Chapter DHS 40

MENTAL HEALTH DAY TREATMENT FOR YOUTH

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Note: Chapter HFS 40 was renumbered to chapter DHS 40 under s. 13.92 (4) (b) 1., Stats., and corrections made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635. **Chapter DHS 40 as it existed on June 30, 2020, was repealed and a new chapter DHS 40 was created by CR 19–018, effective 7–1–20.**

DHS 40.01 Authority and purpose. This chapter is promulgated under the authority of s. 51.42 (7) (b), Stats., and is intended to regulate programs providing mental health day treatment services for youth.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20.

DHS 40.02 Applicability. This chapter applies to all programs providing mental health day treatment services for youth in the state of Wisconsin. This chapter does not regulate other providers of day treatment services for youth, such as alcohol and other substance use disorder treatment programs regulated by ch. DHS 75. If a comprehensive program offers services to youth in addition to mental health day treatment, this chapter applies only to those program components that offer mental health day treatment.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20.

DHS 40.03 Definitions. In this chapter:

(1) “Advanced practice nurse” has the meaning given in s. N 8.02 (1).

(2) “Advanced practice nurse prescriber” has the meaning given in s. N 8.02 (2).

(3) Assessment” means the process required under s. DHS 40.13.

(4) “Biopsychosocial information” means the combination of physical, psychological, social, environmental, and cultural factors that influence a youth’s development and functioning including underlying driving forces or unmet needs that are expressed through challenging behavior that a youth is exhibiting.

(5) “Care coordination” means efforts by day treatment programs to work jointly with other service systems and agencies, including schools, corrections, child welfare, substance use disorder treatment, and mental and physical health providers, in order to enhance services and supports and reduce barriers to service delivery.

(6) “Chemical restraint” means any medication or substance that may decrease a youth’s independent functioning and that is not administered pursuant to a current treatment plan.

(7) “Client” means a youth receiving mental health day treatment services from a program.

(8) “Clinical collaboration” means a joint intellectual and clinical effort by mental health professionals, intended to produce therapeutic benefits and favorable outcomes.

(9) “Clinical supervision” means the process described in s. DHS 40.10 (5).

(10) “Community–based program” means a program providing mental health day treatment services for youth in a facility that is not affiliated with a hospital.

(11) “Co–occurring disorder” means any combination of both a mental health disorder and a substance use disorder.

(12) “Crisis response services” means written policies and procedures for identifying risk of suicidal ideation, attempted suicide, or risk of harm to self or others.

(13) “Cultural responsiveness” means the process by which staff engage respectfully and effectively with a youth or legal representative of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations, and other diversity factors in a manner that does all of the following:

(a) Recognizes, affirms, and values the worth of youth, families and communities.

(b) Protects and preserves the dignity of youth, families and communities.

(c) Provides choices for action that are aligned with the context and preferences that derive from their culture and worldview.

(14) “Deficiency” means a failure to meet a requirement of this chapter.

(15) “Department” means the Wisconsin department of health services.

(16) “Educational service” means a program provided by a local education agency that has a unique identification code assigned by the Wisconsin department of public instruction and that provides or directly supervises PK–12 services.

(17) “Evidence–based practice” means a practice, such as a systemic decision–making process or a service that has been shown, through available scientific evidence, to consistently improve measurable client outcomes.

(18) “Family–driven care” means care that facilitates involvement by family and legal representatives in a youth’s care, in order to improve outcomes.

(19) “Gender–sensitive service” means a service that comprehensively addresses gender–related needs and fosters positive gender identity development.

(20) “Intensive hospital–based program” means a program providing mental health day treatment services for youth with an acute level of need. This setting is meant to support youth with severe symptomology who need closer supervision.

(21) “Legal representative” means any of the following:

(a) A guardian of the person, as defined under s. 54.01 (12), Stats.

(b) An adult client’s health care agent, as defined in s. 155.01 (4), Stats.

(c) A parent of a minor, as defined in s. 48.02 (13), Stats., a guardian, as defined in s. 48.02 (8), Stats., or a legal custodian, as defined in s. 48.02 (11), Stats.

(d) Any other individual or entity with legal authority to represent the client.

(22) "Licensed treatment professional" means any of the following, whose license is in good standing at the time of practice:

(a) A physician licensed under s. 448.03 (1) (a), Stats., who has completed a residency in psychiatry.

(b) A psychologist or a private practice school psychologist licensed under ch. 455, Stats.

(c) A marriage and family therapist licensed under s. 457.10 or 457.11, Stats.

(d) A professional counselor licensed under s. 457.12 or 457.13, Stats.

(e) A clinical social worker licensed under s. 457.08 (4), Stats.

(23) "Local educational agency" means a school district, as provided in s. 115.01 (3), Stats., a cooperative educational services agency (CESA) established under ch. 116, Stats., or a board established under s. 115.817, Stats.

(24) "Major deficiency" means a determination by the department that any of the following occurred:

(a) The program or a staff member created a risk of harm to a client or violated a client right created by this chapter.

(b) A staff member had sexual contact, as defined in s. 940.225 (5) (b), Stats., with a client.

(c) A staff member was convicted of abuse under s. 940.285, 940.29, or 940.295, Stats.

(d) A staff member was included on the Caregiver Misconduct Registry under ch. DHS 13 and did not receive a rehabilitation determination from the department for all instances of substantiated misconduct.

(e) The program or a staff member submitted or caused to be submitted a false statement for purposes of obtaining certification under this chapter.

(f) A license, certification, or required approval of the program expired, was revoked, or was suspended by any local, state, or federal authority, or the program's Medicaid or Medicare provider certification was suspended or terminated for any basis under s. DHS 106.06 or federal law, or by any local, state, or federal authority.

(25) "Measurable objective" means a clear statement of the behavioral changes that are to be made, the conditions under which the behaviors are to occur, and a criterion for success.

(26) "Mechanical restraint" means any physical device, used for the purpose of limiting or controlling a youth's movement.

(27) "Mental health day treatment service" means non–residential care that is prescribed by a physician and that is provided in a clinically supervised therapeutic milieu that provides an integrated system of individual, family, and group psychotherapy, care coordination, and support services pursuant to a treatment plan.

(28) "Mental health professional" means a licensed treatment professional, a qualified treatment trainee, or a recognized psychotherapy practitioner that practices within the scope of their practice.

(29) "Mental health support worker" means an individual who has a bachelor's or master's degree and provides services to implement the treatment plan.

(30) "Mental health technician" means an individual who assists mental health support workers and mental health professionals with implementation of support services.

(31) "Mental illness" means a mental health disorder that a mental health professional determines substantially diminishes a youth's ability to carry out age–appropriate activities of daily living, except that "mental illness" does not include dementia or a developmental disability.

(32) "Occupational therapist" has the meaning given in s. 448.96 (4), Stats.

(33) "Occupational therapy assistant" has the meaning given in s. 448.96 (6), Stats.

(34) "Parent peer specialist" means a person with knowledge gained from parenting youth with social, emotional, behavioral, mental health or substance use challenges and who has training to increase their skills to guide and support other parents or those in a parenting role.

(35) "Physical restraint" means use of physical force for the purpose of interfering with the movement of a youth, which includes forcibly moving or transporting a youth from one location to a seclusion room or area. "Physical restraint" does not include briefly holding a youth, without force, to calm or comfort her or him, or holding a youth's hand to safely escort him or her from one area to another and similar physical guidance and prompting techniques of brief duration.

(36) "Positive behavior support" means specific proactive strategies, documented in the treatment plan, intended to replace challenging behaviors with positive and functional alternatives.

(37) "Physician" has the meaning given in s. 448.01 (5), Stats.

(38) "Physician assistant" has the meaning given in s. 448.01 (6), Stats.

(39) "Prescriber" means a physician, a physician assistant acting within the conditions and limitations set forth in ch. Med 8, or an advanced practice nurse prescriber acting within the conditions and limitations set forth in s. N 8.06.

(40) "Program" means a community–based program or a hospital–based program.

(41) "Psychotherapy" has the meaning given in s. 457.01 (8m), Stats., for marriage and family therapy, professional counseling, and social workers or s. 455.01 (6), Stats for psychologists.

(42) "Psychotropic medication" means a prescription drug, as defined in s. 450.01 (20), Stats., that is prescribed by a prescriber to treat or manage mental illness.

(43) "Qualified treatment trainee" means either of the following:

(a) A graduate student who is enrolled in an accredited institution in psychology, counseling, marriage and family therapy, social work, nursing or a closely related field and is doing a supervised practicum for their graduate degree program.

(b) A person who has been awarded a graduate degree by an accredited institution and has completed coursework in psychology, counseling, marriage and family therapy, social work, nursing or a closely related field who has not yet completed the applicable supervised practice requirements described under s. MPSW 4.01, 12.01, or 16.04, or s. Psy 2.10.

(44) "Recognized psychotherapy practitioner" means an individual who may lawfully practice psychotherapy within the scope of a license, permit, registration or certificate granted by this state, other than under ch. 455 or 457, Stats.

(45) "Registered nurse" means a person licensed under s. 441.06, Stats. as a registered nurse.

(46) "Seclusion" means the involuntary confinement and isolation in a room or area from which the youth is prevented from leaving.

(47) "Sensory interventions" means a treatment or therapy that makes use of, or aims to improve, sensitivity to one or more of the senses.

(48) "Service" means a crisis response service, a mental health day treatment service, a support service, transition service, trauma–informed service, or minimum required service under s. DHS 40.07 (4).

(49) "Severe emotional disturbance" means an emotional or behavioral problem for a youth that currently meets, or at any time during the past year met, criteria for a mental disorder specified within a recognized diagnostic classification, and that produces a functional impairment which substantially interferes with or lim-

its functioning in family, school, employment, relationships, or community activities.

(50) "Staff member" means a person employed or contracted through the program who provides treatment services to a youth or legal representative.

(51) "Support service" means individualized advice, guidance, or assistance with planning, designed to facilitate positive alternatives to challenging behaviors, and to assist a youth with developing adaptive and functional restoration. "Support service" does not include psychotherapy or time spent in educational services, meals, or recreation.

(52) "Therapeutic milieu" means the combination of physical and interpersonal environments established and maintained in the mental health day treatment program to provide safety, trust, and consistency of care, and to model, teach, and reinforce positive and supportive behaviors and interactions among youth and staff.

(53) "Therapeutic specialists" means experiential therapists, art therapists, and music therapists who have complied with the appropriate certification procedures for their profession as required by state statute or administrative rule or the governing body regulating their profession.

(54) "Transition services" means services provided to a youth to ensure continuity of care and management of the youth's needs to ensure gradual reintegration back into school and the community as appropriate.

(55) "Treatment plan" means the document required under s. DHS 40.14.

(56) "Trauma" means significant distress or impairment in a person's social, coping, or other important areas of functioning, resulting from experiences or events.

(57) "Trauma–informed service" means a service that is attentive to the role that trauma plays in the lives of youth and family members, including recognition of the traumatic effect of misdiagnosis, coercive treatment, and inadvertent re–traumatization.

(58) "Variance" means a modification to a requirement of this chapter.

(59) "Voluntary time out" means an intervention intended to accomplish any of the following:

(a) Encourage youth to voluntarily use a calming or safe place that does not physically confine the youth, and that permits program staff members to visually monitor the youth when they are experiencing agitation or anxiety.

(b) Protect a client from another client who is posing a risk of harm or serious disruption.

(60) "Waiver" means an exemption from a specific requirement of this chapter.

(61) "Youth" means a person under 21 years of age.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20; correction in (5), (21) (c), (23), (27), (31), (35), (41), (42), (43) (b), (49), (51) made under s. 35.17, Stats., and correction in (39) made under s. 13.92 (4) (b) 7., Stats., Register June 2020 No. 774.

DHS 40.04 Certification. **(1)** INITIAL CERTIFICATION REQUIREMENTS. (a) *General.* A program that provides mental health day treatment services may not be established without certification from the department.

(b) *Application.* 1. Certification may be granted to establish any of the following:

a. A community–based program.

b. An intensive hospital–based program.

Note: Application materials may be obtained from the Behavioral Health Certification Section, Division of Quality Assurance, PO Box 2969, Madison, WI 53701–2969 or online at DHSDQAMentalHealthAODA@wisconsin.gov. Completed application materials may be submitted by mail to the Behavioral Health Certification Section, Division of Quality Assurance, PO Box 2969, Madison, WI 53701–2969.

2. A program may apply for certification by submitting the following application materials to the department:

a. A completed application form.

b. Payment for the certification fee required under s. 51.04, Stats.

Note: Fee amounts are found at https://www.dhs.wisconsin.gov/regulations/index.htm.

c. A program description, containing all of the following information:

1) The age range and characteristics of youth the program proposes to admit and if the program proposes to offer services based on age, the age range and client characteristics for each service.

2) The maximum number of youth that the program proposes to serve at any given time.

3) The hours and days of the year when the program will operate, and the proposed times during the day and week when youth will receive services from the program.

4) The treatment, services and supports, including parent peer specialists when appropriate, that will be offered by the program, and a rationale for how they will help the youth population achieve and sustain positive outcomes. If the program proposes to incorporate specific evidence–based practices in its array of services, a description of those services, the training and certification that its staff members have received or will receive that qualifies them to offer those services, and how those services will be provided. A description of the therapeutic milieu the program proposes to create with the proposed treatment, services and supports, how it will be maintained, its intended therapeutic benefits, and the rationale supporting its use for the youth served by the program. If the program proposes to offer other services within the same facility or program, it shall indicate the process that the program will use in deciding when and how to offer these services, how it will obtain any necessary authorization for these services, and how these services will be funded and regulated.

5) The program's proposal for meeting staffing level requirements in s. DHS 40.10 (2), the qualifications and roles for each position, and an analysis showing that staffing is adequate to meet the needs of the youth that the program proposes to serve. A description is also required of any specialized training and certification that program staff members have received or will be receiving that will help them better identify and address the specific needs of the youth served by the program.

6) A description of the physical settings indicating where services will be provided and whether these settings will be used for other purposes. Documentation of inspection or permit indicating the state building code requirements have been met, including chs. SPS 361 to 366, American with Disabilities Act, any applicable local ordinance or municipal building codes, and any additional information requested by the department.

7) If a program is proposing to operate a community–based program in a school, an agreement that describes the school in which the program will be located, the area or areas in the school where program operations will occur, the interactions that the program will have with other school activities and classes, the relationship that the program staff will have with school staff, how program staff and school staff will maintain separate duties, and the activities that youth will be participating in while also receiving services through the program.

8) How the program will participate in care coordination for youth within the community.

9) Where client records will be maintained and how confidentiality requirements of those records will be safeguarded, as required under s. DHS 40.15.

10) How the program will arrange for food service to any youth who is in the program for four or more hours during a day.

(c) *Initial on–site inspection.* Upon receipt of all application materials described in sub. (2), the applicant shall do all of the following:

1. Permit the department to conduct an on–site inspection of the program's physical settings to determine compliance with this chapter.

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2. Make available for review by the department any documentation necessary to determine compliance with the standards in this chapter.

(d) *Certification determination.* 1. The department shall make a certification determination within 60 days of receiving all completed application materials.

2. The department may grant certification if all the requirements of this chapter are met.

3. If the department determines that a program applying for certification does not comply with the requirements of this chapter, has a major deficiency, or the program description is not approved, the department may deny certification. A denial of certification shall be in writing and shall contain the reason for the denial and notice of appeal rights.

(e) *Scope of certification.* Certification granted by the department shall only be valid for the program described in the application materials.

(2) ONGOING OVERSIGHT PROVISIONS. (a) *Notification of changes.* A program that has received certification from the department shall notify the department of any change of administration, ownership, program name, required staff, or any other program change that may affect compliance with this chapter before the effective date of the change. A new application will be required if, upon notification, the department determines there is a substantial change in the program.

Note: Program notifications should be made to: Behavioral Health Certification Section, Division of Quality Assurance, PO Box 2969, Madison, WI 53701−2969 or by emailing DHSDQAMentalHealthAODA@wisconsin.gov.

(b) *Duration of certification.* 1g. Certification is valid until suspended or terminated by the department under sub. (11).

1r. Certification may be suspended or terminated under s. DHS 40.04 (11).

2. Any program that intends to close shall notify the department in writing at least 30 days before closing and comply with s. DHS 40.15 (9).

(c) *Biennial report and fees.* Every 24 months, by the date of renewal, the program shall submit a biennial report on the form provided by the department, and shall submit payment of certification continuation fees for the purpose of renewing certification of the program for two years.

(d) *Ongoing on−site inspections.* The program shall permit unannounced, on−site inspections of the program by the department to conduct program reviews, to conduct complaint or death investigations involving any aspect of the program, or to determine a program's progress in correcting a deficiency or major deficiency cited by the department. All of the following conditions apply to an on−site inspection:

1. The department shall use a random selection process for reviewing client records during program reviews.

2. The department shall conduct client interviews as part of the program review process.

(e) *Notice of deficiencies.* 1. If the department determines that a program has a deficiency, the department shall issue a notice of deficiency to the program. The notice of deficiency may place restrictions on the activities of the program, or suspend or terminate the program's certification.

2. The program shall submit a plan of correction to the department as indicated in the notice of deficiency. The plan of correction shall identify the specific steps the program will take to correct the deficiency, the timelines within which the corrections will be made, and the staff members who will implement the plan and monitor for future compliance.

3. If the department determines that the plan of correction submitted by the program does not adequately address deficiencies listed in the notice of deficiency, the department may impose a plan of correction.

(f) *Termination and suspension of certification.* 1. The department may terminate certification at any time for any major deficiency by issuing a notice of major deficiency to the program. The notice shall specify the reason for the department action and contain appeal information.

2. The department may summarily suspend a program's certification if the department determines that immediate action is required to protect the health, safety, or welfare of youth. Notice of suspension may be written or verbal and shall specify the reason for the department action and the date the action becomes effective. Within 10 working days after the order is issued, the department shall either lift the suspension on the program's certification or proceed to terminate the program's certification.

(g) *Appeals.* If the department denies or terminates certification, the program may request a hearing under ch. 227, Stats.

(h) *Reapplication.* If an application for certification is denied, the program may not reapply for certification for one year following the date on which certification was denied.

(i) *Dissemination of results.* Upon completing action on an application for certification, staff of the department shall provide a summary of the results of the process to the applicant, to the subunit within the department responsible for monitoring community mental health programs, and to the department of community programs under s. 51.42, Stats., in the county in which the program is located.

History: CR 19−018: cr. Register June 2020 No. 774, eff. 7−1−20; correction in numbering of (2) (b) 1g., 1r. made under s. 13.92 (4) (b) 1., Stats., and correction in (1) (c) (intro.), (2) (a), (b) 2., (c), (d) made under s. 35.17, Stats., Register June 2020 No. 774.

DHS 40.05 Waivers and variances. (1) REQUEST. A program may request a waiver or a variance from the department. A request shall be made in writing and include all of the following:

(a) The name of the program.

(b) The rule provision from which the waiver or variance is requested.

(c) The time period for which the waiver or variance is requested.

(d) If the request is for a variance, the specific alternative action that the program proposes.

(e) The reasons for the request and a supporting justification.

(f) Any other information requested by the department.

Note: An application for a waiver or variance should be addressed to the Behavioral Health Certification Section, Division of Quality Assurance, P.O. Box 2969, Madison, WI 53701−2969 or emailed to DHSDQAMentalHealthAODA@wisconsin.gov.

(2) REQUIREMENTS. (a) The department may grant a waiver or variance requested by a program, or may impose additional conditions on the proposed waiver or variance, including limiting their duration, or providing that the waiver or variance may be withdrawn for any of the reasons specified in par. (b) if the department determines all of the following:

1. The waiver or variance is not likely to adversely affect the health, safety, or welfare of any youth.

2. The waiver or variance is likely to improve services, or management and operation of the program, or permit piloting of new services.

(b) The department may revoke a waiver or variance granted under par. (a) if any of the following occurs:

1. The program fails to comply with the variance as granted.

2. The program notifies the department that it wishes to relinquish the waiver or variance.

3. There is a change in applicable state or federal law.

4. The department determines the revocation is necessary to protect the health, safety, or welfare of a youth.

(3) NOTIFICATION. (am) Within 60 days of the receipt of a request for a waiver or variance, the department shall notify the program in writing of its decision to do any of the following:

1. Extend the department's review period for the request.

2. Grant or deny the waiver or variance as requested.

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http://docs.legis.wisconsin.gov/code/admin_code

3. Grant the waiver or variance with additional conditions imposed by the department.

(bm) If the department denies a request for a waiver or variance, or revokes a waiver or variance, the department shall notify the program in writing of the reason for the denial or revocation.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20; correction in numbering in (3) made under s. 13.92 (4) (b) 1., Stats., Register June 2020 No. 774.

DHS 40.06 Coordination with educational services. **(1)** Programs shall make reasonable efforts to provide care coordination by executing memoranda of understanding or other forms of interagency agreement with local educational agencies or other services or programs that provide services to program youth.

(2) This chapter does not modify the educational rights and obligations of the youth in the program, any legal representative, or any local educational agency providing services in coordination with a mental health day treatment program certified under this chapter.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20.

DHS 40.07 Program components. **(1)** REQUIRED POLICIES AND PROCEDURES. A program shall develop and implement written policies and procedures for:

(a) Admission and orientation.

(b) Fee agreements.

(c) Assessments.

(d) Contents and implementation of individualized treatment plans.

(e) Implementation of person–centered care, including:

1. Cultural responsiveness.

2. Developmentally appropriate and age–appropriate service planning and delivery.

3. Legal representative involvement.

4. Strength–based approaches and planning.

5. Trauma–informed and responsive approaches and planning.

(f) Care coordination.

(g) Confidentiality and compliance with 42 CFR part 2, 45 CFR parts 160, 162, and 164, s. 51.30, Stats., and ch. DHS 92.

(h) Compliance with Title 2 of the Americans with Disabilities Act of 1990.

(i) Client rights and grievance processes under s. 51.61, Stats., and ch. DHS 94.

(j) Crisis prevention and response, including the program's use of support services, seclusion, and physical restraint and the process for obtaining a written authorization from a physician that allows seclusion and physical restraint for a youth prior to utilizing any emergency intervention with that youth.

(k) Services for minor youth transitioning to adulthood.

(L) Discharge, transfer, and continuity of care.

(m) Quality assurance and performance improvement.

(n) Written personnel policies.

(2) INVOLVEMENT IN TREATMENT PLANNING FOR YOUTH. (a) A program shall provide all of the following to a youth or legal representative upon request:

1. Copies of the policies and procedures, required under sub. (1).

2. Written documentation of each staff member's qualifications per s. DHS 40.09 (2) to (5).

3. Admission paperwork that explains the program and forms required for enrollment prior to the admission meeting, and assistance with understanding the paperwork.

4. A copy of ch. DHS 40.

5. Information about fees, payment sources, and how to access any applicable financial resources, and other community resources that are potentially helpful and how to access them.

(b) A program shall include the youth or legal representative throughout all parts of the treatment process, including screening, assessment, treatment, and discharge. A program shall make reasonable efforts to include any persons or family members that the youth or legal representative has authorized to participate in treatment or treatment planning. All of the following apply to the program's engagement of the youth or legal representative:

1. The assessment process shall engage the youth or legal representative to recognize the strengths and needs of the youth, and ensure that the youth or legal representative's perspectives, opinions, and preferences are included as part the treatment plan.

2. A program shall inform the youth or legal representative of the proposed services and supports within the treatment plan and provide a written copy of the plan.

3. Transition services shall consider the needs and preferences of the youth or legal representative.

(c) To ensure that the proposed services reflect a partnership between the youth or legal representative and program staff, a program shall do all of the following, as available and needed:

1. Employ, contract, or coordinate for the services of parent peer specialists who can help a youth or legal representative understand the operations of the program and support effective input in the planning and implementation of services.

2. Establish flexible schedules for meetings and activities so that legal representatives can participate without taking time off from work.

3. Make arrangements for transportation to the program if possible when legal representatives lack the ability to travel to the program using their own resources.

4. Adjust program services and activities to accommodate cultural and linguistic preferences and needs.

5. Use technological resources to encourage participation when in–person meetings are not possible, consistent with requirements to ensure confidentiality of treatment information.

(3) GENERAL REQUIREMENTS. In addition to services that are necessary to achieve the treatment objectives identified in each youth's assessment and individual treatment plan, all of the following minimum requirements services shall be provided:

(a) *Community–based program.* A community–based program shall offer all of the following:

1. Individual, group and family psychotherapy provided by trained mental health professionals.

2. A structured therapeutic milieu supervised by a clinical coordinator.

3. Care coordination.

4. Support services.

5. Crisis response services.

6. Implementation of transition services designed to support the reintegration of a youth who is completing the program into family, community and school activities and to prevent recurrence of the problems which led to the original placement in the program.

(b) *Intensive hospital–based programs.* An intensive hospital–based program shall offer minimum required services under par. (a) and shall increase the hours of direct clinical services under s. DHS 40.10 (3) (b) and increase the hours of operation under s. DHS 40.10 (4) (b) to meet the needs of youth who have severe symptomology and need closer supervision.

(4) SUPPORT SERVICES. Each program shall provide support services that include all of the following:

(a) Methods for documenting, measuring, and tracking progress on measurable objectives contained in a youth's treatment plan.

(b) Strategies for all of the following:

1. Reducing or eliminating the use of emergency safety interventions.

2. Teaching and increasing positive replacement behaviors, based on baseline measures at intake.

3. Building relationships between youth and staff members that promote trust and safety.

4. Empowering youth to take responsibility for their behavior and regulating their emotions.

5. Sensory interventions within the treatment milieu to enhance functioning and assist with behavioral challenges.

(5) VOLUNTARY TIME OUT. Support services shall be provided to a youth prior to using a voluntary time out. Voluntary time out should be used as a least restrictive measure, prior to involuntary seclusion or physical restraint, unless there is imminent danger due to a youth's aggression to self or others. Voluntary time out shall be encouraged for the shortest time possible and only for the length of time necessary for the youth to de–escalate or regulate his or her emotions. Programs shall encourage voluntary time out for youth who show signs of agitation or anxiety.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20; correction in (1) (g) made under s. 35.17, Stats., Register June 2020 No. 774.

DHS 40.08 Emergency safety interventions. **(1)** PROHIBITED INTERVENTIONS. Mechanical restraints, with the exception of procedures in sub. (5) (e) and chemical restraints are prohibited.

(2) GENERAL REQUIREMENTS FOR SECLUSION AND PHYSICAL RESTRAINT. Seclusion and physical restraint shall comply with the requirements under s. 51.61 (1) (i), Stats., s. DHS 94.10, and this chapter.

(3) STAFF REQUIREMENTS. Seclusion and physical restraint shall only be administered by program staff members who have completed orientation described in s. DHS 40.10 (6) (b).

(4) ADMINISTRATION REQUIREMENTS. Seclusion and physical restraint may only be administered when all of the following requirements are met in addition to the requirements under s. 51.61 (1) (i), Stats., and s. DHS 94.10:

(a) When all other less restrictive methods have been exhausted.

(b) For the shortest time possible and only until the youth is no longer a danger to self or others.

(c) In a manner that is attentive to, and respectful of the trauma history, dignity, and civil rights of the youth.

(d) To avoid or cause the least possible physical or emotional discomfort, harm, and pain to the youth.

(e) Allowing adequate access to bathroom facilities, drinking water, and necessary medication.

(5) SPECIFIC REQUIREMENTS FOR SECLUSION. (a) Program staff members shall provide uninterrupted supervision and monitoring of the youth and entire seclusion area during seclusion by being in the room with the youth or by observation through a window into the room.

(b) A program shall maintain an incident log to document the use of seclusion. The log shall include the time when the seclusion began, the youth's behaviors and staff member's response to those behaviors every 5 minutes, and the time seclusion ended.

(c) Seclusion rooms shall be free of objects or fixtures with which the youth could inflict bodily harm.

(d) Only a single youth may be placed in a seclusion room.

(e) A youth may only be kept in the seclusion area by means of one of the following:

1. A staff member is in a position, such as in a doorway, to prevent a youth from leaving the seclusion area.

2. A staff member physically holds a door shut to a seclusion room.

3. A door to a seclusion room is latched by positive pressure applied by a staff member's hand without which the latch would spring back allowing the door to open on its own accord, except that a hospital–based program may use a magnetic door lock or a lock which requires the turn of a knob to unlock a door. Other designs of door locks shall not be used, including padlock, key lock, or other locks of similar design.

(6) SPECIFIC REQUIREMENTS FOR PHYSICAL RESTRAINT. (a) Physical restraint shall only be administered to a youth during an emergency, when there is a serious threat of violence to other youth or a staff member, personal injury, or attempted suicide.

(b) At a minimum, two staff members trained in the use of emergency safety interventions shall be physically present during the administration of physical restraint, and shall continually monitor the condition of the youth and the safe use of physical restraint throughout the duration of the intervention.

(c) Methods of physical restraint that are likely to cause bodily harm are prohibited, such as:

1. Pressure or weight on the chest, lungs, sternum, diaphragm, back, or abdomen, such as straddling or sitting on the torso.

2. Pressure, weight, or leverage on the neck or throat, on any artery, or on the back of the head or neck, or that otherwise obstructs or restricts the circulation of blood or obstructs an airway, such as choke holds or sleeper holds.

3. Wrestling holds or martial arts techniques.

4. Covering the face with any object, such as a pillow, towel, washcloth, blanket, or other fabric.

5. Pain or pressure points.

6. Hyperextension of limbs, fingers, or neck.

7. Forcible take downs from a standing position to the floor.

8. Restraint in a prone position.

9. Restraint in a supine position.

10. Restraint in a vertical position, with upper body pressed against a wall or hard surface.

11. Any other physical restraint that is not administered during an emergency, that is administered for longer than necessary to prevent immediate injury to a youth or others, or that is administered for a purpose other than to prevent immediate injury to a youth or others.

(d) Immediately upon the termination of a physical restraint, a medical staff member, such as a physician, advanced practice nurse prescriber, physician assistant, advanced practice nurse, or registered nurse, shall conduct a follow–up assessment of the condition of the youth to ensure that the youth was not injured and shall document the finding of the assessment in the youth's file. If a staff member who is a doctor or nurse is not present on site, a licensed treatment professional shall conduct the face–to–face assessment immediately upon termination of the physical restraint and notify a medical staff member.

(e) If any injury is noted following a physical restraint, a staff member shall notify the youth's legal representative, if any, and make a referral for medical care.

(7) DEBRIEFING. (a) Following a seclusion or restraint, a staff member shall talk with the youth face–to–face about each of the following:

1. The circumstances that contributed to the seclusion or physical restraint and what could have been handled differently by the staff member.

2. The youth's psychological well–being and the emotional impact of the intervention.

3. What modifications can be made in the youth's services or treatment plan to prevent future seclusion and physical restraint.

(b) The debriefing should occur within 24 hours following a seclusion and restraint, with the following exceptions:

1. When clinically contraindicated.

File inserted into Admin. Code 8–1–2020. May not be current beginning 1 month after insert date. For current adm. code see:
http://docs.legis.wisconsin.gov/code/admin_code

2. When the 24 hour period falls during non–programming time such as on a weekend or holiday, then debriefing shall occur on the next programming day.

3. When a youth is suspended or discharged from programming following the incident and debriefing is contraindicated due to a serious risk of harm by the youth to others or to staff.

(c) A program shall notify a youth's legal representative, if any, of any seclusion or physical restraint on the same day that it was administered to the youth. The program shall document in the youth's file any situation in which notification has been attempted and the program has been unable to contact the legal representative.

(d) Each administration of seclusion or physical restraint shall be documented in the youth's chart and shall specify all of the following:

1. Less restrictive interventions attempted prior to the seclusion or physical restraint.

2. Events precipitating the seclusion or physical restraint.

3. Length of time the seclusion or physical restraint was used.

4. Assessment of the appropriateness of the seclusion or physical restraint based on threat of harm to self or others.

5. Assessment of any physical injury to the youth, other clients, or to staff members.

6. The youth's response to the emergency safety intervention.

(e) A licensed treatment professional shall review all seclusion and physical restraint documentation prior to the end of the shift in which the intervention occurred and determine whether changes to the youth's safety plan or treatment plan are necessary.

(f) If seclusion or physical restraint is administered to a youth more than three times over a period of five days, or in a single instance for more than 30 minutes within 24 hours, the clinical coordinator, or designee, shall do all of the following:

1. Convene staff to discuss the emergency situation that required seclusion or physical restraint, including the precipitating factors that led up to the intervention and any alternative strategies that might have prevented the use of seclusion or physical restraint in those situations.

2. Convene staff to discuss the procedures, if any, to be implemented to prevent further administration of seclusion or physical restraint.

3. Convene staff to discuss the outcome of the seclusion or physical restraint including any injuries.

4. Convene the youth's interdisciplinary treatment team to review the individualized treatment plan and make any necessary revisions to reduce the need for and likelihood of further use of seclusion or physical restraint, and document the discussion and any resulting changes to the plan in the youth's chart.

5. Determine whether a higher level of care is required for the youth and if a referral for inpatient or residential placement is necessary.

(8) REPORTING. (a) Programs shall report all incidences of seclusion, physical restraint, injury, and involvement of law enforcement to the department within 24 hours of the incident occurring. Reporting shall be completed through the department's online reporting system.

(b) The department will evaluate the circumstances of each incident, conduct any appropriate follow–up, and identify programs in need of technical assistance, training, policy development, or other quality improvement.

Note: The department reporting link is: https://www.dhs.wisconsin.gov/mh/cadaytreatmentproviders.htm. Questions and information about reporting may be directed to the Division of Care and Treatment Services at 608–266–2717.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20; correction in (4) (intro.), (5) (e) 3., (6) (d), (7) (e) made under s. 35.17, Stats., Register June 2020 No. 774.

DHS 40.09 Personnel qualifications. (1) MINIMUM REQUIREMENTS. (a) Each staff member shall have the professional certification, training, experience, and ability to carry out his or her assigned duties.

(b) Each staff member shall pass a criminal history and patient abuse record search as provided in s. 50.065, Stats., and a caregiver background check under ch. DHS 12, before working for the program.

(c) Programs shall comply with caregiver misconduct reporting and investigation requirements in ch. DHS 13.

Note: For a state of Wisconsin background check, information on the process and fees can be found on–line at: http://www.doj.state.wi.us/dles/cib/Fees.asp, or contact the Crime Information Bureau, Wisconsin Department of Justice, P.O. Box 2718, Madison, WI 53701–2718.

(2) QUALIFICATIONS OF PROGRAM DIRECTOR. The program director shall meet all of the following requirements:

(a) Meet the qualifications for any of the program staff listed in sub. (3) (a) to (j).

(b) Have at least one year of experience in a mental health setting working with youth.

(c) Have at least 2 years of experience as an administrator of a program that provides mental health services to youth and families.

(3) QUALIFICATIONS OF PROGRAM STAFF. (a) The clinical coordinator shall meet all of the following qualifications:

1. Be a licensed mental health professional.

2. Have at least 1,500 hours of clinical experience in a practice with youth who have mental illness or severe emotional disturbance.

(b) A psychiatrist shall be a physician licensed to practice medicine and surgery and meet the requirements for certification in child psychiatry by the American board of psychiatry and neurology. If a program can demonstrate that no board–certified or eligible child psychiatrist is available, the program may employ a psychiatrist who has a minimum of 1 year of clinical experience working with youth.

(c) Advanced practice nurse prescribers shall be certified in mental health treatment by an appropriate board and shall have had either training in providing psychiatric services, including work with youth with mental illness or severe emotional disturbance, or one year of experience working in a clinical setting with youth. An advanced practice nurse prescriber shall issue only those prescription orders appropriate to the advanced practice nurse prescriber's areas of competence, as established by his or her education, training, or experience. Advanced practice nurse prescribers shall facilitate collaboration with other health care professionals, at least one of whom shall be a physician. Advanced practice nurse prescribers shall have completed 3,000 hours of supervised clinical psychotherapy experience in order to also provide psychotherapy.

(d) Licensed mental health professionals shall have a minimum of one year of experience working in a clinical setting serving youth with mental illness or severe emotional disturbance.

(e) Physician assistants, advanced practice nurses, registered nurses, and occupational therapists shall have either training in providing services to youth with mental illness or severe emotional disturbance, or one year of experience working in a clinical setting with youth.

(f) Qualified treatment trainees shall have one year of a graduate level education program specific to serving youth with mental illness or severe emotional disturbance and shall provide psychotherapy to clients only under clinical supervision.

(g) Occupational therapy assistants shall be certified and receiving supervision under chs. OT 1 to 5.

(h) Therapeutic specialists shall have one year of experience working with, or one year of a formal educational program spe-

cific to serving youth with mental illness or severe emotional disturbance.

(i) Mental health support workers shall have a minimum of one year of experience or formal education related to working with youth who have severe emotion disturbance or mental illness.

(j) Mental health technicians and parent peer specialists shall be at least 18 years old and have a minimum of 30 hours pre–service training on their role in the program.

(4) VOLUNTEERS. A program may use volunteers to support the activities of staff. Volunteers shall receive a minimum of 10 hours pre–service training under the requirements of s. DHS 40.10 (6) (b) and shall be supervised by a licensed treatment professional employed by the program. Each volunteer shall pass a criminal history and patient abuse record search state background check as provided in s. 50.065, Stats., and a caregiver background check under ch. DHS 12, before being allowed to working for the program.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20; correction in (2) (a) made under s. 13.92 (4) (b) 7., Stats., Register June 2020 No. 774.

DHS 40.10 Required personnel and services. **(1)** OPERATIONAL RESPONSIBILITIES. A program shall include all of the following administrators:

(a) A program director who is responsible for program operations and ensuring that the program is in compliance with this chapter and other applicable state and federal laws.

(b) A clinical coordinator who is responsible for ensuring that all staff members providing mental health services have the qualifications required for their roles in the program and comply with all requirements relating to assessment, treatment planning, service delivery, and service documentation.

1. The program director may also serve as the clinical coordinator, if the program director is qualified under s. DHS 40.09 (3) (a).

2. The program director shall identify one or more staff members qualified under s. DHS 40.09 (3) (a) to (e) to whom authority may be delegated in the absence of the clinical coordinator. The clinical coordinator or designee shall be on the premises at all times that youth are present at a program.

(2) STAFFING REQUIREMENTS. At all times that youth are present at a program, the program shall have a minimum of two staff members qualified under s. DHS 40.09 (3) on duty, at least one of whom shall be a mental health professional. The number of staff available shall be based on meeting the treatment needs of youth based on individualized treatment plans, with additional staff present when higher levels of clinical needs are indicated. Calculation of the staff–to–client ratios for the program shall not include volunteers. Programs shall meet all of the following staffing requirements:

(a) If more than 10 youth are present at a community–based program, an additional staff member qualified under s. DHS 40.09 (3) shall be present for every 10 additional youth.

(b) If more than 10 youth are present at a hospital–based program, an additional staff member qualified under s. DHS 40.09 (3) shall be present for every 5 additional youth.

(3) SERVICE REQUIREMENTS. A program shall make available at least the following hours of direct clinical services, provided either by program staff members or professionals under contract to the program:

(a) A community–based day treatment program shall comply with all of the following:

1. One hour per week of consultation shall be provided by a psychiatrist or advanced practice nurse prescriber. If a program is unable to utilize a psychiatrist or advanced practice nurse prescriber, they may utilize a psychologist as long as there is a written plan in place assuring that consultation with a psychiatrist or advanced practice nurse prescriber occurs for medication related concerns at least monthly or more frequently based on the individual needs of the youth.

2. One hour per week of health–related services shall be provided by a physician, physician assistant, advanced practice nurse, or registered nurse for every 4 full–time youth in the program.

3. Six hours per week of group sessions shall be provided in the program. Only a master's–level mental health professional may provide psychotherapy group sessions. A mental health support worker may provide non–psychotherapy group sessions. Group sessions shall include no more than 10 youth with one staff or a maximum of 12 youth if 2 staff are present with the group.

4. One hour per week of care coordination services shall be provided by a mental health support worker or a mental health professional for every 2 full–time youth in the program.

5. Two hours per week of individual or family psychotherapy shall be provided by a mental health professional for each full–time youth in the program. One of the two required hours may be provided by a mental health support worker if they are under the supervision of the mental health professional implementing a piece of the individualized treatment plan.

6. At least 2 hours per week of support services shall be provided by mental health professionals, mental health support workers, mental health technicians, occupational therapists, or therapeutic specialists in the program.

(b) Intensive Hospital–based day treatment programs shall comply with all of the following:

1. One hour per week of consultation shall be provided by a psychiatrist or advanced practice nurse prescriber.

2. One hour per week of health–related services shall be provided by a physician, physician assistant, advanced practice nurse, or registered nurse for every 4 full–time youth in the program.

3. Crisis response, medical, and nursing services shall be readily available at all times youth are present in the program.

4. A physician, physician assistant, registered nurse, or advanced practice nurse shall be on duty and on–site in the program at all times that youth are present.

5. Eight hours per week of group sessions shall be provided in the program. Only a master's–level mental health professional may provide psychotherapy group sessions. A mental health support worker may provide non–psychotherapy group sessions. Group sessions shall include no more than 10 youth with one staff or a maximum of 12 youth if 2 staff are present with the group.

6. One hour per week of care coordination services shall be provided by a mental health support worker or mental health professional for every full–time youth in the program.

7. Four hours per week of individual or family psychotherapy shall be provided by a mental health professional for each full–time youth in the program. Two of the four required hours may be provided by a mental health support worker if they are under the supervision of the mental health professional implementing a piece of the individualized treatment plan.

8. At least 4 hours per week of support services shall be provided by mental health professionals, mental health support workers, mental health technicians, occupational therapists, or therapeutic specialists in the program.

(4) HOURS OF OPERATION. The amount of time a youth spends at a program shall be established by the individual treatment plan developed under s. DHS 40.14 for each youth, but a program shall be in operation and able to provide services for the following period:

(a) A community–based program shall be in operation and available to provide services to youth for a minimum of 4 hours a day, 5 days a week, and may suspend operations for no more than 4 weeks each year.

(b) An intensive hospital–based program shall be in operation and available to provide services to youth for a minimum of 6 hours a day, 5 days a week, and may suspend operations for no more than 4 weeks each year.

(c) Any youth participating for less than the minimum hours of operation in par. (a) or (b) shall be designated a part–time youth. Two part–time youth shall be calculated as the equivalent of one full–time youth.

(5) CLINICAL SUPERVISION. (a) The clinical coordinator shall have responsibility for oversight of the job performance and actions of each staff member who is providing clinical services and support services, and require each staff member to adhere to all laws and regulations governing care and treatment and the standards of practice for their individual professions.

(b) Each program shall develop and implement a written policy for clinical supervision and clinical collaboration designed to provide sufficient guidance to assure the delivery of effective services. Each policy shall address all of the following:

1. A system to determine the status and achievement of youth outcomes to determine if treatment provided is effective, and a system to identify any necessary corrective actions.

2. Identification of clinical issues, including incidents that pose a significant risk of an adverse outcome for youth that should warrant clinical collaboration, or clinical supervision that is in addition to the supervisions specified under s. MPSW 4.01, 12.01, or 16.04, or s. Psy 2.10, or for a recognized psychotherapy practitioner, whichever is applicable.

(c) Clinical supervision shall be documented in a supervision or collaboration record, containing entries that are signed and dated by the staff member providing supervision.

(d) Clinical supervision shall comply with s. MPSW 4.01, 12.01, or 16.04, or s. Psy 2.10, whichever is applicable.

(6) PERSONNEL ORIENTATION AND TRAINING. (a) *General requirement.* The program director shall ensure each staff member and volunteer receives orientation and ongoing training necessary to perform his or her duties. The program shall develop a written orientation policy.

(b) *Orientation.* The program shall maintain documentation showing that each new staff member listed under s. DHS 40.09 (3) (a) to (f) has completed the training requirements specified in subds. 1. to 16., either as part of orientation to the program or as part of prior education or training. The program director shall require all other staff members and volunteers to complete only the training requirements specified under this paragraph that are necessary, as determined by the program director, for the staff member or volunteer to successfully perform job duties. Training requirements include all of the following:

1. A review of this chapter.

2. A review of the program's policies and procedures.

3. Mental health treatment concepts applicable to providing day treatment services, including the principles of trauma–informed services and trauma history as they are specifically implemented through the program's operations and interactions with youth, the manner in which trauma may be a compounding variable in treatment, and how to identify and anticipate triggers related to trauma that lead to behavior and mental health symptoms.

4. Use of sensory interventions and strategies that promote self–regulation.

5. Techniques and procedures for providing emergency interventions.

6. Principles and techniques for developing and providing culturally responsive and gender–sensitive mental health services.

7. The reactions and side effects of psychotropic medication.

8. Techniques for assessing and responding to the needs of youth who have challenges with co–occurring illnesses and disabilities.

9. How to assess a youth to detect suicidal tendencies and to manage youth at risk of attempting suicide or causing harm to self or others.

10. Resiliency concepts and principles that ensure connection to others and to the community.

11. Applicable parts of chs. 48, 51, 55, 115, and 938, Stats., and any related administrative rules.

12. The provisions of ch. DHS 94 and s. 51.61, Stats., regarding client rights.

13. Current standards regarding documentation and the provisions of 45 CFR parts 160, 162, 164, 42 CFR part 2 regarding confidentiality of treatment records, s. 51.30, Stats., and ch. DHS 92.

14. The basic provisions of civil rights laws, including the Americans with Disabilities Act of 1990 and the Civil Rights Act of 1964, as the laws apply to staff members providing services to youth with disabilities.

15. Job responsibilities of staff members in the program.

16. Any other subject that the program determines is necessary to enable the staff member to perform the staff member's duties effectively, efficiently, and competently.

(c) O*ngoing training.* 1. Each program shall develop a written training plan for each staff member, which shall include all of the following:

a. Time set aside for training.

b. Discussion and presentation of principles and methods of treatment for youth with mental illness or severe emotional disturbance.

2. Each staff member who provides direct services to youth shall participate in a minimum of 30 hours of documented training each year on topics relevant to that staff member's responsibilities in the program and specific to the ages of the youth served in the program. A maximum of 18 hours of this training may include in–service and consultation provided by staff members or consultants of the program.

(d) *Department review of training.* Documentation of training shall be made available to department staff upon request.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20; correction in (3) (a) 3., (b) 5., (4) (c), (5) (b) 2., (d), (6) (b) (intro.), 13. made under s. 35.17, Stats., Register June 2020 No. 774.

DHS 40.11 Referral and Screening. (1) POLICIES. (a) The program director or clinical coordinator or designee shall review all referrals and verify the medical necessity and clinical appropriateness for day treatment services for the referred youth.

(b) A program shall establish written selection criteria for use when screening an applicant for admission, including all of the following:

1. Sources from which referrals may be accepted by the program and how those sources make referrals.

2. Procedures for making admission decisions.

3. Any funding restrictions which will be applied to admissions such as availability of insurance, required support for the placement from other agencies or the youth or legal representatives ability to pay.

4. Any client characteristics for which the program has been specifically designed, including the nature or severity of disorders, including co–occurring disorders, which can be managed within the program, type of needs that can be addressed, whether male or female youth, or both, may be admitted, and the length of time that services may be provided to a youth.

(2) ADMISSION. A program may not admit a youth unless all of the following information has been requested, the request has

been documented, and reasonable efforts have been made to obtain a complete record of the youth's mental health needs:

(a) The most recent psychiatric assessment.

(b) The Individualized Education Plan from the local education agency that is serving the client if the youth has an Individualized Education Plan.

(c) Discharge summaries from any psychiatric hospitalizations that have occurred within the past 12 months.

(d) Available information about any prior trauma history that the youth may have, and any risks of harm to self or others that the youth may present.

(e) Records of all mental health or substance use disorder treatment or services that the applicant has received during the past 12 months.

(3) SCREENING SUMMARY. (a) Once a program has screened an applicant for services and has decided to admit the applicant, a mental health professional shall prepare a written screening summary. The screening summary shall be completed prior to the first day of the youth attending the program. The purpose of the screening summary is to demonstrate the youth's appropriateness for the type of day treatment being initiated and reveal the diagnostic thought process and reasons that led to the decision to admit.

(b) The screening summary shall include all of the following:

1. The names of individuals involved in the referral for admission, those contacted during the screening process, and the dates of meetings or other contacts with those individuals.

2. A summary of reviewed materials deemed to be valid, reliable, and reflect the current functioning of the youth during the screening process.

3. A summary of the reasons for admission or denial.

4. A diagnostic summary and a summary of medications, dosages, and dates.

5. A profile of the needs and strengths of the youth.

6. A summary of the services which will be offered while the assessment and treatment plan are prepared under ss. DHS 40.13 and 40.14, and setting the date on which the youth may begin attending the program.

7. A description of educational and community resources available.

8. A summary of other less and more restrictive service alternatives to day treatment that were considered and an explanation of why they were determined to not be appropriate to meet the youth's needs.

9. A summary of other less restrictive services to day treatment in which the youth is dually involved and the reason for continued dual enrollment.

10. An initial discharge plan with measurable criteria for determining how the youth's needs may be met by less restrictive services following discharge.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20; correction in (3) (b) 4. made under s. 35.17, Stats., Register June 2020 No. 774.

DHS 40.12 Admission. (1) CRITERIA FOR ADMISSION. All of the following are required for a program to admit a youth:

(a) The youth has a psychiatric diagnosis of mental illness.

(b) The youth is unable to obtain sufficient benefit from a less restrictive treatment program.

(c) The youth is reasonably likely to benefit from the services being offered by the program.

(d) The youth is experiencing one or more of the following:

1. Significant dysfunction in 2 or more of the basic domains of life and that require the services offered by the program in order to acquire or restore the skills necessary to perform adequately in those areas.

2. Need for a period of transition from a hospital, residential treatment center or other institutional setting as part of the process of returning to live in the community.

3. A period of acute crisis or other severe stress, so that without the level of services provided by the program, there is a high risk of hospitalization or other institutional placement.

(2) AUTHORIZATION FOR SERVICES. (a) Except as provided in s. 51.14, Stats., a program may admit a youth only after obtaining the written and informed consent of the youth or legal representative, or pursuant to an order of a court with jurisdiction over the youth under ch. 48, 55, or 938 Stats., or if authorized by a county department under s. 51.42 or 51.437, Stats., to which the youth has been committed pursuant to s. 51.20 (13), Stats.

(b) Admission of minors shall comply with the requirements of s. 51.13, Stats.

(3) CARE COORDINATION. A program shall assign a care coordinator to each youth and provide the youth or legal representative with the care coordinator's contact information, a description of the role of the care coordinator, and an explanation of support that is available. The care coordinator shall be a mental health professional or mental health support worker and shall be responsible for all of the following:

(a) Providing the youth or legal representative with a thorough explanation of the nature and goals of the program, and the rights and responsibilities of the client.

(b) Facilitating the youth's assessment, developing and implementing the treatment plan, conducting ongoing case reviews, and identifying services to support the youth at discharge.

(c) Coordinating the program's operations on behalf of the youth with other agencies and schools serving the youth.

(d) Maintaining contact and communication with the youth or legal representative, facilitating the participation of the youth or legal representative in the treatment plan, and encouraging family–driven care whenever possible.

(e) Serving as an advocate for the youth or legal representative with other agencies and programs to help the youth obtain necessary services and benefits from those other agencies and programs.

(4) SAFETY PLAN. An individualized safety plan shall be completed prior to the start of services that considers risk factors, trauma history, medications and possible side effects, and methods for de–escalation of behaviors that are designed to avoid the use of emergency safety interventions in addressing the needs of the youth.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20; correction in (3) (a) made under s. 35.17, Stats., Register June 2020 No. 774.

DHS 40.13 Assessment. (1) INTERDISCIPLINARY TREATMENT TEAM. (a) Within 5 working days following the decision to admit a youth into the program, the care coordinator shall assemble an interdisciplinary treatment team to begin an assessment of the strengths, needs, and current status of the youth.

(b) The team shall include all of the following:

1. The youth, to the extent appropriate to his or her age, maturity and clinical condition, if available and willing to participate.

2. The youth's legal representative.

3. The youth's care coordinator.

4. The program's clinical coordinator.

(c) The youth or legal representative shall be asked to participate in identifying additional members of the interdisciplinary team. With consent of the youth or legal representative, reasonable efforts should be made to include all of the following:

1. An occupational therapist or a registered nurse, based on youth needs identified in the screening summary.

2. An educational professional from the youth's school.

3. Representatives of any other profession or agency necessary in order to adequately and appropriately respond to the treat-

ment needs of the youth which were identified in the referral materials or the intake screening process.

4. Family members who are involved in the life of the youth.

5. If the youth has been placed under the supervision of a county department, the social worker who has been assigned to the case.

(2) ASSESSMENT. (a) The purpose of the assessment is to identify the individual strengths and needs of the youth to address the level of functioning as well as specific strategies that will be utilized to treat the youth. The clinical coordinator shall prepare a written report describing and evaluating all of the following:

1. Biopsychosocial information that is sufficient to identify the goals that the youth or legal representative want to accomplish through their participation in the program, the needs that will have to be addressed to reach those goals, and the strengths of the youth that can form the foundation of the individual treatment plan to meet the identified needs and achieve the chosen goals, through conducting a respectful and thorough series of interviews that engage the youth or legal representative. Biopsychosocial information includes developmental history, significant past events, significant past relationships and prominent influences, behavioral history, financial history, and overall life adjustment.

2. The current mental health status of each youth including frequency, severity and duration of the symptoms and behaviors and the manner in which the symptoms and behaviors impact the youth's ability to function, attitude, judgement, memory, speech, thought content, perception, intellectual functioning, general appearance, diagnosis, or medical impression.

Note: The Diagnostic and Statistical Manual of Mental Disorders is published by the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders. Washington, DC, American Psychiatric Association, 2013. The Diagnostic and Statistical Manual of Mental Disorders may be ordered through http://www.appi.org/Pages/DSM.aspx or other sources.

3. Completing an evaluation of all of the following:

a. Current living arrangements, social relationships, support systems, including the youth's level of social and behavioral functioning in the home, school and community, and the youth's relationship with his or her family members, including an assessment of family member strengths and weaknesses which might affect treatment.

b. A youth's trauma history and experiences and how treatment approaches will avoid re-traumatization.

c. A youth's ability to work in a group setting.

d. The youth's level of academic functioning and educational history, including areas where the youth shows interest, skill and achievement.

e. A youth's history of criminal activity, including sexual perpetration, peer–to–peer violence, battery, and safety concerns.

f. The youth's health, medical history, and prescribed medications, including a youth's prior history of dangerous reactions to psychotropic medications, including procedures for assessing and monitoring the desired objectives and side effects of medications which the youth is taking, dealing with the results of possible medication interactions, medication overdose, an error in medication administration, an unanticipated reaction to the medication, the effects of a concurrent medical illness or condition occurring while the client is receiving the medication, and monitoring the medication regime to determine if any of the medications, solely or in combination, may mask or mimic psychiatric symptoms or behaviors.

g. Suicide risk and self–harm history and risk including criteria for deciding when the level of risk of suicide requires the use of crisis response services or hospitalization.

h. For a youth over the age of 15, the youth's vocational and independent living history, skills and needs.

i. The youth's current or recent use of drugs or alcohol and the possible presence of any co–occurring disorder that will have to be addressed through the treatment plan.

j. Any other assets and needs of the youth which affect the youth's ability to participate effectively in relationships and activities in home, community and school environments.

k. Past treatment, including where it occurred, for how long, and by whom.

L. Recommendations for completing any new test or evaluation which the interdisciplinary treatment team finds is necessary for development of an effective treatment plan for the youth, including psychological, neuropsychological functional, cognitive, behavioral, developmental or early and periodic screening and diagnosis under s. DHS 107.22.

(b) The written assessment shall inform and be completed prior to development of the treatment plan.

(c) The written assessment shall be signed by the youth or legal representative and the clinical coordinator.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20.

DHS 40.14 Treatment Plan. (1) TREATMENT PLAN. (a) The interdisciplinary treatment team shall prepare a written treatment plan for a youth based upon the written assessment under s. DHS 40.13 (2) within 15 calendar days after admission. The treatment plan shall describe measurable objectives that will be met and services that will be provided to the youth.

(b) The written treatment plan shall include all of the following:

1. The youth's strengths, treatment strategies, and measurable outcomes to be accomplished.

2. Clinical and support services to reduce or eliminate the symptoms causing the youth's problems or inability to function in day to day living, and to increase the youth's ability to function as independently as possible.

3. The schedules, frequency, nature of services recommended to support the achievement of the youth's goals, irrespective of the availability of services or funding, and the responsible party for that intervention.

4. The proposed length of time the youth will participate in the program and the amount of time that the youth will attend the program each week.

5. The involvement of a youth's legal representative with the program and any services that a legal representative will participate in while the youth is in the program.

6. A summary of other services the youth will receive while enrolled in the program, including educational services, other services that the program will be providing for the youth, and services and supports that will be provided by other agencies or providers and the process by which those educational and other services will be coordinated with services provided by the program.

7. The procedure for monitoring and managing any risk of suicide if the assessment identified risks.

8. Any medication the youth is receiving, the name of the physician prescribing the medication, the dosages prescribed, the purpose for which it is prescribed, the frequency of administration, a plan for monitoring its administration and effects by the physician, and a plan for care coordination with a psychiatrist or advanced practice nurse prescriber.

9. A transition services component that establishes when a transition process should begin, the staff member responsible for supporting transition services, and a process for the reintegration of the youth who is completing the program into family, community and school activities.

(c) The treatment plan shall be signed by the youth or legal representative and the clinical coordinator. With informed consent, a service provider who is part of the treatment plan may also review and sign the treatment plan.

(2) REVIEW OF TREATMENT PROGRESS. (a) At a minimum, the care coordinator shall reconvene the interdisciplinary treatment team as follows:

1. In community–based programs, within 30 calendar days following approval of the initial treatment plan and at least every 30 days thereafter.

2. In hospital–based programs, within 15 calendar days following approval of the initial treatment plan and at least every 15 days thereafter.

(b) In reviewing case progress, the interdisciplinary treatment team shall determine all of the following:

1. The degree to which the measurable objectives in the treatment plan have been met.

2. Any significant changes suggested or required in the treatment plan.

3. Whether any additional assessment of functional improvement is recommended as a result of information received or observations made during the course of treatment.

4. The youth's assessment of functional improvement toward meeting treatment goals and suggestions for modification.

(c) As part of its review of case progress, the interdisciplinary treatment team shall prepare a written report which includes all of the following:

1. A description of the youth's progress toward measurable objectives established in the treatment plan.

2. Documentation of clinical contacts with youth and interventions required as part of the treatment plan.

3. Identification of all days on which services were actually delivered to the client, and the amount of time the client spent in the program on those days.

(d) The written report shall be prepared as follows:

1. At least every 30 days in community–based programs.

2. At least every 15 days in hospital–based programs.

(e) The written report shall be maintained as a permanent part of the youth's record.

(f) A youth may continue to participate in a day treatment program as long as the review of the youth's treatment plan under par. (b) indicates that the youth remains appropriate for the continued services being offered and services support the achievement of the measurable objectives identified in the treatment plan.

(3) TERMINATION OF SERVICES. (a) *Decision.* Services provided to a youth under an individual treatment plan may be terminated by the program before the youth's goals for discharge are attained under any of the following circumstances:

1. By agreement between the youth or legal representative, the program director, and the clinical coordinator.

2. By direction of the program director and the clinical coordinator acting upon recommendation of the interdisciplinary treatment team, if the team determines any of the following:

a. Further participation of the youth in the program is unlikely to provide any reasonable benefit to the youth.

b. The youth's condition requires a greater or more restrictive level of care than can be provided by the program.

c. The youth's behavior or condition is such that it creates a serious risk of harm to other clients in the program or to program staff members and no modifications of the program procedures or services are possible which will ensure the safety of other clients or staff members.

(b) *Notice.* 1. Unless the youth poses an immediate risk of harm to other clients or staff members or subd. 2. applies, the program shall provide the youth or legal representative and other agencies providing services to the client pursuant to the treatment plan with at least 7 days prior notice of the intent to terminate services.

2. When a youth has been placed in the program by order of a court under ch. 48, 51, 55, or 938, Stats., the program shall provide that court and the social worker responsible for supervising the implementation of the court order with 14 days prior notice of the intent to end services, unless the youth poses an immediate risk of harm to other clients or staff members, in order to permit the court to enter an alternative order regarding the care of the youth.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20; correction in (3) (b) 2. made under s. 35.17, Stats., Register June 2020 No. 774.

DHS 40.15 Client records. (1) LOCATION AND FORMAT. Client records shall be managed in accordance with standard professional practices and any applicable legal requirements for the maintenance of client mental health records, and arranged in a format which provides for consistent recordkeeping within the program and which facilitates accurate and efficient record retrieval.

(2) ELEMENTS. All entries in each client file shall be factual, accurate, legible, permanently recorded, dated, and authenticated with the signature and license or title of the staff member making the entry. An electronic representation of the staff member's signature shall be used only by the staff member who makes the entry. The program shall possess a statement signed by the staff member, which certifies that only that staff member shall use the electronic representation via use of a personal password.

(3) CONFIDENTIALITY AND RETENTION OF RECORDS. Client records shall be kept confidential and safeguarded and retained as required under 42 CFR part 2, 45 CFR parts 160, 162, 164, and s. 51.30, Stats., ch. DHS 92, and any other applicable law.

(4) CONSENT. The treatment record shall document that the youth or legal representative were informed of the nature and policies of the program in their primary language and that the youth or legal representative understood and agreed to participation in the program.

(5) CLIENT TREATMENT RECORD. A treatment file or electronic record shall include all of the following:

(a) Initial referral materials.

(b) Notes and reports made while screening the youth for admission.

(c) A copy of the screening summary under s. DHS 40.11 (3).

(d) The safety plan under s. DHS 40.12 (4).

(e) The written, signed assessment under s. DHS 40.13 (2).

(f) Reports and other evaluations of the youth which were used in developing the assessment, and any necessary releases or authorizations for acquiring and using these reports and evaluations.

(g) Results of additional evaluations and other assessments performed while the youth is enrolled in the program.

(h) The initial, signed individual treatment plan.

(i) Descriptions of significant events that are related to the youth's treatment plan and contribute to an overall understanding of the youth's ongoing level and quality of functioning.

(j) Any recommended changes or improvements of the treatment plan resulting from clinical collaboration or clinical oversight.

(k) Written documentation of the services that have been provided to the youth or their legal representative as required under s. DHS 40.07 (4).

(L) Written summaries of the reviews of the treatment plan pursuant to s. DHS 40.14 (2) (c).

(m) Documentation of transition services and discharge planning, including involuntary discharge.

(n) Informed consent for treatment medication administration and medication records, if staff members dispense medications, including documentation of both over–the–counter and prescription medications dispensed to youth. Medication records shall contain documentation of ongoing monitoring of the administration of medications and detection of adverse drug reactions. All

File inserted into Admin. Code 8–1–2020. May not be current beginning 1 month after insert date. For current adm. code see: http://docs.legis.wisconsin.gov/code/admin_code

medication orders in the youth treatment record shall specify the name, type and purpose of the medication, and the dose, route of administration, frequency of administration, staff member administering, and name of the prescriber who prescribed the medication.

(o) Records of referrals of the youth to outside resources.

(p) Written consent, the court order, or county department authorization under s. DHS 40.12 (2) (a) to admission, and any consent for disclosure or authorization for release of information required under s. 51.30, Stats., and ch. DHS 92.

(q) Treatment plan case reviews and consultation notes.

(r) Care coordination provided with the youth or legal representative.

(s) Any other information that is appropriate for the youth file.

(6) ELECTRONIC TREATMENT RECORDS. (a) Programs may maintain treatment records electronically if the program has a written policy describing the records and the authentication and security policy.

(b) Electronic transmission of information from treatment records to information systems outside the program shall not occur without voluntary written consent for disclosure from the youth or legal representative per s. 51.30, Stats., or as otherwise provided by law.

(7) EDUCATION RECORDS. Education records of a youth shall be kept separate from the youth's treatment record, and shall comply with federal and state statutes and regulations relating to educational records.

Note: Federal and state statutes and regulations relating to educational records are found in 20 USC 1232g and 34 CFR Pt. 99, and s. 118.125, Stats.

(8) MAINTENANCE AND SECURITY. The program director is responsible for the maintenance and security of client treatment records.

(9) DISPOSITION UPON PROGRAM CLOSING. A program shall establish a written policy for maintenance and disposition of records, in accordance with s. DHS 92.12, in the event the program closes.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20; correction in (3), (5) (k) made under s. 35.17, Stats., Register June 2020 No. 774.

DHS 40.16 Client rights. All programs shall comply with s. 51.61, Stats., and ch. DHS 94 on the rights of clients.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20.

DHS 40.17 Program evaluation. (1) OUTCOMES. A program shall at least annually evaluate the effectiveness of services provided to its clients by doing all of the following:

(a) Preparing a statement of the program's clinical and support services outcomes for youth stated in objectively measurable terms.

(b) Preparing and making available to the public an annual report of youth service outcomes.

(2) OPERATIONS. (a) In addition to the outcome evaluation under sub. (1), a program shall arrange for an annual review of its program operations, including all of the following:

1. Appropriateness of referrals, admissions, and clients' length of stay.

2. Efficiency of procedures for conducting assessments and developing treatment plans.

3. Use of a supportive and trauma–informed treatment milieu, and improving quality of care and safety of youth.

4. The use of emergency safety interventions, including an aggregate review of all incidents of seclusion and physical restraint, to assure that the wellbeing of youth is safeguarded and that youth rights are protected.

5. Effectiveness of transition planning and discharge.

6. Functionality of care coordination and integration with other services.

(b) The review of program operations may be conducted by an advisory committee established by the program, an already established quality assurance and performance improvement committee, by a committee of the board of directors of the facility operating the program, or by any other appropriate and objective body. The committee shall include the program director and clinical coordinator, additional program staff members as appropriate, and whenever possible include parents and community members.

(c) A summary of the review of program operations shall be appended to the annual report prepared under sub. (1) (a) 2. and made available to department staff upon request.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20.

DHS 40.18 Death Reporting. Each program shall adopt written policies and procedures for reporting to the department deaths of youth no later than 24 hours after a death due to suicide, psychotropic medications, or use of physical restraints, as required by s. 51.64 (2), Stats.

Note: Copies of the form for reporting these deaths can be obtained from https://www.dhs.wisconsin.gov/regulations/report–death/proc–reportingdeath.htm.

History: CR 19–018: cr. Register June 2020 No. 774, eff. 7–1–20.