minimum of four (4) hours of parental involvement, unless contraindicated.
- B. Third and Subsequent Minor in Possession Offenses
 - 1. A third MIP results in a Class 2 misdemeanor. Youth shall complete a minimum of twenty (20) hours of substance use disorder treatment over a minimum thirteen (13) week period, as determined by the assessment. Groups shall not exceed ninety (90) minutes in duration.
 - 2. Multiple levels of care shall be offered to meet the needs of the individual and family members, when appropriate.

3. Agencies shall include and document parental involvement, unless contraindicated, throughout the length of treatment.

21.200.4 [THIS SECTION HAS BEEN MOVED TO 2 CCR 502-6] <Chapter 4>

21.200.41 [THIS SECTION HAS BEEN MOVED TO 2 CCR 502-6] <Part 4.1>

21.200.42 [THIS SECTION HAS BEEN MOVED TO 2 CCR 502-6] <Part 4.2>

21.200.43 [THIS SECTION HAS BEEN MOVED TO 2 CCR 502-6] <Part 4.3>

21.200.44 [THIS SECTION HAS BEEN MOVED TO 2 CCR 502-6] <Part 4.4>

21.200.45 [THIS SECTION HAS BEEN MOVED TO 2 CCR 502-6] <Part 4.5>

21.200.47 [THIS SECTION HAS BEEN MOVED TO 2 CCR 502-6] <Part 4.7>

21.200.48 [THIS SECTION HAS BEEN MOVED TO 2 CCR 502-6] <Part 4.8>

21.200.481 [THIS SECTION HAS BEEN MOVED TO 2 CCR 502-6] <Part 4.8.1>

21.200.482 [THIS SECTION HAS BEEN MOVED TO 2 CCR 502-6] <Part 4.8.2>

21.200.5 **FAMILY ADVOCACY MENTAL HEALTH JUVENILE JUSTICE PROGRAMS** [Eff. 5/1/16]

These rules and standards implement the Integrated System of Care Family Advocacy Programs for Mental Health Juvenile Justice Populations defined in Section 27-69-101, et seq., C.R.S. The rules and standards do not apply to other forms of family advocacy provided by persons or organizations, nor do they place any requirements or assume authority over such persons or organizations. Families of youth with mental health and co-occurring disorders who are in, or at-risk of becoming involved with, the juvenile justice system, may choose any form of advocacy and support that best meets their needs and are not limited to utilizing entities approved under these rules and standards.

In order to be eligible for state funding for a family advocacy program as described in Section 27-69-101, et seq., C.R.S., and these rules, an entity must be approved by the Department according to the rules described herein. Such funding is contingent on available appropriations.

21.200.51 **Definitions** [Eff. 5/1/16]

“At-risk of involvement with the juvenile justice system” means a youth who has come into contact with law enforcement due to a suspected offense or otherwise exhibits behaviors that will likely result in juvenile justice involvement.

“Family advocacy organization” means an entity governed by individuals who have parented, are parenting, or have legal responsibility for a child or youth with a mental health or co-occurring disorder.

“Family member” means individual who has parented, is parenting, or has legal responsibility for a youth with a mental health or co-occurring disorder.

“Involved in the juvenile justice system” means a youth who has committed a delinquent act as defined at Section 19-1-103(36), C.R.S.

“Partnership” means a relationship between a family advocacy organization and another entity whereby the family advocacy organization works directly with another entity for oversight and management of the family advocate or family systems navigator and family advocacy demonstration program, and the family advocacy organization employs, supervises, mentors, and provides training to the family advocate or family systems navigator.

“System of care” means a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

“Technical assistance and coordination” means linking with resources for the purpose of developing or strengthening a family advocacy program.

“Transition services” include, but are not limited to, assisting a youth and family in accessing services and supports necessary for the youth to become a successful adult; developing life skills necessary to function in the community; returning to home, community, or school from an out-of-home placement.

“Youth” for the purposes of this section means an individual whose age falls within the jurisdiction of the juvenile justice system and is older than ten (10) years of age and under eighteen (18) years of age (see Section 19-1-103 (18) for definition of “child”). A young person receiving family advocacy services may continue to do so up to twenty one (21) years of age if enrolled in the program between the ages of ten (10) and eighteen (18).

21.200.52 Intent to Become a Family Advocacy Program [Eff. 5/1/16]

- A. A partnership will indicate its intent to become a family advocacy program by completing the family advocacy program application and submitting it to the Department.
- B. The partnership will follow all requirements of Section 27-69-101 through 27-69-105, C.R.S. and these corresponding rules.
- C. The Department will acknowledge in writing receipt of the letter of application and state which documents, if any, are required to be forwarded to the Department for review.
- D. A partnership may request the Department to facilitate technical assistance and coordination, as described in Section 21.200.53, needed to complete its application.

21.200.53 Program Standards

- A. Family advocacy programs will consist of a partnership between a family advocacy organization providing family advocacy and the system of care, whereby the family advocacy organization works with other entities to enable youth and families to access necessary services and supports. The family advocacy organization employs or otherwise utilizes, supervises, mentors, and provides training to the family advocate or family systems navigator. A community agency may employ or otherwise utilize, supervise, mentor, and provide training to the family advocate or family systems navigator if there is a written agreement with a family advocacy organization describing how this will occur.
- B. The purpose of a family advocacy program is to provide support to families of youth with mental health and co-occurring disorders who are in, or at-risk of becoming involved with, the juvenile justice system.

- C. The support provided to families and youth will include early intervention, navigation, crisis response, integrated planning, transition services, and diversion. These supports will be provided in collaboration with community agencies with specific expertise in the area.
- D. Family support will be provided by a family advocate or a family systems navigator as outlined in Section 27-69-102(5) and (5.5), C.R.S. The requirements for these roles are as follows:
 - 1. Family advocate:
 - a. Training in assisting families in accessing and receiving services and supports, and the system of care philosophy;
 - b. Experience as a family member of a child or adolescent with a mental health or co-occurring disorder; and,
 - c. Experience in working with multiple youth-serving agencies and providers.
 - 2. Family systems navigator:
 - a. Training in assisting families in accessing and receiving services and supports, and the system of care philosophy;
 - b. Skills, experience, and knowledge to work with children and youth with mental health or co-occurring disorders; and,
 - c. Worked with multiple youth-serving agencies and providers.
- E. A family advocacy program will coordinate its efforts with key service providers to ensure that support provided by family advocates and family systems navigators is integrated with services provided by community agencies. Where applicable, this coordination will include the local Interagency Oversight Group of the Collaborative Management Program, described in Section 24-1.9-102, C.R.S. and local juvenile services planning committee described in Section 19-2-211, C.R.S.
- F. A family advocate or family systems navigator will receive training commensurate with their duties and responsibilities. The training will include content on behavioral and co-occurring conditions, working with youth-serving systems, ethics, confidentiality and HIPAA, system of care, working with families, meeting facilitation, prevention and intervention, and documentation and service planning.
- G. A family advocacy program will provide education to the relevant agencies in the system of care, describing the roles and responsibilities of family advocates and family systems navigators, and the ways in which these positions can benefit youth, families, and agency staff members.
- H. A family advocacy program will ensure that adequate resources are available for program operations and evaluation as described in Section 21.200.54.
- I. Family advocates or family systems navigators will receive supervision commensurate with the needs of the youth and families. Family advocates or family systems navigators working in community agencies will receive supervision consistent with the policies and procedures of the host agency.
- J. Any person providing supervision to a family advocate or family systems navigator will have demonstrable knowledge about Section 27-69-101, et seq., C.R.S., these rules, and the role and function of a family advocacy program.

- K. Family advocacy programs will have policies and procedures concerning the work of family advocates and family systems navigators that address:
 - 1. Experience and hiring requirements, including a name search through the Colorado Bureau of Investigation;
 - 2. The program's standards of practice and code of ethics;
 - 3. Training related to providing support to families of youth with a mental health or co-occurring condition;
 - 4. A description of each aspect of the program, including related staff roles and responsibilities;
 - 5. The handling of grievances and complaints;
 - 6. Confidentiality, HIPAA, and 42 C.F.R. Part 2; and,
 - 7. Methods for recording information concerning each family receiving support including demographics, assessment results, needs and strengths, goals and objectives, support provided, and other information as needed.
- L. The services and supports provided by a family advocacy program will include, but not be limited to, those outlined in Section 27-69-104(3), C.R.S., and the following:
 - 1. An assessment of the needs and strengths of the youth and family;
 - 2. Assisting families with significant transitions in the youth's life;
 - 3. Coordination with the local community mental health center and other behavioral health service, and;
 - 4. Culturally and linguistically appropriate and responsive services including bilingual family advocates and/or family systems navigators, and/or access to translation services for families when necessary.

21.200.54 Data Reporting [Eff. 5/1/16]

- A. Family advocacy programs will collect and report data to the Department. This is necessary for the program and the Department to determine its effectiveness and what, if any, changes are necessary to improve outcomes for youth and families. The results of any data analysis conducted by the Department will be shared with the respective family advocacy program.
- B. The data collected and reported to the Department shall include the following:
 - 1. Types of services and support the youth and families received prior to and during involvement in the family advocacy program;
 - 2. Outcomes of services and supports provided during the youth and family's involvement in the family advocacy program;
 - 3. Indicators of the youth and family's satisfaction with support provided by the family advocate or family systems navigator;
 - 4. Indicators of the effectiveness of the family advocate or family systems navigator;

- 5. Indicators of change in the system of care, e.g., interagency agreements, service access and utilization, leadership development among youth and families; and shared resources;
 - 6. Costs of services provided; and,
 - 7. Types of transition services provided.
- C. Data will be submitted to the Department in an established and standardized format.

21.200.55 Technical Assistance and Coordination [Eff. 5/1/16]

- A. The Department will facilitate the provision of technical assistance and coordination for the purpose of developing or strengthening a family advocacy program.
- B. Technical assistance may include linking with written materials, family organizations, and phone consultation.
- C. Technical assistance provided by organizations other than the Department may require a fee paid to that organization.
- D. Interested entities will request technical assistance by contacting the Department verbally or in writing.

21.210 AGENCIES LICENSED TO PROVIDE SUBSTANCE USE DISORDER SERVICES

In addition to the rules provided in Sections 21.000 through 21.190, all agencies licensed to provide substance use disorder services shall comply with the following rule Sections 21.210.1 through 21.210.924.

21.210.1 Agency Staff Qualification and Training

- A. Agencies shall ensure treatment staff are appropriately trained and properly credentialed to provide substance use disorder services in Colorado and are in good standing with their credentialing body.
- B. Agencies shall ensure treatment staff providing independent treatment services in substance use disorder programs within each licensed site are credentialed in accordance with applicable state laws and regulations and are providing treatment services allowed within their scope of practice. Treatment staff is defined in 21.210.1.E. For clinically managed residential withdrawal management staffing requirements, see 21.210.914.
- C. Counselor-in-training staff or certified addiction technician shall not independently counsel, sign clinical documentation or carry out other duties relegated solely to the treatment staff identified in 21.210.1.E. Counselor-in-training staff and certified addiction technicians shall not comprise more than twenty-five percent (25%) of total staff.
 - 1. Counselor-in-training staff must have all clinical documentation reviewed and co-signed by their agency clinical supervisor able to supervise pursuant to their scope of practice.
 - 2. Certified addiction technicians may independently provide services within the statutorily defined scope of practice pursuant to Section 12-245-805(3)(a), C.R.S.

- D. Unless otherwise noted, all agencies shall have a designated clinical administrator who shall authorize and oversee the clinical practice and supervise the treatment staff defined in 21.210.1.E. The clinical administrator shall be in good standing with his or her credentialing body and properly licensed as a physician or as one of the following mental health professionals:
1. Licensed psychologist;
 2. Licensed clinical social worker;
 3. Licensed marriage and family therapist;
 4. Licensed professional counselor; or
 5. Licensed addiction counselor.
- E. Treatment staff, for the purpose of this Section 21.210, unless otherwise noted, means the following behavioral health professionals trained in substance use disorder identification and treatment and acting within his or her scope of practice:
1. Licensed physician;
 2. Licensed advanced practice nurse included in the advanced practice registry with a population focus in mental health, behavioral health or psychiatry;
 3. Licensed psychologist;
 4. Licensed clinical social worker;
 5. Licensed marriage and family therapist;
 6. Licensed professional counselor;
 7. Licensed addiction counselor;
 8. Certified addiction specialist; or
 9. Candidate status staff receiving supervision to become a licensed or certified mental health professional pursuant to Article 245 of Title 12, C.R.S. Candidate level staff shall not make up more than fifty percent (50%) of an agency's treatment staff.
- F. All agencies shall provide and document initial training in methods of preventing and controlling infectious diseases and in universal precautions providing protection from possible infection when handling blood and other body fluids. Annual refresher training, including updates, shall be provided and documented.
- G. Staff collecting samples for drug or alcohol testing shall be knowledgeable of collection, handling, recording and storing procedures assuring sample viability for evidentiary and therapeutic purposes.
- H. Agencies administering and/or monitoring individual medications shall maintain at least one staff person per shift who is currently qualified by certification and/or training to perform those functions in accordance with applicable Department rules and state and federal regulations.
- I. Agencies shall document that at least one residential treatment staff person per shift is currently certified in cardiopulmonary resuscitation and basic First Aid.

21.210.2 CONTENT OF RECORDS

In addition to 21.190.2, agencies licensed to provide substance use disorder services shall maintain individual records to include:

- A. Individual acknowledgments of:
 - 1. 42 C.F.R. PART 2;
 - 2. HIPAA;
 - 3. Individual rights;
 - 4. Mandatory disclosure statement;
 - 5. Chargeable fees and collection procedures; and,
 - 6. Awareness of agency emergency procedures.
- B. The out-of state offender questionnaire shall be completed and in all clinical records.
- C. Personal belongings inventories, when applicable.
- D. Court documents, when applicable.
- E. Records of required communication with referral sources such as court, probation, child welfare, and parole, when applicable.
- F. Drug and alcohol testing and monitoring results, when applicable.

21.210.3 COUNSELOR AND INDIVIDUALS RECEIVING SERVICES' SIGNATURES [Eff. 11/1/13]

- A. Counselor signatures shall be required on the following treatment documents:
 - 1. Screenings;
 - 2. Assessments;
 - 3. Admission summaries;
 - 4. Service plans;
 - 5. Service plan reviews;
 - 6. Treatment notes;
 - 7. Discharge summaries.
- B. Credentialed counselors who counsel independently shall sign treatment documents with at least first initial, last name, and Colorado addiction counselor credential, other professional credential, or academic degree.
- C. Counselors not credentialed may sign treatment documents if countersigned by supervising credentialed counselors.

- D. Signature stamps shall be permissible in lieu of written signatures if initialed by the counselors whose signatures they represent. Electronic signatures shall be permissible for computerized individual records.
- E. Agencies shall require persons receiving services, or guardians, to sign service plans, service plan reviews, and revisions, consents, acknowledgments, and other documents needing individual authorization.

21.210.4 PROVISION OF SERVICES

21.210.41 Admission Criteria [Eff. 11/1/13]

- A. The following shall not be the sole reason for treatment ineligibility:
 - 1. Relapse;
 - 2. Leaving previous treatment against advice;
 - 3. Pregnancy;
 - 4. Intravenous drug use; or,
 - 5. Involuntary commitment.
- B. Restrictions, priorities, or special admission criteria shall be applied equally to all prospective persons seeking services.

21.210.42 Screening [Eff. 5/1/16]

- A. Agencies shall screen all female individuals of child bearing age seeking or being referred to substance use disorder treatment for pregnancy.
- B. At admission individuals shall be screened for past and present risk factors associated with substance use disorders that are associated with:
 - 1. Pregnancy complications, including risks to the health of the pregnant woman and fetus;
 - 2. Acquiring and transmitting Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), Tuberculosis (TB), Hepatitis A, B, or C, and other infectious diseases; and,
 - 3. If clinically indicated by the presence of continuing risk factors, screening shall be conducted at a minimum on a quarterly basis.
- C. Individuals shall be apprised of risk factors associated with acquiring and transmitting HIV/AIDS, TB, Hepatitis A, B, C, and other infectious diseases. Appropriate testing and pre and post-test counseling shall be offered on-site or through referral.
- D. Criminal justice system referrals for substance use related offenses, such as DUI/DWAI, BUI, FUI, and/or controlled substance violations, may be exempt from further substance use disorder screening if previously assessed, or evaluated. Supporting documentation from the referring agency shall be present in the individual record.

- E. Adults shall be screened for past and present criminal charges in any state. Persons with out-of-state charges must be registered by the licensed agency with the interstate compact office in accordance with Title 17, Article 27.1, Section 101, et seq., C.R.S.

21.210.43 LEVEL OF CARE GENERAL PROVISIONS

- A. In addition to meeting the requirements established in 21.190, Agencies shall:
1. Use the ASAM Criteria as a guide for assessing and placing individuals in the appropriate level of care;
 2. Include information gathered on all six (6) dimensions outlined in The ASAM Criteria in assessments; and
 3. Utilize the decisional flow process as outlined in The ASAM Criteria to determine level of care.
- B. Agencies shall specify the specific level(s) of care services the agency plans to provide, including the population(s) the agency plans to serve.
- C. Each level of care shall offer a range of treatment approaches and support services based on the assessment of the individual's treatment needs. Treatment services may include, but are not limited to:
1. Assessment;
 2. Group and individual counseling;
 3. Motivational enhancement;
 4. Family therapy;
 5. Educational groups;
 6. Occupational and recreational therapy;
 7. Addiction pharmacology;
 8. Medication management;
 9. Peer, social and recovery support;
 10. Case management or service coordination; and
 11. Support for development of life skills.
- D. In addition to meeting the staff qualification and training requirements established in 21.210, agencies shall document that staff are appropriately credentialed and qualified to provide treatment services in the levels of care described in this section and to the individual populations they serve.
- E. Agencies shall apply sliding fee scales equally to all prospective persons seeking services.
- F. Agencies shall be responsible for monitoring and routinely reporting to referring courts and the criminal justice system the individual's progress within treatment, including any ancillary services.

- G. In addition to meeting the requirements established in 21.200, agencies shall ensure all staff working with youth under the age of twenty-one (21) at each level of care are trained and knowledgeable of youth development and engaging youth in care.
- H. agencies shall obtain a Controlled Substance License from the Office of Behavioral Health if the program plans to dispense, compound, or administer a controlled substance in order to treat a substance use disorder or to treat the withdrawal symptoms of a substance use disorder.
- I. Agencies shall continue individuals on their medication-assisted treatment regimen and will only detox individuals from medications treating opioid use disorders at the individual's request or if it is deemed medically necessary.
- J. Agencies shall inform individuals receiving services about access to medication-assisted treatment. Upon the individual's consent, agencies shall provide medication-assisted treatment directly, if the agency or provider is appropriately licensed to do so. If an agency or provider is not licensed to provide medication-assisted treatment and an individual receiving services requests medication-assisted treatment, an agency shall refer the individual to an agency that provides medication-assisted treatment.

21.210.5 LEVELS OF CARE Specific Requirements

Each level of care is based on a specific level of care outlined in The ASAM Criteria.

21.210.6 OUTPATIENT SUBSTANCE USE DISORDER SERVICES (Level 1)

- A. Level 1 services shall generally be intended for individuals who are assessed as not appropriate for more intensive levels of care. Level 1 may also be a step-down from a higher level of care or offered when an individual is in early stages of change and not willing to participate in the higher level of care indicated by the assessment.
- B. Level 1 services are appropriate for individuals with co-occurring mental health and substance-related disorders if the mental health disorders are of moderate severity, or are of high severity but have been stabilized.

21.210.61 Level 1 Service Provisions

- A. Level 1 services shall be conducted in regularly scheduled sessions of less than nine (9) treatment contact hours per week for adults, and less than six (6) treatment contact hours per week for youth under the age of eighteen (18).
- B. Level 1 treatment services shall be provided by treatment staff defined in section 21.210.1.E.
- C. Agencies providing Level 1 services shall inform individuals receiving services how to access emergency services by telephone twenty-four (24) hours per day, seven (7) days per week. At minimum, emergency services information shall include contact information for services provided by the Behavioral Health Crisis Response System created pursuant to § 27-60-103, C.R.S.
- D. Agencies providing Level 1 services shall have direct affiliation or close coordination through referral to more intensive levels of care.
- E. Agencies providing Level 1 services shall ensure treatment staff has staff-to-staff consultation available within twenty-four (24) hours by telephone to discuss when warranted, at minimum, psychiatric or medical concerns of individuals receiving services.

21.210.7 INTENSIVE OUTPATIENT/PARTIAL HOSPITALIZATION SUBSTANCE USE DISORDER SERVICES (Level 2)

21.210.71 INTENSIVE OUTPATIENT SUBSTANCE USE DISORDER SERVICES (Level 2.1)

- A. Level 2.1 services shall generally be intended for individuals who require a more structured substance use disorder outpatient treatment experience than can be received in Level 1 outpatient treatment.
- B. Level 2.1 services are appropriate for individuals with co-occurring mental health and substance-related disorders if the disorders are of moderate severity, or are of higher severity but have been stabilized.

21.210.711 Level 2.1 Service Provisions

- A. Level 2.1 services shall be conducted in regularly scheduled sessions that follow a planned format of treatment services of nine (9) to nineteen (19) contact hours per week for adults and six (6) to nineteen (19) contact hours per week for youth under the age of eighteen (18).
- B. Level 2.1 treatment services shall be provided by treatment staff defined in section 21.210.1.E.
- C. Agencies providing Level 2.1 services shall inform individuals receiving services how to access emergency services by telephone twenty-four (24) hours per day, seven (7) days per week. At minimum, emergency services information shall include contact information for services provided by the behavioral health crisis response system created pursuant to § 27-60-103, C.R.S.
- D. Agencies providing Level 2.1 services shall have direct affiliation or close coordination through referral to more and less intensive levels of care.
- E. Agencies providing Level 2.1 services shall ensure treatment staff has staff-to-staff consultation available within twenty-four (24) hours by telephone and within seventy-two (72) hours in person to discuss when warranted, at minimum, psychiatric or medical concerns of individuals receiving services.

2.210.72 PARTIAL HOSPITALIZATION SUBSTANCE USE DISORDER SERVICES (Level 2.5)

- A. Level 2.5 services shall generally be intended for individuals who require daily monitoring or management to treat substance use disorders that can be provided in a structured outpatient setting. Services include direct access to medical, psychiatric, and laboratory services. Level 2.5 service sites for school aged youth shall include access to educational services and coordination with a school system, as appropriate.
- B. Level 2.5 services are appropriate for individuals with co-occurring mental health and substance-related disorders if the disorders are of moderate severity, or are of higher severity but have been stabilized. Staff of Level 2.5 services shall understand the signs and symptoms of mental health disorders and the uses of psychotropic medications and their interactions with substance use disorders.

21.210.721 Level 2.5 Service Provisions

- A. Level 2.5 services shall be conducted with a minimum frequency of twenty (20) regularly scheduled treatment contact hours per week.
- B. Level 2.5 treatment services shall be provided by treatment staff defined in section 21.210.1.E.

- C. Agencies providing Level 2.5 services shall inform individuals receiving services how to access emergency services by telephone twenty-four (24) hours per day, seven (7) days per week when the program is not in session. At minimum, agencies shall provide emergency services information that includes contact information for services provided by the behavioral health crisis response system created pursuant to § 27-60-103, C.R.S.
- D. Agencies providing Level 2.5 services shall have direct affiliation or close coordination through referral to more and less intensive levels of care.
- E. Agencies providing Level 2.5 services shall ensure treatment staff has staff-to-staff consultation available within eight (8) hours by telephone and within forty-eight (48) hours in person to discuss when warranted, at minimum, psychiatric or medical concerns of individuals receiving services.

21.210.8 RESIDENTIAL/INPATIENT SUBSTANCE USE DISORDER SERVICES (Level 3)

Agencies providing residential/inpatient substance use disorder services (Level 3) shall construct and maintain sound and sight barriers between male and female individuals and between adult and youth under the age of eighteen (18) in bathrooms and sleeping quarters.

21.210.81 CLINICALLY MANAGED LOW-INTENSITY RESIDENTIAL SUBSTANCE USE DISORDER SERVICES (Level 3.1)

- A. Level 3.1 services shall generally be intended for whose history of chronic substance use disorders, lack of supportive living situations, unemployment, levels of social or psychological dysfunction and/or lack of housing necessitates twenty-four (24) hour structure and support. Level 3.1 services are generally provided in settings such as a halfway house, group home or other supportive living environment providing twenty-four (24) hour staff and close integration with treatment services.
- B. Level 3.1 services shall have staff who are able to identify the signs and symptoms of acute psychiatric conditions and understand the signs and symptoms of mental health disorders, the uses of psychotropic medication and their interaction with substance use disorders.
- C. Level 3.1 services shall have the capacity to arrange for psychiatric or addiction medications.

21.210.811 Level 3.1 Service Provisions and Staffing

- A. Level 3.1 services shall be regularly scheduled and include a minimum of five (5) hours of planned treatment services per week.
- B. Agencies providing Level 3.1 services shall maintain individual to staff ratio not exceeding twenty to one (20:1) during nighttime hours, per agency site.
- C. Agencies providing Level 3.1 services shall provide twenty-four (24) hour per day, seven (7) days per week on-site staff. Twenty-four (24) hour on-site staff shall be trained and knowledgeable of substance use disorders and the treatment of substance use disorders and in addition to treatment staff defined in 21.210.1.E may include:
 - 1. Peer support specialists as defined in Section 21.400.1; or
 - 2. Addiction technicians certified pursuant to Part 8 of Article 245 of Title 12, C.R.S. or staff in the process of obtaining addiction counselor certification.

- D. Agencies providing Level 3.1 services shall have at least one (1) treatment staff, as defined in 21.210.1.E, trained and knowledgeable of substance use disorders, the treatment of substance use disorders and able to monitor and identify psychiatric conditions available by telephone twenty-four (24) hours per day, seven (7) days per week and available to be on-site within thirty (30) minutes.
- E. Agencies providing Level 3.1 services shall have direct affiliation or close coordination through referral to more and less intensive levels of care.
- F. Agencies providing Level 3.1 services shall ensure staff have telephone or in-person consultation with a physician and emergency services available twenty-four (24) hours per day, seven (7) days per week.

21.210.82 CLINICALLY MANAGED POPULATION-SPECIFIC HIGH-INTENSITY RESIDENTIAL SUBSTANCE USE DISORDER SERVICES (Level 3.3)

- A. Level 3.3 services are a structured recovery environment in combination with high-intensity clinical services to support recovery from substance-related disorders.
- B. Level 3.3 is appropriate for individuals who are unable to benefit from outpatient services or services in general settings because of cognitive impairments that result in functional limitations. Treatment is focused on preventing relapse, continued problems and/or continued use, and promoting the eventual reintegration of the individual into the community. Therapeutic rehabilitation facilities or traumatic brain injury programs are examples of this level of care.

21.210.821 Level 3.3 Service Provisions and Staffing

- A. Agencies providing Level 3.3 services shall deliver treatment services in a manner that is matched to the individual's functioning and may be provided in a deliberately repetitive fashion to address the special cognitive needs of individuals for whom this level of care is considered a medical necessity.
- B. Agencies shall provide daily scheduled Level 3.3 services and include a minimum of nine (9) hours of planned treatment services per week.
- C. Agencies providing Level 3.3 services shall maintain individual to staff ratios not exceeding twenty to one (20:1) during nighttime hours, per agency site. Staff shall include:
 - 1. At least one (1) treatment staff, as defined in 21.210.1.E, trained and knowledgeable of substance use disorders, the treatment of substance use disorders and able to monitor and identify psychiatric conditions available by telephone twenty-four (24) hours per day, seven (7) days per week and available to be on-site within thirty (30) minutes;
 - 2. Addiction technicians certified pursuant to Part 8 of Article 245 of Title 12, C.R.S.;
 - 3. A physician, physician assistant or nurse practitioner available by telephone or in-person twenty-four (24) hours per day, seven (7) days per week to provide medical evaluation and consultation; and
 - 4. Peer support specialists as defined in Section 21.400.1.
- D. Agencies providing Level 3.3 services shall have direct affiliation or close coordination through referral to more and less intensive levels of care.

21.210.83 CLINICALLY MANAGED HIGH-INTENSITY RESIDENTIAL SUBSTANCE USE DISORDER SERVICES (Level 3.5)

- A. Level 3.5 services provide a safe and stable living environment with treatment focused on promoting skills needed to avoid relapse or continued use. Level 3.5 is appropriate for individuals with multiple limitations including criminal activity, psychological problems, and/or impaired social and/or vocational functioning.
- B. Treatment is directed toward reducing relapse risk, enhancing prosocial behaviors and reintegration into the community. A variable length therapeutic community or residential treatment center are examples of this level of care.

21.210.831 Level 3.5 Service Provisions and Staffing

- A. Agencies shall provide daily Level 3.5 services and include a minimum of ten (10) hours of planned treatment services per week.
- B. Agencies providing Level 3.5 services shall maintain individual to staff ratios not exceeding twenty to one (20:1) during nighttime hours, per agency site, and each shift shall have a minimum of two (2) staff members, whenever one (1) or more individuals are present. Staff shall include:
 - 1. At least one (1) treatment staff, as defined in 21.210.1.E, trained and knowledgeable of substance use disorders, the treatment of substance use disorders and able to monitor and identify psychiatric conditions available twenty-four (24) hours per day, seven (7) days per week;
 - 2. Addiction technicians certified pursuant to Part 8 of Article 245 of Title 12, C.R.S. or staff in the process of obtaining addiction counselor certification;
 - 3. a physician, physician assistant or advanced practice nurse available to provide medical evaluation and consultation and assess and treat co-occurring biomedical disorders, as well as prescribe and monitor the administration of medications; and
 - 4. Peer support specialists as defined in Section 21.400.1.
- C. Agencies providing Level 3.5 services shall have direct affiliation or close coordination through referral to more and less intense levels of care.

21.210.84 MEDICALLY MONITORED INTENSIVE INPATIENT SUBSTANCE USE DISORDER SERVICES (Level 3.7)

- A. Level 3.7 services provide a planned and structured regimen of twenty-four (24) hour evaluation, observation, medical monitoring and addiction treatment.
- B. Level 3.7 services are appropriate for individuals whose medical, emotional, behavioral or cognitive problems are so severe that they require twenty-four (24) hour medical monitoring but do not need the full resources of an acute care general hospital or medically managed inpatient treatment program (Level 4). Treatment is designed for individuals who have functional limitations in the areas of intoxication/withdrawal potential; biomedical conditions; or emotional, behavioral or cognitive conditions.

21.210.841 Level 3.7 Service Provisions and Staffing

- A. Level 3.7 services shall be scheduled daily and include a minimum of twenty (20) hours of planned treatment services per week.

- B. Agencies providing Level 3.7 services shall maintain individual to staff ratios not exceeding twenty to one (20:1) during nighttime hours per agency site, and each shift shall have a minimum of two (2) staff members, whenever one (1) or more individuals are present.
- C. Level 3.7 services shall be staffed with a team that includes physicians, nurses and mental health professionals licensed or certified pursuant to Article 245 of Title 12, C.R.S. that provide twenty-four (24) hour professionally directed evaluation, care and treatment services including administration of prescribed medications, withdrawal management and integrated treatment of co-occurring medical, emotional, behavioral or cognitive conditions.
- D. A licensed physician shall oversee treatment and assure quality of care in Level 3.7 services. A physician, physician assistant or nurse practitioner shall perform physical examinations for all individuals admitted. Examinations shall occur within twenty-four (24) hours of admission and thereafter as necessary.
- E. A registered nurse shall conduct an alcohol or other drug-focused nursing assessment at the time of admission.
- F. A licensed nurse is responsible for monitoring the individual's progress and/or medication administration twenty-four (24) hours per day, seven (7) days per week.
- G. Additional medical specialty consultation, psychological, laboratory and toxicology services are available on-site through consultation or referral. Psychiatric services are available on-site through consultation or referral within eight (8) hours by telephone or twenty-four (24) hours in person.

21.210.9 WITHDRAWAL MANAGEMENT SERVICES

21.210.91 CLINICALLY MANAGED RESIDENTIAL WITHDRAWAL MANAGEMENT (LEVEL 3.2-WM)

- A. Level 3.2-WM programs shall provide twenty-four (24) hour supervised withdrawal from alcohol and/or other drugs in a residential setting.
- B. Level 3.2-WM programs shall provide collaboration and coordination with emergency mental health services as needed.
- C. Level 3.2-WM programs shall obtain a Controlled Substance License from the Office of Behavioral Health if the program plans to dispense, compound, or administer a controlled substance in order to treat a substance use disorder or to treat the withdrawal symptoms of a substance use disorder.
- D. Level 3.2-WM programs shall develop and implement policies and procedures in accordance with federal and state regulations, department rules, and in consultation with medical professionals qualified in substance use disorders. Policies and procedures must address but are not limited to:
 - 1. Handling individuals who are assessed as being a current threat to themselves or others and shall include appropriate uses of law enforcement and monitor any use of individual restraint and/or seclusion;
 - 2. Communication with intoxicated individuals leaving treatment against staff recommendations, including the use of emergency commitments; and
 - 3. Circumstances under which individuals shall be discharged, other than completing withdrawal management or leaving against staff recommendations.

21.210.911 Level 3.2-WM Admission and Monitoring

- A. Individuals admitted to level 3.2-WM services shall be intoxicated, under the influence, or in any stage of withdrawal from alcohol and/or other drugs.
- B. Level 3.2-WM admission procedures shall include at a minimum:
 - 1. Degree of alcohol and other drug intoxication as evidenced by breathalyzer, urinalysis, self-report, observation or other evidence-based or best practices;
 - 2. Initial vital signs;
 - 3. Need for emergency medical and/or psychiatric services;
 - 4. Inventorying and securing personal belongings;
 - 5. Substance use disorder history and the degree to which the use of substance affects personal and social functioning, as soon as clinically feasible following admission;
 - 6. Pregnancy screening; and
 - 7. Administration of a validated clinical withdrawal assessment tool.
- C. Withdrawal management monitoring of individuals shall include:
 - 1. Routine monitoring of physical and mental status including observation of individual;
 - 2. Vital signs taken at least every two (2) hours until they remain at the person's baseline for at least four (4) hours, and then taken every eight (8) hours thereafter until discharge; and
 - 3. Documentation per shift to include all individual monitoring activities.

21.210.912 Level 3.2-WM Service Planning

- A. level 3.2-WM programs shall develop and implement service plans in accordance with Section 21.190.4 and address safe withdrawal, motivational counseling, and referral for treatment.
- B. Level 3.2-WM programs shall provide additional service planning for managing individuals with medical conditions, suicidal ideation, pregnancy, psychiatric conditions, and other conditions which place individuals at additional risk during withdrawal management.
- C. Level 3.2-WM programs shall provide assessments of individual readiness for treatment and interventions based on the service plan and the assessments and interventions shall be documented in the individual's record.

21.210.913 Level 3.2-WM Discharge

- A. Level 3.2-WM programs shall provide discharge information to individuals and document in the individual's records the requirements established in Section 21.190.6, and:
 - 1. Effects of alcohol and other drugs;

2. Risk factors associated with alcohol and other drug abuse for acquiring and transmitting HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome), Tuberculosis (TB), and other infectious diseases, and for pregnancy;
3. Availability of testing and pre/post-test counseling for HIV/AIDS, TB, Hepatitis C and other infectious diseases, and pregnancy; and
4. Availability of alcohol and other drug abuse treatment services.

21.210.914 Level 3.2-WM Staff Requirements

- A. At least fifty percent (50%) of withdrawal management staff including on-call staff shall consist of treatment staff as defined in 21.210.1.E, certified addiction technicians or staff in the process of obtaining addiction counselor certification. Plans for addiction counselor certification shall be available for review. Full-time staff shall obtain at least an addiction technician certification within eighteen (18) months of employment.
- B. Uncertified staff or staff without a plan for addiction counselor certification shall not comprise more than fifty percent (50%) of total withdrawal management staff.
- C. Level 3.2-WM programs' individual to staff ratios shall not exceed ten to one (10:1); and
 1. Procedures for responding to periods of high census and/or emergency situations shall be conspicuously posted; and
 2. Each shift shall have a minimum of two (2) staff members, whenever one (1) or more individuals are present.
- D. The staff person overseeing day-to-day operations shall be:
 1. Certified as an addiction specialist or licensed as an addiction counselor pursuant to Part 8 of Article 245 of Title 12, C.R.S.;
 2. A physician licensed pursuant to Article 240 of Title 12, C.R.S.;
 3. A psychologist licensed pursuant to Part 3 of Article 245 of Title 12, C.R.S.;
 4. An advanced practice nurse licensed pursuant to Section 12-255-111, C.R.S.; or
 5. A licensed clinical social worker, licensed marriage and family therapist, or licensed professional counselor licensed under Part 4, 5, or 6 of Article 245 of Title 12, C.R.S.
- E. Level 3.2-WM programs shall provide twenty-four (24) hour per day, seven (7) days per week on-site staff. Twenty-four (24) hour on-site staff shall be trained and knowledgeable of substance use disorders and the treatment of substance use disorders and in addition to treatment staff as defined in 21.210.1.E, twenty-four (24) hour staff may include:
 1. Peer support specialists as defined in 21.400.1; or
 2. Addiction technicians certified pursuant to Part 8 of Article 245 of Title 12, C.R.S. or staff in the process of obtaining addiction counselor certification.
- F. Programs shall maintain documentation that all direct care staff have training in and evaluated knowledge of the following before providing independent services:

1. Withdrawal management;
2. Infectious diseases (AIDS/HIV, Hepatitis C, TB), including universal precautions against becoming infected;
3. Administering cardiopulmonary resuscitation (CPR) and first aid;
4. Monitoring vital signs;
5. Conducting assessment and triage, including identifying suicidal ideation;
6. Emergency procedures and their implementation;
7. Collecting urine and breath samples;
8. Cultural factors that impact withdrawal management;
9. Ethics and confidentiality;
10. Individual records systems;
11. De-escalating potentially dangerous situations; and
12. Basic counseling and motivational interviewing skills.

21.210.92 MEDICALLY MONITORED INPATIENT WITHDRAWAL MANAGEMENT (LEVEL 3.7-WM)

Level 3.7-WM services shall be provided by licensed medical staff qualified to supervise withdrawal from alcohol and other drugs through use of medication and/or medical procedures in residential settings which possess Controlled Substances Licenses in compliance with Part 2 of Article 80 of Title 27, C.R.S.

21.210.921 Level 3.7-WM Admission and Evaluation

- A. Level 3.7-WM programs shall develop and implement specific admission criteria detail for which drugs, including alcohol, medical withdrawal management is provided.
- B. In addition to the consent requirements established in 21.170.4, level 3.7-WM programs shall provide informed consent to medical withdrawal management that include:
 1. Medications to be used; and
 2. Need to consult with primary care physicians.
- C. Level 3.7-WM programs shall provide medical evaluations by physicians licensed pursuant to Article 240 of Title 12, C.R.S. or authorized health-care professionals under the supervision of authorized physicians. The medical evaluations shall consist of, at minimum:
 1. Medical histories including detailed chronologies of substance use disorders;
 2. Identification of current physical addiction including drug types;
 3. Physical examinations to determine appropriateness for outpatient or inpatient medical withdrawal management; and

4. Appropriate laboratory tests including pregnancy tests, and other evaluations as indicated.
- D. Level 3.7-WM service protocols for usual and customary withdrawal management from each drug delineated in the admission criteria shall be developed in consultation with licensed physicians and other allied health-care professionals and shall be implemented in the form of individualized withdrawal management plans under direct supervision of program medical directors. Protocols shall include:
1. Types of intoxication;
 2. Tolerance levels for the individual's drug of choice;
 3. Degrees of withdrawal;
 4. Possible withdrawal and/or intoxication complications;
 5. Other conditions affecting medical withdrawal management procedures;
 6. Types of medications used;
 7. Recommended dosage levels;
 8. Frequency of visits (outpatient settings);
 9. Procedures to follow in the event of withdrawal management complications;
 10. Daily assessments including expected improvements as well as potential problems; and
 11. Expected duration of withdrawal management.
- E. Medical withdrawal management programs using any controlled substances are required to have Controlled Substance Licenses issued by the Department. Buprenorphine is the only medication that can be used for opioid dependent individuals unless the medical withdrawal management program is licensed as an opioid treatment program and it has been verified through the program and coordinated with the Federal Center for Substance Abuse Treatment.
- F. Authorized physicians may prescribe buprenorphine under his/her own Drug Enforcement Administration (DEA) registration number for individuals admitted to the hospital for inpatient withdrawal management or addiction treatment.
- G. Withdrawal management programs must continue patients on their medication-assisted treatment regimen when available and will only detox individuals from medications treating opioid use disorders at the patient's request or if it is deemed medically necessary.

21.210.922 Level 3.7-WM Clinical Staff

- A. Level 3.7-WM programs shall provide, at minimum, the following clinical staff:
1. One medical director;
 2. One registered nurse or licensed practical nurse (R.N. or L.P.N.) with at least one year of withdrawal management experience; and

3. Treatment staff as defined in 2.210.1.E, staffed at a rate that meets the needs of the individuals receiving level 3.7-WM services.
- B. Level 3.7-WM program medical directors' responsibilities shall include, at minimum:
1. Quarterly reviews and revisions of drug withdrawal management categories and protocols;
 2. Reviews of individual withdrawal management plans;
 3. Reviews of individual prescriptions that deviate from standard withdrawal management protocols;
 4. Five (5) hours of monthly supervision of and consultation with staff providing withdrawal management services;
 5. Direct supervision of individual withdrawal management cases that deviate from standard protocols and/or experience complications; and
 6. Develop and implement back-up systems for physician coverage when medical directors are unavailable and/or for emergencies.
- C. level 3.7-WM programs shall ensure twenty-four (24) hour access to clinical staff by telephone and accommodation for unscheduled visits for crises or problem situations.

21.210.923 Level 3.7-WM Treatment Services

- A. Level 3.7-WM programs shall provide the following treatment services in addition to medication dosing contacts:
1. Motivational counseling and support;
 2. Continuous evaluation and behavioral health intervention; and
 3. Development and monitoring of a service plan per Section 21.190.4.
- B. Level 3.7-WM programs shall ensure a minimum of one (1) daily clinical supportive services contact, which shall be documented in individual records.

21.210.924 Level 3.7-Wm Dispensing and Administration Procedures

- A. Level 3.7-WM programs shall develop and implement policies and procedures for dispensing medications per standard withdrawal management protocols that are in accordance with applicable state and federal statutes and for the following:
1. Individual prescriptions filled and dispensed by a registered pharmacist at a designated pharmacy location; and
 2. Individual prescriptions from medical directors that are filled from stock quantities.
- B. Level 3.7-WM programs shall develop and implement policies and procedures in accordance with applicable federal and state statutes for storing and accounting for all drugs including controlled substances.

21.220 GENDER-RESPONSIVE WOMEN'S TREATMENT IN SUBSTANCE USE DISORDER PROGRAMS [Eff. 11/1/13]

In addition to Section 21.210, agencies licensed to provide Gender-Responsive Women's Treatment shall be in compliance with Subsections 21.220.1 through 21.220.4.

21.220.1 GENERAL PROVISIONS [Eff. 11/1/13]

- A. Treatment staff shall have documented training, supervision and experience in women-specific issues and services.
- B. Treatment for substance use disorders shall be provided to the family as a whole, unless clinically contraindicated. Clinical contraindications to this provision must be documented in the individual record.
- C. Agencies shall offer any pregnant woman admission to treatment within forty-eight (48) hours and shall demonstrate compliance with Section 21.220.4, D, Services to Pregnant Women.
- D. Agencies providing gender specific women's treatment shall include the following components:
 - 1. Emotional and physical safety of individuals take precedence over all other considerations in the delivery of services;
 - 2. Services designed to increase women's access to care, and engagement and retention of individuals (such as comprehensive case management, transportation, child care);
 - 3. Women-only therapeutic environments;
 - 4. Women-specific service needs and topic areas;
 - 5. Program services shall directly address trauma issues currently manifesting in the individual's life either through direct service provision or by referral; and,
 - 6. Multiple modalities that meet the specific needs of women (group and individual therapy, case management and opportunities for women to be in treatment with their children where possible).
- E. Agency policy and procedures shall include the mandatory reporting of suspected child abuse, neglect and/or child safety issues, which shall include definitions of abuse and neglect under the Colorado Children's Code (Section 19-1-103, C.R.S.), and which are consistent with the reporting of child abuse allowed under federal law.
- F. Agency policy and procedures shall include the criteria for interventions offered and expected outcomes of services delivered.

21.220.2 SCREENING [Eff. 11/1/13]

In addition to the Section 21.190.3, screening shall include all of the following unless clinically contraindicated:

- A. Screening and documentation of individual's need for prenatal care (where applicable), primary medical care and family planning services;
- B. Screening for child safety issues utilizing an evidence-based or best practices approved instrument.

21.220.3 TREATMENT [Eff. 11/1/13]

- A. Service plans shall be established in accordance with Section 21.190.4 of these rules, and shall address each of the need areas identified in Section 21.220.3.
- B. When not clinically contraindicated the following topic areas shall be addressed in treatment or by referral when applicable:
 - 1. Reductions or elimination of substance use;
 - 2. Individual safety issues
 - 3. Child safety issues;
 - 4. Trauma issues;
 - 5. Parenting issues;
 - 6. Ways in which substance use disorders impact and are impacted by family and relationships;
 - 7. Medical and primary health issues;
 - 8. Mental health issues;
 - 9. Nutrition.

21.220.4 SERVICES TO PREGNANT WOMEN [Eff. 11/1/13]

- A. Pregnant women shall be given priority admission to treatment for substance use disorders.
- B. Programs shall develop policies and procedures for service delivery to pregnant women, which shall include circumstances under which pregnant women may be discharged from treatment.
 - 1. Pregnant women may not be discharged from treatment solely for failure to maintain abstinence from substance use.
 - 2. Every effort shall be made to retain pregnant women in treatment for the duration of their pregnancies in order to maintain an optimal period of abstinence from substance use.
- C. Every attempt shall be made to admit pregnant women to treatment within forty-eight (48) hours of first contact between the woman and the admitting program.
- D. If a pregnant woman is not admitted to treatment within forty-eight (48) hours of first contact, the denial shall be clearly documented, the women's treatment coordinator for OBH shall be informed, and interim services shall be provided consisting of the following at minimum:
 - 1. Referral for pre-natal care;
 - 2. Information on the effects of alcohol and drug use on the fetus;
 - 3. Daily phone contact with the individual; and,
 - 4. Education regarding the transmission and prevention of communicable diseases such as HIV, hepatitis.

- E. Pregnant women shall be linked to prenatal care immediately and barriers to accessing prenatal care shall be addressed, including transportation to prenatal care.
- F. When a woman refuses to seek prenatal care or fails attempts to link her to care, this shall be documented in her record, and there shall be continuing efforts to link her to prenatal care until this is accomplished.

21.230 SUBSTANCE USE DISORDER EDUCATION AND TREATMENT FOR PERSONS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM

21.230.1 GENERAL PROVISIONS

- A. Education, treatment, and ancillary services shall be provided to individuals convicted of misdemeanors and felonies who are assessed as needing substance use disorder treatment, as provided by Title 16, Article 11.5, Part 1, and C.R.S. and in accordance with current standardized assessment and placement protocol.
- B. All agencies admitting out of state offenders must identify and notify the Interstate compact unit for Adult Offender Supervision per Section 17-27.1-101, C.R.S.
- C. Services shall be based on the results of current screening and assessments.
- D. Agencies shall place individuals involved in the criminal justice system according to the standardized offender assessment provided by the referring criminal justice agency.
- E. Education, treatment and ancillary services as indicated by assessment and included in the service plan shall be provided for by the agency or through referrals.
- F. Agencies shall have a written memorandum of understanding with ancillary providers to make available agreed upon services and require specific data and exchange of information related to the individualized services.
- G. Education and treatment shall be a minimum of nine (9) months or as required by the referring criminal justice agency.
- H. Frequency and intensity of education and treatment services shall be based on assessments and at minimum one two hour session per week.
- I. The following content/topics shall be presented during offender treatment:
 - 1. Physiological and psychological effects of alcohol, marijuana and/or marijuana/THC infused products, stimulants, and other drugs;
 - 2. Signs and symptoms of substance use disorders;
 - 3. Stress management and substance use disorders;
 - 4. Anger management and substance use disorders;
 - 5. Behavioral triggers leading to substance use disorders;
 - 6. Drugs in the work place; and,
 - 7. Legal issues and substance use disorders.

- J. Agencies shall implement treatment curricula that are written in manual format and are evidence-based or best practices. All agency clinical staff working with the individuals involved in the criminal justice system population must be trained on and follow the specific curricula as written.
- K. Individuals will receive a complete copy of the participant materials/workbook associated with the approved curriculum. The agency may charge for the curriculum.
- L. Education and treatment sessions shall only consist of face-to-face (as defined in Section 21.240.1) contact and shall not include administrative procedures or breaks.
- M. Agency staff working directly with individuals shall have documented qualifications and training in forensic populations and criminal justice systems.
- N. Drug and alcohol toxicology collection must be observed by trained staff when requested by the referral source.
- O. Records shall contain monthly documentation of communication with the criminal justice referral source describing progress toward specific treatment goals. Agencies shall be responsible for monitoring and reporting to referring courts or their representatives the individual's progress with ancillary services.
- P. Agencies shall have written documentation in an individual's record that the individual has received services to assist in community reintegration, if applicable.

21.230.2 ENHANCED OUTPATIENT EDUCATION AND TREATMENT SERVICES FOR PERSONS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM [Eff. 5/1/16]

- A. An agency may provide enhanced outpatient services if it:
 - 1. Is licensed by the Department for education and treatment services for individuals involved in the criminal justice system;
 - 2. Is in compliance with Section 21.230.1; and,
 - 3. Provides a minimum of four (4) hours over two (2) group sessions of scheduled treatment per week.
- B. Frequency and intensity of treatment activities shall be based on current assessments and conducted in at least two (2) sessions per week.
- C. Changes in frequency and intensity of education and treatment activities shall be assessed.
- D. If, upon discharge from enhanced outpatient treatment, the minimum number of months required by the referring criminal justice agency have not been met, the agency shall transfer the individual to the appropriate level of care where remaining education and treatment requirements can be met.

21.240 DUI/DWAI, BUI, AND FUI EDUCATION AND TREATMENT

21.240.1 DEFINITIONS

“ADDS” is the Alcohol and Drug Driving Safety program, established under Section 42-4-1301.3, C.R.S. The Judicial Department administers an Alcohol and Drug Driving Safety program in each judicial district that provides pre-sentence and post-sentence alcohol and drug evaluations on all persons convicted of

Driving, Flying, and Boating Under the Influence (DUI, FUI, BUI) and Driving With Ability Impaired (DWAI).

“Alcohol and Drug Evaluation Specialists” (ADES) are persons within the criminal justice system, qualified to conduct pre- and post-sentence evaluations on, and provide supervision for, persons convicted of Driving, Flying, and Boating Under the Influence (DUI, FUI, BUI) and Driving With Ability Impaired (DWAI).

“BUI” means Boating Under the Influence.

“DUI” means Driving Under the Influence.

“DWAI” means Driving With Ability Impaired.

“Face-to-Face”, for purposes of this section 21.240, means that the individual is physically in the same room as a professional person at an office of a behavioral health licensed or approved site or video technology is being utilized.

“FUI” means Flying Under the Influence.

“Persistent Drunk Driver” defined in Section 42-1-102(68.5), C.R.S.

“Level I and Level II Education, Therapy or Treatment” means an approved alcohol and drug driving safety education or treatment program as defined in 42-4-1301.3(3)(c)(IV) C.R.S.

21.240.2 GENERAL PROVISIONS [Eff. 5/1/16]

- A. Agencies providing DUI/DWAI services shall develop and implement policies, procedures, and individualized service planning demonstrating recognition of issues and treatment needs unique to this individual population.
- B. Alcohol and Drug Driving Safety (ADDS) education and treatment services shall be restricted to those arrested, convicted of or receiving deferred prosecutions, sentences, or judgments for alcohol/other drug offenses related to driving (Title 42, Article 4, Part 13, C.R.S. and Title 42, Article 2, Part 1, C.R.S.), boating (Title 33, Article 13, Part 1, C.R.S.), or flying (Title 41, Article 2, Part 1, C.R.S.).
- C. Individuals who are admitted, educated, or treated for Driving Under the Influence (DUI), Driving While Ability Impaired (DWAI), Boating Under the Influence (BUI), or Flying Under the Influence (FUI) shall be screened, referred and placed in accordance with current ADDS program screening, referral, and placement procedures.
 - 1. If an agency does not have a copy of the ADDS referral paperwork, the agency shall conduct a screening of the individual using an evidence-based screening or promising practice process and instrument.
 - 2. If an appropriate level of service has not been determined by the ADDS program screening, the agency shall follow guidelines established by the Colorado Department OF Human Services, Office of Behavioral Health, to determine the most appropriate level of service.
- D. Agencies that do not provide services as identified through the screening or in the individual's court order shall:

1. Refer the individual back to the Alcohol and Drug Evaluation Specialist with documentation of which service(s) will not be provided on site and identified referrals and suggestions for alternative services;
 2. Have a written memorandum of understanding or contract with the ancillary provider to make available agreed upon services and require specific data and exchange of information related to the individualized services; and,
 3. Be responsible for monitoring and reporting to referring courts or their representatives the individual's progress with ancillary services.
- E. Individuals with DUI/DWAI shall not be treated in groups with individuals with other offenses unless they need these groups as determined by the assessment and supported by the service plan.
- F. Agencies providing Level I Education, Level II Therapeutic Education, and Level II Therapy shall submit information using reporting formats and data systems approved by the Department when appropriate to:
1. Sentencing courts;
 2. The Department;
 3. Probation departments;
 4. Alcohol and Drug Evaluation Specialist;
 5. Department of Revenue Hearing Section; and,
 6. Motor Vehicle Division.
- G. Information released shall be in accordance with federal and state confidentiality regulations and shall include:
1. Enrollment;
 2. Cooperation;
 3. Attendance, hours and weeks completed;
 4. Treatment status and progress;
 5. Education/treatment levels;
 6. Fee payment;
 7. Compliance with ancillary services; and,
 8. Discharge status.
- H. Agencies shall establish written policies and procedures to ensure that individual data is accurate and submitted within seven (7) business days of service or change in status.
- I. Level I education, Level II therapeutic education, and Level II therapy shall not be combined, nor shall hours completed for one count as hours completed in another.

- J. Individuals shall not be reported as finishing Level I education, Level II therapeutic education, or Level II therapy until all required content/topics have been completed over the minimum required hours and weeks.
- K. Agencies shall provide proof of individual enrollment and report individual status in Level II education and therapy, including discharge, to the Colorado Department of Revenue, Division of Motor Vehicles, within seven (7) business days using Department prescribed reporting formats, in accordance with Sections 42-2-132 and 42-2-144, C.R.S.
- L. Agencies shall provide accurate and timely submission of DUI/DWAI referral summaries (DRS) and other required data submitted through the Treatment Management System (TMS). Agency staff having access to the Treatment Management System shall do so in accordance with federal confidentiality laws.
- M. Discharge DUI/DWAI Referral Summary

Agencies shall provide a copy of the discharge DUI/DWAI referral summary, validated with an agency authorized signature, to individuals and referral sources within ten (10) business days following discharge from education and/or treatment.
 - 1. A copy of the discharge referral summary shall be provided to individuals at no charge;
 - 2. The discharge referral summary shall not be withheld for any reason including, but not limited to, collection of outstanding balances; and,
 - 3. Each discharge referral summary must reflect all DUI/DWAI services the individual received in a given treatment episode.
- N. Ignition Interlock
 - 1. Agencies shall screen all individuals with DUI/DWAI's for ignition interlock usage and requirements in accordance with the Department's interlock rules;
 - 2. Agencies shall offer interlock counseling to those individuals who have installed, or plan to install, an ignition interlock device in accordance with Department rules; and,
 - 3. Interlock counseling shall be offered on site or by referral to another Department licensed agency.

21.240.3 PROVISION OF SERVICES

- A. Agencies shall use and adhere to a curriculum written in a manual form that is evidence-based or a best practice specific to DUI/DWAI, and contains content and topic areas as determined by the Department.
- B. Agencies shall provide individuals with a complete copy of the participant materials and workbook associated with the approved curriculum being used. The agency may charge individuals for the curriculum materials.
- C. Agencies shall assign individuals to a specific class, group or individual session throughout the treatment episode. Individuals attending DUI/DWAI education may make up sessions missed by attending other education sessions that cover the missed content. Make-up groups for DUI/DWAI therapy are not allowed.
- D. Staff conducting DUI/DWAI, BUI and FUI education and therapy shall:

1. Receive training in the curriculum;
 2. Meet the minimum staff qualifications per Sections 21.160 and 21.210.1, including credentialing and competency in group processes; and,
 3. Possess a CAS or LAC.
- E. Hours of attendance shall only be granted for face-to-face contacts and shall not include administrative procedures or breaks.
- F. Drug and alcohol toxicology collection must be observed by trained staff when requested by the referral source.

21.240.4 YOUTH DUI, DWAI, BUI and FUI EDUCATION AND TREATMENT [Eff. 5/1/16]

Licensed youth DUI/DWAI agencies shall comply with Section 21.200 Behavioral Health Services for Children and Adolescents, the adult DUI, DWAI, BUI, FUI rules (21.240) as well as the following:

- A. Youth under twenty-one (21) years of age that receive a DUI/DWAI are held to the same adult requirements under Alcohol and Drug Driving Safety (ADDS) education and treatment services as identified in (Title 42, Article 4, Part 13 and Title 42, Article 2, Part 1, C.R.S.) boating (Title 33, Article 13, Part 1, C.R.S.), or flying (Title 41, Article 2, Part 1, C.R.S.) and includes Section [42-4-1301.3(3)(c)(IV)] , C.R.S.
- B. Agencies licensed to provide Youth DUI, DWAI, BUI, and FUI education and treatment shall also be licensed to provide DUI/DWAI education and treatment.
- C. Whenever possible providers shall hold a separate group for youth.
1. Providers shall use clinical judgement when determining age appropriate placement of youth under twenty-one (21) years of age in an adult group.
 2. When youth are placed in an adult group, individual sessions shall be offered to meet the developmental needs of the youth, when applicable.
- D. Youth under twenty-one (21) years of age shall receive a complete copy, age appropriate materials/workbook, associated with the approved curriculum. The agency may charge for the curriculum.
- E. Parents, other supportive adults, or significant others, shall participate throughout the length of treatment, unless contraindicated.

21.240.5 CONTENT OF RECORDS

Individual records shall be maintained for all levels of education and therapy and follow Section 21.170 (Records Care and Retention, General Provisions) and include:

- A. Court documents regarding referral and classification and placement;
- B. Attendance, individualized progress notes, and course completion data;
- C. Descriptions of content and topics covered during each session;
- D. Relevant reports and records of communication;

- E. Copies of Discharge DUI/DWAI Referral Summary;

21.240.6 Level I EDUCATION

- A. Level I education shall be twelve (12) hours of face-to-face instruction; hours may include intake.
- B. No more than four (4) hours shall be conducted in one (1) calendar day.
- C. Level I education shall be conducted in outpatient settings.

21.240.7 Level II THERAPEUTIC EDUCATION [Eff. 5/1/16]

- A. Agencies applying for approval to conduct Level II therapeutic education must also apply for approval to conduct Level II therapy and meet the requirements of both.
- B. Provision of Services for Level II therapeutic education shall:
1. Be conducted in outpatient settings;
 2. Consist of twelve (12) attended weeks and a total of twenty-four (24) face-to-face contact hours; and,
 3. Not be conducted concurrently with Level II therapy unless clinical rationale is documented. The combined time in Level II therapeutic education and Level II therapy shall not be less than the minimum number of weeks required for Level II therapy.
- C. Individuals shall not attend more than one (1) session of Level II education per week.

21.240.8 LEVEL II DUI/DWAI THERAPY

21.240.81 LEVEL II Outpatient [Eff. 5/1/16]

- A. Programs applying for approval to conduct Level II therapy must also apply for approval to conduct Level II therapeutic education and meet the requirements for both.
- B. Individuals in Level II therapy shall be assigned treatment tracks in accordance with the ADDS program placement criteria or Department placement guidelines in the absence of the ADDS placement criteria. If a track has not been assigned by the ADDS program, the agency shall assign a track based on the Department's track guidelines. The Department track guidelines are as follows:
1. TRACK A. Individuals whose blood alcohol content was below the statutorily defined persistent drunk driving (PDD) level per Section 42- 1-102(68.5), C.R.S., and who have one offense for DUI/DWAI, BUI, or FUI. Track A is a minimum forty-two (42) face-to-face hours of group and/or individual Level II therapy conducted over twenty-one (21) or more weeks.
 2. TRACK B. Individuals whose blood alcohol content was at or above the statutorily defined PDD level per Section 42-1-102(68.5), C.R.S., and who have one offense for DUI/DWAI, BUI, or FUI. Track B is a minimum of fifty-two (52) face-to-face hours of group and/or individual Level II therapy conducted over twenty-six (26) or more weeks.

3. TRACK C. Individuals whose blood alcohol content was below the statutorily defined PDD level per Section 42-1-102(68.5), C.R.S., and who have two or more offenses for DUI/DWAI, BUI, or FUI. Track C is a minimum of sixty-eight (68) face-to-face hours of group and/ individual Level II therapy conducted over thirty-four (34) or more weeks.
 4. TRACK D. Individuals whose blood alcohol content was at or above the statutorily defined PDD level per Section 42-1- 102 (68.5), C.R.S., and who have two or more offenses for DUI/DWAI, BUI, or FUI. Track D is a minimum of eighty-six (86) face-to-face hours of group and/or individual Level II therapy conducted over forty-three (43) or more weeks.
- C. Level II therapy shall be conducted only after Level II therapeutic education has been completed unless there is documented assessment and clinical rationale.
 - D. Level II therapy group sessions (excluding enhanced or intensive outpatient) shall not be less than two (2) hours of therapeutic contact, and shall not include administrative procedures and breaks.
 - E. Individuals are expected to attend group one (1) time per week. Clinical rationale for any changes in frequency of group attendance (fewer or more) shall be documented, and must reflect at least one (1) session per month. Therapy hours attended shall be conducted over the minimum number of weeks associated with the therapy track assigned.
 - F. The assessment shall be updated at the onset of Level II therapy.
 - G. Using the initial service plan as a basis, a revised service plan and subsequent reviews shall be developed for individuals in Level II therapy in accordance with Section 21.190.4.

21.240.82 DUI/DWAI Enhanced Outpatient THERAPY

- A. An agency licensed to provide DUI/DWAI services may qualify to provide enhanced outpatient therapy if it:
 1. Is approved by the Department for Level II therapy;
 2. Meets all the requirements in Sections 21.110 through 21.190, Sections 21.240.2, 21.240.3, and 21.240.5 and Section 21.240.81; and,
 3. Demonstrates ability to provide eight (8) hours of scheduled treatment activities per week.
- B. Level II DUI/DWAI enhanced outpatient therapy shall:
 1. Be based on assessments;
 2. Include a minimum of three (3) to maximum eight (8) hours of treatment activities;
 3. Be conducted over a minimum of two (2) calendar days per week; and,
 4. Not include Level II education.
- C. DUI/DWAI enhanced outpatient services shall be in addition to any DUI/DWAI level or track requirements.
- D. Treatment activities shall be conducted for a minimum of ninety (90) calendar days.

- E. Changes in frequency and intensity of Level II enhanced outpatient treatment shall be driven and based on treatment service plan reviews.

21.240.83 DUI/DWAI Intensive Outpatient THERAPY

- A. An agency licensed to provide DUI/DWAI services may qualify to provide DUI/DWAI intensive outpatient therapy if it:
 - 1. Is approved by the Department for Level II therapy;
 - 2. Meets all the requirements in Sections 21.110 through 21.190, Sections 21.240.2, 21.240.3, and 21.240.5, and Section 21.240.81; and,
 - 3. Demonstrates ability to provide at least nine (9) hours of scheduled treatment activities per week.
- B. DUI/DWAI intensive outpatient treatment therapy shall:
 - 1. Be based on assessments;
 - 2. Include a minimum of nine (9) hours of treatment activities;
 - 3. Be conducted over a minimum of three (3) calendar days per week; and,
 - 4. Not include Level II education.
- C. DUI/DWAI intensive outpatient services shall be in addition to any DUI/DWAI level or track requirement.
- D. The length of stay in level ii intensive outpatient shall be four (4) to six (6) weeks.
- E. Any changes in frequency and intensity of Level II intensive outpatient treatment shall be based on assessments and service plan reviews.

21.240.84 Partial Hospitalization, Clinically Managed Low Intensity Residential Services, Clinically Managed High Intensity Residential Services, and Medically Monitored Intensive Residential Treatment [Eff. 5/1/16]

- A. Partial Hospitalization, Clinically Managed Low Intensity Residential Services, Clinically Managed High Intensity Residential Services, and Medically Monitored Intensive Residential Treatment may qualify to provide DUI/DWAI therapy if they:
 - 1. Meet all requirements under specific level of care in Section 21.210.5;
 - 2. Meet all requirements in Sections 21.240.2 and 21.240.3; and,
 - 3. Are affiliated with the Department licensed outpatient DUI/DWAI programs.
- B. In order for individuals to receive DUI/DWAI therapy credit for participation in Partial Hospitalization, Clinically Managed Low Intensity Residential Services, Clinically Managed High Intensity Residential Services, and Medically Monitored Intensive Residential Treatment, the assessed and identified DUI/DWAI treatment areas must be included in the individualized service plan.

21.240.85 LEVEL II FOUR PLUS TREATMENT

- A. Level II Four Plus Treatment is an approved alcohol and drug driving safety education or treatment program as defined in Section 42-4-1301.3(3)(c)(IV) C.R.S. (2016), intended for someone who has four (4) or more alcohol and/or drug impaired driving offenses.
- B. In order to provide Level II Four Plus Treatment an agency must be licensed to provide:
 - 1. Level II Therapeutic Education; and,
 - 2. Level II Therapy.
- C. Level II Four Plus Treatment must consist of not less than eighteen (18) months of attendance which includes a minimum of one-hundred eighty (180) hours of treatment.
- D. All Level II Four Plus Treatment shall be driven by the individual's clinical assessment.
- E. Level II Four Plus Staff Requirements
 - 1. Staff providing Level II Four Plus Treatment must meet the requirements in Section 21.240.3(D), and:
 - a. CAS credentialed staff must be receiving clinical supervision or consultation by a CAS or LAC; or,
 - b. Licensed staff must have at least one (1) year of documented addiction counseling experience.
 - 2. Staff providing specialized treatment services must hold current and valid credentials and/or licensure in the area of service provision.
 - 3. Staff providing assessment must hold current and valid credentials and/or licensure in the area of service provision.
- F. Level II Four Plus Clinical Assessment(s)
 - 1. A full assessment must be administered in accordance with section 21.190.3.
 - 2. In addition to the requirements in Section 21.190.3(D), the assessment must contain information on:
 - a. Cognitive functioning;
 - b. Traumatic brain injury;
 - c. Adverse childhood experiences (ACES);
 - d. Grief and loss; and,
 - e. Co-occurring mental health issues.
 - 3. Agencies shall utilize an assessment tool specifically designed to address co-occurring mental health issues in the impaired driver population.
 - 4. Agencies shall document results and coordinate further services as appropriate.

G. Level II Four Plus Service Planning and Reviews

1. Level II Four Plus service planning and reviews must be administered in accordance with Section 21.190.4.
2. Agencies providing Level II Four Plus Treatment shall conduct service plan reviews at a minimum of every sixty (60) days in collaboration with supervising probation officers.
3. Consideration shall be given to clients' needs for aftercare and peer recovery support services.

H. Level II Four Plus Discharge Planning

Level II Four Plus discharge planning must be administered in accordance with Section 21.190.6.

I. Provision of Level II Four Plus services shall:

1. Be determined by the results of the screenings and clinical assessment.
2. Be a combination of education and treatment strategies that include, but not limited to:
 - a. Individual counseling;
 - b. Group therapy, unless clinically contraindicated;
 - c. Family/other supportive adult therapy, if applicable;
 - d. Interlock counseling, if the individual has an ignition interlock installed;
 - e. DUI Level II Education or Level II Therapy, if applicable;
 - f. Education, if applicable;
 - g. Medication assisted treatment, if applicable;
 - h. Residential treatment, if applicable;
 - i. Other treatment as indicated by the initial and ongoing clinical assessment.
3. Agencies providing Level II Four Plus Treatment shall provide case management activities, where applicable, to ensure the coordination of client services and needs, and the continuity of care, with other services.

J. Testing and Monitoring

1. All clients shall be tested and/or monitored for alcohol and drug use. Testing and/or monitoring may include the following:
 - a. Urinalysis;
 - b. Breath analysis;
 - c. Continuous alcohol monitoring;
 - d. Mobile/remote breath testing;

- e. Direct and indirect biomarker testing;
 - f. Drug and other testing as appropriate.
- 2. Agency drug and alcohol toxicology collection shall be observed by trained staff.
- 3. If testing is not done by the agency, there must be documentation of the efforts to obtain test results.
- 4. Testing and sharing of results shall be coordinated with probation.

21.240.9 DUI/DWAI BEHAVIORAL HEALTH SERVICES [Eff. 5/1/16]

Some behavioral health service contact hours and weeks may be included and reported as hours of Level II therapy. Credit for DUI/DWAI therapy hours may be given if the DUI/DWAI agency conducts a current comprehensive assessment and:

- A. The assessment and service plan support the need for behavioral health services.
- B. Supporting documentation that corresponds to requested hours and weeks of behavioral health services from the ancillary provider is requested and documented in the record.
- C. A discharge DUI/DWAI referral summary is completed for the hours and weeks granted.

21.250 [Repealed eff. 10/01/2020]

21.260 ALCOHOL AND DRUG EMERGENCY COMMITMENTS

- A. Emergency commitment policies and procedures, based on and in compliance with Sections 27-81-111 and 27-82-107, C.R.S., and these rules, shall be developed and implemented by the licensed withdrawal management programs to:
 - 1. Ascertain if grounds for commitment exist;
 - 2. Assure that individuals and their legal representatives receive copies of the application for emergency commitment forms and be advised verbally and in writing of the right to challenge commitment through the courts;
 - 3. Determine when grounds for emergency commitment no longer exist.
- B. The treatment facility administrator shall designate, in writing, qualified staff, who meet the criteria established in Section 21.210.914(B), to assume responsibility for accepting, evaluating, informing, and providing treatment to individuals on emergency commitment.
- C. Applications for emergency commitments shall be prepared on Department designated forms.
- D. Daily evaluations for emergency commitment continuance shall be documented.
- E. If individuals on an emergency commitment require treatment in other licensed withdrawal management programs, transfers may be managed by the programs that initially authorized the commitments.
- F. When transferring individuals, withdrawal management programs shall use Department designated transfer forms. Completed copies shall be given to:

1. Individuals or their legal representatives;
 2. The withdrawal management programs to which individuals are being transferred.
- G. When minors are transferred, parents or legal guardians who have given permission for treatment shall receive copies of transfer forms.
- H. When it is determined grounds for emergency commitment no longer exists, the individual shall be transferred to voluntary status and the emergency commitment discontinued and documented. A copy of the form shall be given to the individual and made part of the treatment record.

21.270 ALCOHOL AND DRUG INVOLUNTARY COMMITMENTS [Eff. 5/1/16]

- A. All agencies funded by the Department or by a designated Managed Service Organization shall be licensed to treat individuals on involuntary commitment in accordance with this section.
- B. Involuntary commitment policies and procedures shall be developed and implemented based on and in compliance with Sections 27-81-112 and 27-82-108, C.R.S.
- C. The Department shall be the legal custodian of individuals involuntarily committed to treatment.
- D. Passes shall be issued to individuals on involuntarily commitments in residential settings only if they are directly related to treatment. Passes shall not be issued during the initial thirty (30) days of treatment except in emergencies and with Department approval.
- E. The following information shall be reported to the Department:
1. Non-compliance with program requirements and/or court orders;
 2. Failure to appear for admission to treatment;
 3. Leaving treatment in violation of court orders;
 4. Failure to return from passes;
 5. Treatment status every thirty (30) days.
- F. Discharge summaries, as outlined in Section 21.190.6 shall be submitted to the Department, the referring source, and to the referral treatment or aftercare agency.
- G. Requests for early discharge and/or transfer to other treatment programs shall be submitted to the Department for approval.

21.270.1 STAFF REQUIREMENTS

- A. Primary counselors for individuals on involuntary commitment shall:
1. Be Colorado certified addiction specialists; or,
 2. Be Colorado licensed addiction counselors; or,
 3. Possess a clinical master's degree; and,
 4. Complete fourteen (14) hours of training in interviewing techniques related to engaging individuals in treatment.

- B. Copies of course certificates and other relevant documentation shall be retained in counselor personnel files.

21.280 CARE AND TREATMENT OF PERSONS WITH A MENTAL HEALTH DISORDER IN A DESIGNATED FACILITY

21.280.1 DEFINITIONS

“Facility” for the purposes of this section means any facility designated by the Department pursuant to Title 27, Article 65, C.R.S.

“Facility or community based personnel” means:

- A. A professional person;
- B. A registered professional nurse as defined in Section 12-38-103 (11), C.R.S. who by reason of postgraduate education and additional nursing preparation has gained knowledge, judgment, and skill in psychiatric or mental health nursing;
- C. A licensed marriage and family therapist, licensed professional counselor, or addiction counselor licensed under Part 5, 6, or 8 of Article 43 of Title 12, C.R.S., who by reason of postgraduate education and additional preparation has gained knowledge, judgment, and skill in psychiatric or clinical mental health therapy, forensic psychotherapy, or the evaluation of mental health disorders; or,
- D. A licensed clinical social worker licensed under the provisions of Part 4 of Article 43 of Title 12, C.R.S.

“Involuntary Medication” means psychiatric medication administered without an individual's consent.

“Licensed Independent Practitioner” for the purposes of this section means a practitioner permitted by law and by the agency to provide care, treatment, or services, without direction or supervision, within the scope of the practitioner license and consistent with assigned clinical responsibilities.

“Placement facility” means a public or private facility that has a written agreement with a designated facility to provide care and treatment to any individual undergoing mental health evaluation or treatment by a designated facility. A placement facility may be a general hospital, nursing care facility, or licensed residential child care facility.

“Professional person” means a person licensed to practice medicine in Colorado, a psychologist certified to practice in Colorado, or a person licensed and in good standing to practice medicine in another state or a psychologist certified to practice and in good standing in another state who is providing medical or clinical services at a treatment facility in Colorado that is operated by the armed forces of the United States, the United States Public Health Service, or the United States Department of Veterans Affairs.

“Psychiatric medication” is a medication being used to treat psychiatric illness for the patient including, but not limited to, anti-psychotics, antidepressants, and other medications that may have other medical uses but are accepted within the medical profession for psychiatric use as well.

“Secure Treatment Facility” for the purposes of these rules, means the Robert L. Hawkins High Security Forensic Institute at the Colorado Mental Health Institute at Pueblo.

“Therapy or treatments using special procedures” means a therapy that requires an additional, specific consent, including electro-therapy treatment (electro-convulsive therapy), and behavior modifications using physically painful, aversive, or noxious stimuli.

“Unduplicated” means an individual is counted only once, no matter how many specific services the individual received during the calendar year.

21.280.2 ORGANIZATIONAL PROVISIONS

21.280.21 Employment of Persons Receiving Services in Designated Facilities [Eff. 11/1/13]

- A. All labor, employment or jobs involving facility operation and maintenance which are of an economic benefit to the facility, shall be treated as work and shall be compensated according to applicable minimum wage or certified wage rates.
- B. Maintaining a minimum standard of cleanliness and personal hygiene and personal housekeeping, such as making one's bed or cleaning one's area, shall not be treated as work and shall not be compensated.
- C. Individuals shall not be forced in any way to perform work.
- D. Privileges or release from a designated facility shall not be conditioned upon the performance of work.
- E. Vocational programs and training programs must comply with all applicable federal and state laws.
- F. Vocational programs are not subject to the provisions in Section 21.280.21, A, unless the program is of economic benefit to the facility.
- G. All work assignments, together with a specific consent form, and the hourly compensation received, shall be noted in the individual's record.

21.280.22 Environment and Safety [Eff. 11/1/13]

- A. All individuals being treated under these regulations shall receive such treatment in a clean and safe environment with opportunities for privacy.
- B. A facility shall only place an individual in a bedroom with video monitoring due to good cause and safety or security reasons. Individuals shall be notified when placed in bedrooms with video monitoring capabilities.
- C. Each facility shall maintain reasonable security capabilities to guard against the risk of unauthorized departures. The least restrictive method to prevent an unauthorized departure shall be used.
- D. An unlocked facility may place an individual in seclusion to prevent an unauthorized departure when such departure carries an imminent risk of danger for the individual or for others. Under those circumstances, the seclusion procedures in Section 21.280.42, Use of Seclusion, shall be followed.
- E. Seclusion rooms must be a minimum of 100 square feet.

21.280.23 Facility Designated Pursuant to Title 27, Article 65, C.R.S., Care and Treatment of Persons with Mental Illness Data Requirements

- A. Each facility designated by the Department, pursuant to Title 27, Article 65 C.R.S, shall file an annual report with the Department. The report shall be submitted in the format and timeframe required by the Department. This data shall include individuals being treated in placement agencies under the auspices of the designated facility.
- B. For each designated facility, the annual report shall include the name, county, and address of the facility, as well as facility type as defined in 27-65-102(7), C.R.S.
- C. The data report requirements shall include the following types of information as listed in 1 through 4:

- 1. **Seventy-Two (72) Hour Treatment and Evaluation (Mental Health Holds)**

The facility is required to maintain a data set sufficient to report the following aggregate numbers to the Department annually by July 1, for the most recent, complete calendar year covering January 1 through December 31:

- a. The total number of unduplicated individuals, as defined in Section 21.280.1, who were on a seventy-two hour hold status, as well as:
 - 1) Total number of unduplicated individuals by gender;
 - 2) Total number of unduplicated individuals by race and ethnicity;
 - 3) Total number of unduplicated individuals by age; and,
 - 4) Total number of unduplicated individuals by county of residence.
- B. The total number of seventy-two hour holds, as well as, the total number of seventy-two hour holds grouped by:
 - 1) Who initiated the seventy-two hour hold (each hold can only meet the requirements of one category listed below):
 - a) Certified peace officer;
 - b) Court; or,
 - C) Facility or community based personnel as defined in section 21.280.1.
 - 2) The reason(s) for the seventy-two hour hold (each hold can meet the requirements of multiple categories listed below):
 - a) Dangerous to self;
 - b) Dangerous to others; or,
 - c) Gravely disabled.
 - 3) Disposition of the seventy-two hour hold (each hold can only meet the requirements of one category listed below):

- A) Released without need for further mental health services;
 - B) Referred for further mental health care and treatment on a voluntary basis;
 - C) Certified for treatment pursuant to 27-65-107, C.R.S.; or,
 - D) Transferred to another designated facility while still on the seventy-two hour hold.
- C. The total number of involuntary transportation holds, as defined in Section 21.281.1, received by the facility, as well as total numbers by outcome of the required screening, including at least:
- 1) Total number of involuntary transportation hold screenings resulting in the placement of a seventy-two hour hold;
 - 2) Total number of involuntary transportation hold screenings resulting in a referral for further mental health care and treatment on a voluntary basis; and,
 - 3) Total number of involuntary transportation hold screenings resulting in a release without need for further mental health services.

2. Short and Long-Term Certifications

The facility is required to maintain a data set sufficient to report the following aggregate numbers to the Department annually by July 1, for the most recent, complete calendar year covering January 1 through December 31:

- a. The total number of unduplicated individuals, as defined in Section 21.280.1, who were on a certification, as well as:
- 1) Total number of unduplicated individuals by gender;
 - 2) Total number of unduplicated individuals by race and ethnicity;
 - 3) Total number of unduplicated individuals by age; and,
 - 4) Total number of unduplicated individuals by county of residence.
- B. The total number of certifications, as well as, the total number of certifications grouped by:
- 1) Type of certification (each certification can only meet the requirements of one category listed below):
 - a) Short-term;
 - b) Extended short-term;
 - c) Long-term; or,
 - d) Extended long-term.

- 2) Reason for the certification (each certification can meet the requirements of multiple categories listed below):
 - a) Dangerous to self;
 - b) Dangerous to others; or,
 - c) Gravely disabled.
- 3) Outcome of the certification (each certification can only meet the requirements of one category listed below):
 - A) Released without need for further mental health services;
 - B) Referred for further mental health care and treatment on a voluntary basis; or,
 - c) Certification extended; or,
 - d) Certification transferred.

3. Voluntary Individuals

The facility is required to maintain a data set sufficient to report the following aggregate numbers to the Department annually by July 1 for the most recent, complete calendar year covering January 1 through December 31, the total number of unduplicated individuals, as defined in Section 21.280.1, who accessed mental health treatment voluntarily pursuant to 27-65-103, C.R.S., as well as:

- A. Total number of unduplicated individuals by gender;
- B. Total number of unduplicated individuals by race and ethnicity;
- C. Total number of unduplicated individuals by age; and,
- D. Total number of unduplicated individuals by county of residence.

4. Additional Reporting Requirements

The facility is required to maintain data sets sufficient to report the following aggregate numbers to the Department annually by July 1 for the most recent, complete calendar year covering January 1 through December 31.

a. Involuntary Medications

Total number of involuntary psychiatric medication procedures, including type of order:

- 1) Emergency; or,
- 2) Court-ordered.

b. Involuntary Treatments

- 1) Total number of restraint and/or seclusion episodes.

- 2) Total number by type of restraint.
 - 3) Length of seclusion and/or restraint episode per individual.
 - c. Total number of electroconvulsive therapy procedures.
 - d. Imposition of Legal Disability or Deprivation of a Right
- Total Number of court orders for:
- 1) Imposition of Legal Disability; and,
 - 2) Deprivation of a Right.
- D. Pursuant to § 27-65-121, C.R.S., and HIPAA, as defined in Section 21.100, the facility must maintain confidentiality over the data sets. The reports generated from these data sets are also confidential; but the Department may release aggregated information contained in the reports so long as the total number of individuals in any aggregate data group (including county or facility name) is greater than thirty (30). If the total number in such a data group is less than or equal to thirty (30), the Department may release this information by redacting such number.

21.280.24 Staff Training Requirements [Eff. 11/1/13]

In addition to Section 21.160, facilities designated under these rules shall develop a training curriculum and schedule in order to meet the following requirements. Facilities may choose to use a certification of competency in lieu of training, and shall develop appropriate policies, procedures and testing to assure competency.

- A. All staff participating in the provision of the care and treatment for individuals with mental health disorders shall receive annual training or annual facility certification of competency on the provisions of these rules and the requirements of Section 27-65-101, et seq., C.R.S.
- B. All staff who administer involuntary medications shall receive annual training or annual facility certification of competency on Section 21.280 of these rules and the legal rationale underlying involuntary medication of individuals.
- C. All direct care staff shall receive annual training or annual facility certification of competency in the recognition and response to common side effects of psychiatric medications. These staff shall be trained to respond to emergency drug reactions in accordance with the facility's policies.
- D. All staff who administer restraint/seclusion techniques shall receive annual facility training or annual certification of competency on lower level behavioral interventions and Section 21.280.4 of these rules.
- E. All staff involved in the administration of the treatment program shall receive annual training or annual facility certification of competency on alternative or representative medical decision making, including, but not limited to advance directives, medical durable powers of attorney, and proxy decision making, and guardianships.
- F. Specific staff of placement facilities, as determined by the designated facility, shall receive annual facility training or annual certification of competency on the provisions of these rules and the requirements of Section 27-65-101, et seq., C.R.S.

21.280.25 Placement Facilities [Eff. 5/1/16]

- A. Facilities designated for seventy-two (72) hour evaluation and treatment, short-term, and long-term treatment may provide mental health services directly or through the use of placement facility contract. Whenever a placement facility is used there must be a written agreement with the designated facility. In either case, the designated facility is responsible for assuring an appropriate treatment setting for each individual and services provided in accordance with these rules. Whenever a placement facility is used, the designated facility shall be responsible for the care provided by the placement facility.
- B. All agreements between designated facilities and placement facilities and all supplemental agreements and amendments shall be submitted in writing to the Department no later than ten (10) business days after the effective date of the agreement or amendment.
- C. Only the following Colorado licensed facilities are eligible to be a placement facility:
 - 1. Nursing homes;
 - 2. Residential Child Care Facilities providing mental health services;
 - 3. Non-psychiatric hospitals providing in-patient medical services.
 - 4. Alternative Care Facilities.
- D. Emergency departments are not eligible to be, nor are considered placement facilities.
- E. Whenever a designated facility uses a placement facility, the agreement shall include:
 - 1. An annual training plan for placement facility staff that provides at a minimum training regarding mental health disorders, these rules, Title 27, Article 65, C.R.S., and appropriate, safe behavioral interventions. The implementation of the training plan shall be monitored by the designated facility;
 - 2. A requirement that supervision of direct care staff be provided by professional persons licensed in Colorado to practice medicine or a certified Colorado psychologist employed by or under contract with the designated facility, or designated professional person licensed in Colorado to practice medicine or a certified Colorado psychologist employed by the placement facility to be responsible for direct care supervision provided that the placement facility and the designated facility are operated by the same corporate entity;
 - 3. A requirement that assures the necessary availability and supervision of placement facility staff in order to carry out the contract; and,
 - 4. A requirement that the placement facility adheres to these rules through the placement facility agreement.
- F. Placement facilities agreements shall be executed and signed bi-annually when the designated facility submits its application for designation.
- G. A placement facility can be used by a designated facility, at its discretion under the provisions of these regulations, in order to provide care to any individual undergoing mental health evaluation or treatment. Designated facilities shall not place individuals in a placement facility unless all of the applicable provisions of these rules are met and placement in such facility is appropriate to the clinical needs of the individual. When a placement facility is required, the least restrictive facility possible and available must be used, consistent with the clinical needs of the individual.

H. A placement facility shall not provide services beyond the scope of its license.

21.280.26 Individual Rights of Persons Receiving Evaluation Care or Treatment Pursuant to Title 27, Article 65, C.R.S. [Eff. 11/1/13]

- A. Individuals shall be informed they have the same rights as any individual, except as limited by law. Among these are the rights to:
1. Receive services in the least restrictive setting, subject to available funding.
 2. Have an individualized service plan and the right to participate in the development and subsequent changes.
 3. Review the clinical record, as allowed by law.
 4. Designate a representative(s) verbally or in writing, to represent the individual's interests in matters related to grievances.
 5. Have access to a representative within the designated facility who provides assistance to file a grievance.
 6. Be informed by the designated facility that there will be no retaliation against an individual for exercising his or her rights.
- B. Facilities shall post individual rights in prominent places frequented by individuals receiving services.
- C. For Individuals receiving treatment in facilities designated pursuant to Title 27, Article 65, C.R.S.:
1. The facility shall furnish all individuals receiving evaluation, care or treatment under any provisions of Title 27, Article 65, C.R.S., with a written copy of the rights listed under Subsection 21.280.26, C, 2 (translated into a language that the individual understands) upon admission. If the individual is not able to read the rights, the individual shall be read the rights in a language that s/he understands. These rules shall be interpreted by the Department in accordance with a standard of reasonableness.
 2. The facility shall post the following list of rights (in appropriate languages) in prominent places frequented by individuals and their families receiving services:
 - a. To receive and send sealed correspondence. No incoming or outgoing correspondence shall be opened, delayed, held or censored by the personnel of the facility;
 - b. To have access to letter writing materials, including postage, and to have staff members of the facility assist him/her if unable to write, prepare and mail correspondence;
 - c. To have reasonable and frequent access to a telephone, both to make and receive calls in privacy;

- d. To have frequent and convenient opportunities to meet with visitors. The facility may not deny visits by the individual's attorney, religious representative or physician at any reasonable time. The facility will provide privacy to maintain confidentiality of communication between an individual and spouse or significant other, family member(s), staff member(s), attorney, physician, certified public accountant and religious representative, except that if disclosure is required by law, then such privacy may be terminated;
 - e. To wear his or her own clothing, keep and use his/her own individual possessions within reason and keep and be allowed to spend a reasonable sum of his/her own money;
 - f. To refuse to take psychiatric medications, unless the individual is an imminent danger to self or others or the court has ordered administration of such medications;
 - g. To not be fingerprinted unless required by law;
 - h. To refuse to be photographed except for facility identification and the administrative purposes of the facility. Photographs and/or video recordings shall be confidential and shall not be released by the facility except pursuant to court order. No other non-medical photographs and/or video recordings shall be taken or used without appropriate consent or authorization (Section 27-65-117(4), C.R.S.).
 - i. For individuals who are under certification for care and treatment, to receive twenty-four (24) hour notice before being transferred to another designated or placement facility unless an emergency exists, and the right to have the transferring facility notify someone chosen by the individual about the transfer;
 - j. To confidentiality of treatment records except as required by law;
 - k. To accept treatment voluntarily, unless reasonable grounds exist to believe the individual will not remain in treatment on this basis;
 - l. To receive medical and psychiatric care and treatment in the least restrictive treatment setting possible, suited to meet the individual's needs and subject to available resources;
 - m. To request to see his/her clinical record, to see the records at reasonable times, and if denied access, to be given the reason upon which the request was denied and have documentation of such placed in the individual record;
 - n. To retain and consult with an attorney at any reasonable time; and,
 - o. Every individual who is eighteen (18) years of age or older shall be given the opportunity to exercise his/her right to vote in primary and general elections. The staff of the designated or placement facility shall assist each individual in obtaining voter registration forms and applications for absentee or mail ballots, and in complying with any other prerequisite for voting.
- D. With every mental health hold (M-1) and petition to court for involuntary treatment resulting in a change of legal status, the facility shall advise an individual of his or her rights set forth in this Section 21.280.26, and there shall be evidence of such advisement in the individual's clinical record.

E. Individual Rights Restrictions in Facilities Designated Pursuant to 27-65

1. As set forth in Section 27-65-117, C.R.S., an individual's statutory rights, Section 21.280.26, C, 2, a-e may be limited or denied for good cause by the Colorado licensed physician or psychologist who is providing treatment, as follows:
 - a. Except as otherwise provided in Section 21.280.26, E, 2, each denial of an individual's right shall be made on a case by case basis and the reason for denying the right shall be documented in the individual record and shall be made available, upon request, to the individual or his/her attorney.
 - b. Except as otherwise provided in Section 21.280.26, E, 2, restrictions on rights in Section 21.280.26, C, 2, a-e, shall be evaluated for therapeutic necessity on an ongoing basis and the rationale for continuing the restriction shall be documented at least every seven (7) calendar days.

2. Secure Treatment Facilities

A Colorado licensed physician or psychologist treating persons in a secure treatment facility may limit or deny rights for good cause based upon the safety and security needs of the staff and other individuals in the facility. Safety and security policies applicable to the unit shall be incorporated into the individual's service plan. The following procedures shall be adhered to:

- a. The Department shall approve of safety and security policies for each facility unit that places any limit on the rights set forth in Section 21.280.26 as well as the policy and criteria for placement of an individual committed under Title 27, Article 65, C.R.S., in secure treatment facilities.
- b. The safety and security policies for each facility unit shall be posted in the unit. The secure facility staff shall provide a copy of the unit policy upon an individual's request.
- c. Any good cause restriction of rights based upon the safety and security policy of the facility unit shall be noted in the individual's record. The order for restriction shall be signed by the Colorado licensed physician or psychologist providing care and treatment, and shall be reviewed at least every thirty (30) days.
- d. No safety or security policy may limit an individual's ability to send or receive sealed correspondence. However, to prevent the introduction of contraband into the secure treatment facility, the policy may provide that the individual open the correspondence in the presence of unit staff.
- e. No safety or security policy may limit an individual's right to see his or her attorney, clergy, or physician at reasonable times. However, the safety and security policy may provide that advance notice be given to the secure treatment facility for such visits so that the secure facility can adequately staff for the private visit, and take any measures necessary to ensure the safety of the visit.
- f. For the purposes of this rule, placement of individuals in secure treatment facilities on units that are locked at night:

- 1) Individuals transferred to a secure treatment facility from the Department of Corrections, who are serving a sentence in the Department of Corrections, may be placed on units in which the bedroom doors are locked during sleeping hours.
 - 2) All other individuals who are newly admitted to a secure treatment facility may be placed on units in which the bedroom doors are locked during sleeping hours, for a time period not to exceed sixty (60) calendar days. After sixty (60) calendar days, these individuals will not be placed on a unit with locked doors during sleeping hours unless an individualized assessment is made and the treatment team determines that the individual is imminently dangerous to him/herself or to others.
 - 3) Sleeping hours shall begin no earlier than 9:00 p.m., end no later than 8:00 a.m., and shall not exceed 8-1/2 hours.
 - 4) Individuals shall be provided an effective means of calling for assistance when in a locked room during sleeping hours. The secure treatment facility shall provide staff to promptly assist an individual with his or her individual needs including, but not limited to, staff assigned to a day hall where staff will be able to hear and respond to individuals who knock on their room doors. An intercom call system may also be used. Staff shall monitor each individual's well-being through visual observation checks every fifteen (15) minutes.
- F. As set forth in Sections 27-65-104 and 27-65-127, C.R.S., an individual's rights may be limited or denied under court order by an imposition of legal disability or deprivation of a right.
- G. Information pertaining to the denial of any right shall be made available, upon request, to the individual or his/her attorney.

21.280.3 MEDICAL AND MEDICATION TREATMENT PROVISIONS

21.280.31 Medical/Dental Care [Eff. 11/1/13]

A. Seventy-Two (72) Hour Treatment and Evaluation Facilities

The facility shall ensure the availability of emergency medical care to meet the individual needs of each individual. The facility shall have and adhere to a written plan for providing emergency medical care to include at least:

1. A qualified licensed independent practitioner responsible for the completion of physical examinations within twenty-four (24) hours of admission.
2. The availability of a physician or access to an emergency medical facility on a twenty-four (24) hour, seven (7) days a week basis.
3. Emergency medical treatment, when indicated, shall be accessed immediately (within one hour) upon determination that an emergency exists.
4. Whenever indicated, an individual shall be referred to an appropriate specialist for either further assessment or treatment. The facility shall be responsible for securing an appropriate assessment to determine the need for further specialty consultation. This information shall be contained in the clinical record.

B. Short-Term and Long-Term Treatment Facilities

The facility shall ensure the availability of medical care and emergency dental care to meet the individual needs of each individual. The facility shall have and adhere to a written plan for providing medical and emergency dental care to include at least:

1. A qualified licensed independent practitioner responsible for the completion of physical examinations within twenty-four (24) hours of admission. Subsequent physical examinations shall be completed annually. This information shall be included in the clinical record.
2. The availability of a qualified licensed independent practitioner or emergency medical facility on a twenty-four (24) hour, seven (7) days a week basis.
3. Emergency medical treatment, when indicated, shall be accessed immediately (within one hour) upon determination that an emergency exists.
4. Whenever indicated, an individual shall be referred to an appropriate specialist for either further assessment or treatment. The facility shall be responsible for securing an appropriate assessment to determine the need for further specialty consultation. This information shall be contained in the clinical record.
5. Ongoing appraisals of the general health of each individual, including need for immunizations in accordance with applicable state and federal law and need for corrective and assistive devices such as glasses, hearing aids, prostheses, dentures, walkers, etc. This information shall be contained in the clinical record.

- C. The obligation to ensure the availability of emergency medical services shall not be construed as the obligation to pay for such services; however, the facility shall secure these services regardless of source of payment.

21.280.32 Psychiatric Medications [Eff. 11/1/13]

- A. In all instances where prescription psychiatric medications are to be ordered as a part of a mental health treatment program, the following information shall be provided to the individual and legal guardian(s). For children under the age of fifteen (15), the following information shall be provided to the child's parent(s) or legal guardian(s). When an individual has designated another to act concerning medication issues pursuant to a medical durable power of attorney, advanced directive, or proxy, the information shall be provided to that individual also.

1. The name(s) of the medication being prescribed.
2. The usual uses of the medication(s).
3. The reasons for ordering the medication(s) for this individual.
4. A description of the benefits expected.
5. The common side effects and common discomforts, if any.
6. The major risks, if any.
7. The probable consequences of not taking the medication(s).
8. Any significant harmful drug or alcohol interactions, or food interactions.

9. Appropriate treatment alternatives, if any.
10. That s/he may withdraw agreement to take the medication at any time.
- B. The facility shall have policies and procedures for documenting in the clinical record that the required information was given to the individual, custodian, or guardian and consent obtained before administration of medication(s).
- C. The provider with prescriptive authority or his/her designee shall offer to answer inquiries regarding the medication(s).
- D. No individual shall be threatened with or subjected to adverse consequences by facility staff solely because of a failure to accept psychiatric medication voluntarily.
- E. If an individual has established an advance directive concerning psychiatric medication and the advance directive is still in effect, the Colorado licensed physician or psychologist shall follow the directive unless contraindicated in a psychiatric emergency.
- F. Prescribing, Handling, Administration of Psychiatric Medication(s)

All psychiatric medication(s) shall be administered on the written order of a physician or other professional authorized by statute to order such medications. Verbal medication orders may be given according to facility policies.

1. The facility shall have written policies and procedures regarding Section A, above, and the following:
 - a. Documentation of the administration of medication, medication variances/errors, and adverse medication reactions related to medication administration;
 - b. Notification to a physician or other professional authorized by statute to order such medications in case of medication errors and/or medication reactions/events;
 - c. Discontinuance of medication;
 - d. Disposal of medications; and,
 - e. Acceptance of verbal, fax, or electronically transmitted medication orders.
2. The facility shall note in the individual clinical record all prescription medications administered to the individual by the facility including:
 - a. The name and dosage of medication;
 - b. The reason for ordering the medication;
 - c. The time, date and dosage when medication(s) is administered;
 - d. The name and credentials of the individual who administered the medication;
 - e. The name of the prescribing professional authorized by statute to order such medication; and,

- f. If the medication is administered as an emergency medication or a court-ordered medication.

21.280.33 Involuntary Psychiatric Medications [Eff. 11/1/13]

These rules do not apply to refusal of non-psychiatric medications or medical emergencies. If an individual refuses medications intended to treat general medical conditions and that refusal is likely to cause or precipitates a medical emergency, those professionals who are authorized to order and administer medications may take action in accordance with generally accepted medical practice in an emergency situation.

21.280.34 Psychiatric Emergency Conditions [Eff. 11/1/13]

- A. Individuals who are detained pursuant to Sections 27-65-105, 106, 107, 108 or 109, C.R.S., and refuse psychiatric medication may be administered psychiatric medication(s) ordered up to twenty-four (24) hours without consent under a psychiatric emergency condition.
- B. An emergency condition exists if:
 - 1. The individual is determined to be in imminent danger of harming herself/himself or others, as evidenced by symptoms which have in the past reliably predicted imminent dangerousness in that particular individual; or,
 - 2. By a recent overt act, including, but not limited to, a credible threat of bodily harm, an assault on another individual or self-destructive behavior.
- C. A reasonable attempt to obtain voluntary acceptance of psychiatric medication shall be made prior to the use of involuntary medication.

21.280.35 Continuation of a Psychiatric Emergency

- A. If the psychiatric emergency has abated because of the effect of psychiatric medications and the physician is of the opinion that psychiatric medication is necessary to keep the emergency in abeyance beyond seventy-two (72) hours, then within that seventy-two (72) hours the following steps shall be taken:
 - 1. The facility shall send a written request for a court hearing for an order to administer the medication involuntarily; and,
 - 2. A documented concurring consultation with another physician shall be obtained. The consultation shall include an examination of the individual and a review of the clinical record including an assessment as to whether the psychiatric emergency condition continues to exist.
 - 3. If a concurring consultation is not obtained within seventy-two (72) hours, then emergency psychiatric medication shall be discontinued until such concurring consultation is obtained and documented, except in cases where life threatening consequences could result from an abrupt medication discontinuation. Under these circumstances, the individual shall be safely taken off the medication according to standards of medical practice, with corresponding clinical documentation.
 - 4. In no case shall an individual receive emergency psychiatric medication(s) involuntarily for a period exceeding ten (10) days without an order from a court of competent jurisdiction, including continuation orders from the court.

5. The individual shall be notified of the right to contact his or her attorney and/or the court of competent jurisdiction at the time the written request for court-ordered medication is made. This notification shall be documented in the clinical record. If an individual chooses to exercise this right, the designated facility shall aid the individual if necessary, in accomplishing the foregoing.
- B. The specific facts outlining behaviors supporting the finding of the emergency condition shall be detailed in the clinical record. Every twenty-four (24) hours thereafter until such time a final court order is issued, the emergency is resolved, or the individual accepts psychiatric medications voluntarily, the facility shall document the behaviors that substantiated the need to continue the emergency medication, and the physician shall reorder the psychiatric medications.
- C. During the course of emergency medication administration, the individual shall be offered the medication on a voluntary basis each time the medication is given. If the individual voluntarily consents to take the medication(s), and the attending physician determines that the individual will likely continue to accept the medication on a voluntary basis and no longer requires involuntary medications, this shall be documented in the record and the involuntary medication procedures shall be terminated.
- D. If the individual again refuses to voluntarily accept medication(s) and his or her clinical condition returns to an emergency situation as defined in Section 21.280.34, the emergency psychiatric medication procedures may be re-instituted.

21.280.36 Non-Emergency Involuntary Medications [Eff. 11/1/13]

- A. In non-emergency situations in which an individual who is detained pursuant to Sections 27-65-106, 107, 108, or 109, C.R.S., would benefit from the administration of a psychiatric medication, but the individual does not consent, the facility shall petition the court to obtain permission to administer such medication. The following conditions must be documented in the petition:
 1. The individual is incompetent to effectively participate in the treatment decision;
 2. Treatment by psychiatric medication is necessary to prevent a significant and likely long-term deterioration in the individual's mental condition or to prevent the likelihood of the individual causing serious harm to him/herself or others;
 3. A less intrusive appropriate treatment alternative is not available; and,
 4. The individual's need for treatment by psychiatric medication is sufficiently compelling to override any bona fide and legitimate interest of the individual in refusing treatment.
- B. The petition shall specify what class or name of psychiatric medication is being recommended as potentially beneficial to the individual.
- C. No psychiatric medications shall be administered without the individual's consent until a court order is received authorizing involuntary use, except under emergency conditions under Section 21.280.34.

21.280.37 Involuntary Medication Data [Eff. 11/1/13]

If the facility uses a medication administration record or another mechanism which meets the criteria listed in Section B, below, can correlate this information as required in Section C, below, and places the information in the clinical record, that mechanism may be used in lieu of a separate log.

- A. The designated facility must maintain a log of all cases where involuntary medications were administered.
- B. The record shall contain, at a minimum, the following:
 - 1. Individual's name and identifying number.
 - 2. Specified use of involuntary medication.
 - 3. Physician or other professional authorized by law ordering involuntary medication.
 - 4. Date/time each involuntary medication was administered.
 - 5. Date/time involuntary medication was discontinued.
 - 6. Reason for discontinuation of involuntary medication(s).
- C. The facility shall have the ability to determine, at a minimum, the aggregate number of individuals receiving emergency and involuntary psychiatric medications during a specified period of time, the start and stop dates for each individual's involuntary medication treatment, and shall incorporate the use of this data into the quality improvement program.

**21.280.4 SECLUSION, RESTRAINT, AND PHYSICAL MANAGEMENT FOR 27-65
DESIGNATED FACILITIES [Eff. 11/1/13]**

The following rules covering seclusion and restraint apply to all areas of the designated facility including emergency departments and to placement facilities. If a facility is authorized to use physical management, restraint or seclusion at the facility, the facility shall use physical management, restraint or seclusion only in accordance with the following rules unless the specific rules prohibit, limit or modify the requirements placed upon the facility.

- A. Individuals being detained under Sections 27-65-105 through 109, C.R.S., may be secluded or restrained over their objection under the conditions in Section 21.280.4; otherwise, there must be a signed informed consent for such an intervention as outlined in Section 21.280.5 of these rules.
- B. These rules do not supersede any requirements under Section 26-20-101, et seq., C.R.S.
- C. Staff shall ensure that no individual will harm or harass an individual who is secluded and/or restrained.
- D. These measures may only be used in accordance with a service plan developed in consultation with and based on a written order by a Colorado licensed physician or psychologist. The service plan, which shall document if less restrictive measures were unsuccessful, shall be evaluated by a Colorado licensed physician or psychologist every twenty four (24) hours.

21.280.41 Definitions [Eff. 11/1/13]

"Mechanical Restraint" means a physical device used to involuntarily restrict the movement of an individual or the movement or normal function of a portion of his or her body. Types of mechanical restraints include, but are not limited to: restraint sheets, camisoles, belts attached to cuffs, leather armlets, restraint chairs, and shackles.

“Physical Management” means the physical action of placing one’s hands on an individual. Physical management may be used to gain physical control in order to protect the person or others from harm after all attempts to verbally direct or de-escalate the person have failed. Physical management may be utilized when an emergency situation exists. The physical management continuum may include:

- A. Utilizing transitional measures.
- B. Placing one’s hands on a person to physically guide and/or physically control the person.
- C. Use of an approved restraint method to control or contain the person.
- D. Placing of a person into an approved prolonged restraint method.
- E. Physical management may be used to move or escort a person into seclusion. Seclusion, in itself, is not a form of physical management.

“Physical Restraint” means the use of bodily, physical force to involuntarily limit a person’s freedom of movement, except that “physical restraint” does not include the holding of a child by one adult for the purpose of calming or comforting the child.

“Seclusion” means the confinement of a person alone in a room from which egress is prevented. Seclusion does not include the placement of persons, who are assigned to an intake unit in a secure treatment facility, in locked rooms during sleeping hours pursuant to Section 21.280.26.E thru G.

21.280.42 Use of Seclusion [Eff. 11/1/13]

- A. Seclusion may be used only for the purpose of preventing imminent injury to self or others, or to eliminate prolonged and serious disruption of the treatment environment. Any time an individual is placed alone in a room and not allowed to leave, it shall be construed as seclusion.
- B. An unlocked designated facility may place an individual in seclusion to prevent an unauthorized departure when such departure carries an imminent risk of dangerousness for the individual or for others. Under those circumstances, the seclusion procedures in this section shall be followed.
- C. Any decision to seclude shall be based on a current clinical assessment, and may also be based on other reliable information including information that was used to support the decision to take the individual into custody for treatment and evaluation. The fact that an individual is being evaluated or treated under Sections 27-65-105 through 27-65-109, C.R.S., shall not be the sole justification for the use of seclusion.
- D. Seclusion shall be used only when other less restrictive methods have failed. Documentation of less restrictive methods and the outcome shall be contained in the clinical record.
- E. Seclusion rooms shall be lighted, clean, safe, and have a window for staff to observe.
- F. Seclusion shall only be ordered by a Colorado licensed physician or psychologist.
- G. Seclusion shall not be used for punishment, for the convenience of staff, or as a substitute for a program of care and treatment.

21.280.43 Use of Restraint [Eff. 11/1/13]

Restraint may be used in emergency circumstances, wherein the individual presents a serious, probable imminent threat of bodily harm and has the ability to affect such harm.

- A. The decision to restrain shall be based on a current clinical assessment, and may also be based on other reliable information including information that was used to support the decision to take the individual into custody for treatment and evaluation. The fact that an individual is being evaluated or treated under Sections 27-65-105 through 27-65-109, C.R.S., shall not be the sole justification for the use of restraint.
- B. Mechanical restraints may be used only for the purpose of preventing such bodily movement that is likely to result in imminent injury to self or others. Mechanical restraint shall not be used solely to prevent unauthorized departure.
- C. Restraint of a single limb is not permitted, unless court-ordered or approved by the superintendent and the executive body of the secure treatment facility, utilizing the assessment standards set forth in Section 26-20-101, et seq., C.R.S.; Section 21.280.43, A, of these rules; and the secure treatment facility's policies.
- D. Restraint of an individual by a chemical spray is not permissible.
- E. The type of restraint shall be appropriate to the type of behavior to be controlled, the physical condition of the individual, the age of the individual and the type of effect restraint may have upon the individual.
- F. Restraint shall be applied only if alternative interventions have failed. Alternative interventions shall be documented in the clinical record; however, alternative techniques are not required if the alternatives would be ineffective or unsafe, when the individual is physically combative or actively assaultive or self-destructive.
- G. Justification for immediate use of restraint shall be documented in the clinical record.
- H. Restraint shall only be ordered by a Colorado licensed physician or psychologist.
- I. Restraint shall not be used for punishment, for the convenience of staff, or as a substitute for a program of care and treatment.
- J. Restraint does not include restraints used while the facility is engaged in transporting an individual from one facility or location to another facility or location within a facility when it is within the scope of that facility's powers and authority to effect such transportation pursuant to Section 26-20-101, et seq., C.R.S.

21.280.44 Explanation to Individual [Eff. 11/1/13]

In any situation, information shall be given to the individual, and guardian when applicable, as soon as possible after s/he has been secluded or restrained. The individual shall be given a clear explanation of the reasons for use of such intervention, the observation procedure, the desired effect, and the circumstances under which the procedure will be terminated. The fact that this explanation has been given to the individual shall be documented in the clinical record.

In an emergency situation, information given to the individual pursuant to this rule regarding the desired effect and the circumstances under which the procedure(s) will be terminated may not be as detailed as in a non-emergency situation. However, as the individual's condition improves, staff shall promptly supplement the information given and this shall be documented in the clinical record.

21.280.45 Continued Use of Seclusion and/or Restraint [Eff. 11/1/13]

- A. Staff shall document efforts to assure that the use of seclusion/restraint shall be as brief as possible.

- B. If the seclusion/restraint episode goes beyond one (1) hour, a Colorado licensed physician or psychologist must provide an order. A verbal order, including telephone or other electronic orders, may be used if followed by a written order by the Colorado licensed physician or psychologist.
- C. Seclusion and/or restraint shall not be ordered on an "as needed" basis.
- D. If the individual has not been examined by a Colorado licensed physician or psychologist within the previous twenty-four (24) hours, seclusion and/or restraint continued in excess of four (4) hours will require a face-to-face examination and a new written order by Colorado licensed physician or psychologist. If there has been a documented examination by a Colorado licensed physician or psychologist within the previous twenty-four (24) hours, seclusion/restraint continued in excess of fourteen (14) hours will require a face-to-face examination and a new written order by a Colorado licensed physician or psychologist prior to each succeeding twenty-four (24) hours of seclusion/restraint to assure that the need for these interventions is still present. The reasons for continuation shall be documented in the clinical record by the Colorado licensed physician or psychologist.
- E. An episode of seclusion/restraint is terminated when the individual has been out of seclusion/restraint for a continuous period of two (2) hours.
- F. Continued seclusion/restraint in excess of twenty-four (24) hours shall require an administrative review by the medical/clinical director of the facility or his/her designee, other than the Colorado licensed physician or psychologist in charge of treatment. The reviewer shall be an individual with the authority and knowledge necessary to review clinical information and reach a determination that the extension of a seclusion and/or restraint episode beyond twenty four (24) hours is clinically necessary.
- G. If the reviewer does not concur with the order for continuation of seclusion/restraint, the order shall be discontinued and the professional person in charge of treatment shall be notified of such discontinuation.
- H. An administrative review shall be initiated at the conclusion of each twenty four (24) hour period of continuous use of seclusion/restraint, and shall be completed prior to the expiration of each twenty four (24) hour period.

21.280.46 Chart Documentation for the Use of Seclusion and/or Restraint [Eff. 11/1/13]

- A. A staff member shall record each use of seclusion and/or restraint and the clinical justification for the use in the individual's chart. The justification shall include:
 - 1. The individual's specific behavior(s) and the nature of the danger;
 - 2. Describe attempts made to control the individual's behavior prior to using seclusion and/or restraint;
 - 3. Describe the circumstances under which seclusion/restraint will be terminated and evidence that these criteria were given to the individual; and,
 - 4. Notification to a Colorado licensed physician or psychologist within one (1) hour of the seclusion/restraint intervention.
- B. Administrative review shall document the clinical justification for the continued use of seclusion/restraint in the individual's chart. The justification shall include:

1. Documentation that the professional person ordering the continuous use of seclusion/restraint in excess of twenty-four (24) hours has conducted a face-to-face evaluation of the individual within the previous twenty-four (24) hours.
 2. Documentation of the ongoing behaviors or findings that warrant the continued use of seclusion/restraint and other assessment information as appropriate.
 3. Documentation of a plan for ongoing efforts to actively address the behaviors that resulted in the use of seclusion/restraint.
 4. A determination of the clinical appropriateness of the continuation of seclusion/restraint.
 5. A summary of the information considered by the reviewer and the result of the administrative review with the date, time and signature of the individual completing the review.
- C. Information regarding use of seclusion/restraint shall be readily accessible to authorized individuals for review. Facilities shall have the ability to gather data as follows:
1. Each seclusion/restraint episode including date and time the episode started and ended, specific to each individual.
 2. Aggregated data to include total number of individuals secluded/restrained and average length of time of the episodes over the period of one year.

21.280.47 Observation and Care [Eff. 11/1/13]

- A. An individual who is in seclusion/restraint shall be observed in person by staff at least every fifteen (15) minutes, and such observation, along with the behavior of the individual, shall be recorded each time. Unless contraindicated by the individual's condition, such observation shall include efforts to interact personally with the individual.
- B. Ongoing provisions shall be made for nursing care, hygiene, diet and motion of any restrained limbs. For individuals in mechanical restraints, the facility shall provide relief periods, except when the individual is sleeping, of at least ten (10) minutes as often as every two hours, so long as relief from the mechanical restraint is determined to be safe. Staff shall note in the record relief periods granted. The individual shall have access to food at least every four (4) hours and shall have access to fluids and toileting upon request or during relief periods, but at least every two (2) hours, unless sleeping.
- C. Cameras and other electronic monitoring devices shall not replace the face-to-face observations.
- D. An individual in physical restraint shall be released from such restraint within fifteen (15) minutes after the initiation of physical restraint, except when precluded for safety reasons pursuant to Section 26-20-101, et seq., C.R.S.
- E. To the extent that the duties specified in Section 26-20-101, et seq., C.R.S. are more protective of individual rights, the provisions 26-20-101, et seq., C.R.S. shall apply.

21.280.48 Facility Policies and Procedures for Seclusion/Restraint [Eff. 11/1/13]

The facility shall have and shall implement written policies and procedures that describe the situations in which the use of seclusion and/or restraint are considered appropriate within each specific program and the staff members who can order their use. The policies and procedures shall include the requirements in Section 21.280.4 of these rules and Section 26-20-101, et seq., C.R.S.

In the event a facility does not authorize the use of seclusion and/or restraint of any type, the policy statement shall note the prohibition.

The policies and procedures shall include implementing administrative review including a process for terminating the seclusion and/or restraint episode when the reviewer does not concur with the order for continuation. If the reviewer is not a Colorado licensed physician or psychologist, then the order must be discontinued by a Colorado licensed physician or psychologist.

21.280.5 THERAPY OR TREATMENT USING SPECIAL PROCEDURES

21.280.51 Informed Consent [Eff. 11/1/13]

Therapies using stimuli such as electroconvulsive therapy (ECT), and behavior modifications using physically painful, aversive or noxious stimuli, require special procedures for consent and shall be governed by this rule.

- A. Prior to the administration of a therapy listed above, written informed consent shall be obtained and documented in the clinical record reflecting agreement by both the individual being treated and his/her legal guardian, if one has been appointed or alternative decision maker if one exists. If the individual undergoing treatment using special procedures is a child age sixteen (16) to eighteen (18), the clinical record shall reflect informed consent by both the child and his/her guardian(s).
- B. In the case of electroconvulsive therapy, a consent form prescribed by the Department shall be used and procedures set forth in Sections 13-20-401 through 13-20-403, C.R.S., shall be followed. An informed consent means:
 - 1. It is freely and knowingly given and expressed in writing.
 - 2. That the following has been explained to the individual:
 - a. The reason for such treatment information;
 - b. The nature of the procedures to be used in such treatment, including their probable frequency and duration;
 - c. The probable degree and duration of improvement or remission expected with or without such treatment;
 - d. The nature, degree, duration, and probability of the side effects and significant risks of such treatment commonly known by the medical profession, the possible degree and duration of memory loss, the possibility of permanent irrevocable memory loss, and the remote possibility of death;
 - e. The reasonable alternative treatments, if any, and why the Colorado licensed physician or psychologist is recommending the specific treatment;
 - f. That the individual has the right to refuse or accept the proposed treatment and has the right to revoke his consent for any reason at any time, either orally or in writing;
 - g. That there is a difference of opinion within the medical profession on the use of some treatments;

- h. An offer to answer any inquiries concerning the recommended special procedures; and,
 - i. The number of treatments expected over a specified period of time to achieve maximum benefit.
- 3. The consent agreement entered into by the individual or other individual(s) shall not include exculpatory language through which the individual or other individual(s) is made to waive, or appear to waive, any of his/her legal rights, or to release the facility or any other party from liability for negligence.
- 4. Informed consent for the special procedure shall be renewed each time the maximum number of treatments is given or the specified amount of time has expired. No informed consent for special procedures shall be valid for more than thirty (30) days.
- 5. No one under the age of sixteen (16) shall undergo electroconvulsive treatment.
- 6. Electroconvulsive treatment requires a concurring consultation by a licensed psychiatrist prior to administration of the treatment. Such consultation shall be noted in the clinical record.
- 7. All provisions of Sections 13-20-401 through 13-20-403, C.R.S., shall be followed.

21.280.52 Involuntary Treatment Using Special Procedures [Eff. 11/1/13]

In the event the individual or the legal guardian refuses to or cannot consent, treatments referenced in Section 21.280.51 using special procedures shall be administered only under the following circumstances:

- A. With a prior court order for the treatments using special procedure; or,
- B. In an emergency in which the life of the individual is in imminent danger because of the individual's condition. In an emergency situation in which the individual is unable to grant informed consent and sufficient time does not exist to petition the court for an order prior to the administration of the specific therapy, the individual's physician, in consultation with the director of the facility or his/her designee, may, after careful and informed deliberation and under procedures adopted by the facility, order a special procedure without consent.

21.280.53 Documentation of Special Procedures [Eff. 11/1/13]

Along with the evidence of informed consent as delineated in this section, the reason for the use of any special procedure shall be fully documented in the individual's record. The administration and outcome of such special procedure shall also be documented in the clinical record.

21.280.54 Procedures [Eff. 11/1/13]

Each designated facility shall adopt written procedures for administration of special procedures in accordance with these rules and applicable statutes.

21.280.6 CONTINUITY OF CARE [Eff. 11/1/13]

Each facility shall adopt and implement a written policy for continuity of care. The policy shall include at a minimum the following:

- A. Access to all necessary care and services within the facility, and coordination with any other current mental health care providers or other systems of care or support as appropriate.
- B. Coordination of care with the individual's previous mental health care providers or medical providers as appropriate, including retrieval of psychiatric and medical records.
- C. Coordination of the individual's care with family members, guardians and other interested parties as appropriate and in a manner that reflects the individual's culture and ethnicity.
- D. The facility is not responsible for providing non-psychiatric medical care under these rules, but shall facilitate access to proper medical care and shall be responsible for coordinating mental health treatment with medical treatment provided to the individual.

21.280.7 TRANSFER OF CARE AND TRANSPORTATION

21.280.71 Transfer of Care [Eff. 11/1/13]

- A. The individual shall only be transferred to another designated or placement facility when adequate arrangements for care by the receiving facility have been made and documented in the clinical record. Transfer coordination shall include at least one discharge planning conference, face-to-face or by telephone, with participants from both facilities and the individual and his/her guardian, whenever possible.
- B. At least twenty-four (24) hours advance notice of transfer shall be given to individuals under certification, unless knowingly waived in writing by the individual and guardian as appropriate, except in cases of a medical emergency. Notice of such transfer shall also be provided to the court of competent jurisdiction and the individual's attorney.
- C. The transferring facility shall ask the individual to indicate two (2) individuals to whom notification of transfer should be given and shall notify such individuals within twenty-four (24) hours of notification to the individual. Such notification shall be made by the transferring facility with the appropriate written authorization. Actions taken under this section shall be documented in the clinical record.

21.280.72 Transportation [Eff. 11/1/13]

Whenever transportation of an individual is required, the treating staff of the facility shall assess the individual for dangerousness to self or others and potential for escape. Whenever clinically and safely appropriate, the individual may be transported by other means such as ambulance, care van, private vehicle, and restraints shall not be used, unless authorized as necessary by the treating physician. If the treating staff assesses the individual as dangerous to self or others or as an escape risk, the staff may request transportation by the local Sheriff's Department.

- A. A request for transportation from the Sheriff's Department shall be filed with the court of appropriate jurisdiction and shall include:
 - 1. Statements from the treating Colorado licensed physician or psychologist supporting the need for transportation by the Sheriff's Department;
 - 2. Recommendations concerning the use of mechanical restraints and the impact that handcuffs or shackles would have on the individual;
 - 3. Recommendations for soft restraints, not handcuffs or shackles, if the findings of the assessment support the use of mechanical restraint;

4. Recommendations concerning the placement and management of the individual during the time s/he will be absent from the designated facility due to court hearings;
 5. Recommendations of considerations for management of the individual based on the individual's age, physical abilities, culture, medical and psychiatric status and/or stability.
- B. Notice of the request for transportation by the Sheriff's Department shall be given to the individual and his/her attorney at least twenty-four (24) hours prior to the time it is filed with the court. This notice shall not be required during the time a seventy-two hour hold is in effect or in an emergency situation with an individual under certification or when the individual signs a waiver which has been clearly explained.
- C. Requesting transportation by the Sheriff's Department does not require a finding of dangerousness to self or others or an escape risk if the Sheriff's Department is willing to transport the individual without the use of mechanical restraints.

21.280.8 CERTIFICATION FOR TREATMENT ON AN OUTPATIENT BASIS [Eff. 11/1/13]

An individual who has been treated as an inpatient under a short-term or long-term certification for mental health treatment at a designated facility may be treated on an outpatient basis if the following conditions are met:

- A. A Colorado licensed physician or psychologist who has evaluated the individual and who is on the staff of the designated facility which has been treating the individual, determines that while the individual continues to meet the requirements for certification, professional judgment is that with appropriate treatment modalities in place the individual is unlikely to act dangerously in the community.
- B. Certification on an outpatient basis is the appropriate disposition suited to the individual's needs.
- C. The designated facility that will hold the certification on an outpatient basis has documentation of the results of a recent physical examination.
- D. Arrangements have been made for the individual to have access to:
1. Case management;
 2. Medication management;
 3. Essential food, clothing, shelter; and,
 4. Medical care and emergency dental care.
- E. The service plan shall reflect the outpatient certification status, the arrangements under D, 1-4, above, and meet the requirements in Sections 21.190.4 and 21.280.92 Service Planning.
- F. Content of the individual's outpatient record shall meet the requirements in Sections 21.190 and 21.280.9, Documentation in Individual Records.

21.280.81 Enforcement of Certification [Eff. 11/1/13]

- A. If the individual on outpatient certification substantially fails to comply with the requirements specified in his/her service plan, the Colorado licensed physician or psychologist or staff of the designated facility that holds the certification, shall make reasonable efforts, including outreach, to obtain the individual's compliance with the plan. As part of these efforts, reasonable attempts shall be made to advise the individual that s/he may be picked up and taken into custody for appraisal of the individual's need for continued certification and ability to receive treatment on an outpatient basis.
- B. If the designated facility's medical director or the treating Colorado licensed physician or psychologist reasonably believes that there is a significant risk of deterioration in the individual's condition or that the individual may pose a risk of harm to self or the community, and reasonable efforts to obtain the individual's compliance with the service plan have been unsuccessful, the medical director or the treating professional person shall make arrangements to have the individual transported to a designated facility or the emergency room of a hospital. The individual shall be assessed for current clinical needs and modifications made in legal status or treatment as necessary, including readmission to an inpatient facility.
- C. The individual shall not be physically forced to take prescribed psychiatric medication during this appraisal process, unless an emergency situation exists or the individual is court-ordered to do so as set forth in Section 21.280.33 through 21.280.36.
- D. Following the assessment, if the individual is not detained, the facility holding the certification shall arrange transportation for the individual to return to the individual's residence or other reasonable location, if the individual so desires.

21.280.9 DOCUMENTATION IN INDIVIDUAL RECORDS

21.280.91 Assessment [Eff. 11/1/13]

Records shall include:

- A. Assessment information in accordance with Section 21.190.3.
- B. Evidence of ongoing assessment that at a minimum shall be included in the monthly service plan review process.
- C. Evidence of an assessment update for continued certification every six months for individuals being treated under an outpatient certification or a long-term certification.

21.280.92 Service Planning Requirements [Eff. 11/1/13]

Service plans shall follow requirements in 21.190.4 (noting the exception in 21.280.92, G, below, of monthly service plan reviews), and:

- A. The service plan shall contain specific criteria required for discharge from treatment or to progress to less restrictive treatment alternatives.
- B. For individuals receiving care through outpatient certification, the plan shall assure the individual has access to medical and emergency dental care, case management, medication management, food, clothing, and shelter.

- C. If an individual is discharged during a seventy-two (72) hour hold without certification by the facility, and a service plan has not been completed, then pertinent information shall be included in the discharge summary.
- D. The facility shall appoint a clinical staff person to be responsible for the formulation, implementation, review, and revision of the service plan. The name of the responsible staff person shall be specified in the plan and that individual shall sign the plan. The plan shall also be signed by the treating Colorado licensed physician or psychologist, if he or she is not the responsible staff person.
- E. A physician or other professional person authorized by law to prescribe the medications shall be responsible for the component of the plan requiring medication management services.
- F. Service plans shall be readily identifiable and shall be maintained in a place readily accessible to treatment staff.
- G. The service plan shall be reviewed, and revised if necessary, at least monthly by the staff person responsible for the plan, the treating Colorado licensed physician or psychologist, the individual and the legal guardian. This review shall be documented in the record and include progress toward meeting the criteria for termination of treatment and the need for continued involuntary treatment if the individual is certified. If the monthly review is delayed, the reason for such delay shall be noted in the record and the review shall be completed as promptly as possible.

21.280.93 Treatment Progress and Documentation Requirements [Eff. 11/1/13]

Records shall contain treatment progress notes per Section 21.190.5 and the following:

- A. Documentation of all treatment procedures including, but not limited to: brief physical restraint, seclusion, mechanical restraint, medications voluntary and involuntary, and other therapies or interventions.
- B. Information regarding the serious injury of or by the individual and the circumstances and outcome.
- C. Documentation of all transfers and reasons for transfer.
- D. Legal status and all legal documents related to treatment under Section 27-65-101, et seq., C.R.S.
- E. Consultations and/or case reviews.
- F. Pertinent information from outside agencies or persons or from the individual.
- G. Correspondence to and from relevant agencies and individuals.
- H. Monthly documentation of the results of a Colorado licensed physician or psychologist's review of certification, effectiveness of mental health treatment, legal status of the individual and considerations of less restrictive treatment alternatives.
- I. Consent forms as appropriate for alternative treatments or voluntary treatment.
- J. Use or non-use of advance directives.

21.280.94 Discharge Planning Requirements [Eff. 11/1/13]

- A. Records shall include documentation that written information has been given to the individual upon discharge. This information shall include provision of Section 21.190.6, and:
1. If the individual is being transferred to another facility, information regarding that transfer and the facility shall be included.
 2. Information if the discharge is being made against the advice of the treating Colorado licensed physician or psychologist.
- B. Discharge Summary
- Records shall contain a discharge summary to include the provisions of Section 21.190.62 and the following information:
1. A summary of treatment received including: involuntary treatments, advance directives, progress made, and case management activities.
 2. For transfers between facilities, documentation of appropriate clinical information and coordination of services between the two facilities, including mode of transportation.

21.281 INVOLUNTARY TRANSPORTATION FOR IMMEDIATE SCREENING

21.281.1 DEFINITIONS

“Facility” means any outpatient mental health facility or other clinically appropriate facility designated by the office of behavioral health as a seventy-two (72) hour treatment and evaluation facility that has walk-in capabilities and provides immediate screenings. If such a facility is not available, an emergency medical services facility, as defined in Section 27-65-102(5.5), C.R.S., may be used.

“Immediate screening” means the determination if an individual meets criteria for seventy-two (72) hour treatment and evaluation.

“Intervening professional” as defined in section 27-65-105(1)(a)(II), C.R.S., means a certified peace officer; a professional person; a registered professional nurse as defined in section 12-38-103(11), C.R.S. who by reason of postgraduate education and additional nursing preparation has gained knowledge, judgment, and skill in psychiatric or mental health nursing; a licensed marriage and family therapist, licensed professional counselor, or addiction counselor licensed under Part 5, 6, or 8 of Article 43 of Title 12, C.R.S., who by reason of postgraduate education and additional preparation has gained knowledge, judgment, and skill in psychiatric or clinical mental health therapy, forensic psychotherapy, or the evaluation of mental health disorders; or a licensed clinical social worker licensed under the provisions of Part 4 of Article 43 of Title 12, C.R.S.

“Involuntary transportation form” means the report and application allowing for immediate transport of an individual, in need of an immediate screening for treatment, to a clinically appropriate facility.

“Involuntary transportation hold” means the ability to transport an individual in need of an immediate screening to determine if the individual meets criteria for seventy-two (72) hour treatment and evaluation. Pursuant to Section 27-65-105(1)(a)(I.5), C.R.S., an intervening professional may involuntary transport an individual in need of an immediate screening from the community to an outpatient mental health facility or other clinically appropriate facility. The involuntary transportation hold does not extend or replace the timing or procedures related to a seventy-two (72) hour treatment and evaluation hold or an individual’s ability to voluntarily apply for mental health services.

21.281.2 PROCEDURE

- A. An individual may be placed on an involuntary transportation hold pursuant to section 27-65-105(1)(a)(I.5), C.R.S.
1. The involuntary transportation form shall be completed by an intervening professional and contain:
 - a. The circumstances under which the individual's condition was called to the intervening professional's attention;
 - b. The date and time the individual was placed on the involuntary transportation hold;
 - c. The name of the facility to which the individual will be transported; and,
 - d. The signature of the intervening professional placing the involuntary transportation hold.
 2. A copy of the involuntary transportation form must be given to the facility and made part of the individual's medical record.
 3. A copy of the involuntary transportation form must be given to the individual who was placed on the involuntary transportation hold.
- B. The involuntary transportation hold expires:
1. Six (6) hours after it was placed; or,
 2. Upon the facility receiving the individual for screening; thereby resolving the involuntary transportation hold.
- C. The facility shall ensure that the immediate screening is completed to determine if the individual meets criteria for seventy-two (72) hour treatment and evaluation and follow standard procedures pursuant to section 27-65-105(1)(A)(I), C.R.S.

21.282 EMERGENCY MEDICAL SERVICES FACILITY DATA REPORTING REQUIREMENTS

- A. An emergency medical services facility, as defined in 27-65-102(5.5), C.R.S., providing care to an individual pursuant to Title 27, Article 65, C.R.S. is required to maintain a data set sufficient to report the following aggregate numbers to the Department annually pursuant to 27-65-105(7), C.R.S., in the format and timeframe required by the Department.
- B. For each facility, the annual report shall include:
1. The name, county, and address of each facility site where the service was provided.
 2. The total number of unduplicated individuals, as defined in Section 21.280.1, who had a seventy-two hour hold resolved (this includes release without need for further mental health services, or referral for voluntary treatment) at the facility, as well as:
 - A. Total number of unduplicated individuals by gender;
 - B. Total number of unduplicated individuals by race and ethnicity;

- C. Total number of unduplicated individuals by age; and,
 - D. Total number of unduplicated individuals by county of residence.
- 3. The total number of seventy-two hour holds transferred to a designated facility for continued involuntary services.
- 4. The total number of involuntary transportation holds, as defined in Section 21.281.1, received by the facility, as well as total numbers by outcome of the required screening, including at least:
 - A. Total number of involuntary transportation hold screenings resulting in the placement of a seventy-two hour hold;
 - B. Total number of involuntary transportation hold screenings resulting in a referral for further mental health care and treatment on a voluntary basis; and,
 - C. Total number of involuntary transportation hold screenings resulting in a release without need for further mental health services.
- 5. The total number of seventy-two hour holds where the involuntary status was resolved at the facility, as well as, the total number of seventy-two hour holds where the involuntary status was resolved at the facility grouped by:
 - A. Who initiated the seventy-two hour hold (each hold can only meet the requirements of one category listed below):
 - 1) Certified peace officer;
 - 2) Court; or,
 - 3) Facility or community based personnel as defined in Section 21.280.1.
 - B. The reason for the seventy-two hour hold (each hold can meet the requirements of multiple categories listed below):
 - 1) Dangerous to self;
 - 2) Dangerous to others; or,
 - 3) Gravely disabled.
 - C. Disposition of the seventy-two hour hold (each hold can only meet the requirements of one category listed below):
 - 1) Released without need for further mental health services; or,
 - 2) Referred for further mental health care and treatment on a voluntary basis.
- C. Process of data reporting
 - 1. Facilities must submit their annual data report to the Department by July 1 of each year covering the most recent, complete calendar year covering January 1 through December 31. The report must meet the requirements in section 24-1-136(9), C.R.S.

2. The Department will annually request from the Department of Public Health and Environment a list of licensed facilities that may provide emergency services pursuant to Title 27, Article 65, C.R.S. the facility list shall include, but is not limited to: general hospitals; hospital units; psychiatric hospitals; and, community clinics.
 3. If a facility on the list provided by the Department of Public Health and Environment does not report to the Department, the Department will contact the facility to confirm that the facility did not provide involuntary care to an individual pursuant to Title 27, Article 65, C.R.S. during the reporting cycle. If a facility is found to have provided involuntary care to an individual pursuant to Title 27, Article 65, C.R.S. and did not submit an annual report, an annual report will be requested. If a facility refuses to provide the statutorily required report, the Department may submit a complaint to the Office of the Ombudsperson for Behavioral Health Access to Care.
- D. Pursuant to § 27-65-121, C.R.S. and HIPAA, as defined in Section 21.100, the facility must maintain confidentiality over the data sets. The reports generated from these data sets are also confidential; but the Department may release aggregated information contained in the reports so long as the total number of individuals in any aggregate data group (including county or facility name) is greater than thirty (30). If the total number in such a data group is less than or equal to thirty (30), the Department may release this information by redacting such number.

21.290 ACUTE TREATMENT UNITS

21.290.1 DEFINITIONS [Eff. 11/1/13]

“Acute Treatment Unit” (ATU) means a facility or a distinct part of a facility for short-term psychiatric care, which may include substance use disorder treatment. An ATU provides a twenty-four (24) hour, therapeutically planned and professionally staffed environment for individuals who do not require inpatient hospitalization but need more intense and individualized services, such as crisis management and stabilization services, than are available on an outpatient basis. The average lengths of services are from three (3) to seven (7) days.

“Auxiliary Aid” means any device used by individuals to overcome a physical disability and includes, but is not limited to, a wheelchair, walker or orthopedic appliance.

“Bedridden” means an individual who is unable to ambulate or move about independently or with the assistance of an auxiliary aid, who also requires assistance in turning and repositioning in bed.

“Director” means an individual who is responsible for the overall operation and daily administration, management, and maintenance of the facility.

“Emergency Contact” means one of the individuals identified on the face sheet of the individual record to be contacted in the case of an emergency.

“Facility” means an acute treatment unit.

“Licensee” means the individual or entity to whom a license is issued by the Colorado Department of Public Health and Environment pursuant to Section 25-1.5-103(1)(a), C.R.S., and certification as a 27-65 designated facility has been granted by the Department to operate a facility within the definition herein provided.

“Medical or Nursing Care” means care provided under the direction of a physician and maintained by on-site nursing personnel.

“Owner” means the entity in whose name the license and designation is issued. The entity is responsible for the financial and contractual obligations of the facility. “Entity” means any corporation, Limited Liability Corporation, firm, partnership, or other legally formed body, however organized.

“Personal services” means those services that the director and employees of an acute treatment unit provide for each individual including, but not limited to:

- A. An environment that is sanitary and safe from physical harm;
- B. Assistance with transportation whether by providing transportation or assisting in making arrangements for the individual to obtain transportation; and,
- C. Assistance with activities of daily living.

“Protective Oversight” means guidance as required by the needs of the individual or legal representative or as reasonably requested by the individual including the following:

- A. Being aware of an individual’s general whereabouts, although the individual may travel independently in the facility; and,
- B. Monitoring the activities of the individual on the premises to ensure the individual’s health, safety, and well-being, including monitoring the individual’s needs and ensuring that s/he receives the services and care necessary to protect health, safety, and well-being.

“Short-Term Psychiatric Care” means services that average from three to seven (3-7) days provided to individuals with mental health disorders in accordance with Title 27, Section 65, C.R.S.

21.290.2 DESIGNATION OF ACUTE TREATMENT UNITS [Eff. 11/1/13]

Facilities applying for designation as an acute treatment unit (ATU) must be in compliance with Section 21.280 and the requirements in the following Subsections 21.290.21 through 21.290.58.

21.290.21 Director Minimum Education, Training and Experience Requirements [Eff. 11/1/13]

Any individual serving as a director shall meet the minimum education, training, and experience requirements in one of the following ways:

- A. The director shall have received a Bachelor’s degree from an accredited college or university and have three years of verified experience in the human services field, one of which was in a supervisory or administrative position; or,
- B. The director shall have received a Master’s degree from an accredited college or university and have two years of verified experience in the human services field, one of which was in a supervisory or administrative position.
- C. Training in the following areas:
 - 1. Individual rights;
 - 2. Environment and fire safety, including emergency procedures and First Aid;
 - 3. Assessment skills;
 - 4. Identifying and dealing with difficult situations and behavior management; and,

- 5. Nutrition.

21.290.22 Director Responsibilities [Eff. 11/1/13]

The director shall be responsible for the following:

- A. Overall direction and responsibility for the individuals, program, facility, and fiscal management;
- B. Overall direction and responsibility for supervision of staff;
- C. The selection and training of a capable staff member who can assume responsibility for management of the facility in the director's absence; and,
- D. The establishment of relationships and maintaining contact with allied agencies, services, and mental health resources within the community.

21.290.23 Assistant or Acting Director [Eff. 11/1/13]

- A. In each facility, there shall be a specifically designated staff member, age twenty one (21) or over, capable of acting as a substitute for the director during his/her absence. The duties and responsibilities of the acting director shall be clearly defined in order to avoid confusion and conflict among other staff and individuals.
- B. If the director is regularly absent from the facility more than fifty percent (50%) of his/her working hours, an assistant director shall be appointed who meets the same qualifications as the director found at Sections 21.290.21.

21.290.24 Administrative Coverage [Eff. 11/1/13]

When there is a change in director, or when the director has left the facility permanently without a replacement, the facility shall notify the Department in writing, within twenty four (24) hours. When a possible change in director is anticipated, the facility shall notify the Department prior to the change.

Either the director or assistant or acting director shall be available at all times.

21.290.25 Clinical Director [Eff. 11/1/13]

- A. The clinical director is responsible for assuring that there is adequate training and supervision for staff.
- B. Qualifications of a Clinical Director
 - 1. The clinical director shall possess a Master's degree or Ph.D. in a mental health related field or a Bachelor's degree in a mental health related field and five (5) years of work experience.
 - 2. Additionally, the clinical director shall receive training on:
 - a. Individual rights;
 - b. Environment and fire safety, including emergency procedures and First Aid;
 - c. Assessment skills; and,

- d. Identifying and treating individuals who have received diagnoses from the most current diagnostic and statistical manual of mental disorders and who display behaviors that are common to people with severe and persistent mental health disorders.

21.290.3 PERSONNEL

21.290.31 Physical or Mental Impairment [Eff. 11/1/13]

Any individual who is physically or mentally unable to adequately and safely perform duties that are essential functions may not be assigned duties as a direct care staff member or volunteer at an ATU.

21.290.32 Alcohol or Substance Use [Eff. 11/1/13]

The facility shall not employ or allow any individual who is under the influence of a controlled substance, as defined in Sections 18-18-203, 18-18-204, 18-18-205, 18-18-206, and 18-18-207, C.R.S., or who is under the influence of alcohol in the workplace. This does not apply to employees using controlled substances under the direction of a physician and in accordance with their health care provider's instructions, as long as it does not pose a safety risk to the employee, other employees, or individuals.

21.290.33 Access to Policies and Procedures [Eff. 11/1/13]

- A. The facility shall have a written statement of personnel policies that include:
 - 1. Salary range and provisions for increases;
 - 2. Hours of work and holiday, vacation, sick and other applicable leave information;
 - 3. Conditions of employment, tenure and promotion;
 - 4. Employment benefits; including medical/dental/life insurance, workers compensation insurance, retirement plan, and any other available benefits;
 - 5. Employee performance evaluation procedures;
 - 6. Grievance procedures that may be used by staff; and,
 - 7. Discipline and/or termination procedures.
- B. A copy of the personnel policy shall be given to each staff member at the time of his/her employment.

21.290.34 Specialized Training Requirements for ATU [Eff. 11/1/13]

- A. In addition to the personnel training standards in Sections 21.160 and 21.280.24 for designated facilities, prior to providing direct care, the facility shall provide training on:
 - 1. First Aid and injury response;
 - 2. The care and services for the current individuals; and,
 - 3. The recognition and response to common side effects of psychiatric medications, and response to emergency drug reactions in accordance with facility policies.

- B. Within one month of the date of hire, the facility shall provide training for staff on each of the following topics:
 - 1. Assessment skills;
 - 2. Infection control;
 - 3. Behavior management and de-escalation techniques, to include incidents involving suicide, assault, or elopement.
 - 4. Health emergency response; and,
 - 5. Behavioral/psychiatric emergency response training.

21.290.35 Staffing Requirements [Eff. 11/1/13]

- A. The facility shall employ sufficient staff to ensure that the provision of services meets the needs of individuals. The facility shall maintain at least a one to six (1:6) trained staff member(s) to individual resident ratio at all times.
- B. In determining the staffing levels, the facility shall give consideration to factors including, but not limited to:
 - 1. Services to meet the individuals' needs; and,
 - 2. Services to be provided under the individual service plan.
- C. Each facility shall ensure that, at minimum, an individual qualified as described in Section 21.290.57 is available to administer medications at all times.
- D. Residents of the facility may volunteer in performing housekeeping duties and other tasks suited to the individual's abilities; however, these persons who provide services for the facility on a regular basis may not be included in the facility's staffing plan in lieu of facility employees.
- E. Volunteers may be utilized in the facility, but may not be included in the facility's staffing plan in lieu of facility employees.

21.290.4 POLICIES AND PROCEDURES FOR ATU

21.290.41 Emergency Plan and Fire Escape Procedures [Eff. 11/1/13]

- A. Emergency plan: The emergency plan shall include planned responses to fire, gas explosion, bomb threat, power outages, and tornado. Such plan shall include provisions for alternate housing in the event evacuation is necessary.
- B. Fire escape procedures: The fire escape procedures shall include a diagram developed with local fire department officials which shall be posted in a conspicuous place.
- C. Within three (3) days of admission, emergency procedures, including the plan and diagram of fire exits, shall be explained to each individual.

21.290.42 Serious Illness, Serious Injury, or Death [Eff. 11/1/13]

- A. The policy shall describe the procedures to be followed by the facility in the event of serious illness, serious injury, or death of persons receiving services, including incident reporting requirements.
- B. The policy shall include a requirement that the facility notify an emergency contact when the individual's injury or illness warrants medical treatment or face-to-face medical evaluation. In the case of an emergency room visit or unscheduled hospitalization, a facility must notify an emergency contact immediately.

21.290.43 Physical Health Assessment [Eff. 11/1/13]

The facility shall develop policies and procedures that identify when a physical health assessment by a qualified licensed independent practitioner will be required, including the following indicators:

- A. Within twenty-four (24) hours of admission;
- B. A significant change in the individual's condition;
- C. Evidence of possible infection (open sores, etc.);
- D. Injury or accident sustained by the individual that might cause a change in the individual's condition;
- E. Known exposure of the individual to a communicable disease; or,
- F. Development of any condition that would have initially precluded admission to the facility.

21.290.44 Smoking [Eff. 11/1/13]

- A. Facilities' policies for smoking shall address individuals, staff, volunteers and visitors, and shall comply with applicable state laws and regulations.
- B. Prior to admission or employment, individuals and staff shall be informed of any prohibitions.

21.290.45 Discharge [Eff. 11/1/13]

- A. The facility's discharge policy shall include all of the following:
 - 1. Circumstances and conditions under which the facility may require the individual to be involuntarily transferred or discharged;
 - 2. An explanation of the notice requirements;
 - 3. A description of the relocation assistance offered by the facility; and,
 - 4. The right to call advocates, such as the Governor's protection and advocacy for individuals with mental health disorders, the adult protection services of the appropriate county department of social or human services, and/or the Colorado Department of Human Services, Office of Behavioral Health.

B. Disclosure to Individuals

Upon admission, the facility shall document that the individual or legal representative, as appropriate, has read or had explained the discharge policy.

21.290.46 Management of Personal Funds and Personal Property [Eff. 11/1/13]

The facility shall develop written policies that include the procedures for managing individual funds or property.

- A. Upon admission, a written inventory of all personal belongings shall be conducted. This inventory shall be signed and reviewed by facility staff and the individual, and shall be maintained in the individual's clinical record.
- B. All inventoried items shall be stored in a secure location during the individual's stay in the facility.
- C. All inventoried property shall be returned to the individual upon discharge. The individual and facility staff shall sign the inventory form indicating that all items were returned.

21.290.5 ADMINISTRATIVE FUNCTIONS

21.290.51 Admissions [Eff. 11/1/13]

- A. The facility shall develop written admission criteria based on the facility's ability to meet the individual's needs. Admission criteria shall be based upon a comprehensive pre-admission assessment of the individual's mental health, physical health, substance use, and capacity for self-care. The assessment shall determine the level of intervention and supervision required, including medication management, behavioral health services and stabilization prior to return to the community.
- B. Acute treatment units shall not admit individuals with a mental health disorder into a locked setting unless there is no less restrictive alternative and unless they are otherwise in compliance with the requirements of Title 27, Article 65, Colorado Revised Statutes.
- C. Individuals may be admitted to a locked setting as a voluntary or involuntary individual. If voluntary, the individual shall sign a form that documents the following information:
 - 1. The individual is aware that the facility is locked.
 - 2. The individual may exit the facility with staff assistance and/or permission.
 - 3. The individual may leave the facility at any point in time, unless he/she presents as a danger to self or others, or is gravely disabled as defined in Section 27-65-101, et seq., C.R.S.
- D. An individual who is imminently suicidal or homicidal shall only be admitted to the locked facility, upon completion of the facility's assessment and the facility's determination that the individual's safety and the safety of others can be maintained by the facility. If an individual is admitted and facility staff determine that his/her behavior cannot be safely and successfully treated at the ATU, then staff shall make arrangements to transfer the individual to the nearest hospital for further assessment and disposition.
- E. A facility shall not admit or keep any individual who meets the following exclusion criteria:

1. Is consistently incontinent unless the individual or staff is capable of preventing such incontinence from becoming a health hazard.
 2. Is under the age of eighteen (18).
 3. Is bedridden with limited potential for improvement.
 4. Has a communicable disease or infection that is:
 - a. Reportable under the Department of Public Health and Environment's regulations (6 CCR 1009-1 and 2); and,
 - b. Potentially transmittable in a facility, unless the individual is receiving medical or drug treatment for the condition and the admission is approved by a physician.
 5. Has acute withdrawal symptoms, is at risk of withdrawal symptoms, or is incapacitated due to a substance use disorder.
- F. Facilities shall not admit an individual diagnosed with a developmental disability unless he/she has a mental health disorder and has been diagnosed using the most current diagnostic and statistical manual of mental disorders, and whose behaviors can be managed and/or modified by facility staff during the designated length of stay, and whose behaviors will not endanger the safety of the individual, staff or other individuals.
- G. The facility shall maintain a current list of individuals and their assigned room.

21.290.52 Acknowledgements and Disclosures [Eff. 11/1/13]

There shall be written evidence of consent to treat as outlined in Section 21.170.4 and the following upon admission to the individual or individual's legal representative, as appropriate:

- A. Acknowledgements shall specify the understanding between the parties regarding, at a minimum:
1. Charges;
 2. Services included in the rates and charges;
 3. Types of services provided by the facility, those services which are not provided, and those which the facility will assist the individual in obtaining;
 4. Transportation services;
 5. Therapeutic diets;
 6. A physically safe and sanitary environment;
 7. Personal services;
 8. Protective oversight;
 9. Social and recreational activities; and,
 10. A provision that the facility must give individuals thirty (30) calendar days' notice of closure.

- B. Disclosure to individuals shall include:
 - 1. Management of personal funds and property;
 - 2. Facility rules, established pursuant to Section 21.290.53;
 - 3. Staffing levels based on individual needs;
 - 4. Types of daily activities, including examples of such activities that will be provided.

21.290.53 Facility Rules [Eff. 11/1/13]

The facility shall establish written policies, which shall list all possible actions that may be taken by the facility if any policy is knowingly violated by an individual. Facility policies may not violate or contravene any rule herein, or in any way discourage or hinder an individual's rights.

The facility shall prominently post its policies in writing, which shall be available at all times to individuals. Such policies shall address at least the following:

- A. Smoking;
- B. Cooking;
- C. Visitors;
- D. Telephone usage including frequency and duration of calls;
- E. Use of common areas, including the use of television, radio;
- F. Consumption of alcohol and/or illicit drugs;
- G. Dress;
- H. Pets, which shall not be allowed in the facility; however, in no event shall such rules prohibit service or guide animals.

21.290.54 Content of Record [Eff. 11/1/13]

Records shall include Section 21.190.2, Content of Records, and the following:

- A. Demographic and medical information;
- B. A cover sheet to contain the following information:
 - 1. Individual's full name, including maiden name if applicable;
 - 2. Individual's sex, date of birth, marital status and social security number, where needed for Medicaid or employment purposes;
 - 3. Individual's current address of residence;
 - 4. Date of admission;
 - 5. Name, address and telephone number of relatives or legal representative(s), or other individual(s) to be notified in an emergency;

6. Name, address and telephone number of individual's primary physician, and case manager if applicable, and an indication of religious preference, if any, for use in emergency;
 7. Individual's diagnoses, at the time of admission;
 8. Current record of the individual's allergies;
- C. Medication administration record;
- D. Physician's orders.

21.290.55 Service Planning [Eff. 11/1/13]

The facility shall develop and implement a written service plan in accordance with Section 21.190.4 and include the following:

- A. An initial written safety and stabilization plan for each individual detailing risk issues and the stabilization process resulting in discharge shall be completed at the time of admission.
- B. Within twenty four (24) hours of admission, an individualized service plan for each individual shall be written and shall include, but not be limited to:
 1. Special dietary instructions, if any;
 2. Any physical or cognitive limitations; and,
 3. A description of the services which the facility will provide to meet the needs identified in the comprehensive assessment.
- C. The individual may request a modification of the services identified in the service plan at any time.
- D. The individual and his/her service plan shall be reassessed on an ongoing basis to address significant changes in the individual's physical, behavioral, cognitive and functional condition, and identify the services that the facility shall provide to address the individual's changing needs. The service plan shall be updated to reflect the results of the reassessment.

21.290.56 Discharge [Eff. 11/1/13]

- A. An individual shall be discharged for one or more of the following reasons:
 1. When the facility cannot protect the individual from harming him or herself or others;
 2. When the facility is no longer able to meet the individual's identified needs;
 3. When the individual is no longer in need of this level of care; or,
 4. Failure of the individual to comply with facility rules, which contain notice that discharge may result from violation of same.
- B. Notice of discharge shall be provided to the individual or individual's legal representatives as follows:

1. At least twenty-four (24) hours in advance of discharge or transfer, in accordance with the rules governing the care and treatment of persons with a mental health disorder in Sections 21.280.7 and 21.280.8.
 2. In cases of a medical or psychiatric emergency, the emergency contact shall be notified as soon as possible.
- C. Discharge shall be coordinated with the individual, and, with permission, the individual's family, legal representative, or appropriate agency.

21.290.57 Medication

21.290.571 Storage, Disposition, and Disposal [Eff. 11/1/13]

A. Storage and Disposition

1. All personal medication must be surrendered to the facility to be logged in and stored by the facility. Individuals are not allowed to self-administer medication in the facility.
2. Personal medication shall be returned to the individual or individual's legal representative, upon discharge or death, except that return of medication to the individual may be withheld if specified in the individual's service if a physician or other authorized medical practitioner has determined that the individual lacks the decisional capacity to possess or administer such medication safely.
3. Medications shall be labeled with the individual's full name, pursuant to Article 42.5 of Title 12.
4. Any medication container that has a detached, excessively soiled or damaged label shall be returned to the issuing pharmacy for re-labeling or disposed of appropriately.
5. All medication shall be stored in a manner that ensures the safety of all individuals.
6. Medication shall be stored in a central location, including refrigerators, and shall be kept under lock and shall be stored in separate or compartmentalized packages, containers, or shelves for each individual in order to prevent intermingling of medication.
7. Individuals shall not have access to medication that is kept in a central location.
8. Medications that require refrigeration shall be stored separately in locked containers in the refrigerator. If medication is stored in a refrigerator dedicated to that purpose, and the refrigerator is in a locked room, then the medications do not need to be stored in locked containers.
9. Prescription and over the counter medication shall not be kept in stock or bulk quantities, unless such medication is administered by a licensed medical practitioner.

B. Disposal

1. The return of medication shall be documented by the facility.
2. Medication that has a specific expiration date shall not be administered after that date and shall be disposed of appropriately.

21.290.572 Administration of Medication [Eff. 11/1/13]

Facilities shall follow psychiatric medication standards as outlined in Section 21.280.32 and the following:

- A. To be qualified to administer medication, an individual shall be a licensed practical nurse, registered nurse, physician, physician's assistant, or pharmacist.
- B. Only a licensed nurse may accept telephone orders for medication from a physician or other authorized practitioner. All telephone orders shall be evidenced by a written and signed order and documented in the individual's record and the facility's medication administration record.
- C. These rules apply to medications and treatment which do not conflict with state law and regulations pertaining to acute treatment units and which are within the scope of services provided by the facility, as outlined in the individual agreement or the facility rules.
- D. The facility shall be responsible for complying with physician orders associated with the administration of medication or treatment. The facility shall implement a system that obtains clarification from the physician, as necessary and documents that the physician:
 - 1. Has been asked whether refusal of the medication or treatment should result in physician notification.
 - 2. Has been notified, where such notification is appropriate.
 - 3. Has provided documentation of such notification shall be made in the individual's clinical record.
 - 4. Coordinates with external providers or accepts responsibility to perform the care using facility staff.
 - 5. Trains staff regarding the parameters of the ordered care as appropriate.
 - 6. Documents the delivery of the care, including refusal by the individual, of the medication or treatment.

21.290.58 Administration of Oxygen [Eff. 11/1/13]

Individuals may administer oxygen, if the individual is able to manage the administration himself or herself and staff shall assist with the administration as needed for safety, when prescribed by a physician and if the facility follows appropriate safety requirements regarding oxygen herein.

- A. Oxygen tanks shall be secured upright at all times to prevent falling over and secured in a manner to prevent tanks from being dropped or from striking violently against each other.
- B. Tank valves shall be closed except when in use.
- C. Transferring oxygen from one container to another shall be conducted in a well-ventilated room with the door shut. Transfer shall be conducted by a trained staff member or by the individual for whom the oxygen is being transferred, if the individual is capable of performing this task safely. When the transfer is being conducted, no individual, except for an individual conducting such transfer, shall be present in the room.
- D. Tanks and other oxygen containers shall not be exposed to electrical sparks, cigarettes or open flames.

- E. Tanks shall not be placed against electrical panels or live electrical cords where the cylinder can become part of an electric circuit.
- F. Tanks shall not be rolled on their side or dragged.
- G. Smoking shall be prohibited in rooms where oxygen is used or stored. Rooms in which oxygen is used shall be posted with a conspicuous “no smoking” sign.
- H. Tanks shall not be stored near radiators or other heat sources. If stored outdoors, tanks shall be protected from weather extremes and damp ground to prevent corrosion.

21.400 BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM

21.400.1 DEFINITIONS [Eff. 11/1/16]

“Assessment” means a formal and continuous process of collecting and evaluating information about an individual for service planning, treatment and referral. Assessments establish justification for services.

“Chief complaint/presenting problem” means the reason/concern/motivation which prompts the client to seek services or that which their referral source identifies as the issue which requires intervention, usually in the person’s own words. Also includes, onset, duration, other symptoms noted, progression of the problem, solutions attempted at alleviating the problem, how the person’s life has been impacted and how the person views responsibility for the problem. This information can be from a referral source, family member or other professional.

“Crisis stabilization unit” or “CSU” means a facility, utilizing a restrictive egress alert device, which serves individuals requiring 24-hour intensive behavioral health crisis intervention for up to five days and cannot be accommodated in a less restrictive environment. Crisis stabilization units are licensed by the Colorado department of public health and environment as an acute treatment unit, pursuant to 6 CCR 1011-1, Chapter 6, or as a Community Clinic, pursuant to 6 CCR 1011-1, chapter 9.

“Integrated care model” means the systematic coordination of mental health, substance use, and primary care services.

“Licensed mental health professional” means a psychologist licensed pursuant to Section 12-43-301, et seq., C.R.S., a psychiatrist licensed pursuant to Section 12-36-101, et seq., C.R.S., a clinical social worker licensed pursuant to Section 12-43-401, et seq., C.R.S., a marriage and family therapist licensed pursuant to Section 12-43-501, a professional counselor licensed pursuant to Section 12-43-601, et seq., C.R.S., or an addiction counselor licensed pursuant to Section 12-43-801, et seq., C.R.S.

“Peer specialist,” or peer support specialist, recovery coach, peer and family recovery support specialist, peer mentor, family advocate or family systems navigator, means an individual who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings. A family advocate or family systems navigator uses his or her lived experience of having a family member with a mental illness or substance use disorder and the knowledge of the behavioral health care system gained through navigation and support of that family member.

“Peer support” means recovery-oriented services provided by peer specialists that promote self-management of psychiatric symptoms, relapse prevention, treatment choices, mutual support, enrichment, and rights protection. Peer support also provides social supports and a lifeline for individuals who have difficulties developing and maintaining relationships.

“Physician” is defined in Section 27-65-102(16), C.R.S.

“Restrictive egress alert device” means a device used to prevent the elopement of a resident who is at risk if he or she leaves the facility unsupervised. Egress alert devices are not considered restrictive when used only to alert staff regarding the ingress and egress of residents, visitors, and others.

“Screening” means a brief process used to identify current behavioral health needs, including assessment, referral, or immediate intervention services, and is typically documented through the use of a standardized instrument.

“Skilled professional” means a person who has a minimum of a master’s degree in a behavioral health field, has completed a pre-service training program specific to their modality of service and has clinical crisis intervention experience.

“Supervision” means weekly clinical guidance from a licensed mental health professional.

“Triage” means a dynamic process of evaluating and prioritizing the urgency of crisis intervention needed based on the nature and severity of the individuals’ presenting situation.

“Trauma informed” means being aware of and responsive to the presence of trauma and the potential effects of past and current traumatic experiences in an individual’s life.

“Warm line/support line” means a telephonic service where individuals can “opt in” from the statewide crisis line to receive individualized screening and resources by peer specialists.

21.400.2 GENERAL PROVISIONS [Eff. 11/1/16]

A. The Behavioral Health Crisis Response System is based on the following principles, established pursuant to Section 27-60-103(1)(a)(I) through (VII), C.R.S.:

1. Cultural competence;
2. Strong community relationships;
3. The use of peer supports;
4. The use of evidence based practices;
5. Building on existing foundations with an eye towards innovation;
6. Utilization of an integrated system of care; and,
7. Outreach to students through school-based clinics.

B. Each component within the behavioral health crisis response system must be capable of serving:

1. Children, adolescents, adults and older adults;
2. Individuals with co-occurring conditions; including:
 - a. Mental health conditions;
 - b. Substance use disorders;
 - c. Medical needs;
 - d. Intellectual/developmental disabilities;

- e. Physical disabilities;
 - f. Traumatic brain injuries; and/or,
 - g. Dementia.
- 3. Individuals demonstrating aggressive behavior;
- 4. Individuals who are uninsured or unable to pay for services; and,
- 5. Individuals who may lack Colorado residency or legal immigration status.
- C. Each component within the Behavioral Health Crisis Response System must provide services in a culturally competent manner.
- D. Each modality of service within the Behavioral Health Crisis Response System must incorporate peer support into the services they provide, when clinically appropriate.

21.400.3 TELEPHONE CRISIS SERVICES [Eff. 11/1/16]

The Department shall maintain a comprehensive telephonic system capable of assessing any individual experiencing a self-defined crisis situation and making appropriate referrals. Telephone crisis services must be accessible to all individuals throughout the state of Colorado 24 hours per day, 7 days per week, and 365 days per year.

- A. The telephone crisis service must provide:
 - 1. Screening and triage;
 - 2. Psycho-social support;
 - 3. Connection to appropriate resources;
 - 4. Follow-up capability to callers as clinically appropriate; and,
 - 5. Access to a support line (also known as a warm line) provided by peer specialists. Peer specialists must have the ability to seamlessly transfer individuals to the crisis line when urgent clinical intervention is warranted.
- B. The telephone crisis service must be staffed by skilled professionals capable of assessing and making culturally competent, appropriate referrals.
- C. The telephone crisis service must use trauma-informed screenings and assessments and incorporate this information into safety planning, referrals and follow-up interventions.
- D. The telephone crisis service must initiate mobile crisis services when appropriate and be linked with walk-in crisis service facilities.

21.400.4 WALK-IN CRISIS SERVICES [Eff. 11/1/16]

Walk-in crisis services facilities offer confidential, in-person support for anyone experiencing a self-defined crisis. Every walk-in crisis services facility must have the ability to provide information and referrals to anyone in need, including, if appropriate, access and clinically appropriate transportation to crisis stabilization for up to five days in a crisis stabilization unit.

- A. Each walk-in crisis services facility, including crisis stabilization units, must be designated pursuant to Title 27, Article 65, C.R.S., Care and Treatment of Persons with Mental Illness, and be in compliance with Section 21.280.
- B. Walk-in crisis services must employ an integrated care model based on evidence-based practices that consider an individual's physical and emotional health.
- C. Walk-in crisis services must include screening, assessment, and referrals to appropriate resources.

1. Screening.

- a. Screening must collect at least the following information from an individual seeking crisis services:
 - 1) Identifying information;
 - 2) Chief complaint/presenting problem;
 - 3) Medical concerns/chronic health issues; and,
 - 4) Current healthcare providers.
- b. Screenings must be reviewed by a skilled professional who is licensed or receiving supervision from a licensed mental health professional.

2. Assessment.

A full assessment must be administered in accordance with Section 21.190.3, if clinically indicated by the initial screening in Section 21.340.4(C)(1).

3. Referrals.

The facility shall refer all individuals seeking crisis services to appropriate resources based on the level of care indicated by the screening or assessment.

D. Crisis stabilization units

- 1. Services provided on a crisis stabilization unit must include:
 - a. Full psychiatric evaluation;
 - 1) By a physician or other professional authorized by statute to order medications; and,
 - 2) Within 24 hours of admission.
 - b. Medical and medication treatment in accordance with Section 21.280.3;
 - c. Service planning in accordance with Section 21.190.4;
 - d. Peer support, when clinically appropriate;
 - e. Treatment, to include:

- 1) Individual counseling; and/or,
 - 2) Groups.
 - f. Coordination with medical services;
 - g. Case management;
 - h. Service coordination and referral; and,
 - i. Discharge planning.
2. Crisis stabilization unit staffing requirements
- a. In addition to the walk-in crisis service staffing requirements listed in 21.400.41, crisis stabilization units must have:
 - 1) Access to a physician or other professional authorized by statute to order medications upon admission; and,
 - 2) At minimum, one on-site staff member qualified to administer medications.

21.400.41 Walk-In Crisis Services Staffing Requirements [Eff. 11/1/16]

- A. A walk-in crisis services facility must be staffed 24 hours per day, 7 days per week, and 365 days per year.
- B. A walk-in crisis services facility must employ sufficient staff to ensure that the provision of services meets the needs of individuals. At minimum, a facility must have two staff on-site at all times.
- C. A walk-in crisis services facility must be staffed by skilled professionals who are licensed or receiving supervision from a licensed mental health professional.
- D. If a walk-in crisis services facility is staffed by unlicensed skilled professionals, a licensed mental health professional must be on-call and able to respond to the facility within thirty (30) minutes.
- E. A walk-in crisis services facility must have the ability to provide peer support on-site when clinically appropriate.

21.400.5 MOBILE CRISIS SERVICES AND UNITS [Eff. 11/1/16]

Mobile crisis services provide a timely in-person response to a behavioral health crisis in the community. Mobile crisis services must collaborate with telephone crisis services, walk-in crisis services, and crisis residential and in-home respite services.

- A. A mobile crisis unit must have the capacity to:
 - 1. Intervene wherever the crisis occurs;
 - 2. Serve individuals unknown to the system;
 - 3. Coordinate multiple simultaneous requests for services; and,

4. Work closely with police, crisis hotlines, schools, and hospital emergency departments;
- B. A mobile crisis unit must operate 24 hours per day, 7 days per week, and 365 days per year in providing community-based crisis intervention, screening, assessment, and referrals to appropriate resources.
1. In screening the individual in crisis, the mobile crisis unit must collect at least the following information:
 - a. Identifying information;
 - b. Chief complaint/presenting problem;
 - c. Medical concerns/chronic health issues; and,
 - d. Current healthcare providers.
 2. The mobile crisis unit must administer a full assessment in accordance with Section 21.190.3 if clinically indicated by the initial screening in Section 21.400.5(C)(1).
- C. A mobile crisis unit must be staffed by skilled professionals who are licensed themselves or receiving supervision from a licensed mental health professional.
- D. If a mobile crisis staff member is an unlicensed skilled professional, he or she must have, at minimum, immediate phone access to a licensed mental health professional.
- E. A mobile crisis unit must utilize peer supports, in conjunction with a skilled professional, in a mobile response when clinically appropriate.

21.400.6 RESIDENTIAL AND IN-HOME RESPITE CRISIS SERVICES [Eff. 11/1/16]

Residential and in-home respite crisis services allow an individual experiencing a crisis to stabilize, resolve problems, and link with resources for ongoing support in a safe environment.

- A. Residential and in-home respite services include a range of short-term, not to exceed 14 calendar days, services 24 hours per day, 7 days per week, and 365 days per year.
- B. In order to be eligible for residential or in-home respite services, an individual experiencing a behavioral health crisis must:
1. Be referred by a walk-in crisis services professional or a mobile crisis services professional;
 2. Agree to residential or in-home respite services;
 3. Not meet emergency procedure criteria outlined in Section 27-65-105, C.R.S., Care and Treatment for Persons with Mental Illness;
 4. Present a minimal risk of significant withdrawal complications;
 5. Cooperate with program guidelines; and,
 6. Be able and willing to participate in forming a service plan.

- C. Residential and in-home respite providers will utilize peer specialists to provide support, when appropriate.

21.410 COMMUNITY TRANSITION SPECIALIST PROGRAM

- A. Pursuant to Title 27, Article 66.5, C.R.S. the Community Transition Specialist Program is a statewide program that receives referrals from hospitals and withdrawal management facilities and coordinates services for individuals prior to their release or discharge to the community.
- B. The Office is responsible for the administration and oversight of the Community Transition Specialist Program. Pursuant to § 27-66.5-103(5), C.R.S., the Office may contract with a vendor to provide the referral and coordination services required for statewide implementation of the Community Transition Specialist Program. The Office shall coordinate the vendor-provided services with other relevant state supported programs and services.
- C. The Community Transition Specialist Program will coordinate services for individuals meeting the section 27-66.5-102(3), C.R.S. definition of a “high-risk individual”. “High-risk individual” means a person who:
 - 1. Is under:
 - A. An emergency procedure for a seventy-two-hour hold pursuant to section 27-65-105, C.R.S.;
 - B. A certification for short-term treatment or extended short-term treatment pursuant to section 27-65-107, C.R.S. or section 27-65-108, C.R.S.;
 - C. Long-term care and treatment pursuant to section 27-65-109, C.R.S.;
 - D. An emergency commitment pursuant to section 27-81-111, C.R.S. or section 27-82-107, C.R.S.; or,
 - E. An involuntary commitment pursuant to section 27-81-112, C.R.S. or section 27-82-108, C.R.S.;
 - 2. Has a significant mental health or substance use disorder, which means:
 - A. The individual has had two (2) or more seventy-two hour holds or emergency commitments in the previous twelve (12) months;
 - B. The individual has been certified for short-term treatment pursuant to section 27-65-107, C.R.S., certified for extended short-term treatment pursuant to section 27-65-108, C.R.S. or, ordered for long-term care and treatment pursuant to section 27-65-109, C.R.S. one (1) or more times in the previous twelve (12) months; or,
 - C. The individual has been arrested or detained two (2) or more times related to an alcohol or substance use disorder in the last twelve (12) months and does not have a probation or parole officer; and,

3. Is not currently engaged in consistent behavioral health treatment, which means the individual has not received any local or available outpatient behavioral health treatment services in the last forty-five (45) calendar days or has been terminated from outpatient behavioral health services within the last forty-five (45) calendar days. Outpatient behavioral health treatment services do not include crisis services, emergency care, withdrawal management services, initial intake appointments, assessments, or inpatient hospitalization.

21.500 RECOVERY RESIDENCE CERTIFICATION PROGRAM

21.500.1 STATUTORY AUTHORITY

The statutory authority to promulgate these rules is set forth in Sections 25-1.5-108.5(4), C.R.S. and 27-80-122(4), C.R.S.

21.500.2 DEFINITIONS

“Recovery residence certifying body” means an entity that has been approved by the office of behavioral health to certify recovery residences pursuant to 25-1.5-108.5, C.R.S.

“Recovery residence”, “sober living facility”, or “sober home” as defined in 25-1.5-108.5(1), C.R.S., means any premises, place, facility, or building that provides housing accommodation for individuals with a primary diagnosis of a substance use disorder that: is free from alcohol and nonprescribed or illicit drugs; promotes independent living and life skill development; and provides structured activities and recovery support services that are primarily intended to promote recovery from substance use disorders. A “recovery residence” does not include: a private residence in which an individual related to the owner of the residence by blood, adoption, or marriage is required to abstain from substance use or receive behavioral health services for a substance use disorder as a condition of residing in the residence; the supportive residential community for individuals who are homeless operated under Section 24-32-724, C.R.S. at the Fort Lyon property for the purpose of providing substance abuse supportive services, medical care, job training, and skill development for the residents; a facility approved for residential treatment by the office of behavioral health in the department of human services; or permanent supportive housing units incorporated into affordable housing developments.

“The NARR Standard” means the National Standard for Recovery Residences Version 3.0 (2018) established by the National Alliance of Recovery Residences, which is hereby incorporated by reference. No later additions or amendments are incorporated. The National Standard for Recovery Residences Version 3.0 (2018) is available at <https://narronline.org> and is also available for public inspection at the Colorado Department of Human Services, Office of Behavioral Health, 3824 West Princeton Circle, Denver, Colorado 80236, during regular business hours.

21.500.3 RECOVERY RESIDENCE CERTIFYING BODY APPROVAL PROGRAM

- A. Recovery residence certifying body obligations prior to approval
 1. A recovery residence certifying body applicant must submit an application to the office of behavioral health for approval as a recovery residence certifying body. The application must contain information on how the recovery residence certifying body applicant will meet the standards established in Section 21.500.3(B).
- B. Recovery residence certifying body obligations after approval

1. A recovery residence certifying body must ensure that any premises, place, facility, or building they certify meets minimum standards that provide safe and healthy housing environments that support individuals in achieving and sustaining substance use disorder recovery.
2. A recovery residence certifying body must ensure that each recovery residence that it certifies in Colorado, complies with The NARR Standard as defined in 21.500.2 for providing the appropriate level of support and housing accommodations for individuals with a primary diagnosis of a substance use disorder.
3. A recovery residence certifying body must ensure recovery residences comply with the standards established in 25-1.5-108.5, C.R.S.
4. A recovery residence certifying body must have written policies and procedures that must be posted on the recovery residence certifying body's website. At minimum, the written policies and procedures must include:
 - a. The certification process;
 - b. Application submission requirements, including the cost for certification;
 - c. How certification fees relate to service delivery and how recovery residences are informed about changes to certification fees;
 - d. The application review process;
 - e. The approval, revocation, denial, suspension, limitation, or modification process for certification;
 - f. The right and process to appeal decisions made by the recovery residence certifying body;
 - g. Re-application timeframes; and,
 - h. How grievances will be managed.
5. A recovery residence certifying body must maintain a website that contains, at minimum:
 - a. Information on how a recovery residence can apply for certification, as outlined in 21.500.3(b)(3);
 - b. The standards a recovery residence must meet to obtain differing levels of certification as defined by The NARR Standard as defined in 21.500.2, including the cost of certification for each level.
 - c. Board information as outlined in 21.500.3(B)(5);
 - d. Contact information for how individuals can submit a grievance to the recovery residence certifying body; and,
 - e. A list of certified recovery residences to ensure people throughout Colorado have access to information and locations of certified recovery residences; and,
 - f. The written policies and procedures outlined in 21.500.3(B)(3).

6. A recovery residence certifying body must have a board that has approval oversight of the recovery residence certifying body's practices, policies, and procedures. At minimum, the recovery residence certifying body must ensure:
 - a. A representative from the office of behavioral health is on the board;
 - b. A minimum of twenty-five percent (25%) of board members must represent recovery residences that are certified and do not otherwise have a conflict of interest with the certifying body;
 - c. The board includes at least two board members that represent individuals in recovery. The representatives for individuals in recovery must not own, volunteer at, or be employed by the recovery residence certifying body or a certified recovery residence;
 - d. That board members disclose any potential conflict of interest and have standards for how a conflict of interest is acknowledged, determined, and reconciled in regard to the execution of board duties;
 - e. That board meetings are open to the public, except as to the portion of the meeting that information that is confidential pursuant to state or federal statute is being discussed; and,
 - f. That board information is publicly posted on the recovery residence certifying body's website, including:
 - 1) A list of board members, each board member's representative role on the board, and each board member's term limit;
 - 2) The board member application and selection process;
 - 3) Board bylaws;
 - 4) Board meeting dates, times, and locations posted at least one (1) week prior to the board meeting; and,
 - 5) Board agendas and minutes.
7. On or before February 1, of each year, a recovery residence certifying body must submit an annual report to the Office of Behavioral Health that covers the previous calendar year. At minimum, the annual report must include:
 - a. The total number of recovery residences certified in Colorado, as of the previous January 1.
 - b. The percentage of certified recovery residences which are also members of the approved recovery residence certifying body's association;
 - c. The total number of recovery residences which applied for certification in the previous calendar year;
 - d. The total number of recovery residences which applied for certification and were granted certification;

- e. The total number of recovery residences which applied for certification and were denied certification, including the reason(s) why each recovery residence was denied;
 - f. The total number of recovery residences which certification was revoked, denied, suspended, or modified, including the reason(s) for the certification change;
 - g. The total number of grievances received, including the topic and outcome of each grievance;
 - h. Increases or decreases in certification fees, including justification for each fee change; and,
 - i. Any changes to the makeup, structure, and/or duties of the certifying body's board.
- C. An approval from the Office of Behavioral Health as a recovery residence certifying body is not time limited, with the exception that at the Office of Behavioral Health's discretion, an approval as a recovery residence certifying body may be revoked, denied, suspended, or modified. Written notification of the basis for action must be sent by certified mail to the last known address of the recovery residence certifying body. If the affected recovery residence certifying body disagrees with the decision, it has the right to appeal to the Colorado Department of Personnel and Administration, Office of Administrative Courts in accordance with the regulations set forth at 2 CCR 502-1 § 21.105, except that the time for answering the notice of charges will be thirty (30) days after the mailing of such notice. An affected recovery residence certifying body may subsequently seek judicial review of the Office of Behavioral Health's action in accordance with Section 24-4-101, et seq., C.R.S.

21.500.4 RECOVERY RESIDENCE CERTIFICATION GRANT PROGRAM

Subject to available appropriations as established in 27-80-122(3), C.R.S., a recovery residence may be eligible for a grant from the Office of Behavioral Health to pay a portion of, or all, application for certification and/or membership fees and/or dues required by a recovery residence certifying body.

21.500.41 RECOVERY RESIDENCE CERTIFICATION GRANT PROGRAM CRITERIA

- A. A recovery residence seeking a recovery residence certification grant must complete, in its entirety, the recovery residence certification grant application available on the Colorado Department of Human Services website.
- B. A recovery residence certification grant must only be used to pay fees related to gaining certification and/or membership from a recovery residence certifying body, which may include the payment of membership dues.
- C. A recovery residence certification grant application must be submitted to the Office of Behavioral Health by the last business day of each month.
- D. Recovery residence certification grant applications received by the Office of Behavioral Health within the time frame established in 21.500.41(C), must be reviewed by the Office of Behavioral Health to determine approval or denial. Grants will be awarded in alignment with state fiscal rules created pursuant to 24-30-202, C.R.S.
- E. Recovery residence certification grant applications that are not complete, contain inaccurate or false information, or express intent to use the recovery residence certification grant money in a manner that does not comply with state statutes or regulations, may be denied.

- F. A recovery residence which previously received a recovery residence certification grant must submit a new application each time they are seeking another recovery residence certification grant.
- G. A recovery residence which applies for a recovery residence certification grant must provide the office of behavioral health with documentation of the paid certification fees and/or membership dues from the approved recovery residence certifying body. A recovery residence that does not provide the required documentation may have their current or any subsequent recovery residence certification grant applications denied.
- H. The Office of Behavioral Health's decision regarding the recovery residence certification grant application is a final agency decision. If the affected recovery residence disagrees with the final agency decision, it may seek judicial review of the Office of Behavioral Health's action in accordance with Section 24-4-101, et seq., C.R.S.

21.700 (NONE)

Editor's Notes

History

Rules SB&P, 19.500 eff. 11/01/2007.

Rules SB&P, 19.421.3 eff. 09/01/2013.

Entire rule eff. 11/01/2013.

Rules SB&P, 21.900-21.950 emer. rules eff. 11/06/2015.

Rules SB&P, 21.900-21.950 eff. 02/01/2016.

Rules SB&P, 21.000-21.120.35, 21.190-21.210.59, 21.230-21.280.25, 21.330-21.330.2 eff. 05/01/2016.

Rules SB&P, 21.120.3-21.120.31, 21.400 eff. 11/01/2016.

Rules 21.240.1, 21.240.85 eff. 07/01/2017.

Rule 21.281 eff. 06/01/2018.

Rules 21.100, 21.120.36 eff. 08/01/2018.

Rules 21.160.2 A.3, 21.200.53 K.1 emer. rules eff. 08/03/2018.

Rules 21.160.2 A.3, 21.200.53 K.1 emer. rules eff. 11/02/2018.

Rules 21.100, 21.120.1 G, 21.120.24 A, 21.120.24 C-F, 21.120.42 A-G, 21.140 A.2, 21.170.1 A, 21.170.3 A, 21.200.53 K.6, 21.210.1 E.1.a, 21.210.2 A.1-2, 21.210.43 A, 21.210.51 D, 21.210.52 C, 21.210.53 C, 21.210.54 D, 21.210.55, 21.210.56 I, 21.210.57 G, 21.210.58 D, 21.210.59, 21.230.1 D, 21.240.5 F, 21.240.6 A, 21.240.82 B.5, 21.240.83 B, 21.280.1, 21.280.23, 21.282, 21.410 eff. 01/01/2019.

Rules 21.160.2 A.3, 21.200.53 K.1, 21.200.4 eff. 02/01/2019.

Rules 21.160.1 A.4, 21.250.5 C, 21.260 B, 21.500 eff. 12/01/2019.

Rules 21.100, 21.120.1 D, 21.120.22 B, 21.120.23 C, 21.120.26 D, 21.120.4 D-E, 21.120.42 E, 21.170.4, 21.200.13 B, 21.200.4, 21.200.41, 21.240.1, 21.280.35 A.4, 21.300.22 C, 21.300.23 D, 21.200.5, 21.320.31 A.5 emer. rules eff. 04/03/2020.

Rules 21.100, 21.120.1 D, 21.120.22 B, 21.120.23 C, 21.120.26, 21.120.4 D-E, 21.120.42 E, 21.170.4, 21.200.13 B, 21.200.4, 21.200.41, 21.240.1, 21.280.35 A.4, 21.300.22 C, 21.300.23 D, 21.200.5, 21.320.31 A.5 eff. 08/01/2020.

Rules 21.100, 21.210, 21.210.1 A-E, 21.210.43-21.210.924, 21.260 B eff. 10/01/2020. Rules 21.250, 21.310 repealed eff. 10/01/2020.

Rules 21.300.1, 21.300.2, 21.300.21-21.300.23, 21.300.24 A.2, 21.300.3 A, 21.300.3 C, 21.300.3 I-J, 21.300.6, 21.300.7, 21.300.8 A, 21.320, 21.320.1, 21.320.2, 21.320.31, 21.320.32, 21.320.41,

21.320.42 D, 21.320.5, 21.320.61, 21.320.62, 21.320.63 A, 21.320.63 B.2, 21.320.7, 21.320.81, 21.320.9 eff. 03/02/2021.

Rules 21.100, 21.210.1 C, 21.240.3 D, 21.240.85 E, 21.270.1 A, 21.330-21.331.3 eff. 04/01/2021. Rules 21.330.3-21.330.92 repealed eff. 04/01/2021.

Rules 21.120.1 D, 21.120.22 B, 21.120.23 C, 21.120.4 D-e, 21.120.42 E, 21.240.1 emer. rules eff. 08/06/2021.

Rules 21.100, 21.120.1 D, 21.120.22 B, 21.120.23 C, 21.120.4 D-E, 21.120.42 E, 21.200.11, 21.200.12, 21.200.13 C, 21.240.1 eff. 11/01/2021.

Rules 21.300.1, 21.300.21, 21.300.22 D-F, 21.300.23-21.300.25, 21.300.9, 21.320.1, 21.320.2 A-B, 21.320.21, 21.320.31, 21.320.32, 21.320.41, 31.320.5 A, 31.320.61, 21.320.62, 21.320.63 A, 21.320.64, 21.320.7 G, 21.320.81 eff. 02/01/2022.

Rules 21.330.1, 21.330.31, 21.330.32 eff. 03/02/2022. Rules 21.330.4, 21.331-21.331.3 repealed eff. 03/02/2022.

Rules 21.600-21.600.9 eff. 07/01/2022.

Rules 21.800-21.900 repealed eff. 07/30/2023.

Rules Chapters 1-12 eff. 01/01/2024.

Rules 1.2, 2.5.1 D.12.12.1 C.5.d(1), 2.12.1 D, 2.12.2 A, 2.12.3 A, 2.13.1 A.3, 2.13.1 A.5, 2.24.1 B, 2.27.5 A, 3.4 A, 4.2.4 F, 4.3.4 G, 5.2.2 E, 6.3.3 A-B, 6.3.4 B, 6.3.4 D-E, 6.5.4 A, 6.6.2 A, 6.6.4 C, 10.6 C, 10.7 C, 10.8 C, 11.3.1 B, 11.8.3 A-B, 11.8.4 A, 11.9.6, 11.10.1, 11.13, 11.17.2 E, 12.3.2 B.8.d(1), 12.5.1 E, 12.5.4, 12.6.1 F-J, Chapter 13, Chapter 14 eff. 08/01/2025. Rules 21.200.4, 21.200.41-45, 21.200.47-48, 21.200.481-482 recodified as 2 CCR 502-6 eff. 08/01/2025.