

## Chapter DHS 75

## COMMUNITY SUBSTANCE ABUSE SERVICE STANDARDS

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**Note:** Chapter HFS 75 was renumbered to chapter DHS 75 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 75 was reprinted Register December 2010 No. 660 to reflect a Note revision in s. DHS 75.03 (24).

**DHS 75.01 Authority, purpose and applicability.**

**(1) AUTHORITY AND PURPOSE.** (a) This chapter is promulgated under the authority of ss. 46.973 (2) (c), 51.42 (7) (b) and 51.45 (8) and (9), Stats., to establish standards for community substance abuse prevention and treatment services under ss. 51.42 and 51.45, Stats. Sections 51.42 (1) and 51.45 (1) and (7), Stats., provide that a full continuum of substance abuse services be available to Wisconsin citizens from county departments of community programs, either directly or through written agreements or contracts that document the availability of services. This chapter provides that service recommendations for initial placement, continued stay, level of care transfer and discharge of a patient be made through the use of Wisconsin uniform placement criteria (WI–UPC), American society of addiction medicine (ASAM) placement criteria or similar placement criteria that may be approved by the department.

(b) Use of approved placement criteria serves as a contributor to the process of obtaining prior authorization from the treatment service funding source. It does not establish funding eligibility regardless of the funding source. The results yielded by application of these criteria serve as a starting point for further consultations among the provider, patient and payer as to an initial recommendation for the type and amount of services that may be medically necessary and appropriate in the particular case. Use of WI–UPC or any other department–approved placement criteria does not replace the need to do a complete assessment and diagnosis of a patient in accordance with DSM–IV.

**Note:** See s. DHS 75.03 (12) on required assessment procedures.

**(2) APPLICABILITY.** This chapter applies to each substance abuse service that receives funds under ch. 51, Stats., is approved by the state methadone authority, is funded through the department as the federally designated single state agency for substance abuse services, receives substance abuse prevention and treatment funding or other funding specifically designated for providing services under ss. DHS 75.04 to 75.16 or is a service operated by a private agency that requests certification.

**Note:** In this chapter, a certified service–providing entity is called a “service” rather than a “program,” as in s. 51.42, Stats., or a “facility,” as in s. 51.45, Stats.

**History:** Cr. Register, July, 2000, No. 535, eff. 8–1–00; CR 06–035: am. (2), Register November 2006 No. 611, eff. 12–1–06.

**DHS 75.02 Definitions.** In this chapter:

**(1)** “Aftercare” has the meaning prescribed for “continuing care” in this chapter.

**(1m)** “Alternative education” means a course of traffic safety instruction that is designed to meet the goals of a group dynamic traffic safety program or a multiple offender traffic safety program for clients that cannot be accommodated by a group dynamic traffic safety program or a multiple offender traffic safety program.

**(2)** “Ambulatory detoxification service” means a medically managed or monitored and structured detoxification service,

delivered on an outpatient basis, provided by a physician or other service personnel acting under the supervision of a physician.

**(3)** “Applicant” means, unless otherwise indicated, a person who has initiated but not completed the intake process.

**(4)** “Approved placement criteria” means WI–UPC, ASAM or similar placement criteria that may be approved by the department.

**(5)** “ASAM placement criteria” means a set of placement criteria for substance abuse patients published by the American Society of Addiction Medicine.

**Note:** The publication, *Patient Placement Criteria for the Treatment of Substance–Related Disorders*, published by the American Society of Addiction Medicine (ASAM), may be consulted at the department’s bureau of prevention, treatment and recovery or at the Secretary of State’s office or the Legislative Reference Bureau. Send inquiries about the ASAM placement criteria to American Society of Addiction Medicine, 4601 N. Park Ave., Suite 101 Upper Arcade, Chevy Chase, MD 20815, or check ASAM’s internet site at [www.asam.org](http://www.asam.org).

**(7)** “Case management” means an organized process for bringing services, agencies, resources and people together within a planned framework for linking, advocating for and monitoring the provision of appropriate educational, intervention, treatment, or support services to a client with alcohol or other drug abuse problems in a coordinated, efficient and effective manner.

**(8)** “Certification” means approval of a service by the department.

**(9)** “Certification specialist” means a department employee responsible for certifying a service under this chapter.

**(9m)** “Clinical supervision” has the meaning given in s. SPS 160.02 (6).

**(11)** “Clinical supervisor” means any of the following:

(a) An individual who meets the qualifications established in s. SPS 160.02 (7).

(b) A physician knowledgeable in addiction treatment.

(c) A psychologist knowledgeable in psychopharmacology and addiction treatment.

**(12)** “Clinical supervision” means intermittent face–to–face contact provided on or off the site of a service between a clinical supervisor and treatment staff to ensure that each patient has an individualized treatment plan and is receiving quality care. “Clinical supervision” includes auditing of patient files, review and discussion of active cases and direct observation of treatment, and means also exercising supervisory responsibility over substance abuse counselors in regard to at least the following: counselor development, counselor skill assessment and performance evaluation, staff management and administration, and professional responsibility.

**(13)** “Consultation” means discussing the aspects of the individual patient’s circumstance with other professionals to assure comprehensive and quality care for the patient, consistent with the objectives in the patient’s treatment plan or for purposes of making adjustments to the patient’s treatment plan.

**(14)** “Continuing care” means the stage of treatment in which the patient no longer requires counseling at the intensity described

in ss. DHS 75.10 to 75.12. Continuing care is treatment that follows a treatment plan, is designed to support and sustain the process of recovery and is provided on an outpatient basis and at a frequency agreed upon between the patient and the provider.

**(15)** “Counseling” means the application of recognized theories, principles, techniques and strategies to manage and facilitate the progress of diverse patients toward mutually determined treatment goals and objectives using culturally sensitive modalities as described in s. SPS 160.02 (10m) or s. MPSW 2.01 (10).

**(16)** “Crisis intervention” means services that respond to a substance abuser’s needs during acute episodes that may involve physical distress.

**(17)** “Day treatment service” means a medically monitored and structured non-residential treatment service consisting of regularly scheduled sessions of various modalities such as counseling, case management, group or individual therapy, medical services and mental health services, as indicated, by interdisciplinary providers for a scheduled number of sessions per day and week.

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

**(19)** “Detoxification plan” means a planned procedure based on clinical findings for managing or monitoring withdrawal from alcohol or other drugs.

**(20)** “Detoxification service” means any of the services under ss. DHS 75.06 to 75.09.

**(21)** “Discharge planning” means planning and coordination of treatment and social services associated with the patient’s discharge from treatment, including the preparation of a discharge summary as required under s. DHS 75.03 (17).

**(21m)** “DSPS” means the Wisconsin department of safety and professional services.

**(22)** “DSM-IV” means the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, published by the American Psychiatric Association.

**(23)** “Drug detoxification treatment” means the dispensing of a narcotic drug in decreasing doses to a patient to alleviate adverse physiological or psychological effects incidental to the patient’s withdrawal from continuous or sustained use of a narcotic drug and as a method of bringing the individual to a narcotic drug-free state.

**(24)** “Dually diagnosed” means a patient diagnosed as having a substance use disorder listed in the DSM-IV that is accompanied by dependency, trauma or dementia and a diagnosed mental disorder.

**(25)** “Early intervention” means activities that take place with high-risk individuals, families or populations with the goal of averting or interrupting the further progression of problems associated with substance use or abuse. These activities may include problem identification and resolution, referral for screening, specialized education, alternative activities development, social policy development, environmental change, training and development of risk reduction skills.

**(26)** “Employee assistance program service” means an intervention service provided to employees by an employer for the purpose of identifying, motivating to seek help and referring for assistance those employees whose job performance is impaired or is at risk of impairment by personal problems, such as medical, family, marital, financial, legal, emotional and substance abuse or dependency problems.

**(27)** “FDA” means the U.S. food and drug administration.

**(28)** “First priority for services” means that an individual assessed as needing services will be referred immediately to available treatment resources and, in the event there is a waiting list for any treatment resource, the individual will be placed on the waiting list immediately before any person not entitled to first priority for services.

**(29)** “Follow-up” means a process used by a treatment provider to periodically assess the referral process and rehabilitation progress of a patient who has completed treatment, has been discharged from treatment or has been referred for concurrent services.

**(30)** “Group counseling” means the application of counseling techniques which involve interaction among members of a group consisting of at least 2 patients but not more than 16 patients with a minimum of one counselor for every 8 patients.

**(31)** “Hospital services” means services typically provided only in a hospital as defined in s. 50.33 (2), Stats.

**(32)** “Incapacitated person” means a person who, as a result of the use of or withdrawal from alcohol or other drugs, is unconscious or has his or her judgment otherwise so impaired that he or she is incapable of making a rational decision, as evidenced objectively by the service using such indicators as extreme physical harm or threats of harm to himself or herself, to any other person or to property.

**(33)** “Intake process” means the specific tasks necessary to admit a person to a substance abuse service, such as completion of admission forms, notification of patient rights, explanation of the general nature and goals of the service, review of policies and procedures of the service and orientation.

**(33m)** “Intensive supervision” means a program to promote public safety and reduce incarceration and recidivism related to substance abuse that includes all of the following:

(a) Centralized screening, review, evaluation, and monitoring of offenders by caseworkers in coordination with law enforcement, the district attorney, the courts, or the department of corrections.

(b) Community supervision of offenders from the time of arrest and formal charging through adjudication and compliance with court orders.

(c) Coordination of an array of interventions for the offender while under community supervision. Interventions to be coordinated may include any of the following:

1. Assessment.
2. Case management.
3. Alcohol or other drug abuse treatment.
4. Education.
5. Specialized education or skill-building programs.
6. Obtaining an intoxicated driver assessment under ch. DHS 62.
7. Periodic breath tests or urine analysis.
8. Attendance at victim impact panels.

(d) Programs such as the treatment alternative program under ch. DHS 66.

(e) A pretrial intervention program under s. 51.49, Stats.

(f) A corrective sanction program for juveniles under s. 938.533, Stats., or an intensive supervision program for juveniles under s. 938.534, Stats., a drug court, or other similar program.

**(34)** “Intervention” means a process of interrupting an action or a behavior that is harmful to an individual. “Intervention” may be a formal substance abuse service under s. DHS 75.16, or may be included in, but is not limited to, an educational program, an employee assistance program, an intoxicated driver assessment or driver safety plan program under ch. DHS 62, screening procedures under s. DHS 75.03 (10), or consultation provided to non-substance abuse professionals.

**(35)** “Intoxicated person” means a person whose mental or physical functioning, as determined and documented by the service, is substantially impaired as a result of the use of alcohol or other drugs.

**(36)** “Level of care” means the intensity and frequency of services provided by a service under ss. DHS 75.06 to 75.15. “Intensity of services” refers to both the degree of restrictiveness for a

patient to participate and to the range of specific services expected, including the involvement of medical professionals in the delivery of care. “Frequency of service” refers to how often the service may be provided or is available to the patient.

**(37)** “Licensed practical nurse” means a person who is licensed under s. 441.10, Stats., as a licensed practical nurse.

**(38)** “Maintenance treatment” means the dispensing of a narcotic drug in the treatment of an individual for dependence on heroin or another morphine–like drug.

**(39)** “Medical director” means a physician knowledgeable in the practice of addiction medicine, certified in addiction medicine by the American society of addiction medicine or certified in addiction psychiatry by the American board of psychiatry and neurology, who is employed as the chief medical officer for a service.

**Note:** A medical director of a certified service who is not certified in addiction medicine or in addiction psychiatry is encouraged to work toward and complete the requirements for certification in addiction medicine by the American society of addiction, or work toward and complete the requirements for certification by the American board of psychiatry and neurology in addiction psychiatry.

**(40)** “Medical personnel” means a physician, a physician assistant, nurse practitioner or other health care personnel licensed to at least the level of a registered nurse or licensed practical nurse.

**(41)** “Medical screening” means the examination conducted by medical personnel of a person to ascertain eligibility for admission to a substance abuse treatment service and to assess the person’s medical needs.

**(42)** “Medical services” means services designed to address the medical needs of a patient, including a physical examination, evaluating, managing and monitoring health–related risks of withdrawal from alcohol and other substances, administration of medications and emergency medical care.

**(43)** “Medical supervision” means regular coordination, direction and inspection by a physician of an individual’s exercise of delegation to deliver medical services when the individual is not licensed to administer medical services.

**(44)** “Medically directed” means the carrying out of standing orders under the supervision of a physician for delivering the medical aspects of a service, including review and consultation provided to treatment staff in regard to the admission, treatment, transfer and discharge of patients.

**(45)** “Medically managed inpatient detoxification service” means a 24–hour per day observation and monitoring service, with nursing care, physician management and all of the resources of a general or specialty inpatient hospital.

**(46)** “Medically managed inpatient treatment service” means a service provided in a general or specialty hospital with 24–hour per day nursing care, physician management and all the resources of a hospital approved under ch. DHS 124.

**(47)** “Medically managed services” means services provided or directly managed by a physician.

**(48)** “Medically monitored residential detoxification service” means a 24–hour per day service in a residential setting providing detoxification service and monitoring, with care provided by a multi–disciplinary team of service personnel including 24–hour nursing care under the supervision of a physician.

**(49)** “Medically monitored services” means services provided under the direction and supervision of a physician. The physician may or may not directly administer care to the patient.

**(50)** “Medically monitored treatment service” means a community or hospital based, 24–hour treatment service which provides a minimum of 12 hours of counseling per patient per week, including observation, and monitoring provided by a multi–disciplinary staff under the supervision of a physician.

**(51)** “Mental health professional” means an individual with training and supervised clinical experience in the field of mental health who is qualified under appendix B.

**(52)** “Mental disorder” means a condition listed in DSM–IV.

**(53)** “Narcotic dependent” means an individual who is physiologically and psychologically dependent on heroin or another morphine–like drug to prevent the onset of withdrawal symptoms.

**(54)** “Narcotic treatment service for opiate addiction” means an organization that includes a physician who administers or dispenses a narcotic drug to a narcotic addict for treatment or detoxification treatment with a comprehensive range of medical and rehabilitation services and that is approved by the state methadone authority and the designated federal regulatory authority and registered with the U.S. drug enforcement administration to use a narcotic drug for treatment of narcotic addiction.

**(55)** “Nurse practitioner” means a registered nurse licensed under ch. 441, Stats., and certified by a national certifying body approved by the Wisconsin board of nursing to perform patient services under the supervision and direction of a physician.

**(56)** “Outpatient treatment service” means a non–residential treatment service that provides a variety of evaluation, diagnostic, intervention, crisis and counseling services relating to substance abuse in order to ameliorate symptoms and restore effective functioning.

**(57)** “Paraprofessional” means an individual hired on the basis of skills and knowledge to perform specific functions in connection with a substance abuse service, who is not licensed, credentialed or otherwise formally recognized as a medical services provider or a mental health professional.

**(58)** “Patient” means an individual who has completed the screening, placement and intake process and is receiving substance abuse treatment services.

**(59)** “Patient–identifying information” means the name, address, social security number, photograph or similar information by which the identity of a patient can be determined with reasonable accuracy and speed, either directly or by reference to other publicly available information.

**(60)** “Patient and family education” means the provision of information to a patient and, as appropriate, to the patient’s family, concerning the effects of use and abuse of alcohol or other substances, the dynamics of abuse and dependency and available services and resources.

**(61)** “Patient satisfaction survey” means a written questionnaire to be completed by an individual who has participated in a substance abuse service to assess the individual’s perception of the effectiveness of the service in meeting his or her needs.

**(62)** “Physically accessible” means a facility that persons with functional limitations caused by impairments of sight, hearing, coordination, cognition or perception, or persons with disabilities that cause them to be semi–ambulatory or non–ambulatory may readily enter, leave and circulate within, and in which they can use public rest rooms and elevators.

**(63)** “Physician” or “service physician” means a person licensed under ch. 448, Stats., to practice medicine and surgery, who is certified in addiction medicine by the American society of addiction medicine, certified in addiction psychiatry by the American board of psychiatry and neurology or otherwise knowledgeable in the practice of addiction medicine.

**Note:** A physician providing or supervising addiction treatment in a certified service who is not certified in addiction medicine or in addiction psychiatry is encouraged to work toward and complete the requirements for certification by the American society of addiction medicine in addiction medicine as an addiction specialist, or work toward and complete the requirements for certification by the American board of psychiatry and neurology in addiction psychiatry.

**(64)** “Physician assistant” means a person licensed under s. 448.05 (5), Stats., to perform patient services under the supervision and direction of a physician.

**(65)** “Placement criteria summary” means documentation that identifies the treatment service qualifying criteria and severity indicators applicable to a patient, and shall include the interviewer’s comments, the patient’s statement regarding willingness to accept the level of care placement recommendation, reasons for

selecting an alternative level of care placement, if applicable, the name, address and phone number of the agency the patient is being referred to and signatures of the patient and the interviewer.

**(66)** “Potentiation” means the increasing of potency and, in particular, the synergistic action of 2 drugs which produces an effect that is greater than the sum of the effect of each drug used alone.

**(67)** “Prescription” means a written instruction for preparation and administration of a medication or for treatment that includes the date of the order, the name and address of the prescriber, the patient’s name and address and the prescriber’s signature.

**(68)** “Prevention” has the meaning given in s. SPS 160.02 (21).

**(69)** “Prevention measures” means preventive interventions that use a combination of prevention strategies to affect 3 population groups, as follows:

(a) Universal prevention measures are designed to affect a general population.

(b) Selective prevention measures are designed to target subgroups of the general population distinguished by age, gender, occupation, culture or other obvious characteristics whose members are at risk for developing substance abuse problems.

(c) Indicated prevention measures are designed to affect persons who, upon substance abuse screening, are found to manifest a risk factor, condition or circumstance of daily living that identifies them individually as at risk for substance abuse and in need of supportive interventions.

**(70)** “Prevention service” means an integrated combination of universal, selective and indicated measures that use a variety of strategies in order to prevent substance abuse and its effects.

**(70g)** “Prevention specialist” means an individual who meets the qualifications established in s. SPS 160.02 (23).

**(70r)** “Prevention specialist–in–training” means an individual who meets the qualifications established in s. SPS 160.02 (24).

**(71)** “Prevention strategy” means activities targeted to a specific population or the larger community that are designed to be implemented before the onset of problems as a means to prevent substance abuse or its detrimental effects from occurring.

**(72)** “Preventive intervention” means any strategy or action directed at a population or person not at the time suffering from any discomfort or disability due to the use of alcohol or another substance but identified as being at high risk to develop problems associated either with his or her own use of alcohol or other substances or another person’s use of alcohol or other substance.

**(73)** “Primary counselor” means a substance abuse counselor who is assigned by the service to develop and implement a patient’s individualized treatment program and to evaluate the patient’s progress in treatment.

**(74)** “Referral” means the establishment of a link between a patient and another service by providing patient authorized documentation to the other service of the patient’s needs and recommendations for treatment services, and includes follow-up within one week as to the disposition of the recommendations.

**(75)** “Registered nurse” means a person who is licensed under ch. 441, Stats., as a registered nurse.

**(76)** “Relapse prevention” means services designed to support the recovery of the individual and to prevent recurrence of substance abuse.

**(77)** “Residential intoxication monitoring service” means a service providing 24-hour per day observation by non-medical staff to monitor the resolution of alcohol or sedative intoxication and to monitor alcohol withdrawal.

**(78)** “Service” means a structured delivery system, formerly called a program, for providing substance abuse prevention, intervention or treatment services.

**(78m)** “Social worker” has the meaning given in s. MPSW 2.01 (16).

**(79)** “Staff development” means activities designed to improve staff competency and job performance which may include the following:

(a) Orientation that includes learning activities that provide understanding of the contextual relationship of concepts, ideas and processes required for job performance.

(b) Education that includes learning activities that provide cognitive information to build the knowledge base required for improving job performance.

(c) Training that includes learning activities that develop knowledge, skills and attitudes aimed at changing behaviors to enhance or improve job performance.

**(80)** “Staffing” means a regularly scheduled review of a patient’s treatment goals, the treatment strategies and objectives being utilized or proposed, potential amendments to the treatment plan and the patient’s progress or lack of progress, including placement criteria for the level of care the patient is in, with participants to include at least the patient’s primary counselor and the clinical supervisor, and a mental health professional if the patient is dually diagnosed.

**(81)** “State methadone authority” means the department’s bureau of prevention, treatment and recovery which is the state agency designated by the governor pursuant to 42 CFR 8.2 to exercise the responsibility and authority within Wisconsin for governing the treatment of narcotic addiction with a narcotic drug.

**(82)** “Substance” means a psychoactive agent or chemical which principally affects the central nervous system and alters mood or behavior and may include nicotine if the individual is being treated for abuse of or dependence on alcohol or a controlled substance or a controlled substance analog under ch. 961, Stats.

**(83)** “Substance abuse” means use of alcohol or another substance individually or in combination in a manner that interferes with functioning in any of the following areas of an individual’s life: educational, vocational, health, financial, legal, personal relationships or role as a caregiver or homemaker.

**(84)** “Substance abuse counselor” or “counselor” means any of the following:

(a) A clinical substance abuse counselor as defined in s. SPS 160.02 (5).

(b) A substance abuse counselor as defined in s. SPS 160.02 (26).

(c) A substance abuse counselor–in–training as defined in s. SPS 160.02 (27).

(d) An individual who holds a clinical social worker, marriage and family therapist, or professional counselor license granted under ch. 457, Stats.

**(85)** “Substance abuse screening” means the process by which a patient is determined appropriate and eligible for service in the substance abuse treatment delivery system.

**(86)** “Substance use disorder” means the existence of a diagnosis of “substance dependence” or “substance abuse,” listed in DSM–IV, excluding nicotine dependence.

**(87)** “Supervised clinical experience” means supervision of a master’s level mental health professional in clinical practice by a mental health professional qualified under s. DHS 34.21 (3) (b) 1. to 9. gained after the person being supervised has received a master’s degree.

**Note:** See Appendix B–8.

**(88)** “Transfer” means the change of a patient from one level of care to another. The change may take place at the same location or by physically moving the patient to a different site for the new level of care.

**(89)** “Transitional residential treatment service” means a clinically supervised, peer-supported therapeutic environment with clinical involvement. The service provides substance abuse treat-

ment in the form of counseling equaling between 3 to 11 hours weekly, immediate access to peer support and intensive case management which may include direct education and monitoring in the areas of personal health and hygiene, community socialization, job readiness, problem resolution counseling, housekeeping and financial planning.

**(90)** “Treatment” means the planned provision of services that are sensitive and responsive to a patient’s age, disability, if any, gender and culture, and that are conducted under clinical supervision to assist the patient through the process of recovery.

**Note:** Treatment functions include screening, application of approved placement criteria, intake, orientation, assessment, individualized treatment planning, intervention, individual or group and family counseling, referral, discharge planning, after care or continuing care, recordkeeping, consultation with other professionals regarding the patient’s treatment services, recovery and case management, and may include crisis intervention, client education, employment and problem resolution in life skills functioning.

**(91)** “Treatment plan” or “plan” means identified and ranked goals and objectives and resources agreed upon by the patient, the counselor and the consulting physician to be utilized in facilitation of the patient’s recovery.

**(92)** “Treatment planning” means the process by which the counselor, the patient and, whenever possible, the patient’s family, identify and rank problems needing resolution, establish agreed-upon immediate, short-term and long-term goals and decide on a treatment process and resources to be utilized based upon the severity of the patient’s presenting problems.

**(93)** “Treatment service” means any service under ss. DHS 75.10 to 75.15.

**(95)** “Withdrawal” means the development of a psychological and physical syndrome caused by the abrupt cessation of or reduction in substance use that has been heavy and prolonged. The symptoms include clinically significant distress or impairment in social, occupational or other important areas of functioning and are not due to a general medical condition or better accounted for by another mental disorder.

**(96)** “Withdrawal screening” means the evaluation of a patient’s condition as it relates to current or potential withdrawal from alcohol or another substance.

**(97)** “WI–UPC” means Wisconsin uniform placement criteria, a placement instrument that yields a placement recommendation as to an appropriate level of care at which a patient should receive services. The criteria determine if a patient is clinically eligible for substance abuse services and then provide a basis for examining the degree of impairment in specific dimensions of the patient’s life.

**Note:** The publication, *Wisconsin Uniform Placement Criteria*, may be consulted at the department’s bureau of prevention, treatment and recovery, Room 437, 1 W. Wilson Street, Madison, Wisconsin. To request a copy, write Bureau of Prevention, Treatment and Recovery, P.O. Box 7851, Madison, WI 53707–7851.

**(98)** “WI–UPC assets criteria” means the strengths the patient possesses. Examples are evidence that the patient is free of withdrawal symptoms, the patient is not under the influence of substances, the patient has a supportive and safe living environment and the patient is willing to follow the agreed-upon elements of the treatment plan.

**(99)** “WI–UPC needs criteria” means the identified problems or condition of a patient which help in determining the level of intensity of service required for progress in achieving treatment goals and bringing about the patient’s recovery.

**History:** Cr. Register, July, 2000, No. 535, eff. 8–1–00; CR 06–035: cr. (1m) and (34m), am. (82), r. and recr. (7) and (34), Register November 2006 No. 611, eff. 12–1–06; corrections in (18), (33m) (d), (34), (46) and (87) made under s. 13.92 (4) (b) 6. and 7., Stats., Register November 2008 No. 635; CR 09–109: r. (6), (10), (11) (d) to (f) and (94), am. (7), (11) (a), (15), (68) and (81), cr. (9m), (21m), (70g), (70r) and (78m), r. and recr. (84) Register May 2010 No. 653, eff. 6–1–10; correction in (9m), (11) (a), (15), (21m), (68), (70g), (70r), (84) (a) to (d), made under s. 13.92 (4) (b) 6., 7., Stats., Register November 2011 No. 671; correction in (33m) (e) made under s. 13.92 (4) (b) 7., Stats., Register October 2015 No. 718; 2017 Wis. Act 262: am. (15), (84) (d) Register April 2018 No. 748, eff. 5–1–18.

**DHS 75.03 General requirements. (1) APPLICABILITY.** This section establishes general requirements that apply to the 13 types of community substance abuse services under ss. DHS 75.04 to 75.16. Not all general requirements apply to all services. Table DHS 75.03 indicates the general requirement subsections that apply to specific services.

TABLE DHS 75.03  
 GENERAL REQUIREMENTS  
 APPLICABLE TO EACH SERVICE

DHS 75.03 GENERAL REQUIREMENTS	75.04	75.05	75.06	75.07	75.08	75.09	75.10	75.11	75.12	75.13	75.14	75.15	75.16
(2) Certification	X	X	X	X	X	X	X	X	X	X	X	X	X
(3) Governing Authority	X	X	X	X	X	X	X	X	X	X	X	X	X
(4) Personnel	X	X	X	X	X	X	X	X	X	X	X	X	X
(5) Staff Development	X	X	X	X	X	X	X	X	X	X	X	X	X
(6) Trng in Mgmt of Suicidal Individuals	X	X	X	X	X	X	X	X	X	X	X	X	X
(7) Confidentiality	X	X	X	X	X	X	X	X	X	X	X	X	X
(8) Patient Case Records	O	O	X	X	X	X	X	X	X	X	X	X	O
(9) Case Records for Emergency Services	O	O	X	X	O	O	O	O	O	O	O	X	O
(10) Screening	O	X	X	X	X	X	X	X	X	X	X	X	O
(11) Intake	O	O	X	X	X	X	X	X	X	X	X	X	O
(12) Assessment	O	O	O	O	O	O	X	X	X	X	X	X	O
(13) Treatment Plan	O	O	O	O	O	O	X	X	X	X	X	X	O
(14) Staffing	O	O	X	X	X	X	X	X	X	X	X	X	O
(15) Progress Notes	O	O	X	X	X	X	X	X	X	X	X	X	O
(16) Transfer	O	O	X	X	X	X	X	X	X	X	X	X	O
(17) Discharge or Termination	O	O	X	X	X	X	X	X	X	X	X	X	O
(18) Referral	X	X	X	X	X	X	X	X	X	X	X	X	X
(19) Follow-up	O	O	X	X	X	X	X	X	X	X	X	X	O
(20) Service Evaluation	X	X	X	X	X	X	X	X	X	X	X	X	O
(21) Communicable Disease Screening	O	O	X	X	X	X	X	X	X	X	X	X	O
(22) Unlawful Substance Use	X	X	X	X	X	X	X	X	X	X	X	X	X
(23) Emergency Shelter and Care	O	O	X	X	O	X	X	X	O	O	X	O	O
(24) Death Reporting	O	X	X	X	X	X	X	X	X	X	X	X	O

X = required O = not required

**(2) CERTIFICATION.** (a) *Approval.* Each service that receives funds under ch. 51, Stats., is approved by the state methadone authority, is funded through the department's bureau of prevention, treatment, and recovery, or receives other substance abuse prevention and treatment funding or other funding specifically designated to be used for providing services described under ss. DHS 75.04 to 75.16, shall be certified by the department under this chapter.

(b) *Application.* An individual or organization seeking certification of a service under this chapter shall apply to the department for certification on a form provided by the department.

**Note:** For a copy of the application for certification, write to Behavioral Health Certification Section, P.O. Box 2969, Madison, WI 53701-2969.

(c) *Determination.* Upon receipt of a completed application for certification the department shall review the application for compliance with this chapter, which may include an on-site survey. Within 45 days after receiving a completed application, the department shall either approve or deny the application. If the application for certification is denied, the department shall give

the individual or organization applying for certification reasons, in writing, for the denial and shall inform the individual or organization of a right to appeal that decision under par. (h).

(d) *Duration.* The department may issue a certification for a period of up to 2 years. The certification shall remain in effect for that period unless suspended or revoked prior to expiration.

(e) *Renewal.* The department shall send a renewal notice and instructions to the certificate holder 60 days before expiration of the certification.

(f) *Denial.* 1. The department may refuse to issue a certification if an applicant fails to meet all requirements of this chapter or may refuse to renew a certification if the applicant no longer meets or has violated any provision of this chapter.

2. The department may refuse to issue a certification if the applicant has previously had a certification revoked for failure to comply with rules promulgated by the department or a comparable agency in another state.

(g) *Suspension or revocation.* The department may at any time upon written notice to a certificate holder suspend or revoke the certificate if the department finds that the service does not comply with this chapter. The notice shall state the reasons for the suspension or revocation and shall inform the certificate holder of the right under par. (h) to appeal that decision.

(h) *Responsibility for interpretation.* The department's bureau of prevention, treatment and recovery is responsible for the interpretation of the meaning and intent of the provisions of this chapter.

(i) *Appeals.* 1. If the department denies, refuses to renew, suspends or revokes a certification, the individual, organization or service applying for certification or renewal may request an administrative hearing under ch. 227, Stats. If a timely request for hearing is made on a decision to suspend or revoke or not renew a certification, that action is stayed pending the decision on the appeal except when the department finds that the health, safety or welfare of patients requires that the action take effect immediately. A finding of a requirement for immediate action shall be made in writing by the department.

2. A client shall file his or her request for a fair hearing in writing with the division of hearings and appeals in the department of administration within 30 days after the date of the notice of adverse action under par. (c) or (g). If a request is not received within 30 days, no hearing is available. A request is considered filed when received by the division of hearings and appeals. Receipt of notice is presumed within 5 days of the date the notice was mailed.

**Note:** The mailing address of the Division of Hearings and Appeals is P.O. Box 7875, Madison, WI, 53707, 608–266–3096. Hearing requests may be delivered in person to the office at 5005 University Avenue, Room 201, Madison, WI.

3. In accordance with ch. HA 3, the division of hearings and appeals shall consider and apply all standards and requirements of this chapter.

**(3) GOVERNING AUTHORITY.** The governing authority or legal owner of a service shall do all of the following:

(a) Establish written policies and procedures for the operation of the service and exercise general direction over the service.

(b) Appoint a director whose qualifications, authority and duties are defined in writing.

(c) Develop and provide a policy manual that describes the policies and procedures for the delivery of services.

(d) Comply with local, state and federal laws.

(e) Establish a written policy stating that the service will comply with patient rights requirements as specified in this chapter and in ch. DHS 94.

(f) Establish written policies and procedures stating that services will be available and accessible and, that with the exception of par. (g), no person will be denied service or discriminated against on the basis of sex, race, color, creed, sexual orientation, handicap or age, in accordance with Title VI of the Civil Rights Act of 1964, as amended, 42 USC 2000d, Title XI of the Education Amendments of 1972, 20 USC 1681–1686 and s. 504 of the Rehabilitation Act of 1973, as amended, 29 USC 794, and the Americans with Disabilities Act of 1990, as amended, 42 USC 12101–12213.

(g) State clearly in writing the criteria for determining the eligibility of individuals for admission, with first priority for services given to pregnant women who are alcohol or drug abusers.

(h) Develop written policies and procedures stating that, in the selection of staff, consideration will be given to each applicant's competence, responsiveness and sensitivity toward and training in serving the characteristics of the service's patient population, including gender, age, cultural background, sexual orientation, developmental, cognitive or communication barriers and physical or sensory disabilities.

(i) Develop written policies and procedures to ensure that recommendations relating to a patient's initial placement, continued

stay, level of care transfer and discharge recommendations are determined through the application of approved uniform placement criteria.

**(4) PERSONNEL.** (a) A service shall have a director appointed by the governing authority or legal owner. The director is responsible for administration of the service.

(b) A service shall comply with chs. DHS 12 and 13. Chapter DHS 12 directs the service to perform background information checks on applicants for employment and persons with whom the service contracts and who have direct, regular contact with patients and, periodically, on existing employees, and not hire or retain persons who because of specified past actions are prohibited from working with patients. Chapter DHS 13 directs the service to report to the department all allegations that come to the attention of the service that a staff member or contracted employee has misappropriated property of a patient or has abused or neglected a patient.

(c) If a service uses volunteers, the service shall have written policies and procedures governing their activities.

(d) All staff who provide substance abuse counseling, except physicians knowledgeable in the practice of addiction medicine and psychologists knowledgeable in psychopharmacology and addiction treatment, shall be substance abuse counselors.

**Note:** According to s. SPS 160.03, a person may use the title "addiction counselor," "substance abuse counselor," "alcohol and drug counselor," "substance use disorder counselor" or "chemical dependency counselor" only if he or she is certified as a substance abuse counselor or a clinical substance abuse counselor under s. 440.88, Stats., or as allowed under the provisions of s. 457.02 (5m), Stats.

(e) Any staff who provides clinical supervision, as defined in s. SPS 160.02 (6), shall be a clinical supervisor, as defined in s. SPS 160.02 (7), except for a physician knowledgeable in addiction treatment, licensed psychologist with a knowledge of psychopharmacology and addiction treatment, or professional possessing a clinical social worker, marriage and family therapist, or professional counselor license granted under ch. 457, Stats., and knowledgeable in addiction treatment.

(f) All staff who provide mental health treatment services to dually diagnosed clients shall meet the appropriate qualifications under appendix B.

(g) Provision of clinical supervision for a substance abuse counselor shall be evidenced in that person's personnel file by documentation which identifies hours of supervision provided, issues addressed in the areas of counselor development, counselor skill assessment and performance evaluation, management and administration and professional responsibility and plans for problem resolution. The documentation shall be signed by the clinical supervisor.

**(5) STAFF DEVELOPMENT.** A service shall have written policies and procedures for determining staff training needs, formulating individualized training plans and documenting the progress and completion of staff development goals.

**(6) TRAINING STAFF IN ASSESSMENT AND MANAGEMENT OF SUICIDAL INDIVIDUALS.** (a) Each service shall have a written policy requiring each new staff person who may have responsibility for assessing or treating patients who present significant risks for suicide to do one of the following:

1. Receive documented training in assessment and management of suicidal individuals within two months after being hired by the service.

2. Provide written documentation of past training or supervised experience in assessment and management of suicidal individuals.

(b) Staff who provide crisis intervention or are on call to provide crisis intervention shall, within one month of being hired to provide these services, receive specific training in crisis assessment and treatment of persons presenting a significant risk for suicide or document that they have already received the training. The service shall have written policies and procedures covering the

nature and extent of this training to ensure that crisis and on–call staff will be able to provide the necessary services given the range of needs and symptoms generally exhibited by patients receiving care through the service.

(c) Staff employed by the program on August 1, 2000, shall either receive training in assessment and management of suicidal individuals within one year from that date or provide documentation of past training.

**(7) CONFIDENTIALITY.** Services shall have written policies, procedures and staff training to ensure compliance with provisions of 42 CFR Part 2, confidentiality of alcohol and drug abuse patient records, and s. 51.30, Stats., and ch. DHS 92, confidentiality of records. Each staff member shall sign a statement acknowledging his or her responsibility to maintain confidentiality of personal information about patients.

**(8) PATIENT CASE RECORDS.** (a) There shall be a case record for each patient. For a person receiving only emergency services under s. DHS 75.06, 75.07 or 75.15, the case record requirements are found in sub. (9).

(b) A staff person of the service shall be designated to be responsible for the maintenance and security of patient case records.

(c) Patient case records shall be safeguarded as provided in sub. (7) and maintained with the security precautions specified in 42 CFR Part 2.

(d) The case record format shall provide for consistency and facilitate information retrieval.

(e) A patient's case record shall include all of the following:

1. Consent for treatment forms signed by the patient or, as appropriate, the patient's legal guardian.

2. An acknowledgment by the patient or the patient's legal guardian, if any, that the service policies and procedures were explained to the patient or the patient's legal guardian.

3. A copy of the signed and dated patient notification that was reviewed with and provided to the patient and patient's legal guardian, if any, which identifies patient rights, and explains provisions for confidentiality and the patient's recourse in the event that the patient's rights have been abused.

4. Results of all screening, examinations, tests and other assessment information.

5. A completed copy of the most current placement criteria summary for initial placement or for documentation of the applicable approved placement criteria or WI–UPC assets and needs criteria if the patient has been transferred to a level of care different from the initial placement. Alternative forms that include all the information from the WI–UPC summary or other approved placement criteria may be used in place of the actual scoring document.

6. Treatment plans.

7. Medication records that allow for ongoing monitoring of all staff–administered medications and the documentation of adverse drug reactions.

8. All medication orders. These shall specify the name of the medication, dose, route of administration, frequency of administration, person administering and name of the physician who prescribed the medication.

9. Reports from referring sources, each to include the name of the referral source, the date of the report and the date the patient was referred to the service.

10. Records of referral by the service, including documentation that referral follow–up activities occurred.

11. Multi–disciplinary case conference and consultation notes signed by the primary counselor.

12. Correspondence relevant to the patient's treatment, including all letters and dated notations of telephone conversations.

13. Consent forms authorizing disclosure of specific information about the patient.

14. Progress notes, including staffings, in accordance with the service's policies and procedures.

15. A record of services provided that includes documentation of all case management, education, services and referrals.

16. Staffing notes signed by the primary counselor and the clinical supervisor, and by the mental health professional if the patient is dually diagnosed.

17. Documentation of transfer from one level of care to another. Documentation shall identify the applicable criteria from approved placement criteria, and shall include the dates the transfer was recommended and initiated.

18. Discharge documentation.

(f) A service shall have policies and procedures to ensure the security and confidentiality of all case records when clinical supervision is provided off site.

**Note:** An example of when clinical supervision may be provided off site is a staffing held at a central location attended by counselors from one or more branch clinics.

(g) If the service discontinues operations or is taken over by another service, records containing patient identifying information may be turned over to the replacement service or any other service provided the patient consents in writing. If no patient consent is obtained, the records shall be sealed and turned over to the department to be retained for 7 years and then destroyed.

(h) A patient's case record shall be maintained by the service for a period of 7 years from the date of termination of treatment or service.

(i) A service is the custodian and owner of the patient file and may release information only in compliance with sub. (7).

**(9) CASE RECORDS FOR PERSONS RECEIVING EMERGENCY SERVICES.** (a) A service shall keep a case record for every person requesting or receiving emergency services under s. DHS 75.06, 75.07 or 75.15, except where the only contact made is by telephone.

(b) A case record prepared under this subsection shall comply with requirements under s. DHS 124.14, if the service is operated by a hospital, or include all of the following:

1. The individual's name and address.

2. The individual's date of birth, sex and race or ethnic origin.

3. Time of first contact with the individual.

4. Time of the individual's arrival, means of arrival and method of transportation.

5. Presenting problem.

6. Time emergency services began.

7. History of recent substance use, if determinable.

8. Pertinent history of the problem, including details of first aid or emergency care given to the individual before being seen by the emergency service.

9. Description of clinical and laboratory findings.

10. Results of emergency screening, diagnosis or other assessment completed.

11. Detailed description of services provided.

12. Progress notes.

13. Condition of the individual on transfer or discharge.

14. Final disposition, including instructions given to the individual regarding necessary follow–up care.

15. Record of services provided, which shall be signed by the physician in attendance when medical diagnosis or treatment has been provided.

16. Name, address and phone number of a person to be notified in case of an emergency provided that there is a release of information signed by the patient that enables the agency to contact that person, unless the person is incapacitated and is unable to sign a release of information.



**(10) SCREENING.** (a) A service shall complete withdrawal screening for a patient who is currently experiencing withdrawal symptoms or who presents the potential to develop withdrawal symptoms.

(b) Acceptance of a patient for substance abuse services shall be based on a written screening procedure and the application of approved patient placement criteria. The written screening procedure shall clearly state the criteria for determining eligibility for admission.

(c) All substance abuse screening procedures shall include the collection of data relating to impairment due to substance use consistent with the WI–UPC, ASAM patient placement criteria or other similar patient placement criteria approved by the department.

**(11) INTAKE.** (a) *Basis for admission.* Admission of an individual to a service for treatment shall be based upon an intake procedure that includes screening, placement, initial assessment and required administrative tasks.

(b) *Policies and procedures for intake.* A service shall have written policies and procedures to govern the intake process, including all of the following:

1. A description of the types of information to be obtained from an applicant before admission.

2. A written consent to treatment statement attached to the initial service plan, which shall be signed by the prospective patient before admission is completed.

3. A method of informing the patient about and ensuring that the patient understands all of the following, and for obtaining the patient's signed acknowledgment of having been informed and understanding all of the following:

a. The general nature and purpose of the service.

b. Patient rights and the protection of privacy provided by the confidentiality laws.

c. Service regulations governing patient conduct, the types of infractions that result in corrective action or discharge from the service and the process for review or appeal.

d. The hours during which services are available.

e. Procedures for follow-up after discharge.

f. Information about the cost of treatment, who will be billed and the accepted methods of payment if the patient will be billed.

(c) *Initial assessment.* The initial assessment shall include all of the following:

1. An alcohol and drug history that identifies:

a. The substance or substances used.

b. The duration of use for each substance.

c. Pattern of use in terms of frequency and amount.

d. Method of administration.

e. Status of use immediately prior to entering into treatment.

2. Available information regarding the patient's family, significant relationships, legal, social and financial status, treatment history and other factors that appear to have a relationship to the patient's substance abuse and physical and mental health.

3. Documentation of how the information identified in subs. 1. and 2. relate to the patient's presenting problem.

4. Documentation about the current mental and physical health status of the patient.

(d) *Preliminary service plan.* A preliminary service plan shall be developed, based upon the initial assessment.

(e) *Explanation of initial assessment and service plan.* The initial assessment and preliminary service plan shall be clearly explained to the patient and, when appropriate, to the patient's family members during the intake process.

(f) *Information and referral relating to communicable diseases.* The service shall provide patients with information concerning communicable diseases, such as sexually transmitted dis-

eases (STDs), hepatitis B, tuberculosis (TB), and human immunodeficiency virus (HIV), and shall refer patients with communicable disease for treatment when appropriate.

(g) *Court-ordered admission.* Admission of a person under court order shall be in accordance with ss. 51.15 and 51.45 (12), Stats.

**(12) ASSESSMENT.** (a) Staff of a service shall assess each patient through screening interviews, data obtained during intake, counselor observation and talking with people who know the patient. Information for the assessment shall include all of the following:

1. The substance abuse counselor's evaluation of the patient and documentation of psychological, social and physiological signs and symptoms of substance abuse and dependence, mental health disorders and trauma, based on criteria in DSM–IV.

2. The summarized results of all psychometric, cognitive, vocational and physical examinations taken for, or as a result of, the patient's enrollment into treatment.

(b) The counselor's recommendations for treatment shall be included in a written case history that includes a summary of the assessment information leading to the conclusions and outcomes determined from the counselor's evaluation of the patient's problems and needs.

(c) If a counselor identifies symptoms of a mental health disorder and trauma in the assessment process, the service shall refer the individual for a mental health assessment conducted by a mental health professional.

(d) If a counselor identifies symptoms of physical health problems in the assessment process, the service shall refer the individual for a physical health assessment conducted by medical personnel.

(e) Initial assessment shall be conducted for treatment planning. The service shall implement an ongoing process of assessment to ensure that the patient's treatment plan is modified if the need arises as determined through a staffing at least every 30 days.

**(13) TREATMENT PLAN.** (a) *Basis and signatures.* A service shall develop a treatment plan for each patient. A patient's treatment plan shall be based on the assessment under sub. (12) and a discussion with the patient to ensure that the plan is tailored to the individual patient's needs. The treatment plan shall be developed in collaboration with other professional staff, the patient and, when feasible, the patient's family or another person who is important to the patient, and shall address culture, gender, disability, if any, and age-responsive treatment needs related to substance use disorders, mental disorders and trauma. The patient's participation in the development of the treatment plan shall be documented. The treatment plan shall be reviewed and signed first by the clinical supervisor and the counselor and secondly reviewed and signed by the patient and the consulting physician.

(b) *Content.* 1. The treatment plan shall describe the patient's individual or distinct problems and specify short and long-term individualized treatment goals that are expressed in behavioral and measurable terms, and are explained as necessary in a manner that is understandable to the patient.

2. The goals shall be expressed as realistic expected outcomes.

3. The treatment plan shall specify the treatment, rehabilitation, and other therapeutic interventions and services to reach the patient's treatment goals.

4. The treatment plan shall describe the criteria for discharge from services.

5. The treatment plan shall provide specific goals for treatment of dual diagnosis for those who are identified as being dually diagnosed, with input from a mental health professional.

6. Tasks performed in meeting the goals shall be reflected in progress notes and in the staffing reports.

(c) *Contract.* A patient's treatment plan constitutes a treatment contract between the patient and the service.

(d) *Review.* A patient's treatment plan shall be reviewed at regular intervals as identified in sub. (14) and modified as appropriate with date and results documented in the patient's case record through staffing reports.

**(14) STAFFING.** (a) Staffing shall be completed for each patient and shall be documented in the patient's case record as follows:

1. Staffing for patients in an outpatient treatment service who attend treatment sessions one day per week or less frequently shall be completed at least every 90 days.

2. Staffing for patients who attend treatment sessions more frequently than one day per week shall be completed at least every 30 days.

(b) A staffing report shall include information on treatment goals, strategies, objectives, amendments to the treatment plan and the patient's progress or lack of progress, including applicable criteria from the approved placement criteria being used to recommend the appropriate level of care for the patient.

(c) The counselor and clinical supervisor shall review the patient's progress and the current status of the treatment plan in regularly scheduled case conferences and shall discuss with the patient the patient's progress and status and make an appropriate notation in the patient's progress notes.

(d) If a patient is dually diagnosed, the patient's treatment plan shall be reviewed by the counselor and a mental health professional and appropriate notation made in the patient's progress notes.

(e) A staffing report shall be signed by the primary counselor and the clinical supervisor, and by a mental health professional if the patient is dually diagnosed. The consulting physician shall review and sign the staffing report.

**(15) PROGRESS NOTES.** (a) A service shall enter progress notes into the patient's case record for each contact the service has with a patient or with a collateral source regarding the patient. Notes shall be entered by the counselor and may be entered by the consulting physician, clinical supervisor, mental health professional and other staff members to document the content of the contact with the patient or with a collateral source for the patient. In this paragraph, "collateral source" means a source from which information may be obtained regarding a patient, which may include a family member, clinical records, a friend, a co-worker, a child welfare worker, a probation and parole agent or a health care provider.

(b) Progress notes shall include, at a minimum, all of the following:

1. Chronological documentation of treatment that is directly related to the patient's treatment plan.

2. Documentation of the patient's response to treatment.

(c) The person making the entry shall sign and date progress notes that are continuous and unbroken. Blank lines or spaces between the narrative statement and the signature of the person making the entry shall be connected with a continuous line to avoid the possibility of additional narrative being inserted.

(d) Staff shall make efforts to obtain reports and other case records for a patient receiving concurrent services from an outside source. The reports and other case records shall be made part of the patient's case record.

**(16) TRANSFER.** (a) If the service transfers a patient to another provider or if a change is made in the patient's level of care, documentation of the transfer or change in the level of care shall be made in the patient's case record. The transfer documentation shall include the date the transfer is recommended and initiated, the level of care from which the patient is being transferred and the applicable criteria from approved placement criteria that are

being used to recommend the appropriate level of care to which the patient is being transferred.

(b) The service shall forward a copy of the transfer documentation to the service to which the patient has been transferred within one week after the transfer date.

**(17) DISCHARGE OR TERMINATION.** (a) A patient's discharge date shall be the date the patient no longer meets criteria for any level of care in the substance abuse treatment service system, and is excluded from each of these levels of care as determined by approved placement criteria.

(b) A discharge summary shall be entered in the patient's case record within one week after the discharge date.

(c) The discharge summary shall include all of the following:

1. Recommendations regarding care after discharge.

2. A description of the reasons for discharge.

3. The patient's treatment status and condition at discharge.

4. A final evaluation of the patient's progress toward the goals set forth in the treatment plan.

5. The signature of the patient, the counselor, the clinical supervisor and, if the patient is dually diagnosed, the mental health professional, with the signature of the consulting physician included within 30 days after the discharge date.

(d) The patient shall be informed of the circumstances under which return to treatment services may be needed.

(e) Treatment terminated before its completion shall also be documented in a discharge summary. Treatment termination may occur if the patient requests in writing that treatment be terminated or if the service terminates treatment upon determining and documenting that the patient cannot be located, refuses further services or is deceased.

**(18) REFERRAL.** (a) A service shall have written policies and procedures for referring patients to other community service providers.

(b) The service director shall approve all relationships of the service with outside resources.

(c) Any written agreement with an outside resource shall specify all of the following:

1. The services the outside resource will provide.

2. The unit costs for the services, if applicable.

3. The duration of the agreement.

4. The maximum extent of services available during the period of the agreement.

5. The procedure to be followed in making referrals to the outside resource.

6. The reports that can be expected from the outside resource and how and to whom this information is to be communicated.

7. The agreement of the outside resource to comply with this chapter.

8. The degree to which the service and the outside resource will share responsibility for the patient's care.

(d) There shall be documentation that the service director has annually reviewed and approved the referral policies and procedures.

**(19) FOLLOW-UP.** (a) All follow-up activities undertaken by the service for a current patient or for a patient after discharge shall be done with the written consent of the patient.

(b) A service that refers a patient to an outside resource for additional, ancillary or follow-up services shall determine the disposition of the referral within one week from the day the referral is initiated.

(c) A service that refers a patient to an outside resource for additional or ancillary services while still retaining treatment responsibility shall request information on a regular basis as to the status and progress of the patient.

(d) The date, method and results of follow-up attempts shall be entered in the former patient's or current patient's case-record and shall be signed and dated by the individual making the entry. If follow-up information cannot be obtained, the reason shall be entered in the former patient's or current patient's case record.

(e) A service shall follow-up on a patient transfer through contact with the service the patient is being transferred to within 5 days following initiation of the transfer and every 10 days after that until the patient is either engaged in the service or has been identified as refusing to participate.

**(20) SERVICE EVALUATION.** (a) A service shall have an evaluation plan. The evaluation plan shall include all of the following:

1. A written statement of the service's goals, objectives and measurable expected outcomes that relate directly to the service's patients or target population.

2. Measurable criteria and a statistical sampling protocol which are to be applied in determining whether or not established goals, objectives and desired patient outcomes are being achieved.

3. A process for measuring and gathering data on progress and outcomes achieved with respect to individual treatment goals on a representative sample of the population served, and evaluations of some or all of the following patient outcome areas but including at least those in subd. 3. a., b., c. and f.:

- a. Living situation.
- b. Substance use.
- c. Employment, school or work activity.
- d. Interpersonal relationships.
- e. Treatment recidivism.
- f. Criminal justice system involvement.
- g. Support group involvement.
- h. Patient satisfaction.
- i. Retention in treatment.
- j. Self-esteem.
- k. Psychological functioning.

4. Methods for evaluating and measuring the effectiveness of services and using the information for service improvement.

(b) A service shall have a process in place for determining the effective utilization of staff and resources toward the attainment of patient treatment outcomes and the service's goals and objectives.

(c) A service shall have a system for regular review of the appropriateness of the components of the treatment service and other factors that may contribute to the effective use of the service's resources.

(d) A service shall obtain a completed patient satisfaction survey from a representative sample of all patients at or following their discharge from the service. The service shall keep all satisfaction surveys on file for 2 years and shall make them available for review by authorized representatives of the department upon request.

(e) A service shall collect data on patient outcomes at patient discharge and may collect data on patient outcomes after discharge.

(f) The service director shall complete an annual report on the service's progress in meeting goals, objectives and patient outcomes, and shall keep the report on file and shall make it available for review to an authorized representative of the department upon request.

(g) The governing authority or legal owner of the service and the service director shall review all evaluation reports and make changes in service operations, as appropriate.

(h) If a service holds current accreditation from a recognized accreditation organization, such as the joint commission on accreditation of health organizations, the commission on accreditation of rehabilitation facilities or the national committee for

quality assurance, the requirements under this section may be waived by the department.

**(21) COMMUNICABLE DISEASE SCREENING.** Service staff shall discuss risk factors for communicable diseases with each patient upon admission and at least annually while the patient continues in the service and shall include in the discussion the patient's prior behaviors that could lead to sexually transmitted diseases (STDs), human immunodeficiency virus (HIV), hepatitis B and C or tuberculosis (TB).

**(22) UNLAWFUL ALCOHOL OR PSYCHOACTIVE SUBSTANCE USE.** The unlawful, illicit or unauthorized use of alcohol or psychoactive substances at the service location is prohibited.

**(23) EMERGENCY SHELTER AND CARE.** A service that provides 24-hour residential care shall have a written plan for the provision of shelter and care for patients in the event of an emergency that would render the facility unsuitable for habitation.

**(24) REPORTING OF DEATHS DUE TO SUICIDE OR THE EFFECTS OF PSYCHOTROPIC MEDICINE.** Each service shall adopt written policies and procedures for reporting deaths of patients due to suicide or the effects of psychotropic medicines, as required by s. 51.64 (2), Stats. A report shall be made on a form furnished by the department.

**Note:** Copies of Form DQA F-62470 for reporting deaths under this subsection may be obtained from any Division of Quality Assurance regional office or the department's website at: <http://www.dhs.wisconsin.gov/forms/DQANum.asp>. See Appendix C for the address and phone number of the Division of Quality Assurance Office.

**History:** Cr. Register, July, 2000, No. 535, eff. 8-1-00; correction in (9) (a) made under s. 13.93 (2m) (b) 7., Stats., Register, June, 2001, No. 546; CR 06-035: am. (1), (2), and Table 75.03, Register November 2006 No. 611, eff. 12-1-06; corrections in (1), (3) (e), (4) (b), (7), and (9) (b) (intro.) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; CR 09-109: am. (2) (a), (h) and (4) (e) Register May 2010 No. 653, eff. 6-1-10; correction in (4) (e) made under s. 13.92 (4) (b) 6., 7., Stats., Register November 2011 No. 671; 2017 Wis. Act 262: am. (4) (e) Register April 2018 No. 748, eff. 5-1-18.

**DHS 75.04 Prevention service. (1) SERVICE DESCRIPTION.** A prevention service makes use of universal, selective and indicated prevention measures described in appendix A. Preventive interventions may be focused on reducing behaviors and actions that increase the risk of abusing substances or being affected by another person's substance abuse.

**(2) REQUIREMENTS.** To receive certification from the department under this chapter, a prevention service shall comply with all requirements included in s. DHS 75.03 that apply to a prevention service, as shown in Table 75.03, and, in addition, a prevention service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. DHS 75.03, the requirement in this section shall be followed.

**(3) REQUIRED PERSONNEL.** (a) A professional employed by the service shall be knowledgeable and skilled in all areas of substance abuse prevention domains as required by DSPS.

(b) Paraprofessional personnel shall be knowledgeable and skilled in the areas of substance abuse prevention domains as required by the DSPS.

(c) Staff without previous experience in substance abuse prevention shall receive inservice training and shall be supervised in performing work activities identified in sub. (4) by a professional qualified under par. (a).

**(4) OPERATION OF THE PREVENTION SERVICE.** (a) *Strategies.* A prevention service shall utilize all of the following strategies in seeking to prevent substance abuse and its effects:

1. 'Information dissemination.' This strategy aims at providing awareness and knowledge of the nature and extent of the identified problem and providing knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience. Examples of activities that may be conducted and methods used in carrying out this strategy include the following:

- a. Operation of an information clearinghouse.
- b. Development and distribution of a resource directory.
- c. Media campaigns.
- d. Development and distribution of brochures.
- e. Radio and TV public service announcements.
- f. Speaking engagements.
- g. Participation in health fairs and other health promotion activities.

2. ‘Education.’ This strategy involves two–way communication and is distinguished from the information dissemination strategy by interaction between the educator or facilitator and the participants. Activities under this strategy are directed at affecting critical life and social skills, including decision–making, refusal skills, critical analysis, for instance, of media messages, and systematic judgment abilities. Examples of activities that may be conducted and methods used in carrying out this strategy are the following:

- a. Classroom or small group sessions.
- b. Parenting and family management classes.
- c. Peer leader or helper programs.
- d. Education programs for youth groups.
- e. Children of substance abuser groups.

3. ‘Promotion of healthy activities.’ This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco and other drug use or promote activities that lend themselves to the building of resiliency among youth and families. The assumption is that constructive and healthy activities offset the attraction to or otherwise meet the needs that may be fulfilled by alcohol, tobacco and other drugs. Alternative activities also provide a means of character–building and may promote healthy relationships between youth and adults in that participants may internalize the values and attitudes of the individuals involved in establishing the prevention services objectives. Examples of healthy activities that may be promoted or conducted under this strategy may include the following:

- a. Drug–free dances and parties.
- b. Youth or adult leadership activities.
- c. After–school activities such as participation in athletic activities, in music lessons, an art club or the school newspaper.
- d. Community drop–in centers.
- e. Community service activities.

4. ‘Problem identification and referral.’ This strategy is to identify individuals who have demonstrated at–risk behavior, such as indulging in illegal or age–inappropriate use of tobacco or alcohol or indulging in the first use of illicit drugs, to determine if their behavior can be reversed through education. This strategy does not include activities designed to determine if a person is in need of treatment. Examples of activities that may be conducted and methods used in carrying out this strategy are the following:

- a. Employee assistance programs.
- b. Student assistance programs.
- c. Educational programs for individuals charged with driving while under the influence or driving while intoxicated.

5. ‘Environmental.’ This strategy aims at establishing written or unwritten community standards, codes and attitudes, thereby influencing the incidence and prevalence of at–risk behavior in the general population. This strategy distinguishes between activities that center on legal and regulatory initiatives and those which relate to the service and action–oriented initiatives. Examples of activities that may be conducted and methods used in carrying out this strategy are the following:

- a. Promoting the establishment and review of policies for schools related to the use of alcohol, tobacco and drugs.

b. Providing technical assistance to communities to maximize local enforcement procedures governing availability and distribution of alcohol, tobacco and other drug use.

- c. Modifying alcohol and tobacco advertising practices.

d. Supporting local enforcement procedures to limit violent behavior.

e. Establishing policies that create opportunities for youth to become involved in their communities.

6. ‘Community–based process’. This strategy seeks to enhance the ability of the community to more effectively provide prevention, remediation and treatment services for behaviors that lead to intensive services. Activities under this strategy include organizing, planning, enhancing the efficiency and effectiveness of services implementation, interagency collaboration, coalition building and networking. Examples of activities that may be conducted and methods used in carrying out this strategy are the following:

a. Community and volunteer training, such as neighborhood action training and training of key people in the system.

- b. Systematic planning in the above areas.

- c. Multi–agency coordination and collaboration.

- d. Facilitating access to services and funding.

- e. Community team–building.

(b) *Goals and objectives.* A prevention service shall have written operational goals and objectives and shall specify in writing the methods by which they will be achieved and the target populations.

(c) *Documentation of coordination.* A prevention service shall provide written documentation of coordination with other human service agencies, organizations or services that share similar goals.

(d) *Records.* A prevention service shall maintain records on the number of individuals served by implementation of each prevention strategy and retain records as necessary for meeting certification and funding requirements.

(5) PREVENTION SERVICE EVALUATION. (a) A prevention service shall have an evaluation process that measures the outcomes of the services provided.

(b) A prevention service shall evaluate the views of consumers about the service as they are provided and shall adjust goals and objectives accordingly.

(c) A prevention service shall have a written policy and a defined process to provide individuals with the opportunity to express opinions regarding ongoing services, staff and the methods by which individual prevention activities are offered.

**History:** Cr. Register, July, 2000, No. 535, eff. 8–1–00; CR 09–109: am. (3) (a) and (b) Register May 2010 No. 653, eff. 6–1–10; correction in (3) (a), (b) made under s. 13.92 (4) (b) 6., Stats., Register November 2011 No. 671.

**DHS 75.05 Emergency outpatient service. (1) SERVICE DESCRIPTION.** An emergency outpatient service operates an emergency phone service and provides on–site crisis intervention to deal with all outpatient emergencies related to substance abuse, including socio–emotional crises, attempted suicide and family crises; provides the examination required under s. 51.45 (11) (c), Stats.; and, if needed, provides or arranges for transportation of a patient to the emergency room of a general hospital for medical treatment.

(2) REQUIREMENTS. To receive certification from the department under this chapter, an emergency outpatient service shall comply with all requirements included in s. DHS 75.03 that apply to an emergency outpatient service, as shown in Table 75.03, and, in addition, an emergency outpatient service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. DHS 75.03, the requirement in this section shall be followed.

**(3) REQUIRED PERSONNEL.** (a) An emergency outpatient service shall have staff available who are capable of providing coverage for an emergency phone service and for providing on-site crisis intervention.

(b) A service shall have a written plan for staffing the service and shall document that all of the following have been taken into consideration:

1. The nature of previously observed and anticipated emergencies and the probability of emergencies as related to geographical, seasonal, temporal and demographic factors.
2. The adequacy of the emergency communication system used by the service when consultation is required.
3. The types of emergency services to be provided.
4. The skills of staff members in providing emergency services.
5. Difficulty in contacting staff members.
6. The estimated travel time for a staff member to arrive at an emergency care facility or at the location of an emergency.

**(4) SERVICE OPERATIONS.** (a) An emergency outpatient service shall provide emergency telephone coverage 24 hours per day and 7 days a week, as follows:

1. The telephone number of the program shall be well-publicized.
2. A log shall be kept of all emergency calls as well as of calls requesting treatment information. For each call, the log shall describe all of the following:
  - a. The purpose of the call.
  - b. Caller identification information, if available.
  - c. Time and date of call.
  - d. Recommendations made.
  - e. Other action taken.

(b) A service shall have written procedures that ensure prompt evaluation of both the physiological and psychological status of the individual so that rapid determination can be made of the nature and urgency of the problem and of the type of treatment required.

(c) A service shall have written procedures for dealing with anticipated medical and psychiatric complications of substance abuse emergencies.

(d) A service shall either be able to provide medical support for substance abuse-related emergencies on-site or have the capability of transporting the individual to a local hospital or other recognized medical facility.

(e) If the emergency outpatient service is not a part of a general hospital, the service shall enter into a formal agreement with a local hospital for the hospital to receive referrals from the service on a 24-hour basis and provide services with the same standards of care prevailing for emergency cases treated in the hospital that are not related to substance abuse.

**History:** Cr. Register, July, 2000, No. 535, eff. 8–1–00.

**DHS 75.06 Medically managed inpatient detoxification service.** **(1) SERVICE DESCRIPTION.** A medically managed inpatient detoxification service provides 24-hour per day observation and monitoring of patients in a hospital setting, with round-the-clock nursing care, physician management and availability of all other resources of the hospital.

**(2) REQUIREMENTS.** To receive certification from the department under this chapter, a medically managed inpatient detoxification service shall comply with all requirements included in s. DHS 75.03 that apply to a medically managed inpatient detoxification service, as shown in Table 75.03, and, in addition, a medically managed detoxification service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. DHS 75.03, the requirement in this section shall be followed.

**(3) REQUIRED PERSONNEL.** (a) A medically managed inpatient detoxification service shall have a staffing pattern that is consistent with s. DHS 124.13 requirements.

(b) The service shall ensure that a patient receives consultation from a substance abuse counselor before the patient is discharged from the service.

**(4) SERVICE OPERATIONS.** (a) A medically managed inpatient detoxification service shall have written agreements with certified substance abuse service providers or systems to provide rehabilitative substance abuse care if determined necessary by substance abuse screening and the application of approved patient placement criteria administered by the service.

(b) A service shall have written policies and procedures for the management of belligerent and disturbed patients, which shall include transfer of patients to another appropriate facility if necessary.

(c) A service shall develop with each patient a detoxification plan and a discharge plan for the patient that addresses the patient's follow-up service needs determined by application of approved patient placement criteria, and the provision for referral, escort and transportation to other treatment services, as necessary, to ensure that continuity of care is provided.

**History:** Cr. Register, July, 2000, No. 535, eff. 8–1–00; correction in (3) (a) made under s. 13.92 (4) (b) 7. Stats., Register November 2008 No. 635.

**DHS 75.07 Medically monitored residential detoxification service.** **(1) SERVICE DESCRIPTION.** A medically monitored residential detoxification service is a 24-hour per day service in a residential setting providing detoxification service and monitoring. Care is provided by a multi-disciplinary team of service personnel, including 24-hour nursing care under the supervision of a physician. Included is the provision of an examination in accordance with s. 51.45 (11) (c), Stats., and transportation, if needed, to an emergency room of a general hospital for medical treatment.

**(2) REQUIREMENTS.** To receive certification from the department under this chapter, a medically monitored residential detoxification service shall comply with all requirements included in s. DHS 75.03 that apply to a medically monitored detoxification service, as shown in Table 75.03, and, in addition, a medically monitored residential detoxification service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. DHS 75.03, the requirement in this section shall be followed.

**(3) ORGANIZATIONAL REQUIREMENTS.** Before operating or expanding a medically monitored residential detoxification service, a facility shall be approved under ch. DHS 124 as a hospital or licensed under ch. DHS 83 as a community-based residential facility.

**(4) REQUIRED PERSONNEL.** (a) A medically monitored residential detoxification service shall ensure that a patient receives consultation from a substance abuse counselor before the patient is discharged from the service.

(b) The service shall have a nursing director who is a registered nurse.

(c) A registered nurse shall be available on site on a 24-hour basis.

(d) A physician shall be available on site [on call] on a 24-hour basis.

**Note:** The department's intent is that physicians will be on call rather than on site.

**(5) SERVICE OPERATIONS.** (a) A physician shall review and document the medical status of a patient within 72 hours after admission.

(b) A service shall have written policies and procedures for the management of belligerent and disturbed patients, which shall include transfer of a patient to another appropriate facility if necessary.

(c) A service shall have a written agreement with certified substance abuse service providers or systems to provide care after the patient is discharged from the service.

(d) A service shall have a written agreement with a hospital for the hospital to provide emergency medical services for patients and shall provide escort and transportation to the hospital. If necessary, the service shall also provide escort and transportation for return to the service.

(e) The service shall develop with each patient a detoxification plan and a discharge plan for the patient that addresses the patient's follow-up service needs, determined from the application of approved patient placement criteria administered by the service, and shall include provision for referral, escort and transportation to other treatment services, as necessary, to ensure that continuity of care is provided.

(f) A service shall have a treatment room that has in it at least the following:

1. First aid supplies maintained and readily available to all personnel responsible for the care of patients.
2. Separate locked cabinets exclusively for all pharmaceutical supplies.

**History:** Cr. Register, July, 2000, No. 535, eff. 8–1–00; correction in (3) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.

#### DHS 75.08 Ambulatory detoxification service.

**(1) SERVICE DESCRIPTION.** An ambulatory detoxification service is a medically managed or monitored structured detoxification service on an outpatient basis, delivered by a physician or other service personnel acting under the supervision of a physician.

**(2) REQUIREMENTS.** To receive certification from the department under this chapter, an ambulatory detoxification service shall comply with all requirements included in s. DHS 75.03 that apply to an ambulatory detoxification service, as shown in Table 75.03, and, in addition, an ambulatory detoxification service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. DHS 75.03, the requirement in this section shall be followed.

**(3) REQUIRED PERSONNEL.** (a) An ambulatory detoxification service shall ensure that a patient receives consultation from a substance abuse counselor before the patient is discharged from the service.

(b) The service shall have a nursing director who is a registered nurse.

(c) A registered nurse shall be available on a 24-hour basis.

(d) A physician shall be available on a 24-hour basis.

**(4) SERVICE OPERATIONS.** (a) An ambulatory detoxification service shall provide patients with 24-hour access to medical personnel and a substance abuse counselor.

(b) The service shall have written agreements with certified substance abuse service providers or systems to provide care after the patient is discharged from the service.

(c) A physician shall document review of admission data within 24 hours after a person's admission.

(d) The service shall have a written agreement with a hospital for the hospital to provide emergency medical services for patients and shall provide escort and transportation to the hospital. If necessary, the service shall also provide escort and transportation for return to the service.

(e) The service shall have a treatment room, which has in it at least the following:

1. First aid supplies maintained and readily available to all personnel responsible for the care of patients.
2. Separate locked cabinets exclusively for all pharmaceutical supplies.

(f) The service shall have written policies and procedures for the management of belligerent and disturbed patients, which shall

include transfer of a patient to another appropriate facility if necessary.

(g) The service shall develop a detoxification plan and a discharge plan for each patient that addresses the patient's follow-up service needs determined by application of approved patient placement criteria administered by the service, and the provision for referral, escort and transportation to other treatment services, as necessary, to ensure that continuity of care is provided.

**History:** Cr. Register, July, 2000, No. 535, eff. 8–1–00.

#### DHS 75.09 Residential intoxication monitoring service.

**(1) SERVICE DESCRIPTION.** A residential intoxication monitoring service provides 24-hour per day observation by staff to monitor the safe resolution of alcohol or sedative intoxication and to monitor for the development of alcohol withdrawal for intoxicated patients who are not in need of emergency medical or psychological care. The service is provided in a supportive setting that includes provision of nourishment and emotional support.

**(2) REQUIREMENTS.** To receive certification from the department under this chapter, a residential intoxication monitoring service shall comply with all requirements included in s. DHS 75.03 that apply to a residential intoxication monitoring service, as shown in Table 75.03, and, in addition, a residential intoxication monitoring service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. DHS 75.03, the requirement in this section shall be followed.

**(3) ORGANIZATIONAL REQUIREMENTS.** Before operating or expanding a residential intoxication monitoring service, a facility shall be approved under ch. DHS 124 as a hospital, licensed under ch. DHS 83 as a community-based residential facility, certified under ch. DHS 82 or licensed under ch. DHS 88 as an adult family home.

**(4) REQUIRED PERSONNEL.** (a) A service shall have at least one staff person trained in the recognition of withdrawal symptoms on duty 24 hours per day, 7 days per week.

(b) A service shall ensure that a patient receives consultation from a substance abuse counselor before the patient is discharged from the service.

**(5) SERVICE OPERATIONS.** (a) *Screening.* A patient shall be screened by medical personnel before admission to the service, unless the service has documentation of the patient's current physical condition.

(b) *Prohibited admissions.* No person may be admitted if any of the following apply:

1. His or her behavior is determined by the service to be dangerous to self or others.
2. He or she requires professional nursing or medical care.
3. He or she is incapacitated by alcohol and is placed in or is determined to be in need of protective custody by a law enforcement officer as required under s. 51.45 (11) (b), Stats.
4. He or she is under the influence of any substance other than alcohol or a sedative.
5. He or she requires restraints.
6. He or she requires medication normally used for the detoxification process.

(c) *Observation.* Trained staff shall observe a patient and record the patient's condition at intervals no greater than every 30 minutes during the first 12 hours following admission.

(d) *Emergency medical treatment.* A service shall have a written agreement with a general hospital for the hospital to provide emergency medical treatment of patients. Escort and transportation shall be provided as necessary to a patient who requires emergency medical treatment.

(e) *Medications.* 1. A service shall not administer or dispense medications.

2. When a patient has been admitted with prescribed medication, staff shall consult with the patient's physician or other person licensed to prescribe and administer medications to determine the appropriateness of the patient's continued use of the medication while under the influence of alcohol or sedatives.

3. If approval for continued use of prescribed medication is received from a physician, the patient may self-administer the medication under the observation of service staff.

(f) *Discharge plan.* A service shall develop with each patient a discharge plan for the patient which shall address the patient's follow-up service needs determined by application of approved patient placement criteria administered by the service, and the provision for referral, escort and transportation to other treatment services, as necessary, to ensure that continuity of care is provided.

**History:** Cr. Register, July, 2000, No. 535, eff. 8–1–00; correction in (3) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.

**DHS 75.10 Medically managed inpatient treatment service.** (1) **SERVICE DESCRIPTION.** A medically managed inpatient treatment service is operated by a general or specialty hospital, and includes 24-hour nursing care, physician management and the availability of all other resources of the hospital.

(2) **REQUIREMENTS.** To receive certification from the department under this chapter, a medically managed inpatient treatment service shall comply with all requirements included in s. DHS 75.03 that apply to a medically managed inpatient treatment service, as shown in Table 75.03, and, in addition, a medically managed inpatient treatment service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. DHS 75.03, the requirement in this section shall be followed.

(3) **ORGANIZATIONAL REQUIREMENTS.** Before operating or expanding an inpatient treatment service, a facility shall do all of the following:

(a) Submit for approval to the department, a written justification for the service, documenting if the service has been operating, the service's effectiveness and the need for additional inpatient treatment resources in the geographic area in which the service will operate or is operating.

(b) Notify the county department of community programs under s. 51.42, Stats., in the area in which the service will operate or is operating of the intention to begin to operate or expand the service.

(c) Be approved as a hospital under ch. DHS 124.

(4) **REQUIRED PERSONNEL.** (a) An inpatient treatment service shall have all of the following personnel:

1. A director who is responsible for the overall operation of the service, including the therapeutic design and delivery of services.

2. A medical director.

3. A consulting psychiatrist who is licensed under ch. 448, Stats., and board-certified or eligible for certification by the American board of psychiatry and neurology or a consulting clinical psychologist licensed under ch. 455, Stats., who will be available as needed, with a written agreement to that effect. Each consultant shall be sufficiently knowledgeable about substance abuse and dependence treatment to carry out his or her assigned duties.

4. A mental health professional who is available either as an employee of the service or through written agreement to provide joint and concurrent services for the treatment of dually diagnosed patients.

5. At least one full-time certified substance abuse counselor for every 10 patients or fraction thereof.

6. At least one clinical supervisor on staff to provide ongoing clinical supervision of the counseling staff, or a person outside the

agency who is a clinical supervisor and who by written agreement will provide ongoing clinical supervision of the counseling staff.

(b) A clinical supervisor who meets the requirements of a substance abuse counselor may provide direct counseling services in addition to his or her supervisory responsibilities.

(c) A trained staff member designated to be responsible for the operation of the service shall be on the premises at all times. That person may provide direct counseling or other duties in addition to being in charge of the service.

(d) Other persons, such as volunteers and students, may work in an inpatient treatment facility if all of the following conditions are met:

1. Volunteers and students do not replace direct care staff required under par. (a) or carry out the duties of direct care staff, and there are written descriptions of their responsibilities and duties.

2. Volunteers and students are supervised by professional staff.

3. The inpatient treatment service has written procedures for selecting, orienting and providing in-service training to volunteers.

4. Volunteers and students meet the sensitivity and training expectations under s. DHS 75.03 (3) (h).

(5) **CLINICAL SUPERVISION.** (a) A medically managed inpatient treatment service shall provide for ongoing clinical supervision of the counseling staff. Ongoing clinical supervision shall be provided as required in s. SPS 162.01.

**Note:** Section SPS 162.01 (1) states that a clinical supervisor shall provide a minimum of:

1. Two hours of clinical supervision for every 40 hours of work performed by a substance abuse counselor-in-training.

2. Two hours of clinical supervision for every 40 hours of counseling provided by a substance abuse counselor.

3. One hour of clinical supervision for every 40 hours of counseling provided by a clinical substance abuse counselor.

4. One in person meeting each calendar month with a substance abuse counselor-in-training, substance abuse counselor, or clinical substance abuse counselor. This meeting may fulfill a part of the requirements above.

(b) A clinical supervisor shall provide supervision to substance abuse counselors in the areas identified in s. SPS 162.01 (5).

**Note:** Section SPS 162.01 (5) states that the goals of clinical supervision are to provide the opportunity to develop competency in the transdisciplinary foundations, practice dimensions and care functions, provide a context for professional growth and development and ensure a continuance of quality patient care.

(6) **SERVICE OPERATIONS.** (a) A physician, registered nurse or physician assistant shall conduct medical screening of a patient no later than 24 hours after the person's admission to a service to identify health problems and to screen for communicable diseases.

(b) A service shall arrange for services for a patient with medical needs unless otherwise arranged for by the patient.

(c) A service shall complete intake within 24 hours of a person's admission to the service except that the initial assessment and treatment plan shall be completed within 4 days of admission.

(d) A service shall arrange for additional psychological tests for a patient as needed.

(e) A service shall have a written statement describing its treatment philosophy and objectives in providing care and treatment for substance abuse problems.

(f) A substance abuse counselor or other qualified staff member of a service shall provide a minimum of 12 hours of counseling per week for each patient, including individual and group counseling. Family and couples counseling shall be provided or made available, when appropriate. The service shall ensure that:

1. Each patient receives at least one hour of individual counseling per week.

2. The service's treatment schedule is communicated to patients in writing and by any other means necessary for patients with communication difficulties.

(g) Services required by a patient but not provided by a service shall be provided by other appropriate hospital services or outside agencies.

(h) A service staff member shall be trained in life-sustaining techniques and emergency first aid.

(i) A service shall have a written policy on urinalysis that shall include both the following:

1. Procedures for collection and analysis of samples.
2. A description of how urinalysis reports are used in the treatment of a patient.

(7) **ADMISSION.** (a) Admission to an inpatient treatment service shall be by order of a physician. The physician's referral shall be in writing or indicated by the physician's signature on the placement criteria summary.

(b) Admission to an inpatient treatment service is appropriate only if one of the following conditions is met:

1. The person to be admitted is determined appropriate for placement in this level of care by the application of approved placement criteria.

2. The person to be admitted is determined appropriate for this level of care through the alternative placement recommendations of WI-UPC or other approved placement criteria.

**History:** Cr. Register, July, 2000, No. 535, eff. 8-1-00; correction in (3) (c) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; CR 09-109: am. (5) Register May 2010 No. 653, eff. 6-1-10; correction in (5) (a), (b) made under s. 13.92 (4) (b) 7., Stats., Register November 2011 No. 671.

### DHS 75.11 Medically monitored treatment service.

(1) **SERVICE DESCRIPTION.** A medically monitored treatment service operates as a 24-hour, community-based service providing observation, monitoring and treatment by a multidisciplinary team under supervision of a physician, with a minimum of 12 hours of counseling provided per week for each patient.

(2) **REQUIREMENTS.** To receive certification from the department under this chapter, a medically monitored treatment service shall comply with all requirements included in s. DHS 75.03 that apply to a medically monitored treatment service as shown in Table 75.03 and, in addition, shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. DHS 75.03, the requirement in this section shall be followed.

(3) **ORGANIZATIONAL REQUIREMENTS.** Before operating or expanding a medically monitored treatment service, a facility shall be approved under ch. DHS 124 as a hospital or shall be licensed under ch. DHS 83 as a community-based residential facility.

(4) **REQUIRED PERSONNEL.** (a) A medically monitored treatment service shall have the following personnel:

1. A director responsible for the overall operation of the service, including the therapeutic design and delivery of services.
2. At least one full-time substance abuse counselor for every 15 patients or fraction thereof enrolled in the service.
3. A physician available to provide medical supervision and clinical consultation as either an employee of the service or through a written agreement.
4. At least one clinical supervisor on staff to provide ongoing clinical supervision of the counseling staff or a person outside the agency who is a clinical supervisor and who by written agreement will provide ongoing clinical supervision of the counseling staff.
5. A mental health professional available either as an employee of the service or through written agreement to provide joint and concurrent services for the treatment of dually diagnosed patients.

(b) A clinical supervisor who meets the requirements of a substance abuse counselor may provide direct counseling services in addition to his or her supervisory responsibilities.

(c) A trained staff member designated by the director to be responsible for the operation of the service shall be on the premises at all times the service is in operation. That person may provide direct counseling or other duties in addition to being in charge of the service.

(5) **CLINICAL SUPERVISION.** (a) A medically monitored treatment service shall provide for ongoing clinical supervision of the counseling staff. Ongoing clinical supervision shall be provided as required in s. SPS 162.01.

**Note:** Section SPS 162.01 (1) states that a clinical supervisor shall provide a minimum of:

1. Two hours of clinical supervision for every 40 hours of work performed by a substance abuse counselor-in-training.
2. Two hours of clinical supervision for every 40 hours of counseling provided by a substance abuse counselor.
3. One hour of clinical supervision for every 40 hours of counseling provided by a clinical substance abuse counselor.
4. One in person meeting each calendar month with a substance abuse counselor-in-training, substance abuse counselor, or clinical substance abuse counselor. This meeting may fulfill a part of the requirements above.

(b) The clinical supervisor shall provide supervision and performance evaluation of substance abuse counselors in the areas identified in s. SPS 162.01 (5).

**Note:** Section SPS 162.01 (5) states that the goals of clinical supervision are to provide the opportunity to develop competency in the transdisciplinary foundations, practice dimensions and care functions, provide a context for professional growth and development and ensure a continuance of quality patient care.

(6) **SERVICE OPERATIONS.** (a) 1. A physician, registered nurse or physician assistant shall conduct a medical screening of a patient no later than 7 working days after the person's admission to a service to identify health problems and screen for communicable diseases unless there is documentation that screening was completed within 90 days prior to admission.

2. A service shall arrange for services for a patient with medical needs unless otherwise arranged by the patient.

(b) A service shall complete intake within 24 hours of a person's admission to the service except that the assessment and treatment plan shall be completed within 4 days of admission.

(c) A service shall arrange for additional psychological tests for a patient as needed.

(d) A service shall operate 24 hours per day, 7 days per week.

(e) Each service shall have a written statement describing its treatment philosophy and objectives in providing care and treatment for substance abuse problems.

(f) A service shall provide a minimum of 12 hours per week of treatment for each patient, including individual and group counseling. Family and couples counseling shall be provided or made available, when appropriate. The service shall ensure that:

1. Each patient receives at least one hour of individual counseling per week.

2. The service's treatment schedule is communicated to patients in writing and by any other means necessary for patients with communication difficulties.

(g) A service shall ensure that 3 meals per day are provided to each patient.

(h) A service shall ensure that services required by a patient that are not provided by the service are provided to the patient by referral to an appropriate agency.

(i) A service shall have a written agreement with a hospital for provision of emergency and inpatient medical services, when needed.

(j) A service staff member shall be trained in life-sustaining techniques and emergency first aid.

(k) A service shall have a written policy on urinalysis that includes all of the following:

1. Procedures for collection and analysis of samples.



2. A description of how urinalysis reports are used in the treatment of the patient.

**(7) ADMISSION.** Admission to a medically monitored treatment service is appropriate only if one of the following conditions is met:

(a) The person to be admitted is determined appropriate for placement in this level of care by the application of approved placement criteria.

(b) The person to be admitted is determined appropriate for this level of care through the alternative placement recommendations of WI–UPC or other approved placement criteria.

**History:** Cr. Register, July, 2000, No. 535, eff. 8–1–00; correction in (3) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; CR 09–109: am. (5) Register May 2010 No. 653, eff. 6–1–10; correction in (5) (a), (b) made under s. 13.92 (4) (b) 7., Stats., Register November 2011 No. 671.

**DHS 75.12 Day treatment service. (1) SERVICE DESCRIPTION.** A day treatment service is a medically monitored, and non–residential substance abuse treatment service which consists of regularly scheduled sessions of various modalities, such as individual and group counseling and case management, provided under the supervision of a physician. Services are provided in a scheduled number of sessions per day and week, with each patient receiving a minimum of 12 hours of counseling per week.

**(2) REQUIREMENTS.** To receive certification from the department under this chapter, a day treatment service shall comply with all requirements included in s. DHS 75.03 that apply to a day treatment service, as shown in Table 75.03, and, in addition, a day treatment service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. DHS 75.03, the requirement in this section shall be followed.

**(3) ORGANIZATIONAL REQUIREMENTS.** A day treatment service may be a stand–alone service or may be co–located in a facility that includes other services.

**(4) REQUIRED PERSONNEL.** (a) A day treatment service shall have the following personnel:

1. A director responsible for the overall operation of the service, including the therapeutic design and delivery of services.

2. At least one full–time substance abuse counselor for every 15 patients or fraction thereof enrolled in the service.

3. A physician available to provide medical consultation and clinical consultation as either an employee of the service or through a written agreement.

4. A mental health professional available either as an employee of the service or through a written agreement to provide joint and concurrent services for the treatment of dually diagnosed patients.

5. At least one clinical supervisor on staff to provide ongoing clinical supervision of the counseling staff or a person outside the agency who is a clinical supervisor and who by written agreement will provide ongoing clinical supervision of the counseling staff.

(b) A clinical supervisor who meets the requirements of a substance abuse counselor may provide direct counseling services in addition to his or her supervisory responsibilities.

(c) A trained staff member designated by the director to be responsible for the operation of the service shall be on the premises at all times the service is in operation. That person may provide direct counseling or other duties in addition to being in charge of the service.

**(5) CLINICAL SUPERVISION.** (a) A day treatment service shall provide for ongoing clinical supervision of the counseling staff. Ongoing clinical supervision shall be provided as required in s. SPS 162.01.

**Note:** Section SPS 162.01 (1) states that a clinical supervisor shall provide a minimum of:

1. Two hours of clinical supervision for every 40 hours of work performed by a substance abuse counselor–in–training.

2. Two hours of clinical supervision for every 40 hours of counseling provided by a substance abuse counselor.

3. One hour of clinical supervision for every 40 hours of counseling provided by a clinical substance abuse counselor.

4. One in person meeting each calendar month with a substance abuse counselor–in–training, substance abuse counselor, or clinical substance abuse counselor. This meeting may fulfill a part of the requirements above.

(b) The clinical supervisor shall provide supervision and performance evaluation of substance abuse counselors in the areas identified in s. SPS 162.01 (5).

**Note:** Section SPS 162.01 (5) states that the goals of clinical supervision are to provide the opportunity to develop competency in the transdisciplinary foundations, practice dimensions and care functions, provide a context for professional growth and development and ensure a continuance of quality patient care.

**(6) SERVICE OPERATIONS.** (a) A service shall work with patients who need health care services but do not have access to them to help them gain access to those services.

(b) A service shall complete a patient’s treatment plan within 2 visits after admission.

(c) A service shall arrange for additional psychological tests for a patient as needed.

(d) Each service shall have a written statement describing its treatment philosophy and objectives in providing care and treatment for substance abuse problems.

(e) A substance abuse counselor shall provide a minimum of 12 hours of counseling per week for each patient, including individual and group counseling. Family and couples counseling shall be provided or made available, when appropriate. The service shall ensure that:

1. Each patient receives at least one hour of individual counseling per week.

2. The service’s treatment schedule is communicated to patients in writing and by any other means necessary for patients with communication difficulties.

3. The maximum amount of time between counseling sessions does not exceed 72 hours in any consecutive 7–day period.

(f) A service shall provide services at times that allow the majority of the patient population to maintain employment or attend school.

(g) A service patient may not simultaneously be an active patient in a medically managed inpatient treatment service, a medically monitored treatment service or an outpatient treatment service.

(h) Services required by a patient that are not provided by the service shall be provided by referral to an appropriate agency.

(i) A service shall have a written agreement with a hospital for provision of emergency and inpatient medical services when needed.

(j) A service staff member shall be trained in life–sustaining techniques and emergency first aid.

(k) A service shall have a written policy on urinalysis that includes all of the following:

1. Procedures for collection and analysis of samples.

2. A description of how urinalysis reports are used in the treatment of the patient.

**(7) ADMISSION.** Admission to a day treatment service is appropriate only if one of the following conditions is met:

(a) The person to be admitted is determined appropriate for placement in this level of care by the application of approved placement criteria.

(b) The person to be admitted is determined appropriate for this level of care through the alternative placement recommendations of WI–UPC or other approved placement criteria.

**History:** Cr. Register, July, 2000, No. 535, eff. 8–1–00; CR 09–109: am. (5) Register May 2010 No. 653, eff. 6–1–10; correction in (5) (a), (b) made under s. 13.92 (4) (b) 7., Stats., Register November 2011 No. 671.

**DHS 75.13 Outpatient treatment service. (1) SERVICE DESCRIPTION.** An outpatient treatment service is a non–residential treatment service totaling less than 12 hours of counseling

per patient per week, which provides a variety of evaluation, diagnostic, crisis and treatment services relating to substance abuse to ameliorate negative symptoms and restore effective functioning. Services include individual counseling and intervention and may include group therapy and referral to non–substance abuse services that may occur over an extended period.

**(2) REQUIREMENTS.** To receive certification from the department under this chapter, an outpatient treatment service shall comply with all requirements included in s. DHS 75.03 that apply to an outpatient treatment service, as shown in Table 75.03, and, in addition, an outpatient treatment service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. DHS 75.03, the requirement in this section shall be followed.

**(2m)** If an outpatient treatment service is designated by a board under s. DHS 62.04 (1) as an assessment facility, the outpatient treatment service shall also comply with the requirements under ch. DHS 62.

**(3) REQUIRED PERSONNEL.** (a) An outpatient treatment service shall have the following personnel:

1. A director responsible for the overall operation of the service, including the therapeutic design and delivery of services.
2. A physician available to provide medical supervision and clinical consultation as either an employee of the service or through a written agreement.
3. A substance abuse counselor available during hours of operation.
4. A mental health professional available either as an employee of the service or through a written agreement to provide joint and concurrent services for the treatment of dually diagnosed patients.
5. A clinical supervisor to provide ongoing clinical supervision of the counseling staff, or a person outside the agency who is a clinical supervisor and who by a written agreement will provide ongoing clinical supervision of the counseling staff.

(b) A clinical supervisor who meets the requirements of a substance abuse counselor may provide direct counseling services in addition to his or her supervisory responsibilities.

(c) A trained staff member designated by the director to be responsible for the operation of the service shall be on the premises at all times the service is in operation. That person may provide direct counseling or other duties in addition to being in charge of the service.

**(4) CLINICAL SUPERVISION.** (a) An outpatient treatment service shall provide for ongoing clinical supervision of the counseling staff. Ongoing clinical supervision shall be provided as required in s. SPS 162.01.

**Note:** Section SPS 162.01 (1) states that a clinical supervisor shall provide a minimum of:

1. Two hours of clinical supervision for every 40 hours of work performed by a substance abuse counselor–in–training.
2. Two hours of clinical supervision for every 40 hours of counseling provided by a substance abuse counselor.
3. One hour of clinical supervision for every 40 hours of counseling provided by a clinical substance abuse counselor.
4. One in person meeting each calendar month with a substance abuse counselor–in–training, substance abuse counselor, or clinical substance abuse counselor. This meeting may fulfill a part of the requirements above.

(b) A clinical supervisor shall provide supervision and performance evaluation of substance abuse counselors in the areas identified in s. SPS 162.01 (5).

**Note:** Section SPS 162.01 (5) states that the goals of clinical supervision are to provide the opportunity to develop competency in the transdisciplinary foundations, practice dimensions and care functions, provide a context for professional growth and development and ensure a continuance of quality patient care.

**(5) SERVICE OPERATIONS.** (a) A service shall work with patients who need health care services but do not have access to them to help them gain access to those services.

(b) A service shall complete a patient’s treatment plan within two visits after admission.

(c) A service shall arrange for additional psychological tests for a patient as needed.

(d) Service staff shall review, evaluate and revise a patient’s treatment plan, as needed, in consultation with the clinical supervisor, based on ongoing assessment of the patient. If a patient is dually diagnosed, service staff shall review, evaluate and revise the patient’s treatment plan, as needed, in consultation also with a mental health professional.

(e) The service medical director or licensed clinical psychologist shall establish the patient’s diagnosis or review and concur with the diagnosis made by the patient’s primary physician, and shall review the recommended level of care needed, the assessment report and the treatment plan. The medical director or licensed clinical psychologist shall sign and date a statement that these tasks have been carried out and shall insert the statement in the patient’s case record.

**(6) ADMISSION.** Admission to an outpatient treatment service is appropriate only if one of the following conditions is met:

(a) The person to be admitted is determined appropriate for placement in this level of care by the application of approved placement criteria.

(b) The person to be admitted is determined appropriate for this level of care through the alternative placement recommendations of WI–UPC or other approved placement criteria.

**History:** Cr. Register, July, 2000, No. 535, eff. 8–1–00; CR 06–035: cr. (2m), Register November 2006 No. 611, eff. 12–1–06; correction in (2m) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; CR 09–109: am. (4) Register May 2010 No. 653, eff. 6–1–10; correction in (4) (a), (b) made under s. 13.92 (4) (b) 7., Stats., Register November 2011 No. 671.

#### **DHS 75.14 Transitional residential treatment service.**

**(1) SERVICE DESCRIPTION.** A transitional residential treatment service is a clinically supervised, peer–supported therapeutic environment with clinical involvement. The service provides substance abuse treatment in the form of counseling for 3 to 11 hours per patient weekly, immediate access to peer support through the environment and intensive case management which may include direct education and monitoring in the areas of personal health and hygiene, community socialization, job readiness, problem resolution counseling, housekeeping and financial planning.

**(2) REQUIREMENTS.** To receive certification from the department under this chapter, a transitional residential treatment service shall comply with all requirements included in s. DHS 75.03 that apply to a transitional residential treatment service, as shown in Table 75.03, and, in addition, a transitional residential treatment service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. DHS 75.03, the requirement in this section shall be followed.

**(3) ORGANIZATIONAL REQUIREMENTS.** Before operating or expanding a transitional residential treatment service, a facility shall be approved under ch. DHS 124 as a hospital, licensed under ch. DHS 83 as a community–based residential facility, certified under ch. DHS 82 or licensed under ch. DHS 88 as an adult family home.

**(4) REQUIRED PERSONNEL.** (a) A transitional residential treatment service shall have the following personnel:

1. A director responsible for the overall operation of the service, including the therapeutic design and delivery of services.
2. A physician available to provide medical supervision and clinical consultation as either an employee of the service or under a written contract with the service.
3. At least one full–time substance abuse counselor for every 15 patients or fraction thereof.
4. At least one clinical supervisor on staff to provide ongoing clinical supervision of the counseling staff, or a person outside the agency who is a clinical supervisor and who by a written agree-

ment will provide ongoing clinical supervision of the counseling staff.

5. A mental health professional available either as an employee of the service or through written agreement to provide joint and concurrent services for the treatment of dually diagnosed patients.

(b) A certified clinical supervisor who meets the requirements of a substance abuse counselor may provide direct counseling services in addition to his or her supervisory responsibilities.

**(5) CLINICAL SUPERVISION.** (a) A transitional residential treatment service shall provide for ongoing clinical supervision of the counseling staff. Ongoing clinical supervision shall be provided as required in s. SPS 162.01.

**Note:** Section SPS 162.01 (1) states that a clinical supervisor shall provide a minimum of:

1. Two hours of clinical supervision for every 40 hours of work performed by a substance abuse counselor-in-training.
2. Two hours of clinical supervision for every 40 hours of counseling provided by a substance abuse counselor.
3. One hour of clinical supervision for every 40 hours of counseling provided by a clinical substance abuse counselor.
4. One in person meeting each calendar month with a substance abuse counselor-in-training, substance abuse counselor, or clinical substance abuse counselor. This meeting may fulfill a part of the requirements above.

(b) The clinical supervisor shall provide supervision and performance evaluation of substance abuse counselors in the areas identified in s. SPS 162.01 (5).

**Note:** Section SPS 162.01 (5) states that the goals of clinical supervision are to provide the opportunity to develop competency in the transdisciplinary foundations, practice dimensions and care functions, provide a context for professional growth and development and ensure a continuance of quality patient care.

**(6) SERVICE OPERATIONS.** (a) *Medical screening.* 1. A physician, registered nurse or physician assistant shall conduct medical screening of a patient no later than 7 working days after the person's admission to identify health problems and to screen for communicable diseases unless there is documentation that screening was completed within 90 days prior to admission.

2. A patient continuing in treatment shall receive an annual follow-up medical screening unless the patient is being seen regularly by a personal physician.

(b) *Medical service needs.* A service shall arrange for services for a patient with medical needs unless otherwise arranged for by the patient.

(c) *Intake.* A service shall complete intake within 24 hours of a person's admission to the service except that the initial assessment and initial treatment plan shall be completed within 4 working days of admission.

(d) *Hours of operation.* A service shall operate 24 hours per day and 7 days per week.

(e) *Policies and procedures manual.* A service shall have a written policy and procedures manual that includes all of the following:

1. The service philosophy and objectives.
2. The service's patient capacity.
3. A statement concerning the type and physical condition of patients appropriate for the service.
4. Admission policy, including:
  - a. Target group served, if any.
  - b. Limitations on admission.
5. Procedures for screening for communicable disease.
6. Service goals and services defined and justified in terms of patient needs, including:
  - a. Staff assignments to accomplish service goals.
  - b. Description of community resources available to assist in meeting the service's treatment goals.

(f) *Documentation of review.* 1. A service shall maintain documentation that the governing body, director and representatives of the administrative and direct service staffs have annually revised, updated as necessary and approved the policy and procedures manual, including the service philosophy and objectives.

2. The service shall maintain documentation to verify that each staff member has reviewed a copy of the policy and procedures manual.

(g) *Emergency medical care.* A service shall have a written agreement with a hospital or clinic for the hospital or clinic to provide emergency medical care to patients.

(h) *Emergency transportation.* A service shall have arrangements for emergency transportation, when needed, of patients to emergency medical care services.

(i) *Treatment plan.* The service's treatment staff shall prepare a written treatment plan for each patient referred from prior treatment service, which is designed to establish continuing contact for the support of the patient. A patient's treatment plan shall include information, unmet goals and objectives from the patient's prior treatment experience and treatment staff shall review and update the treatment plan every 30 days.

(j) *Support services.* A service shall provide support services that promote self-care by the patient, which shall include all of the following:

1. Planned activities of daily living.
2. Planned development of social skills to promote personal adjustment to society upon discharge.

(k) *Employment related services.* A service shall make job readiness counseling, problem-resolution counseling and pre-vocational and vocational training activities available to patients.

(L) *Recreational services.* A service shall have planned recreational services for patients, which shall include all of the following:

1. Emphasis on recreation skills in independent living situations.
2. Use of both internal and community recreational resources.

**(7) ADMISSION.** Admission to a transitional residential treatment service is appropriate only for one of the following reasons:

(a) The person was admitted to and discharged from one or more services under s. DHS 75.10, 75.11, 75.12 or 75.13 within the past 12 months or is currently being served under either s. DHS 75.12 or 75.13.

(b) The person has an extensive lifetime treatment history and has experienced at least two detoxification episodes during the past 12 months, and one of the following conditions is met:

1. The person to be admitted is determined appropriate for placement in this level of care by the application of approved placement criteria.
2. The person to be admitted is determined appropriate for this level of care through the alternative placement recommendations of WI-UPC or other approved placement criteria.

**History:** Cr. Register, July, 2000, No. 535, eff. 8–1–00; correction in (3) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; CR 09–109: am. (5) Register May 2010 No. 653, eff. 6–1–10; correction in (5) (a), (b) made under s. 13.92 (4) (b) 7., Stats. Register November 2011 No. 671.

### **DHS 75.15 Narcotic treatment service for opiate addiction.** (1) **SERVICE DESCRIPTION.** A narcotic treatment service for opiate addiction provides for the management and rehabilitation of selected narcotic addicts through the use of methadone or other FDA-approved narcotics and a broad range of medical and psychological services, substance abuse counseling and social services. Methadone and other FDA-approved narcotics are used to prevent the onset of withdrawal symptoms for 24 hours or more, reduce or eliminate drug hunger or craving and block the euphoric effects of any illicitly self-administered narcotics while the patient is undergoing rehabilitation.

**(2) REQUIREMENTS.** To receive certification from the department under this chapter, a narcotic treatment service for opiate addiction shall comply with all requirements included in s. DHS 75.03 and all requirements included in s. DHS 75.13 that apply to a narcotic treatment service for opiate addiction, as shown in Table 75.03, and, in addition, a narcotic treatment service for opi-

ate addiction shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. DHS 75.03, the requirement in this section shall be followed.

**(3) DEFINITIONS.** In this section:

(a) “Biochemical monitoring” means the collection and analysis of specimens of body fluids, such as blood or urine, to determine use of licit or illicit drugs.

(b) “Central registry” means an organization that obtains from 2 or more methadone programs patient identifying information about individuals applying for maintenance treatment or detoxification treatment for the purpose of preventing an individual’s concurrent enrollment in more than one program.

(c) “Clinical probation” means the period of time determined by the treatment team that a patient is required to increase frequency of service attendance.

(d) “Initial dosing” means the first administration of methadone or other FDA–approved narcotic to relieve a degree of withdrawal and drug craving of the patient.

(e) “Mandatory schedule” means the required dosing schedule for a patient and the established frequency that the patient must attend the service.

(f) “Medication unit” means a facility established as part of a service but geographically separate from the service, from which licensed private practitioners and community pharmacists are:

1. Permitted to administer and dispense a narcotic drug.
2. Authorized to conduct biochemical monitoring for narcotic drugs.

(g) “Objectively intoxicated person” means a person who is determined through a breathalyzer test to be under the influence of alcohol.

(h) “Opioid addiction” means psychological and physiological dependence on an opiate substance, either natural or synthetic, that is beyond voluntary control.

(i) “Patient identifying information” means the name, address, social security number, photograph or similar information by which the identity of a patient can be determined with reasonable accuracy and speed, either directly or by reference to other publicly available information.

(j) “Phase” means a patient’s level of dosing frequency.

(k) “Service physician” means a physician licensed to practice medicine in the jurisdiction in which the program is located, who assumes responsibility for the administration of all medical services performed by the narcotic treatment service including ensuring that the service is in compliance with all federal, state and local laws relating to medical treatment of narcotic addiction with a narcotic drug.

(L) “Service sponsor” means a person or a representative of an organization who is responsible for the operation of a narcotic treatment service and for all service employees including any practitioners, agents or other persons providing services at the service or at a medication unit.

(m) “Take–homes” means medications such as methadone that reduce the frequency of a patient’s service visits and with the approval of the service physician, are dispensed in an oral form and are in a container that discloses the treatment service name, address and telephone number and the patient’s name, the dosage amount and the date on which the medication is to be ingested.

(n) “Treatment contracting” means an agreement developed between the primary counselor or the program director and the patient in an effort to allow the patient to remain in treatment on condition that the patient adheres to service rules.

(o) “Treatment team” means a team established to evaluate the progress of a patient and consisting of at least the primary counselor, the service staff nurse who administers doses and the program director.

**(4) REQUIRED PERSONNEL.** (a) A narcotic treatment service for opiate addiction shall designate a physician licensed under ch. 448, Stats., as its medical director. The physician shall be readily accessible and able to respond in person in a reasonable period of time, not to exceed 45 minutes.

(b) The service shall have a registered nurse on staff to supervise the dosing process and perform other functions delegated by the physician.

(c) The service may employ nursing assistants and related medical ancillary personnel to perform functions permitted under state medical and nursing practice statutes and administrative rules.

(d) The service shall employ substance abuse counselors, substance abuse counselors–in training, or clinical substance abuse counselors who are under the supervision of a clinical supervisor on a ratio of at least one to 50 patients in the service or fraction thereof.

(dm) A narcotic treatment services for opiate addiction shall provide for ongoing clinical supervision of the counseling staff. Ongoing clinical supervision shall be provided as required as required in s. SPS 162.01.

**Note:** Section SPS 162.01 (1) states that a clinical supervisor shall provide a minimum of:

1. Two hours of clinical supervision for every 40 hours of work performed by a substance abuse counselor–in–training.
2. Two hours of clinical supervision for every 40 hours of counseling provided by a substance abuse counselor.
3. One hour of clinical supervision for every 40 hours of counseling provided by a clinical substance abuse counselor.
4. One in person meeting each calendar month with a substance abuse counselor–in–training, substance abuse counselor, or clinical substance abuse counselor. This meeting may fulfill a part of the requirements above.

(e) The clinical supervisor shall provide supervision and performance evaluation of substance abuse counselors in the areas identified in s. SPS 162.01 (5).

**Note:** Section SPS 162.01 (5) states that the goals of clinical supervision are to provide the opportunity to develop competency in the transdisciplinary foundations, practice dimensions and care functions, provide a context for professional growth and development and ensure a continuance of quality patient care.

**(5) ADMISSION.** (a) *Admission criteria.* For admission to a narcotic addiction treatment service for opiate addiction, a person shall meet all of the following criteria as determined by the service physician:

1. The person is physiologically and psychologically dependent upon a narcotic drug that may be a synthetic narcotic.

2. The person has been physiologically and psychologically dependent upon the narcotic drug not less than one year before admission.

3. In instances where the presenting drug history is inadequate to substantiate such a diagnosis, the material submitted by other health care professionals indicates a high degree of probability of such a diagnosis, based on further evaluation.

4. When the person receives health care services from outside the service, the person has provided names, addresses and written consents for release of information from each health care provider to allow the service to contact the providers, and agrees to update releases if changes occur.

(b) *Voluntary treatment.* Participation in narcotic addiction treatment shall be voluntary.

(c) *Explanation.* Service staff shall clearly and adequately explain to the person being admitted all relevant facts concerning the use of the narcotic drug used by the service.

(d) *Consent.* The service shall require a person being admitted to complete the most current version of FDA form 2635, “Consent to Narcotic Addiction Treatment.”

**Note:** For copies of FDA Form 2635, Consent to Narcotic Addiction Treatment, a service may write to Commissioner, Food and Drug Administration, Division of Scientific Investigations, 5600 Fishers Lane, Rockville, MD 20857.

(e) *Examination.* For each applicant eligible for narcotic addiction treatment, the service shall arrange for completion of a comprehensive physical examination, clinically indicated labora-

tory work-up prescribed by the physician, psycho-social assessment, initial treatment plan and patient orientation during the admission process.

(f) *Initial dose.* If a person meets the admission criteria under par. (a), an initial dose of narcotic medication may be administered to the patient on the day of application.

(g) *Distance of service from residence.* A person shall receive treatment at a service located in the same county or at the nearest location to the person's residence, except that if a service is unavailable within a radius of 50 miles from the patient's residence, the patient may, in writing, request the state methadone authority to approve an exception. In no case may a patient be allowed to attend a service at a greater distance to obtain take-home doses.

(h) *Non-residents.* A self-pay person who is not a resident of Wisconsin may be accepted for treatment only after written notification to the Wisconsin state methadone authority. Permission shall be obtained before initial dosing.

(i) *Central registry.* 1. The service shall participate in a central registry, or an alternative acceptable to the state methadone authority, in order to prevent multiple enrollments in detoxification and narcotic addiction treatment services for opiate addiction. The central registry may include services and programs in bordering states.

2. The service shall make a disclosure to the central registry whenever any of the following occurs:

- a. A person is accepted for treatment.
- b. The person is disenrolled in the service.
3. The disclosure shall be limited to:
  - a. Patient-identifying information.
  - b. Dates of admission, transfer or discharge from treatment.
4. A disclosure shall be made with the patient's written consent that meets the requirements of 42 CFR Part 2, relating to alcohol and drug abuse patient records, except that the consent shall list the name and address of each central registry or acceptable alternative and each known detoxification or narcotic treatment service for opiate addiction to which a disclosure will be made.

(j) *Admissions protocol.* The service shall have a written admissions protocol that accomplishes all of the following:

1. Identifies the person on the basis of appropriate substantiated documents that contain the individual's name and address, date of birth, sex and race or ethnic origin as evidenced by a valid driver's license or other suitable documentation such as a passport.
2. Determines the person's current addiction, to the extent possible, the current degree of dependence on narcotics or opiates, or both, including route of administration, length of time of the patient's dependence, old and new needle marks, past treatment history and arrest record.
3. Determines the person's age. The patient shall verify that he or she is 18 years or older.
4. Identifies the substances being used. To the extent possible, service staff shall obtain information on all substances used, route of administration, length of time used and amount and frequency of use.
5. Obtains information about past treatment. To the extent possible, service staff shall obtain information on a person's treatment history, use of secondary substances while in the treatment, dates and length of time in treatment and reasons for discharge.
6. Obtains personal information about the person. Personal information includes history and current status regarding employment, education, legal status, military service, family and psychiatric and medical information.
7. Identifies the person's reasons for seeking treatment. Reasons shall include why the person chose the service and whether the person fully understands the treatment options and the nature

and requirements of narcotic addiction treatment are fully understood.

8. Completes an initial drug screening or analysis of the person's urine to detect use of opiates, methadone, amphetamines, benzodiazepines, cocaine or barbiturates. The analysis shall show positive for narcotics, or an adequate explanation for negative results shall be provided and noted in the applicant's record. The primary counselor shall enter into the patient's case record the counselor's name, the content of a patient's initial assessment and the initial treatment plan. The primary counselor shall make these entries immediately after the patient is stabilized on a dose or within 4 weeks of admission, whichever is sooner.

9. If the service is at capacity, immediately advises the applicant of the existence of a waiting list and providing that person with a referral to another treatment service that can serve the person's treatment needs.

10. Refers a person who also has a physical health or mental health problem that cannot be treated within the service to an appropriate agency for appropriate treatment.

11. Obtains the person's written consent for the service to secure records from other agencies that may assist the service with treatment planning.

12. Arranges for hospital detoxification for patients seriously addicted to alcohol or sedatives or to anxiolytics before initiating outpatient treatment.

(k) *Priority admissions.* A service shall offer priority admission either through immediate admission or priority placement on a waiting list in the following order:

1. Pregnant women.
2. Persons with serious medical or psychiatric problems.
3. Persons identified by the service through screening as having an infectious or communicable disease, including screening for risk behaviors related to human immunodeficiency virus infection, sexually transmitted diseases and tuberculosis.

(L) *Appropriate and uncoerced treatment.* Service staff shall determine through a screening process that narcotic addiction treatment is the most appropriate treatment modality for the applicant and that treatment is not coerced.

(m) *Correctional supervision notification.* A service shall require a person who is under correctional supervision to provide written information releases that are necessary for the service to notify and communicate with the patient's probation and parole officer and any other correctional authority regarding the patient's participation in the service.

(6) **ORIENTATION OF NEW PATIENTS.** A service shall provide new patients with an orientation to the service that includes all of the following:

- (a) A description of treatment policies and procedures.
- (b) A description of patient rights and responsibilities.
- (c) Provision of a copy of a patient handbook that covers treatment policies and procedures, and patient rights and responsibilities. The service shall require a new patient to acknowledge, in writing, receipt of the handbook.

(7) **RESEARCH AND HUMAN RIGHTS COMMITTEE.** A narcotic treatment service conducting or permitting research involving human subjects shall establish a research and human rights committee in accordance with s. 51.61 (4), Stats., and 45 CFR Part 46.

(8) **RESEARCH.** (a) All proposed research involving patients shall meet the requirements of s. 51.61 (1) (j), Stats., 45 CFR Part 46 and this subsection.

(b) No patient may be subjected to any experimental diagnostic or treatment technique or to any other experimental intervention unless the patient gives written informed consent and the research and human rights committee established under s. 51.61 (4), Stats., has determined that adequate provisions are made to do all of the following:

1. Protect the privacy of the patient.

2. Protect the confidentiality of treatment records in accordance with s. 51.30, Stats., and ch. DHS 92.

3. Ensure that no patient may be approached to participate in the research unless the patient's participation is approved by the person responsible for the patient's treatment plan.

**(9) MEDICAL SERVICES.** (b) The medical director of a service is responsible for all of the following:

1. Administering all medical services provided by the service.  
2. Ensuring that the service complies with all federal, state, and local statutes, ordinances and regulations regarding medical treatment of narcotic addiction.

3. Ensuring that evidence of current physiological or psychological dependence, length of history of addiction and exceptions as granted by the state methadone authority to criteria for admission are documented in the patient's case record before the initial dose is administered.

4. Ensuring that a medical evaluation including a medical history and a physical examination have been completed for a patient before the initial dose is administered.

5. Ensuring that appropriate laboratory studies have been performed and reviewed.

6. Signing or countersigning all medical orders as required by federal or state law, including all of the following:

a. Initial medical orders and all subsequent medical order changes.

b. Approval of all take-home medications.

c. Approval of all changes in frequency of take-home medication.

d. Prescriptions for additional take-home medication for an emergency situation.

7. Reviewing and countersigning each treatment plan 4 times annually.

8. Ensuring that justification is recorded in the patient's case record for reducing the frequency of service visits for observed drug ingesting and providing additional take-home medication under exceptional circumstances or when there is physical disability, as well as when any medication is prescribed for physical health or psychiatric problems.

9. The amount of narcotic drug administered or dispensed, and for recording, signing and dating each change in the dosage schedule in a patient's case record.

(c) A service physician is responsible for all of the following:

1. Determining the amount of the narcotic drug to be administered or dispensed and recording, signing and dating each change in a patient's dosage schedule in the patient's case record.

2. Ensuring that written justification is included in a patient's case record for a daily dose greater than 100 milligrams.

3. Approving, by signature and date, any request for an exception to the requirements under sub. (11) relating to take-home medications.

4. Detoxification of a patient from narcotic drugs and administering the narcotic drug or authorizing an agent to administer it under physician supervision and physician orders in a manner that prevents the onset of withdrawal symptoms.

5. Making a clinical judgment that treatment is medically justified for a person who has resided in a penal or chronic care institution for one month or longer, under the following conditions:

a. The person is admitted to treatment within 14 days before release or discharge or within 6 months after release without documented evidence to support findings of physiological dependence.

b. The person would be eligible for admission if he or she were not incarcerated or institutionalized before eligibility was established.

c. The admitting service physician or service personnel supervised by the service physician records in the new patient's case record evidence of the person's prior residence in a penal or chronic care institution and evidence of all other findings of addiction.

d. The service physician signs and dates the recordings under subd. 5. c. before the initial dose is administered to the patient or within 48 hours after administration of the initial dose to the patient.

(d) A patient's history and physical examination shall support a judgment on the part of the service physician that the patient is a suitable candidate for narcotic addiction treatment.

(e) A service shall provide narcotic addiction treatment to a patient for a maximum of 2 years from the date of the person's admission to the service, unless clear justification for longer service provision is documented in the treatment plan and progress notes. Clear justification for longer service shall include documentation of all of the following:

1. The patient continues to benefit from the treatment.

2. The risk of relapse is no longer present.

3. The patient exhibits no side effects from the treatment.

4. Continued treatment is medically necessary in the professional judgment of the service physician.

**Note:** Be aware that federal law, including but not limited to 21 CFR 1306.07 and 42 CFR 8.12, does apply to this service. A service that holds both a s. DHS 75.15 Narcotic Treatment Service for Opiate Addiction certification and a s. DHS 75.13 CSAS Outpatient Treatment Service certification may issue prescription orders for buprenorphine products to a client who is only enrolled in the s. DHS 75.13 CSAS Outpatient Treatment Service, pursuant to the 2009 SAMHSA Dear Colleague letter [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/medication\\_assisted/dear\\_colleague\\_letters/2009-colleague-letter-prescribing-subutex-suboxone.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dear_colleague_letters/2009-colleague-letter-prescribing-subutex-suboxone.pdf).

**(10) DOSAGE.** (a) Because methadone and other FDA-approved narcotics are medications, the dose determination for a patient is a matter of clinical judgment by a physician in consultation with the patient and appropriate staff of the service.

(b) The service physician who has examined a patient shall determine, on the basis of clinical judgment, the appropriate narcotic dose for the patient.

(c) Any dose adjustment, either up or down, to sanction the patient, to reinforce the patient's behavior or for purposes of treatment contracting, is prohibited, except as provided in par. (h).

(d) The service shall delay administration of methadone to an objectively intoxicated patient until diminution of intoxication symptoms can be documented, or the patient shall be readmitted for observation for withdrawal symptoms while augmenting the patient's daily dose in a controlled, observable fashion.

(e) The narcotic dose that a service provides to a patient shall be sufficient to produce the desired response in the patient for the desired duration of time.

(f) A patient's initial dose shall be based on the service physician's evaluation of the history and present condition of the patient. The evaluation shall include knowledge of local conditions, such as the relative purity of available street drugs. The initial dose may not exceed 30 milligrams except that the total dose for the first day may not exceed 40 milligrams.

(g) A service shall incorporate withdrawal planning as a goal in a patient's treatment plan, and shall begin to address it once the patient is stabilized. A service physician shall determine the rate of withdrawal to prevent relapse or withdrawal symptoms.

(h) 1. A service physician may order the withdrawal of a patient from medication for administrative reasons, such as extreme antisocial behavior or noncompliance with minimal service standards.

2. The process of withdrawal from medication for administrative reasons shall be conducted in a humane manner as determined by the service physician, and referral shall be made to other treatment services.

**(11) TAKE-HOME MEDICATION PRACTICES.** (a) *Granting take-home privileges.* During treatment, a patient may benefit from less frequent required visits for dosing. This shall be based on an assessment by the treatment staff. Time in treatment is not the sole consideration for granting take-home privileges. After consideration of treatment progress, the service physician shall determine if take-home doses are appropriate or if approval to take home doses should be rescinded. Federal requirements that shall be adhered to by the state methadone authority and the service are as follows:

1. Take-home doses are not allowed during the first 90 days of treatment. Patients shall be expected to attend the service daily, except Sundays, during the initial 90-day period with no exceptions granted.

2. Take-home doses may not be granted if the patient continues to use illicit drugs and if the primary counselor and the treatment team determine that the patient is not making progress in treatment and has continued drug use or legal problems.

3. Take-home doses shall only be provided when the patient is clearly adhering to the requirements of the service. The patient shall be expected to show responsibility for security and handling of take-home doses.

4. Service staff shall go over the requirements for take-home privileges with a patient before the take-home practice for self-dosing is implemented. The service staff shall require the patient to provide written acknowledgment that all the rules for self-dosing have been provided and understood at the time the review occurs.

5. Service staff may not use the level of the daily dose to determine whether a patient receives take-home medication.

(b) *Treatment team recommendation.* A treatment team of appropriate staff in consultation with a patient shall collect and evaluate the necessary information regarding a decision about take-home medication for the patient and make the recommendation to grant take-home privileges to the service physician.

(c) *Service physician review.* The rationale for approving, denying or rescinding take-home privileges shall be recorded in the patient's case record and the documentation shall be reviewed, signed and dated by the service physician.

(d) *Service physician determination.* The service physician shall consider and attest to all of the following in determining whether, in the service physician's reasonable clinical judgment, a patient is responsible in handling narcotic drugs and has made substantial progress in rehabilitation:

1. The patient is not abusing substances, including alcohol.  
2. The patient keeps scheduled service appointments.  
3. The patient exhibits no serious behavioral problems at the service.

4. The patient is not involved in criminal activity, such as drug dealing and selling take-home doses.

5. The patient has a stable home environment and social relationships.

6. The patient has met the following criteria for length of time in treatment starting from the date of admission:

a. Three months in treatment before being allowed to take home doses for 2 days.

b. Two years in treatment before being allowed to take home doses for 3 days.

c. Three years in treatment before being allowed to take home doses for 6 days.

7. The patient provides assurance that take-home medication will be safely stored in a locked metal box within the home.

8. The rehabilitative benefit to the patient in decreasing the frequency of service attendance outweighs the potential risks of diversion.

(e) *Time in treatment criteria.* The time in treatment criteria under par. (d) 6. shall be the minimum time before take-home medications will be considered unless there are exceptional circumstances and the service applies for and receives approval from the FDA and the state methadone authority for a particular patient for a longer period of time.

(f) *Individual consideration of request.* A request for take-home privileges shall be considered on an individual basis. No request for take-home privileges may be granted automatically to any patient.

(g) *Additional criteria for 6-day take-homes.* When a patient is considered for 6-day take-homes, the patient shall meet the following additional criteria:

1. The patient is employed, attends school, is a homemaker or is disabled.

2. The patient is not known to have used or abused substances, including alcohol, in the previous year.

3. The patient is not known to have engaged in criminal activity in the previous year.

(h) *Observation requirement.* A patient receiving a daily dose of a narcotic medication above 100 milligrams is required to be under observation while ingesting the drug at least 6 days per week, irrespective of the length of time in treatment, unless the service has received prior approval from the designated federal agency, with concurrence by the state methadone authority, to waive this requirement.

(i) *Denial or rescinding of approval.* A service shall deny or rescind approval for take-home privileges for any of the following reasons:

1. Signs or symptoms of withdrawal.

2. Continued illicit substance use.

3. The absence of laboratory evidence of FDA-approved narcotic treatment in test samples, including serum levels.

4. Potential complications from concurrent disorders.

5. Ongoing or renewed criminal behavior.

6. An unstable home environment.

(j) *Review.* 1. The service physician shall review the status of every patient provided with take-home medication at least every 90 days and more frequently if clinically indicated.

2. The service treatment team shall review the merits and detriments of continuing a patient's take-home privilege and shall make appropriate recommendations to the service physician as part of the service physician's 90-day review.

3. Service staff shall use biochemical monitoring to ensure that a patient with take-home privileges is not using illicit substances and is consuming the FDA-approved narcotic provided.

4. Service staff may not recommend denial or rescinding of a patient's take-home privilege to punish the patient for an action not related to meeting requirements for take-home privileges.

(k) *Reduction of take-home privileges or requirement of more frequent visits to the service.* 1. A service may reduce a patient's take-home privileges or may require more frequent visits to the service if the patient inexcusably misses a scheduled appointment with the service, including an appointment for dosing, counseling, a medical review or a psychosocial review or for an annual physical or an evaluation.

2. A service may reduce a patient's take-home privileges or may require more frequent visits to the service if the patient shows positive results in drug test analysis for morphine-like substances or substances of abuse or if the patient tests negative for the narcotic drug administered or dispensed by the service.

(L) *Reinstatement.* A service shall not reinstate take-home privileges that have been revoked until the patient has had at least 3 consecutive months of tests or analyses that are neither positive for morphine-like substances or substances of abuse or negative for the narcotic drug administered or dispensed by the service, and

the service physician determines that the patient is responsible in handling narcotic drugs.

(m) *Clinical probation.* 1. A patient receiving a 6–day supply of take–home medication who has a test or analysis that is confirmed to be positive for a substance of abuse or negative for the narcotic drug dispensed by the service shall be placed on clinical probation for 3 months.

2. A patient on 3–month clinical probation who has a test or analysis that is confirmed to be positive for a substance of abuse or negative for the narcotic drug administered or dispensed by the service shall be required to attend the service at least twice weekly for observation of the ingestion of medication, and may receive no more than a 3–day take–home supply of medication.

(n) *Employment–related exception to 6–day supply.* A patient who is employed and working on Saturdays may apply for an exception to the dosing requirements if dosing schedules of the service conflict with working hours of the patient. A service may give the patient an additional take–home dose after verification of work hours through pay slips or other reliable means, and following approval for the exception from the state methadone authority.

**(12) EXCEPTIONS TO TAKE–HOME REQUIREMENTS.** (a) A service may grant an exception to certain take–home requirements for a particular patient if, in the reasonable clinical judgment of the program physician, any of the following conditions is met:

1. The patient has a physical disability that interferes with his or her ability to conform to the applicable mandatory schedule. The patient may be permitted a temporarily or permanently reduced schedule provided that she or he is found under par. (c) to be responsible in handling narcotic drugs.

2. The patient, because of an exceptional circumstance such as illness, personal or family crisis, travel or other hardship, is unable to conform to the applicable mandatory schedule. The patient may be permitted a temporarily reduced schedule, provided that she or he is found under par. (c) to be responsible in handling narcotic drugs.

(b) The program physician or program personnel supervised by the program physician shall record the rationale for an exception to an applicable mandatory schedule in the patient's case record. If program personnel record the rationale, the physician shall review, countersign and date the rationale in the patient's record. A patient may not be given more than a 14–day supply of narcotic drugs at one time.

(c) The service physician's judgment that a patient is responsible in handling narcotic drugs shall be supported by information in the patient's case file that the patient meets all of the following criteria:

1. Absence of recent abuse of narcotic or non–narcotic drugs including alcohol.
2. Regularity of service attendance.
3. Absence of serious behavior problems in the service.
4. Absence of known recent criminal activity such as drug dealing.
5. Stability of the patient's home environment and social relationships.
6. Length of time in maintenance treatment.
7. Assurance that take–home medication can be safely stored within the patient's home.
8. The rehabilitative benefit to the patient derived from decreasing the frequency of attendance outweighs the potential risks of diversion.

(d) 1. Any exception to the take–home requirements exceeding 2 times the amount in that phase is subject to approval of the designated federal agency and the state methadone authority. The following is the amount of additional take–home doses needing approval: Phase 1 = 2 additional (excluding Sunday); phase 2 = 4 additional; phase 3 = 6 additional; phase 4 = 12 take–home doses required for approval.

2. Service staff on receipt of notices of approval or denial of a request for an extension from the state methadone authority and the designated federal agency shall place the notices in the patient's case record.

(e) Service staff shall review an exception when the conditions of the request change or at the time of review of the treatment plan, whichever occurs first.

(f) An exception shall remain in effect only as long as the conditions establishing the exception remain in effect.

**(13) TESTING AND ANALYSIS FOR DRUGS.** (a) *Use.* 1. A service shall use drug tests and analyses to determine the presence in a patient of opiates, methadone, amphetamines, cocaine or barbiturates. If any other drug has been determined by a service or the state methadone authority to be abused in that service's locality, a specimen shall also be analyzed for that drug. Any laboratory that performs the testing shall comply with 42 CFR Part 493.

2. A service shall use the results of a drug test or analysis on a patient as a guide to review and modify treatment approaches and not as the sole criterion to discharge the patient from treatment.

3. A service's policies and procedures shall integrate testing and analysis into treatment planning and clinical practice.

(b) *Drawing blood for testing.* A service shall determine a patient's drug levels in plasma or serum at the time the person is admitted to the service to determine a baseline. The determinations shall also be made at 3 months, 6 months and annually subsequently. If a patient requests and receives doses above 100 milligrams, serum levels shall be drawn to evaluate peak and trough determinations after the patient's dose is stabilized.

(c) *Obtaining urine specimens.* A service shall obtain urine specimens for testing from a patient in a clinical atmosphere that respects the patient's confidentiality, as follows:

1. A urine specimen shall be collected upon each patient's service visit and specimens shall be tested on a random basis.

2. The patient shall be informed about how test specimens are collected and the responsibility of the patient to provide a specimen when asked.

3. The bathroom used for collection shall be clean and always supplied with soap and toilet articles.

4. Specimens shall be collected in a manner that minimizes the possibility of falsification.

5. When service staff must directly observe the collection of a urine sample, this task shall be done with respect for patient privacy.

(d) *Response to positive test results.* 1. Service staff shall discuss positive test results with the patient within one week after receipt of results and shall document them in the patient's case record with the patient's response noted.

2. The service shall provide counseling, casework, medical review and other interventions when continued use of substances is identified. Punishment is not appropriate.

3. When there is a positive test result, service staff shall allow sufficient time before retesting to prevent a second positive test result from the same substance use.

4. Service staff confronted with a patient's denial of substance use shall consider the possibility of a false positive test.

5. Service staff shall review a patient's dosage and shall counsel the patient when test reports are positive for morphine–like substances and negative for the FDA–approved narcotic treatment.

(e) *Monitoring of test reports.* A service shall monitor test reports to do all of the following:

1. Ensure compliance with this section and with federal regulations.

2. Discover trends in substance use that may require a redirection of clinical resources.



3. Ensure that staff appropriately address with the patient a positive test report within one week after the report is received and that the report and the patient's response is documented in the patient's case record.

(f) *Frequency of drug screens.* 1. The frequency that a service shall require drug screening shall be clinically appropriate for each patient and allow for a rapid response to the possibility of relapse.

2. A service shall arrange for drug screens with sufficient frequency so that they can be used to assist in making informed decisions about take-home privileges.

**(14) TREATMENT DURATION AND RETENTION.** (a) Patient retention shall be a major objective of treatment. The service shall do all of the following to retain patients for the planned course of treatment:

1. Make the service physically accessible.
2. Render treatment in a way that is least disruptive to the patient's travel, work, educational activities, ability to use supportive services and family life.
3. Determine hours based on patient needs.
4. Provide affordable treatment to all needing it.
5. Ensure that a patient has ready access to staff, particularly to the patient's primary counselor.
6. Ensure that staff are adequately trained and are sensitive to gender-specific and culture-specific issues.
7. Provide services that incorporate good practice standards for substance abuse treatment.
8. Ensure that patients receive adequate doses of narcotic medication based on their individual needs.
9. Ensure that the attitude of staff is accepting of narcotic addiction treatment.
10. Ensure that patients understand that they are responsible for complying with all aspects of their treatment, including participating in counseling sessions.

(b) Since treatment duration and retention are directly correlated to rehabilitation success, a service shall make a concerted effort to retain patients within the first year following admission. Evidence of this concerted effort shall include written documentation of all of the following:

1. The patient continues to benefit from the treatment.
2. The risk of relapse is discontinued.
3. The patient exhibits no side effects from the treatment.
4. Continued treatment is medically necessary in the professional judgement of the service physician.

(c) A service shall refer an individual discharged from the service to a more suitable treatment modality when further treatment is required or is requested by that person and cannot be provided by the service.

(d) For services needed by a patient but not provided by the service, the service shall refer the individual to an appropriate service provider.

**(15) MULTIPLE SUBSTANCE USE AND DUAL DIAGNOSIS TREATMENT.** (a) *Assessment.* A service shall assess an applicant for admission during the admission process and a patient, as appropriate, to distinguish substance use, abuse and dependence, and determine patterns of other substance use and self-reported etiologies, including non-prescription, non-therapeutic and prescribed therapeutic use and mental health problems.

(b) *Multiple substance use patients.* 1. A service shall provide a variety of services that support cessation by a patient of alcohol and prescription and non-prescription substance abuse as the desired goal.

2. Service objectives shall indicate that abstinence by a patient from alcohol and prescription and non-prescription substance abuse should extend for increasing periods, progress

toward long-term abstinence and be associated with improved life functioning and well-being.

3. Service staff shall instruct multiple substance use patients about their vulnerabilities to cross-tolerance, drug-to-drug interaction and potentiation and the risk of dependency substitution associated with self-medication.

(c) *Dually-diagnosed patients.* 1. A service shall have the ability to provide concurrent treatment for a patient diagnosed with both a mental health disorder and a substance use disorder. The service shall arrange for coordination of treatment options and for provision of a continuum of care across the boundaries of physical sites, services and outside treatment referral sources.

2. When a dual diagnosis exists, a service shall develop with the patient a treatment plan that integrates measures for treating all alcohol, drug and mental health problems. For the treatment of a dually-diagnosed patient, the service shall arrange for a mental health professional to help develop the treatment plan and provide ongoing treatment services. The mental health professional shall be available either as an employee of the service or through a written agreement.

**(16) PREGNANCY.** (a) A service that provides narcotic addiction treatment to pregnant women shall provide that treatment within a comprehensive treatment service that addresses medical, prenatal, obstetrical, psychosocial and addiction issues.

(b) A diagnosis of opioid addiction and need of the patient to avoid use of narcotic antagonists shall be based on the same factors, such as medical and substance abuse history, psychosocial history, physical examination, test toxicology and signs and symptoms of withdrawal, that are used in diagnosing opiate addiction in non-pregnant opioid-dependent women. In this paragraph, "narcotic antagonist" means a drug primarily used to counter narcotic-induced respiratory depression.

(c) A pregnant woman seeking narcotic addiction treatment shall be referred to a perinatal specialist or obstetrician as soon as possible after initiating narcotic addiction treatment with follow up contact, to coordinate care of the woman's prenatal health status, evaluate fetal growth and document physiologic dependence.

(d) 1. When withdrawal from narcotic medication is the selected treatment option, withdrawal shall be conducted under the supervision of a service physician experienced in perinatal addiction, ideally in a perinatal unit equipped with fetal monitoring equipment.

2. Withdrawal shall not be initiated before the 14th week of pregnancy or after the 32nd week of pregnancy.

(e) Pregnant women shall be monitored and their dosages individualized, as needed.

(f) A service shall not change the methadone dose that a pregnant woman was receiving before her pregnancy unless necessary to avoid withdrawal.

(g) A service shall increase the methadone dose for a patient, if needed, during the later stages of the patient's pregnancy to maintain the same plasma level and avoid withdrawal.

(h) A service shall arrange for appropriate assistance for pregnant patients, including education and parent support groups, to improve mother-infant interaction after birth and to lessen the behavioral consequences of poor mother-infant bonding.

**(17) COMMUNICABLE DISEASE.** (a) A narcotic treatment service for opiate addiction shall screen patients immediately following admission and annually thereafter for tuberculosis (TB). Tuberculosis treatment may be provided by referral to an appropriate public health agency or community medical service.

(b) A service shall screen prospective new staff for TB, and shall annually test all service staff for TB.

(c) A service shall screen all patients at admission and annually thereafter for viral hepatitis and sexually transmitted diseases (STDs) and shall ensure that any necessary medical follow-up

occurs, either on-site or through referral to community medical services.

(d) A service shall ensure that all service staff have been immunized against hepatitis B. Documentation of refusal to be immunized shall be entered in the staff member's case record.

**(18) FACILITY.** A service shall provide a setting that is conducive to rehabilitation of the patients and that meets all of the following requirements:

(a) The waiting area for dosing shall be clean.

(b) Waiting areas, dosing stations and all other areas for patients shall be provided with adequate ventilation and lighting.

(c) Dosing stations and adjacent areas shall be kept sanitary and ensure privacy and confidentiality.

(d) Patient counseling rooms, physical examination rooms and other rooms or areas in the facility that are used to meet with patients shall have adequate sound proofing so that normal conversations will be confidential.

(e) Adequate security shall be provided inside and outside the facility for the safety of the patients and to prevent loitering and illegal activities.

(f) Separate toilet facilities shall be provided for patient and staff use.

(g) The facility and areas within the facility shall be accessible to persons with physical disabilities.

(h) The physical environment within the facility shall be conducive to promoting improved functioning and a drug free life-style.

**(19) DIVERSION CONTROL.** (a) Each staff member of the narcotic treatment service for opiate addiction is responsible for being alert to potential diversion of narcotic medication by patients and staff.

(b) Service staff shall take all of the following measures to minimize diversion:

1. Doses of narcotic medication shall be dispensed only in liquid form.

2. Bottles of narcotic medication shall be labeled with the patient's name, the dose, the source service, the prescribing physician and the date by which the dose is to be consumed.

3. The service shall require a patient to return all empty take-home bottles on the patient's next day of service attendance following take-home dosing. Service staff shall examine the bottles to ensure that the bottles are received from the appropriate patient and in an intact state.

4. The service shall discontinue take-home medications for patients who fail to return empty take-home bottles in the prescribed manner.

(c) If a service receives reliable information that a patient is diverting narcotic medication, the patient's primary counselor shall immediately discuss the problem with the patient.

(d) Based on information provided by the patient or continuing reports of diversion, a service may revoke take-home privileges of the patient.

(e) The state methadone authority may, based on reports of diversion, revoke take-home privileges, exceptions or exemptions granted to or by the service for all patients.

(f) The state methadone authority may revoke the authority of a narcotic treatment service for opiate addiction to grant take-home privileges when the service cannot demonstrate that all requirements have been met in granting take-home privileges.

(g) A narcotic treatment service for opiate addiction shall have a written policy to discourage the congregation of patients at a location inside or outside the service facility for non-programmatic reasons, and shall post that policy in the facility.

**(20) SERVICE APPROVAL.** (a) *Approval of primary service.* An applicant for approval to operate a narcotic treatment service for opiate addiction in Wisconsin with the intent of administering or

dispensing a narcotic drug to narcotic addicts for maintenance or detoxification treatment shall submit all of the following to the state methadone authority:

1. Copies of all completed designated federal agency applications.

2. A copy of the request for registration with the U.S. drug enforcement administration for the use of narcotic medications in the treatment of opiate addiction.

3. A narrative description of the treatment services that will be provided in addition to chemotherapy.

4. Documentation of the need for the service.

5. Criteria for admitting a patient.

6. A copy of the policy and procedures manual for the service, detailing the operation of the service as follows:

a. A description of the intake process.

b. A description of the treatment process.

c. A description of the expectations the service has for a patient.

d. Descriptions of any service privileges or sanctions.

e. A description of the service's use of testing or analysis to detect substances and the purposes for which the results of testing or analysis are used as well as the frequency of use.

7. Documentation that there are adequate physical facilities to provide all necessary services.

8. a. Documentation that the service will have ready access to a comprehensive range of medical and rehabilitative services that will be available if needed.

b. The name, address, and a description of each hospital, institution, clinical laboratory or other facility available to provide the necessary services.

9. A list of persons working in the service who are licensed to administer or dispense narcotic drugs even if they are not responsible for administering or dispensing narcotic drugs.

(b) *Approval of service sites.* Only service sites approved by the FDA, the U.S. drug enforcement administration and the state methadone authority may be used for treating narcotic addicts with a narcotic drug.

(c) *Approval of medication units.* 1. To operate a medication unit, a service shall apply to the department for approval to operate the medication unit. A separate approval is required for each medication unit to be operated by the service. A medication unit is established to facilitate the needs of patients who are stabilized on an optimal dosage level. The department shall approve a medication unit before it may begin operation.

2. Approval of a medication unit shall take into consideration the distribution of patients and other medication units in a geographic area.

3. If a service has its approval revoked, the approval of each medication unit operated by the service is automatically revoked. Revocation of the approval of a medication unit does not automatically affect the approval of the primary service.

**Note:** To apply for approval to operate a medication unit, contact the State Methadone Authority in the Bureau of Prevention, Treatment and Recovery at P.O. Box 7851, Madison, WI 53707-7851. Approvals of the Center for Substance Abuse Treatment and the U.S. Drug Enforcement Administration to operate a medication unit are also required. The State Methadone Authority will facilitate the application consideration by the Center for Substance Abuse Treatment and the U.S. Drug Enforcement Administration.

**(21) ASSENT TO REGULATION.** (a) A person who sponsors a narcotic treatment service for opiate addiction and any personnel responsible for a particular service shall agree in writing to adhere to all applicable requirements of this chapter and 21 CFR Part 291 and 42 CFR Part 2.

(b) The service sponsor is responsible for all service staff and for all other service providers who work in the service at the primary facility or at other facilities or medication units.

(c) The service sponsor shall agree in writing to inform all service staff and all contracted service providers of the provisions of

all pertinent state rules and federal regulations and shall monitor their activities to ensure that they comply with those rules and regulations.

(d) The service shall notify the designated federal agency and state methadone authority within 3 weeks after replacement of the service sponsor or medical director.

**(22) DEATH REPORTING.** A narcotic treatment service for opiate addiction shall report the death of any of its patients to the state methadone authority within one week after learning of the patient's death.

**History:** Cr. Register, July, 2000, No. 535, eff. 8–1–00; correction in (8) (b) 2. made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; CR 09–109; am. (4) (d) and (e), cr. (4) (dm) Register May 2010 No. 653, eff. 6–1–10; correction in (4) (dm), (e) made under s. 13.92 (4) (b) 7., Stats. Register November 2011 No. 671; **CR 19–021: r. (9) (a) Register December 2019 No. 768, eff. 1–1–20.**

**DHS 75.16 Intervention service. (1) SERVICE DESCRIPTION.** Intervention services may include outreach; problem identification; referral; information; specialized education; case management; consultation; training; support or drop-in services; intensive supervision; alternative education; and intoxicated driver assessments under ch. DHS 62.

**(2) REQUIREMENTS.** (a) To receive certification from the department under this chapter, an intervention service shall comply with the requirements included in s. DHS 75.03 that apply to an intervention service, and with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. DHS 75.03, the requirement in this section shall be followed.

(b) If an intervention service is designated by a board under s. DHS 62.04 (1) as an assessment facility, the intervention service shall also comply with the requirements under ch. DHS 62.

**(3) REQUIRED PERSONNEL.** In addition to the personnel required under s. DHS 75.03 (4), an intervention service shall have the following personnel:

(a) Staff knowledgeable of the pharmacology of substances, addiction, and addiction intervention with training and experience in alcohol and drug problem outreach, detecting and identifying problems, screening under s. DHS 75.03 (10) (c), family intervention, and referral. Staff shall have knowledge, training, and experience in the service which they are responsible for providing.

(b) A substance abuse counselor, employed by or under contract with an approved service under ss. DHS 75.05 to 75.16, shall be available to conduct substance use evaluations and develop treatment recommendations as needed. A substance abuse counselor is not required for the assessment of drivers under ch. DHS 62.

(c) Qualified staff, designated by the agency director, may conduct psychosocial evaluations, administer multidisciplinary screening tools, provide education, outreach, intervention and support, and make referrals as needed.

(d) Social workers, physicians, psychologists, and psychiatrists shall be available for referral as needed.

**(4) SERVICE OPERATIONS.** (a) A plan for outreach and intervention services to various target populations shall be developed and implemented. Included in this plan shall be a provision of outreach and intervention services outside regular office hours and office location.

(b) Substance use screenings and evaluations shall be completed by qualified staff to determine the presence of alcohol and other drug use problems.

(c) Information shall be provided about alcohol and other drug use or abuse to assist clients in decision making.

(d) Assistance shall be provided to individuals regarding sources of help, referrals and arrangements for services.

(e) The service shall develop a system of referral that includes a current listing of agencies, organizations, and individuals to

whom referrals may be made and a brief description of the range of services available from each referral resource.

(f) There shall be a written plan for and follow-up that includes qualified service organization agreements with treatment agencies to determine follow-through on referrals for service.

(g) Operating hours of the program shall be scheduled to allow access at reasonable times and shall be so documented.

(h) The program shall provide reasonable access for walk-in or drop-in clients.

(i) Information shall be provided to ensure public awareness of program operation, location, purpose, and accessibility.

(j) There shall be a written agreement for provision of 24-hour telephone coverage, 7 days a week, to provide crisis counseling, alcohol and drug information, referral to service agencies and related information. Staff without previous experience in providing these telephone services shall complete 40 hours of staff development training prior to assuming job responsibilities.

(k) Records shall be maintained to document the services provided.

(L) The service shall have an evaluation plan. The evaluation plan shall include all of the following:

1. A written statement of the service's goals, objectives, and measurable expected outcomes that relate directly to the service's participants or target population.

2. Methods for evaluating and measuring the effectiveness of services and using the information for service improvement.

3. The service director shall complete an annual report on the service's progress in meeting goals and objectives and shall keep the report on file and shall make it available for review to an authorized representative of the department upon request.

4. The governing authority or legal owner of the service and the service director shall review all evaluation reports and make changes in service operations as appropriate.

(m) Intervention services under this section are not required to meet the conditions under s. DHS 75.03 (3) (i).

**(5) ALTERNATIVE EDUCATION PROGRAMS.** (a) *General.* 1. Alternative education programs shall be modeled after group dynamic traffic safety and multiple offender traffic safety programs and shall achieve a constructive, interactive, cohesive, and trusting atmosphere in the group; review and discuss operating while intoxicated laws and penalties; address the central causes and consequences of driving while intoxicated; discuss the effects of alcohol and substances on the mind, body, and driving ability; discuss the psycho-social factors involved in alcohol and substance use; explore blood alcohol concentration and the differences between alcohol and substance use, abuse, and addiction and where participants are at in relation to it; and assist the participant in developing and following a personal change plan.

2. In addition to the content and objectives under subd. 1., programs in lieu of a multiple offender traffic safety program shall involve concerned others, such as a spouse, parent, adult relative, or other appropriate person approved by the instructor and shall provide education on basic skills in the areas of stress-reduction, alcohol and drug refusal, interpersonal communication, and anger management.

3. Classroom instruction time for programs that are in lieu of group dynamic traffic safety programs shall be a minimum of 16 hours.

4. Classroom instruction time for programs that are in lieu of multiple offender traffic safety programs shall be a minimum of 24 hours, including a group-oriented follow-up session. The group-oriented follow-up session shall be held within 3 months after completion of the initial 23 hours of the program. If a participant's residence is 60 miles or more from the site of the group-oriented follow-up session, the follow-up session may be conducted

by telephone with the participant and a concerned other, such as a spouse, parent, adult relative, or other appropriate person.

5. Classroom instruction time may not exceed 8 hours per day.

6. A report of course completion or non-completion shall be submitted to the intoxicated driver assessment facility designated under s. DHS 62.04 (1) for each client assessed by that facility.

7. Participants completing a program under this section are not entitled to a 3–point reduction in the points assessed against the participant’s operator’s license.

8. The effectiveness of alternative education programs shall be evaluated by administering pretests and posttests of knowledge gained by participants, changed attitudes of participants, and participant satisfaction surveys.

(b) *Instructor qualifications.* Instructors conducting alternative education shall have the following qualifications:

1. Alcohol and other drug abuse experience equal to one of the following:

a. Two years of employment experience or a comparable amount of experience and education in the area of alcohol and other drug abuse counseling, assessment, education, or treatment or related fields such as student assistance program director or employee assistance program director.

b. Completed a minimum of a one semester, 3–credit, 45–hour course in the area of alcohol and other drug abuse education or treatment from an accredited college.

2. Group process experience equal to one of the following:

a. Two years employment experience in group process work or group counseling as a treatment or education professional.

b. Completed a minimum of a one semester, 3–credit, 45–hour course in the area of group work methods, group counseling or group process from an accredited college.

c. Bachelor’s or master’s degree in guidance counseling, psychology, behavioral studies or social work.

3. Hold a valid driver’s license from the state of Wisconsin or from the jurisdiction in which the person resides. Programs having nonresident instructors shall maintain a record of the non-resident’s driver’s license and traffic conviction status in the past 12 months.

4. Possess a satisfactory driving record as defined under s. Trans 106.02 (11).

a. An individual may not be employed as an instructor until 6 months after the date of any traffic conviction that results in an accumulation of 7 or more points against the individual’s driver’s license, or until 12 months from the date of an operating while intoxicated conviction under s. 23.33, 30.68, 346.63, 350.101, 940.09, or 940.25, Stats., or an order under s. 343.305, Stats.

b. Instructors under this section are not eligible to receive a 3–point reduction by completing a traffic safety course.

c. Once employed as an instructor under this section, an individual’s failure to maintain a satisfactory driving record shall result in the suspension of the individual’s instruction duties for 6 months from the date of conviction for a violation which places the point total over 6 points or for 12 months from the date of an operating while intoxicated conviction. If additional points are incurred or the individual is convicted of an operating while intoxicated during the suspension period, the individual’s instruction duties shall be suspended for 12 months from the date of conviction for a violation which results in points or for 24 months from the date of an operating while intoxicated conviction.

5. Instructors shall document receiving a minimum of 6 hours of continuing education in a related area, approved by the department, during each 12 months that the individual is employed as an instructor under this section. This training may include formal

courses awarding credits or continuing education units, workshops, seminars, or correspondence courses.

(c) Agencies providing an alternative education program shall comply with all requirements included in s. DHS 75.03 that apply to an intervention service as shown in Table DHS 75.03 and this section except alternative education services are not required to meet the requirement under sub. (4) (j).

(d) Alternative education programs provided by agencies certified under s. DHS 75.13 need not also be approved under this section. However, the program shall comply with all the requirements that apply to alternative education programs under this subsection.

**(6) CASE MANAGEMENT SERVICES.** (a) The purpose of case management under this section is to bring services, agencies, resources and people together within a planned framework for in order to develop, link, advocate for and monitor the provision of appropriate educational, intervention, treatment, or support services for a client with alcohol or other drug abuse problems in a coordinated, efficient and effective manner and meet the client’s individual needs or the requirements of the driver safety plan under s. DHS 62.07 (6).

(b) Staff providing case management services shall have knowledge, training, and experience in providing case management.

(c) Agencies providing case management shall comply with all requirements included in s. DHS 75.03 that apply to an intervention service as shown in Table DHS 75.03 and this subsection except case management services are not required to meet the requirement under sub. (4) (j).

(d) Case management services provided by agencies certified under s. DHS 75.13 need not also be approved under this section. However, the program shall comply with all the requirements that apply to case management services under this subsection.

**(7) INTENSIVE SUPERVISION SERVICE.** (a) The purpose of intensive supervision under this section is to promote public safety and reduce incarceration and recidivism related to substance abuse through centralized screening, review, evaluation, and monitoring of offenders by caseworkers in coordination with law enforcement, the district attorney, the courts, or the department of corrections and includes all of the following services:

1. Screening under s. DHS 75.03 (10) (c) and other multidisciplinary screenings and psychosocial evaluations.

2. Conducting substance use evaluations and developing treatment recommendations by a substance abuse counselor.

3. Facilitating specialized education and skill–building groups where the primary group topic is alcohol and other drug abuse education, intervention, or relapse prevention and the participants are persons having alcohol or other drug abuse problems.

(b) Staff providing approved intensive supervision program service components shall have knowledge, training, and experience in the component they are providing or otherwise meet the qualifications to provide the service.

(c) Agencies providing intensive supervision shall comply with all requirements included in s. DHS 75.03 that apply to an intervention service as shown in Table DHS 75.03 and this subsection except intensive supervision services are not required to meet the requirement under sub. (4) (j).

(d) Intensive supervision services provided by agencies certified under s. DHS 75.12 or 75.13 need not also be approved under this section. However, the program shall comply with all the requirements that apply to intensive supervision programs under this subsection.

**History:** CR 06–035: cr. Register November 2006 No. 611, eff. 12–1–06; corrections in (1), (2) (b), (3) (b), (5) (a) 6. and (6) (a) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.