

908 KAR 2:060

Mental health and mental retardation manuals for funding
instructions, program policies and standards, and
reimbursement guidelines

Section 2. Program Policies and Standards Manual.

September 1, 1995

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Department for Mental Health
and Mental Retardation
Program Policies and
Standards Manual

908 KAR 2:060 Section 2

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Section I
Introduction

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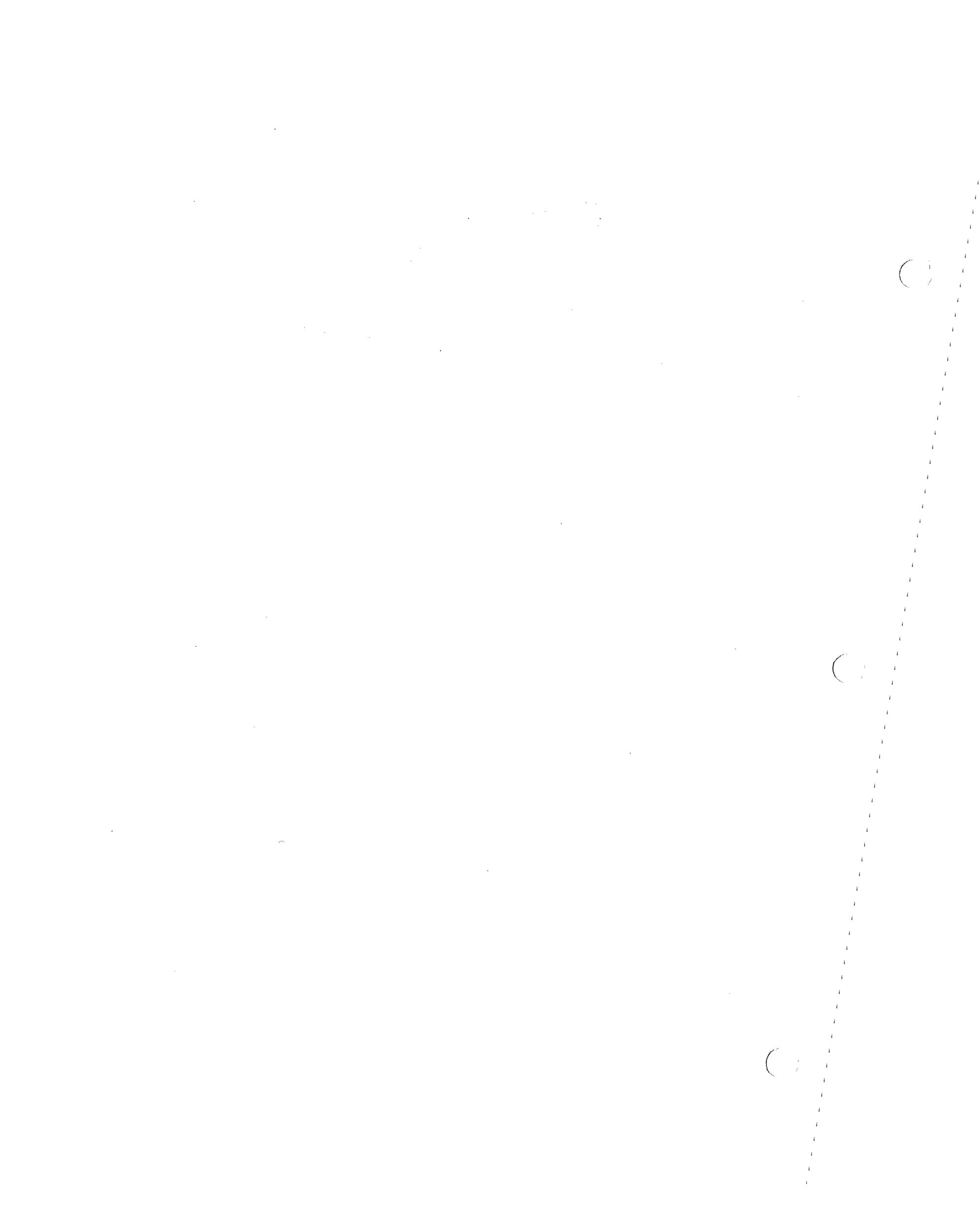
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Section I
Introduction

This manual delineates general standards applicable to all services and standards particular to individual service categories, staffing, recordkeeping and general operations of Community Mental Health and Mental Retardation Boards.

The standards for particular service categories pertain to services provided to persons with mental health problems and persons with mental retardation or developmental disabilities. Standards for substance abuse services are delineated in 908 KAR Chapter 1.



Section II
Definitions

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Section II
Definitions

1. **Applicant** means an individual who comes to a center for services to cope with or overcome a mental illness, mental retardation or chemical dependency who is not a client.
2. **Behavioral objectives** are short-range outcomes that describe the individual's behavior as a result of training. They are generally expected to be achieved within one year, and specify the learned response to be exhibited by the individual and the criteria against which progress is to be assessed. Objectives are based on knowledge of assessed developmental strengths and needs and are sequenced within a relevant progression directed toward the achievement of established goals.
3. **Cabinet** means the Kentucky Cabinet for Human Resources.
4. **Center** means the organization recognized as a Community Mental Health/Mental Retardation Board pursuant to KRS 210.380.
5. **CHAMPIONS** means the Governor's statewide substance abuse prevention public awareness and community involvement program.
6. **CHAMPIONS Regional Action Group** means a community task force consisting of citizens committed to developing and implementing programs and activities aimed at reducing alcohol and other drug problems and recognized by the Department for Mental Health and Mental Retardation Services as the CHAMPIONS Group for the region.
7. **Client** means a person participating in a center program for whom the center has established an individual service plan.
8. [7] **Core Team Model** means a program model which utilizes the training and active participation of a minimum of six (6) staff per school building in the identification, intervention and referral of troubled students. The Core Team is specifically trained in the prevention, intervention, and recovery aspects of chemical dependency and to recognize chemical dependency as a primary disease.
9. **Department** means the Department for Mental Health and Mental Retardation Services.
10. **Drug (or drugs)** means substances including tobacco, alcohol, pharmaceuticals, household products and illegal drugs that are used for their psychoactive properties.

11. Goals are long-range outcomes that provide the framework upon which objectives are developed. They are written in measurable terms, so that their achievement can be determined. Goals are developed from the synthesis of evaluations of the individual's present performance, abilities, environmental needs, and desires as these relate to what society expects of persons of the same age and culture who do not have a disability. Generally goals are expected to be achieved within three to five years.
12. **Individual Service Plan** means a written plan that delineates services to be provided to a particular client and contains the information specified under record keeping in this manual. This may be an Individual Habilitation Plan, an Individual Treatment Plan or an Individual Family Services Plan.
13. **Interdisciplinary Team** means a group of persons who use their skills, competencies, insights and experience to identify the needs of the individual being served, to devise ways to meet those needs, and to develop an Individualized Plan. The team includes the individual being served, those who provide assessments or services, those who have worked or will work closely with the individual, as well as the family (when appropriate), guardian or advocate.
14. **Mental Health Associate** means an individual with a Bachelor's degree in a mental health related field, who is working under the supervision of a qualified mental health professional and who is working toward Professional Equivalency status.
15. **Paraprofessional** means an individual who does not meet the educational requirement for a mental health professional and who is working under the supervision of a Qualified Mental Health Professional, Mental Health Associate or Mental Health Case Manager.
16. **Prevention** means the prevention of problems resulting from alcohol and other drug use.
17. **Qualified Mental Health Case Manager** means an individual with a Bachelor's Degree in psychology, social work, nursing, sociology, human services, special education or other behavioral sciences who has completed the Department's case management certification course within six (6) months of employment and who are working under the supervision of a Qualified Mental Health Professional with Department approved case management certification.

18. **Qualified Mental Health Professional (QMHP)** means a board certified or board eligible psychiatrist, a licensed clinical or counseling psychologist, certified psychologist, a psychological associate, a social worker with a Masters degree in social work from an accredited school of social work, a person recognized as a professional equivalent by the Kentucky Medical Assistance Program, or a registered nurse with one of the following combinations of education and experience:
- A. Master of Science in Nursing (MSN) with specialty in psychiatric, mental health nursing and no experience.
 - B. Four (4) year educational program, with a Bachelor of Science in Nursing (BSN) and a minimum of one (1) year of experience in a mental health setting.
 - C. Three (3) year educational program Diploma Graduate with two (2) years of experience in a mental health setting.
 - D. Two (2) year educational program Associate Degree in Nursing (ADN) with three (3) years of experience in a mental health setting.
19. **Qualified Mental Retardation Professional (QMRP)** means a doctor of medicine or osteopathy, a registered nurse, a licensed occupational therapist, a person with at least a master's degree in psychology from an accredited school, an individual who has a graduate degree or Bachelor of Social Work from an accredited school of social work, a licensed speech or language pathologist or audiologist, a recreation therapist, a registered dietitian, or a human services professional with at least a bachelor's degree in a human services field including, sociology, special education, rehabilitation counseling, or psychology and has at least one (1) year of experience working directly with persons with mental retardation or other developmental disabilities.
20. **Qualified Substance Abuse Professional (QSAP)** means an individual who meets the qualifications of the Kentucky Chemical Dependency Counselor's Professional Certification Board, Inc., a person who meets the qualifications stipulated in 908 KAR 1:050 Section 1(4)(a)(b) and 908 KAR 1:190 Section 1(4)(a)(b) or a QMHP with eighty (80) hours of substance abuse training.
21. **Regional Prevention Center (RPC)** means a program funded by the Department for Mental Health and Mental Retardation Services for the purpose of developing, providing, and coordinating substance abuse prevention programs and activities in a specified region of the state.

22. Service objectives are short-range or ongoing outcomes that describe the individual's movement or status change as an outcome of support services. Such objectives cannot be achieved as a result of learning or training and may include:

- a. outcomes related to enhancing community integration or developing and maintaining social relationships, or
- b. outcomes dependent on staff, such as provision of adaptive or mobility orthotic or prosthetic equipment, use of mechanical supports for body position/balance, modified diets, weight control, seizure disorders, obtaining specialized assessments, obtaining job opportunities in community businesses, or securing the environmental changes and social supports necessary to promote the successful functioning of the individual in the community.

23. Student Assistance Program (SAP) means a school-based program funded by the Department for Mental health and Mental Retardation Services which:

- a. provides for the prevention, early identification, intervention and referral of youth who may be experiencing problems related to their own alcohol or drug use, the alcohol or drug use of a family member, or related to a variety of personal or behavioral problems; and
- b. increases the capacity of the school system to respond more effectively to alcohol and drug problems.

Section III
Standards

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Section III
Standards

1. General Operating

- A. The Center shall be operated and administered in accordance with all applicable federal and state laws and regulations and particularly KRS 210, KRS 222, 908 KAR Chapters 1 and 2 and 902 KAR 20:091.
- B. The Center shall permit Department staff or persons acting on behalf of the Cabinet to examine all records of services provided pursuant to a program administration contract between the Cabinet and the Center.
- C. The Center shall have on file at the Administrative or Executive Director's office a written plan for services which shall describe:
 - (1) a statement of mission and service philosophy with clearly defined assumptions and values. For Mental Retardation services this shall include a commitment to principles of normalization or social role valorization, provision of services in the least restrictive environment and the use of an interdisciplinary team approach to service delivery.
 - (2) estimates of the clinical needs of the community served by the organization;
 - (3) services provided by the organization;
 - (4) populations served, including age groups and other relevant characteristics of the populations served;
 - (5) how services provided by the organization can be accessed and used;
 - (6) hours and days the organization operates;
 - (7) methods used to perform initial screening or triage;
 - (8) intake or admission process, including how the initial contact is made with the individual served and the family or significant others;
 - (9) assessment and evaluation procedures provided by the organization;
 - (10) methods used to deliver services to meet the identified clinical needs of individuals served;
 - (11) basic programs offered by the organization;
 - (12) individual service plan development and review process;
 - (13) discharge and post discharge planning processes;
 - (14) organizational relationships of each of the Center's programs, including channels of staff communication, responsibility, and authority, as well as supervisory

relationships;

(15) how the Center provides, or makes arrangements for providing, other medical, special assessment, and therapeutic, habilitative, educational, emergency and crisis intervention for individuals served.

- D. The Center shall have a written Client Bill of Rights that clearly describes the legal and human rights of the clients. Each client shall be informed of their rights during intake and this shall be documented in the client record. These rights shall be posted in each facility the Center occupies and contain the phone number and address of the Center's Ombudsperson.
- E. The Center shall have a written client grievance procedure which describes the means by which client rights are protected and exercised. Grievances shall be maintained in a separate file.
- F. The Center shall designate an Ombudsperson who shall make reports of all client grievances and their resolution to the Program Planning and Evaluations Committee of the Center's board at least quarterly.
- G. The Center shall establish procedures that assure allegations of abuse, neglect or exploitation of applicants or clients are reported pursuant to KRS 620 or KRS 209 as applicable and that records shall be kept of reports made.
- H. The Center shall establish procedures for staff orientation and training and for assuring that training is documented in each employee's personnel file.
- I. A Center shall not charge the Department for any service which is not provided in accordance with the service definitions in the Department's Billing Manual and the standards in this manual unless a waiver is granted in writing by the Department.
- J. All services shall be provided by or under the supervision of a QMHP, QMRP or QSAP as defined in this manual.
- K. All services to clients shall be provided in accordance with an Individual Service Plan. The client shall be involved in the development of their Individual Service Plan unless:
- (1) the client refuses; or
 - (2) there is documentation in the client record that

- participation would not be in the client's best interest; or
(3) the client is unable to participate.

L. The Center shall report in writing to the DMHMRS Ombudsperson any publicized impropriety by staff reflecting on the program and any abuse, neglect or exploitation of a client.

(1) The incident report shall be submitted to the Department Ombudsperson within five (5) working days of the incident.

(2) In the event of death of a client, serious injury to a client or confirmed abuse of a client, the Department Ombudsperson shall be notified by telephone no later than the end of the first working day following the incident.

2. Client Records

A. The Center shall establish and adhere to written policies and procedures governing client records which assure compliance with 902 KAR 20:091 Section 3(4).

B. An individual record shall be established for each applicant and client.

(1) Applicant records shall contain:

- a. an intake or application form which contains the applicant's name, address, age, gender, marital status, expected source of payment and referral source;
- b. the reason for seeking services;
- c. staff notes describing each service provided;
- d. the service provider's initial assessment of the applicant's need for services;
- e. documentation of referrals made on behalf of the applicant if any.

(2) Client records shall contain:

- a. an intake or application form that includes the minimum data set required in the Departments' Reporting Manual for Centers (908 KAR 2:060 Section 5);
- b. a psychosocial history for mental health and substance abuse clients and a social history and evaluation for mental retardation clients that includes a developmental history, a description of

the type and frequency of social interactions and a description of the individuals social support network. [7]

- c. the findings of any other evaluation and assessments conducted by Center staff or secured by the Center. For Mental Retardation clients this shall include a psychological evaluation to assess emotional and cognitive status and adaptive skills or behaviors. For individuals under the age of five (5) years a diagnostic evaluation specific to their age or need may be used.
- d. an Individual Service Plan;
- e. staff notes describing services provided;
- f. a discharge summary if a client is discharged from services;
- g. copies of all correspondence related to the client;
- h. authorization to receive or disclose information on behalf of the client, if applicable;
- i. if a client is participating in supported employment the record shall also contain:
 - i. vocational Assessment;
 - ii. vocational goals and objectives;
 - iii. place of employment;
 - iv. job title;
 - v. rate of pay and fringe benefits;
 - vi. date of employment;
 - vii. name of immediate supervisor;
 - viii. work site; and
 - ix. employment follow-up reports.

- (3) Individual records shall show that services address the client's identified needs:
 - a. Assessments and evaluation shall be appropriate in relation to the reasons for seeking services.
 - b. Individual service plans shall address the findings of evaluations.
 - c. Staff notes shall describe services in relation to goals and objectives in the Individual Service Plans.

C. A psychosocial history shall be obtained at intake, updated at least annually and shall include information relating to:

- (1) environment and home;
- (2) religion;
- (3) childhood history;
- (4) military service history;
- (5) financial status;

- (6) social, peer group, and environmental setting;
- (7) family circumstances, the current living situation;
- (8) social, ethnic, cultural, emotional, and health factors;
and
- (9) alcohol and other drug use patterns.

D. An Individual Service Plan shall be developed for each client, shall be updated annually and shall specify:

- (1) services to be provided by the Center;
- (2) functional abilities of the client;
- (3) functional limitations of the client;
- (4) goals and measurable objectives and expected dates of achievement for each goal and objective;
- (5) the frequency of service;
- (6) staff assigned to provide services;
- (7) a diagnosis listed in the current Diagnostic and Statistical Manual;
- (8) services to be provided by other entities outside the center;
- (9) methods of involving the client's family or significant others if indicated;
- (10) criteria for termination of services; and
- (11) the date scheduled for review of the plan.

NOTE: For Mental Retardation clients the Individual Service Plan shall be developed by an interdisciplinary team. For substance abuse and mental health clients the plan shall be signed by a physician with specialty training in psychiatry.

E. A description of each service provided to an applicant or client shall be recorded as a staff note in one (1) of the following formats within two (2) working days following the service.

- (1) Staff notes for services rendered may be either a separate note for each occurrence or a weekly summary note that shall include:
 - a. month, day, and year of service;
 - b. the title of the type of service rendered;
 - c. a description of the service provided;
 - d. a description of the client's symptoms, behavior, and reaction to the service;
 - e. an assessment of the client's progress toward achieving goals and objectives specified in the individual service plan;
 - f. changes in the treatment plan and the need for continued treatment;
 - g. the name, signature and position title of the

person rendering the service. Staff notes shall be

documented by the person rendering the service. Staff notes documenting services provided by or paraprofessionals shall be co-signed by the supervisory professional, mental health associates.

- h. If case management services are provided to a mental retardation client by someone other than the person's assigned case manager the note shall indicate the reason and shall be cosigned by the assigned case manager.
- (2) Each occurrence of outpatient, case management mental retardation, case management substance abuse, leisure services, therapeutic recreation and in-home support shall have a separate staff note. Each individual counseling session provided in a substance abuse residential setting shall have a separate staff note.
 - (3) Staff notes describing group services may include a photocopied description of group activities and shall include an original entry describing the participation of the individual client and the original signature of the staff making the entry.
 - (4) For mental health case management, an individual monthly service log may be maintained in lieu of separate staff notes for each occurrence of service. A case management monthly service log shall contain:
 - a. a separate entry for each service contact during the month which lists the date of contact, person contacted, type of contact, brief identification of purpose or content of contact and initials of person recording the contract; and
 - b. a monthly summary of progress relative to the client's service plan goals.
 - (5) A monthly summary note shall be used to document Work Habilitation services and shall contain the same elements specified above for separate staff and weekly summary notes.

A separate expansion staff note shall be recorded whenever additional space is required to document important actions, decisions or additional information resulting from a contact.

(6) The Center shall establish standardized procedures and forms for recording:

a. prevention, consultation and education services, social club drop in services and Preadmission Screening and Annual Residential Review (PASARR) consultation services provided to persons other than applicants or clients. Information shall include:

- i. the date of the service;
- ii. the staff providing the service;
- iii. the purpose of the service;
- iv. the recipient(s) of the service;
- v. a description of the activity; and
- vi. the length of service.

b. substance abuse prevention provided by a Regional Prevention Center (RPC) which shall also include:

- i. methods used, whether information, training, training of impactors, consultation, training or trainers or community organizing,
- ii. an outline of the content of any education or training program,
- iii. the location where the service was delivered;
- iv. type of prevention strategy, whether educational or environmental,
- v. results of any evaluation conducted, and
- vi. follow-up plans.

(7) Documentation for a PASARR evaluation shall include a separate file for each person who receives a Level II PASARR evaluation. Each record shall include at least the following:

- a. documentation of referral;
- b. initial comprehensive assessment (including necessary attachments);
- c. interpretation of findings;
- d. computer summary form;
- e. staff notes, if necessary;
- f. correspondence related to PASARR;
- g. annual resident review (ARR); and
- h. documentation to substantiate units billed, including billing tickets, if appropriate.

F. A discharge summary shall be entered in the client record within fifteen (15) days following discharge.

G. All adults discharged from a state hospital and referred by hospital staff for center-based services shall be given an appointment with a center QMHP within two (2) weeks of discharge.

(1) When the hospital staff referral specifies psychiatric services, the QMHP shall be a psychiatrist. Compliance shall be documented in accordance with the appropriate state psychiatric hospitals' aftercare reporting requirements.

(2) When a referred individual fails to keep the first appointment, the Center shall initiate and document a follow-up contact in an attempt to engage the person in the Center's services.

3. Quality Assessment and Improvement

A. The Center shall have a written quality assessment and improvement plan that describes the scope, organization, objectives and mechanisms for overseeing the effectiveness of internal monitoring, evaluation and corrective actions including:

(1) the establishment of a quality Assurance Committee; and
(2) procedures for informing the board of directors of the results of committee action.

B. Procedures shall be implemented for ongoing monitoring, evaluation and improvement of the quality of care provided and governance, managerial and support activities. Procedures shall:

(1) identify important indicators of quality which are objective and measurable;
(2) collect data for each indicator;
(3) analyze patterns or trends in cumulative data;
(4) identify problems or opportunities for improvement;
(5) assure that appropriate action is taken when an opportunity for improvement is identified;
(6) assess the effectiveness of action taken; and
(7) document and report the findings, recommendations, actions taken and results of actions taken.

C. The effectiveness of the monitoring and evaluation process shall be assessed annually.

4. Service Delivery Standards

A. All services defined in the Department's Billing Instructions

Manual shall be provided in accordance with Section III 1. General Operating (C) (J) and (K) of this manual.

B. Certain services shall also comply with additional standards. They are:

1. Therapeutic Rehabilitation Services for Adults

- a. A psychiatrist shall be present in the therapeutic rehabilitation program on a regularly scheduled basis, at least monthly, and shall assume clinical responsibility for all participants, including the development of the plan of treatment.
- b. The program shall have direct supervision by a QMHP. This professional shall be present at all times in the program while participants are present and shall direct, supervise, and guide other members of the therapeutic team, which may include Mental Health Associates and paraprofessionals.
- c. Services shall be designed to address the needs of adults who have a chronic or severe mental illness. If participants who do not have severe mental illness are served in the program the need for this service shall be documented in the individual's record.
- d. A therapeutic rehabilitation program which has been in operation more than six (6) months shall operate a minimum of four (4) hours per day, three (3) days per week.
- e. Individual service plans shall be reviewed, and revised as appropriate, every three (3) months.

2. Therapeutic Rehabilitation for Children

- a. The program shall have the direct supervision of a QMHP. This professional shall be present in the therapeutic rehabilitation program to provide direct, ongoing supervision and to serve as a source of guidance for other members of the therapeutic team.
- b. A Mental Health Associate may be involved in the provision of therapeutic rehabilitation services for children under the supervision of a QMHP.
- c. Individual service plans shall be reviewed, and revised as appropriate, every three (3) months.

- d. The program shall have scheduled family involvement activities.
- e. If the service is a day treatment program operated in conjunction with a school there shall be a written agreement between the center and the local education authority outlining the responsibilities of each agency for the day treatment program. The written agreement shall include:
 - (1) assurance that the mental health professional shall participate in the formulation of the child's Individual Education Plan;
 - (2) a description of less restrictive educational alternatives for children with emotional and behavioral disorders available through the local education authority;
 - (3) assurance that teachers and classroom aides shall be certified;
 - (4) assurance that the program shall be provided according to the school calendar and provide a school day;
 - (5) assurance that structured group therapy oriented toward goals shall be provided by the center a minimum of two (2) times per week to each child for at least one (1) hour;
 - (6) assurance that individual therapy shall be provided by the Center at least one (1) time weekly for one (1) hour and shall be available as needed during program hours;
 - (7) assurance that family therapy shall be available to clients and their families as needed;
 - (8) assurance that the services of a psychiatric nurse or a psychiatrist shall be available to clients as needed;
 - (9) a description of how the mental health professional shall establish and maintain the therapeutic milieu; and
 - (10) a provision for weekly meetings between mental health staff and education staff to measure progress of students on short-term goals, identify therapeutic issues, and set new short-term goals if indicated.
- f. If the service is a day treatment program, each individual service plan shall include provisions for involving the family in the program.
- g. If the service is an after-school program,
 - (1) The program shall be available at least three (3)

days weekly for at least two (2) hours per day during the school year. Summer programming shall be optional.

- (2) Activities shall be planned; and schedules of weekly activities shall be maintained by the Center.

3. Work and Adult Habilitation Services

- a. The program shall employ a minimum of two (2) direct client service staff for the first fifteen (15) or fewer clients.
- b. When there are over fifteen (15) clients in the program, one (1) additional employee shall be in direct client service for each additional group of ten (10) or any part thereof.
- c. Services shall be provided a minimum of six (6) hours per day, excluding transportation time, five (5) days per week, twelve (12) months per year excluding customary holidays, weather permitting.
- d. A monthly assessment shall be completed on each client and shall be documented in the client's record including:
 - (1) graphed or charted data on the individual's progress toward the attainment of criteria within priority behavioral objectives. Data shall be traceable back to a daily data collection system;
 - (2) individual's progress toward the attainment of service objectives;
 - (3) summary of community integration activities and informal developmental skill training; and
 - (4) changes in routine and other behavioral and medical noteworthy events.
- e. The program shall be located in a non-residential setting.
- f. The program shall comply with applicable state and federal wage and hour laws and regulations.
- g. All participants in the program receiving wages shall be provided with:
 - (1) Social Security coverage except where earnings do not exceed the Social Security minimum in a quarter; and

(2) Worker's Compensation Insurance.

- h. The program shall meet applicable local, state and federal safety requirements, particularly with reference to machinery, power equipment, including power hand tools, and storage for both raw materials and finished products.

4. Community Residential Services

- a. Residential services shall not be provided in the same building where other training and habilitation services such as work and adult habilitation shall be provided.
- b. For Mental Retardation clients each unit shall have its own bath and kitchen facilities and may not be occupied by more than three (3) clients.

5. Personal Care Home Special Purpose

- a. The facility shall serve those individuals eligible for services as specified in 902 KAR 20:036. Only individuals referred from a state psychiatric facility shall be eligible for admission, unless an exception has been granted by the Commissioner of the Department.

- b. The program shall include:

(1) skill building activities

- a. money management;
- b. daily living skills;
- c. social skills;
- d. remedial reading, writing and math;
- e. leisure and recreation skills;
- f. mobility in the community;
- g. conflict resolution;
- h. assertiveness;
- i. self-advocacy; and
- j. stress management;

(2) educational activities

- a. substance abuse education; and
- b. illness and wellness education

(3) opportunities to participate in self-help groups;

(4) psychiatric services;

(5) chemotherapy, individual and group therapy;

(6) crisis intervention services; and

(7) case management and discharge planning services to assist residents to gain access to less restrictive learning, living and work experiences in the

community.

- c. A security risk management plan shall be established for dealing with residents who pose a danger to themselves or others.
- d. An interdisciplinary team of qualified mental health professionals, including a psychiatrist, mental health associates, and paraprofessionals shall meet on a regularly scheduled basis to:
 - (1) discuss new residents; and
 - (2) update individual service plans for current residents and review clinical issues. Residents shall have input into developing their individual service plan. Evidence of such input shall be:
 - a. resident's signature on the individual service plan;
 - b. the resident's attendance at the individual service planning meeting; and
 - c. a functional assessment of the resident's skills and skill deficits.
- e. The personal care home shall provide transportation to outside community resources based on the needs and interests of the residents.

6. Respite

- a. The following information shall be provided in writing to the respite provider:
 - (1) telephone number and address of a person to contact in an emergency;
 - (2) medical information--medication, allergies, relevant history;
 - (3) the client's self-care skills;
 - (4) written authorization to obtain emergency medical treatment of a minor signed by a parent or guardian;
 - (5) the client's eating preferences--methods, routine, snacks;
 - (6) the client's communication skills;
 - (7) a description of the client's behavior problems, if any, and methods of intervention;
 - (8) preferred leisure activities of adult clients;
 - (9) play preferences of children;
 - (10) special equipment needed;
 - (11) bedtime routine, sleep pattern and schedule; and

(12) any special precautions that may be necessary.

- b. The provider shall assure that educational services, shall be provided for school-age clients receiving extended respite care during the school term. Educational services shall be in accord with any Individualized Education Plan (IEP) if one has been developed.

7. Standards for Supported Employment

- a. Program admission criteria shall require that persons served:

- (1) have mental retardation, mental illness or have developmental disabilities with severe handicapping conditions; and
- (2) shall require ongoing support and shall be referred to the Department for Vocational Rehabilitation.

- b. Clients shall be placed in a work environment that includes workers who do not have disabilities. Programs using supported employment models such as enclaves or mobile work crews shall not exceed eight (8) workers with disabilities. Within an enclave, payment for work performed shall be commensurate with pay to others within the host company doing the same type and amount of work. A mobile work crew shall have a supervisor and shall perform work in regular industry. Jobs may be provided on a contractual basis with a business and may require an individual to work at different job sites.

- c. The supported employment program shall comply with state and federal wage and hour laws and regulations.

- d. Needed support services shall be provided to clients indefinitely.

8. Adult Mental Health Case Management

- a. All adults with a chronic mental illness, as defined by KRS 210.005, who are discharged from a state psychiatric facility, who are determined by hospital staff to be in need of intensive case management services and who agree to receive those services shall receive the services of a case manager.

- (1) The assignment of a case manager shall occur prior to or on the date of discharge. Exception: if the individual refuses the receipt of those services or

when the hospital's staff fails to notify the appropriate staff of the Center of the need for this service.

- (2) Re-evaluation of ongoing need for intensive case management shall be the responsibility of the Center.
- (3) Compliance with this assurance shall be documented in accordance with the appropriate state psychiatric hospitals' aftercare reporting requirements.

b. A written comprehensive needs assessment shall be obtained by face-to-face contact with the client, and other family members, as indicated. The assessment shall include:

- (1) identifying information (living arrangements, emergency contacts, source of assessment information);
- (2) family life (ability to function and interact with other family members);
- (3) physical health (note any health problems or concerns, treatments, medications, handicaps, etc.);
- (4) emotional health (behavior problem, alcohol/substance abuse, etc. which may be further defined in the treatment plan);
- (5) social relationships (support, friends, family, volunteers, recreation, etc.);
- (6) physical environment (safety, cleanliness, accessibility, etc);
- (7) self-care (activities of daily living, ability to care for one's own needs, functional assessment skills and skill deficits);
- (8) educational status (educational needs, vocational needs, prognosis for employment skills);
- (9) legal status (guardian, conservatorship, involvement with the legal system);
- (10) financial resources (client's income or other resources); and
- (11) community resources (formal and informal resources in the client's community).

c. The case manager shall provide assistance in the development of the client's individual service plan. While the case manager shall not be responsible for developing the client's individual service plan, it shall be the responsibility of the case manager to document:

- (1) all needed services;
- (2) anticipated dates of delivery;
- (3) all services arranged;
- (4) follow-up on services; and
- (5) unmet needs and service gaps.

d. Case Managers, whether they are employed part-time or full-time, shall deliver only case management services to adults.

e. The caseload size shall be small enough to permit the delivery of intensive case management services to each client given the unpredictability of the manifestations of severe mental illness. The recommended caseload size shall not exceed twenty-five (25) with no more than fifteen (15) clients receiving the most intensive of service. The maximum caseload shall be thirty-five (35).

f. Caseloads shall be reviewed and reassessed on a three (3) month basis allowing for termination of intensive case management for clients whose most pressing goals have been achieved. This may also imply transition to supportive case management to be provided by the client's friends, family, primary therapist or others. Time dated goals shall be instituted and goals not achieved within one year shall be reevaluated.

g. Minimum standards for the supervision of case managers shall be as follows:

- (1) The supervisor shall be a QMHP who has completed the required adult case management certification program.
- (2) Supervision shall occur both individually (per case plan) and in group (resource development) at least one (1) time a month.
- (3) The supervisor may provide direct case management services in the event of staff absence or position vacancy.

9. Case Management for Children with Severe Emotional Disabilities

a. To be eligible for case management services, a child shall be identified by a Regional Interagency Council (RIAC) as a child with a severe emotional disability pursuant to KRS 200.503, who is in need of case management services. Children who present impairments or behavior of possibly short duration yet of high

intensity, such as suicidal or psychotic trauma reactions where prognosis regarding duration of symptoms cannot be accurately assessed, may be considered to be a child with a severe emotional disability.

- b. Case managers, regardless of whether they are employed part-time or full-time, shall deliver only case management services for children or adults under the age of twenty-one (21) who were receiving targeted case management services prior to age eighteen (18) that must be continued for therapeutic benefit.
- c. Case managers shall be supervised by a QMHP with experience in providing children's services. The supervisor shall have completed the Department's approved children's case management certification course. Both individual and group supervision shall be performed at least one (1) time a month.
- d. Caseload size shall be small enough to permit the case manager to have frequent contact with the child, family members and other service providers. The maximum caseload size shall be twenty (20) with no more than ten (10) children at one (1) time who are receiving intensive services or are in the intake phase.
- e. Children receiving case management shall have an interagency team representing key systems in which the child and the child's family are involved. This team shall plan services for the child. The interagency team shall be convened and facilitated by the child's case manager or local resource coordinator. Families shall be involved in planning to the maximum degree possible. The child shall be included in the planning as appropriate.
- f. The interagency service plan shall include goals, tasks, timelines, responsible parties, and when appropriate, financial responsibilities. It shall be updated as necessary by the case manager and the interagency service planning team, but not less frequently than every six (6) months.
- g. All parties responsible for implementing the interagency service plan shall sign the plan or a plan summary as their acknowledgement and acceptance of the plan. Each party shall receive a copy of the plan. A copy of the plan shall be maintained in the Center record.
- h. For children in the IMPACT Program, implementation of the interagency service plan shall be reviewed by the

RIAC at a frequency which has been determined by the RIAC.

10. Pre-Admission Screening and Annual Resident Review (PASARR) Evaluation
 - a. PASARR evaluations shall be conducted by a QMHP or a QMRP as defined in the definitions section of this manual or by a MHA, if co-signed by a QMHP. PASARR evaluators shall complete a PASARR evaluator training and certification provided by the Department within three (3) months of their assignment to the program.
 - b. The client shall be seen by the PASARR assessor. The PASARR evaluation shall occur at the applicant's current place of lodging.
 - c. A comprehensive evaluation for mental illness shall include a:
 - (1) comprehensive history and physical examination;
 - (2) comprehensive drug history;
 - (3) psychosocial evaluation;
 - (4) psychiatric evaluation; and
 - (5) functional assessment of activities of daily living ability.
 - d. A comprehensive evaluation for mental retardation shall include:
 - (1) medical problems and the impact these have on independent functioning; current medications;
 - (2) self-monitoring of health status, medical treatments, and nutritional status;
 - (3) development of skill areas such as self-help, sensorimotor, speech and language, social, academic, educational, independent living and vocational;
 - (4) the presence of identifiable maladaptive or inappropriate behaviors; and
 - (5) a psychological evaluation which in the professional opinion of the evaluator remains current.
 - e. A comprehensive evaluation for dual diagnosis shall include:
 - (1) a completed PASARR II Mental Retardation Evaluation; and
 - (2) the mental status psychiatric assessment portion of the Comprehensive Evaluation for Mental Illness.

- f. The findings of each PASARR evaluation shall be interpreted to the applicant and, if applicable, to his or her legal representative.

11. Behavior Intervention (Outpatient)

- a. Behavior intervention to address maladaptive behaviors shall be implemented:
 - (1) in a manner that enhances the development of the individual;
 - (2) in accordance with the developmental model;
 - (3) in the least restrictive environment; and
 - (4) In accordance with principles of normalization.
- b. Behavior intervention shall emphasize the development of desirable and adaptive behaviors, rather than merely the elimination or suppression of undesirable behaviors.
- c. Prior to the development of a behavior intervention plan, a written functional and ecological analysis of the behavior shall be completed and shall include:
 - (1) an analysis of the potential communicative intent of the behavior;
 - (2) the history of reinforcement for the behavior;
 - (3) critical variables that precede or result from the behavior;
 - (4) effects of different situations on the behavior;
 - (5) environments where the behavior does and does not occur;
 - (6) the social context; and
 - (7) hypotheses regarding the motivation, purpose and factors which maintain the behavior.

Physical, social and environmental factors shall be analyzed and needed modifications made when possible. Possible medical causes for maladaptive behavior shall be ruled out or treated before other behavior intervention strategies shall be used.

- d. Behavior intervention plans shall be approved by a Behavior Intervention Committee.
- e. Implementation of behavior intervention plan shall be the decision of the interdisciplinary team and be incorporated in the individual habilitation plan. Behavior intervention for emergencies, data collection, or functional analyses purposes shall not occur over thirty (30) days without an approved behavior intervention plan or approval by the Behavior

Intervention Committee.

- f. Implementation of behavior intervention programs shall be applied across all relevant program areas by all staff as part of their operations.
- g. When rights are restricted, the behavior intervention plan shall be approved by the Center's Human Rights Committee.
- h. Legally adequate consent and approval of a human rights committee shall be obtained and renewed at least annually when any of the following methods shall be used:
 - (1) manual or mechanical restraints;
 - (2) time-out;
 - (3) drugs for behavior intervention; and
 - (4) aversive conditioning.
- i. Medication may only be used for behavior intervention as part of a comprehensive behavior intervention plan which shall include:
 - (1) other strategies; and
 - (2) a drug reduction plan.
- j. The following methods of behavior control shall be prohibited:
 - (1) corporal punishment;
 - (2) seclusion;
 - (3) verbal abuse;
 - (4) forced exercise;
 - (5) electric shock; and
 - (6) denial of a nutritionally adequate diet.
- k. Behavior intervention services shall be provided by a behavior specialist. When the behavior specialist is not a psychologist, they shall be supervised by a licensed or certified psychologist.

12. Case Management for Persons with Mental Retardation

- a. Case management shall:
 - (1) identify client's needs;
 - (2) identify services to satisfy those needs;
 - (3) refer clients to other service delivery agencies;
 - (4) arrange for services available;
 - (5) advocate for services needed but not readily

- available; and
- (6) coordinate a client's service to facilitate maximum benefit with minimum distress.
- b. Case managers shall have access to a resource directory of the available services and agencies in the service areas.
- c. Case managers shall coordinate the development of an Individual Habilitation Plan for each client.
- d. Case managers shall monitor the services provided and the progress attained on the objectives in the Individual Habilitation Plan.
- e. Case managers shall coordinate revision of Individual Habilitation Plans to reflect the current services, goals and objectives.
- f. Provision of case management services in a group setting shall be prohibited.
- g. Case managers shall encourage and assist the individual or responsible party to take responsibility for as many case management functions as possible.
- h. All persons receiving this service shall have an assigned case manager.

13. Early Intervention Services

- a. Children may be enrolled in an early intervention program if:
- (1) They have a developmental delay in:
- a. cognitive development,
 - b. communication development,
 - c. physical development,
 - d. social or emotional development, or
 - e. adaptive development.
- (2) They have a condition likely to cause delay including:
- a. chromosome abnormalities associated with developmental delay, e.g., Down Syndrome, Fragile X Syndrome;
 - b. recognizable syndromes associated with developmental delay, e.g. DeLange Syndrome, Rubinstein Taybi Syndrome;
 - c. abnormality in central nervous system development, e.g., microcephaly, congenital hydrocephalus, agenesis of the corpus

- d. callosum;
 - d. neurological/neuromuscular disorders associated with developmental delay, e.g., cerebral palsy, spinal muscular atrophy, muscular dystrophy;
 - e. symptomatic intrauterine infection or neonatal central nervous system infection, e.g., cytomegalovirus (CMV), toxoplasmosis, rubella, AIDS, neonatal meningitis;
 - f. sensory impairments: significant visual or hearing loss, or a combination of both, interfering with the ability to respond effectively to environmental stimulus;
 - g. metabolic disease having a high likelihood of being associated with developmental delay, even with treatment, e.g., urea cycle defect, nonketotic hyperglycemia;
 - h. maternal teratogen exposure at a level known to have a high risk for developmental delay, e.g., alcohol, accutane, anticonvulsant;
 - i. behavioral or emotional disorder associated with extreme excesses or deficits which inhibit function, e.g., pervasive developmental disorder, infantile autism, reactive attachment disorder; and
 - j. central nervous system malignancy or trauma resulting in developmental delay.
- b. Children may be determined to have a developmental delay when:
- (1) scores on appropriate diagnostic instruments:
 - a. are two (2) standard deviations below the mean in any one (1) of the skill areas listed in standard A(1); or
 - b. are one and one-half (1 1/2) standard deviations below the mean in two (2) skill areas listed in standard A(1); or
 - c. calculate a developmental quotient of seventy-five (75%) or less from scores on multiple instruments.
 - (2) scores on appropriate diagnostic instruments are inconclusive and a child shows an atypical pattern of development.
- c. All children, ages birth through two (2), determined through appropriate screening to need an evaluation, shall receive a developmental and medical evaluation at no cost to the family, unless a family refuses services.
- d. All children with developmental delay or condition shall

receive the services of a service coordinator at no cost to the family and shall receive assessments required for service planning.

A service coordinator shall be assigned and the Individual Family Service Plan (IFSP) shall be completed within forty-five (45) days.

e. When developmental intervention services are provided they shall include:

- (1) design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social intervention;
- (2) curriculum planning, including the planned interaction of personnel, materials, and time and space, that leads to achieving the outcomes in the child's individualized family service plan;
- (3) provision for family or care-givers with information, special instruction and support related to enhancing the skill development of the child; and
- (4) face-to-face, best practices, instructional strategies to enhance the child's development.

f. When occupational therapy services are provided they shall include:

- (1) adaptation of the environment, selection, design and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and
- (2) activities designed to prevent or minimize the impact of initial or future impairment, delay in development, or loss of functional ability.

g. When Physical Therapy are provided it shall include:

- (1) screening of infants and toddlers to identify movement dysfunctions;
- (2) obtaining, interpreting and integrating information appropriate to program planning, to prevent or alleviate movement dysfunction and related functional problems; and
- (3) providing services to prevent or alleviate movement dysfunction and related problems.

h. When communication development services (Speech and Language Therapy) are provided they shall include:

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- (4) identification of children with a communicative or oral pharyngeal disorder and delays in the development of communication skills, including the diagnosis and appraisal of specific disorders in those skills;
 - (5) referral for medical or other professional services necessary for the habilitation or rehabilitation of children with the above speech-language disorders; and
 - (6) provision of services for habilitation, rehabilitation or prevention of the above speech-language disorders.

i. When sensory development services (Auditory and Visual) are provided they shall include:

- (1) identification of impairments, using at risk criteria and appropriate audiological and visual screening techniques;
- (2) referral for medical and other services necessary for the habilitation or rehabilitation of children with auditory or visual impairment;
- (3) provision of services for prevention of visual and hearing loss;
- (4) audilogically determining the range, nature and degree of hearing loss and communication functions;
- (5) provision of auditory training, aural rehabilitation, speech reading, listening device orientation and training, and other services;
- (6) auditorily determining the child's need for individual amplification, including selecting, fitting, and dispensing appropriate listening devices, orientation and training and vibrotactile devices, and evaluation of the effectiveness of those devices;
- (7) visually determining the need for magnification, assisting selection, sizing and acquiring appropriate visual items; and
- (8) provision of visual training, orientation and mobility for the child and training for the child's family members.

14. Champions Services

a. All program activities supported by the CHAMPIONS Regional Action Group Grant shall be consistent with:

- (1) Part B of 20 U.S. Code (Drug Free Schools and Communities Act of 1986);
- (2) 34 CFR Parts 76 and 80; and
- (3) Drug-Free Schools and Communities Act Nonregulatory

Guidance for State and Local Programs.

- b. Champions Regional Action Groups shall participate in the community prevention planning activities conducted by the Regional Prevention Center.
- c. Champions Regional Action Groups shall submit an annual plan to the Department which shall describe the proposed community program activities and expenditures.

15. Student Assistance Program

- a. All Student Assistance Program Grant activities shall be consistent with:
 - (1) Part B of 20 U.S. Code (Drug Free Schools and Communities Act of 1986);
 - (2) 34 CFR Parts 76 and 80; and
 - (3) the Drug-Free Schools and Communities Act Nonregulatory Guidance for State and Local Programs.
- b. A Student Assistance Program seeking Department funding shall submit a Funding Application for Student Assistance Programs to a Center which shall contain:
 - (1) statement of need;
 - (2) description of resources available to the program;
 - (3) goals and objectives;
 - (4) description of collaboration and linkages with other community agencies;
 - (5) description of education and professional experience of the program staff;
 - (6) description of training activities; and
 - (7) evaluation design.
- c. The Student Assistance Program shall adhere to the Core Team Model and shall utilize a specially trained team in each building to assist in the identification, intervention and referral of troubled students.
- d. A Student Assistance Program shall employ a minimum of one (1) full-time coordinator. The ratio of the number of students per coordinator shall not exceed 4,000.
- e. A Student Assistance Program Coordinator shall have:
 - (1) a masters degree in education or human services;
 - (2) experience in education programs; and
 - (3) experience working with adolescent alcohol and drug dependency.

- f. The Student Assistance Program coordinator shall:
- (1) assess school policies and discipline codes and recommend changes that support the prevention and early intervention of alcohol and drug problems;
 - (2) meet with the Regional Prevention Center Staff at least quarterly for prevention program consultations;
 - (3) inform students, staff, parents, and the community of the Student Assistance Program;
 - (4) provide three (3) hours in-service training for all school staff on the fundamentals of the program and the basics of early identification and referral;
 - (5) form a Core Team in each school with a minimum of four (4) staff at the elementary level and six (6) staff in each junior high and high school;
 - (6) arrange for training of the Core Teams;
 - (7) establish working relationships with treatment agencies within and outside the community;
 - (8) arrange for student and family access to area agencies, support groups, and resources that are available to provide assistance which may include:
 - a. Big Brothers and Big Sisters;
 - b. Scouts;
 - c. Alcoholics Anonymous; Alanon;
 - d. parenting training;
 - e. Family Resource Centers;
 - f. Youth Service Center;
 - (9) plan and initiate a variety of prevention programs through collaboration with school staff and the community;
 - (10) provide structured intervention for students who have been referred for alcohol and drug problems;
 - (11) provide referrals to treatment resources for evaluation;
 - (12) establish linkages with school health, safety, and counseling staff to address students' needs;
 - (13) provide public relations and information to community groups and the media; and
 - (14) conduct time-limited student support and education groups that address specific topics.
- g. Staff with less than three (3) years experience as the Student Assistance Program Coordinator shall attend a minimum of six (6) consultation meetings per year conducted by the Department.
- h. The Student Assistance Program Coordinator shall attend a minimum of twelve (12) days of training per year.
- i. The Student Assistance Program Coordinator shall receive

monthly clinical consultation from an individual who has demonstrated experience working with chemically dependent adolescents or is certified by the Kentucky Chemical Dependency Counselor Certification Board. The clinical consultation may be provided by Center staff.

- j. The Core Team shall meet at least one (1) time a month to:
 - (1) receive referrals;
 - (2) collect data and develop individualized plans for assessing students;
 - (3) mobilize and motivate all staff for active involvement; and
 - (4) plan and implement a variety of prevention programs.

- k. The Student Assistance Program Coordinator and Core Team members shall receive the three (3) day Core Team training conducted by the Prevention Research Institute.

- l. The school system receiving funding shall:
 - (1) maintain pre-existing student services while participating in the program unless there is a decrease in student enrollment;
 - (2) arrange for office space and separate telephone line which assures privacy and confidentiality;
 - (3) provide for locked student files;
 - (4) schedule a three (3) hour in-service time for all school staff;
 - (5) formally notify parents and students about the program, its various services and names of Core Team members;
 - (6) hold a faculty meeting to explain the program and methods of referral; and
 - (7) facilitate students participation in group sessions and other program activities by promoting school policies that permit them to miss academic classes except when tests have been scheduled.

- m. The Student Assistance Program shall assure that students participating shall meet the eligibility criteria as defined in Part B of 20 U.S. Code (Drug Free Schools and Communities Act of 1986).

- n. The Student Assistance Program shall coordinate activities with the programs of the Regional Prevention Center, the Family Resource Center, the Youth Services Center and prevention programs funded with Drug-Free

Schools and Communities funds.

16. Regional Prevention Centers

- a. The Regional Prevention Centers (RPCs) primary mission shall be to assist communities to develop and implement a full range of strategies to prevent the use of illegal drugs, alcohol abuse, and the abuse of other chemicals such as tobacco, pharmaceuticals, and household products that have psychoactive properties by both adults and youth.
- b. RPCs shall collaborate with other community agencies and organizations in the provision of prevention services.
- c. RPC's shall employ educational and environmental strategies aimed at reducing drug abuse by adults and by children.
- d. RPCs shall conduct the following program management functions:
 - (1) planning;
 - (2) staffing;
 - (3) policy development;
 - (4) program development; and
 - (5) program evaluation.
- e. RPCs shall employ the following:
 - (1) Information
 - a. information on subjects relevant to substance abuse prevention via the telephone, personal contacts, and the distribution of printed materials;
 - b. books, pamphlets, audio visuals and training materials shall be made available for use by the community;
 - c. professional information shall be available to assist community members in acquiring the knowledge necessary for their involvement in prevention efforts;
 - d. prevention consultants shall assist in the identification of resources for use in community prevention programs;
 - e. RPCs shall also communicate prevention messages through the print and broadcast media; and
 - f. shall coordinate national prevention media campaigns.
 - (2) Community Organization

- a. RPCs shall facilitate cooperation among agencies, groups and individuals involved in prevention.
 - b. RPCs shall facilitate and encourage the development of regional and county drug abuse task forces; and
 - c. RPC's shall create forums for coordination and networking of substance abuse prevention programs.
- (3) Consultation - RPC staff shall consult with community organizations that wish to develop comprehensive prevention programs, providing expert guidance for these efforts.
 - (4) Training - RPC staff shall provide well-defined, structured learning experiences which shall include both information and skill development. Training shall be designed to directly influence the drug use behavior of the recipients.
 - (5) Training of Impactors - RPC staff shall train persons to reach others with prevention information or lead prevention activities in groups with which they are involved.
 - (6) Training of Trainers - RPC staff shall train professionals and volunteers in the community to prepare them to provide the same or similar training for others.
- f. The RPCs shall operate a substance abuse prevention library with adequate space and facilities to serve the public.
 - g. RPCs shall coordinate all prevention programs funded by the Department in the region, including early intervention programs that have a substantial prevention component.
 - h. RPCs shall tailor programs to the characteristics of specific target audiences, including age, gender, drug-use pattern, racial, ethnic and cultural heritage.
 - i. RPCs shall search for and utilize research-based and professionally-developed curricula for training programs.
 - j. RPCs shall review all informational materials including printed matter, audiovisuals, and curricula prior to use for accuracy, potential effectiveness, appropriateness for the target audience.
 - k. RPC staff shall gather and disseminate information about all drug-specific prevention activities provided by

other agencies, organizations or individuals within their region and shall coordinate RPC services with these other activities.

- l. RPC staff shall participate in mentoring activities and statewide planning and advisory meetings as designated by the Department.
- m. RPCs shall implement state and federally sponsored prevention initiatives and activities.
- n. RPCs shall participate in a computerized communication system with the Department and other RPCs.
- o. RPCs shall have a written philosophy statement, program operations manual, and long range community prevention plan which shall be updated at least one (1) time per year.
- p. RPCs shall submit schedules of trainings and other RPC events upon request by the Department.
- q. RPC staff shall provide only those prevention programs with a primary content that deals specifically with drug use. Staff shall not deliver programs with a primary content aimed at raising self-esteem, increasing general wellness, raising socio-economic status, or similar factors that may be indirectly related to drug abuse. However, RPCs may:
 - (1) raise community awareness of the need for these activities as part of a comprehensive approach to prevention;
 - (2) encourage and assist in community planning for such activities; and
 - (3) provide consultation and training for providers of these programs.
- r. RPC staff shall not provide intervention and recovery programs for persons who are in need of substance abuse treatment. However, RPCs may:
 - (1) raise community awareness of the need for these activities as part of a comprehensive approach to prevention;
 - (2) encourage and assist in community planning for such activities; and
 - (3) provide consultation and training for providers of these programs.
- s. RPC Staff Requirements

- (1) All RPC staff shall be employed full-time. The minimum complement of staff shall include a prevention director, two (2) prevention specialists, and a secretary.
 - (2) One hundred percent (100%) of RPC staff time shall be spent on prevention program activities
 - (3) All RPC staff hired after 7/1/94 shall meet the minimum qualifications as follows:
 - i. Prevention Director: Master's degree in social sciences or education plus at least three (3) years of experience in substance abuse prevention or in the administration and management of a similar community-based health/education program.
 - ii. Prevention Specialist: Level 1 - Master's degree in social sciences or education.
 - iii. Prevention Specialist: Level 2 - Master's degree in social sciences or education plus two (2) years prevention experience.
 - (4) The Center shall have a specialized prevention personnel series and appropriate job descriptions for RPC staff.
 - (5) RPC staff shall attend ninety percent (90%) of required training sessions and meetings as designated by the Department.
- t. Center's operating RPCs shall include drug abuse prevention as a part of the agency's mission statement.

5. Mental Retardation Program Staffing

- a. A mental retardation and developmental disabilities program director shall be a QMRP with at least one (1) year of administrative experience in human services.
- b. A case manager shall be a QMRP.
- c. A vocational, residential, educational program supervisor shall hold a bachelor's degree in human services and one (1) year of experience in the area which pertains to the position.
- d. A behavioral specialist shall have a bachelor's degree in a human services area with one (1) year of direct contact experience working with clients who have behavioral difficulties.
- e. A psychological services provider shall be a licensed psychologist a certified psychologist or psychological associate.

- f. A recreation therapist shall have a bachelor's degree in:
 - (1) recreation;
 - (2) therapeutic recreation; or
 - (3) physical education or an Associate Degree in one (1) of those fields with two (2) years experience in mental retardation.
- g. Leisure or recreation activity staff shall have a high school diploma or G.E.D.
- h. A supported employment program supervisor shall have a bachelor's degree.
- i. Supported employment staff shall be eighteen (18) years of age or older.
- j. In-home trainers shall have a high school diploma or G.E.D.
- k. Early childhood staff shall have a high school diploma or G.E.D.
- l. Work and adult habilitation staff shall:
 - (1) be eighteen (18) years of age or older; and
 - (2) have a high school diploma or G.E.D.
- m. Respite and personal care staff shall be eighteen (18) years of age or older.
- n. Residential staff shall be twenty-one (21) years of age or older.
- o. Speech, occupational and physical therapists shall hold a current license issued by the Commonwealth of Kentucky in the area of specialization.

6. Mental Retardation Staff Training

- a. The Center shall provide orientation to all new staff which shall include the Center's mission, philosophy, values, policies and procedures.
- b. The Center shall provide competency based training to all staff based on their job responsibilities. The training shall incorporate the following principles: normalization or social role valorization, least restrictive environment, developmental model, self-

fulfilling prophecy and rhythms of life.

- c. All staff shall receive at least semi-annual in-service training designed to further develop their job skills and competencies.
- d. There shall be clear documentation of each individual's training. This shall include at least the title or type of training, trainer, length of training, date completed and the employee's signature verifying completion, based on competency requirements. Annual medications administration reviews and updates shall also be documented.
- e. The training plan shall include the trainers, resources used in training, length of training, the post tests with the criteria used to determine competency.
- f. Staff who have had previous training may take the test and be exempt from additional training if they pass the required percentage of test items.
- g. All staff shall receive additional training as outlined in the Individual Plan for the client for whom they are responsible. Example: 1) A provider who works with a nonambulatory client would need training in positioning, turning and transferring. 2) A respite provider would need training in nutrition if they provide meals.
- h. All MR/DD staff, including contract providers, shall receive at least the training outlined below. This shall be completed within the specified time frames with all training completed within six (6) months of employment.
- i. Providers of a single service such as speech, physical or occupational therapies, who are qualified by either license or certification issued by the appropriate licensing agent in the Commonwealth of Kentucky shall not be required to receive the training outlined below:
 - (1) Upon employment all staff shall be given a general overview of the agency, mental retardation and developmental disabilities services, and the training goals and schedules.
 - (2) Training Specific to Various Positions:
New staff in any position shall have at least Basic I. The following includes the minimum training for various positions.
Case managers - Basic I, II and Introduction to Assessment

Residential Staff - all
Leisure Recreation Staff - Basic I, II
In-Home Trainers - Basic I, II, and Introduction to
Assessment
Work, Adult Day Habilitation and Supported
Employment Staff - Basic I, II and Introduction to
Assessments
Respite Provider - Basic I, Medications
Administration, Introduction to Behavior Change
Personal Care Providers - Basic I
Early Childhood Staff - CPR, Medications and
Seizures, Medication Administration, Working with
Families, and any other training needed to meet a
child's needs.

(3) Time requirements for Basic I

- a. The following topics shall be completed within the first six (6) weeks of employment:
Introduction to mental retardation and developmental disabilities
Values, Principles and Normalization
Medication and Seizures
Safety Awareness
- b. The following topics shall be completed within the first three (3) months of employment:
Rights of Persons with Mental Retardation or other Developmental Disabilities
Record Keeping
Working with Families
Social and Sexual Aspects of Life
- c. First Aid and CPR. These shall be completed with staff appropriately certified prior to working independently with clients.

(4) Time requirements for Basic II

- a. The following topic shall be completed within the first six (6) weeks of employment:
Introduction to Behavior Change
- b. The following topics shall be completed within the first three (3) months of employment:

Introduction to Behavioral Goals and Objectives
Introduction to Individualized Program Planning

(5) Other Topics below shall be completed within the

first six (6) months of employment, but prior to
assuming independent function:

Introduction to Assessment
Nutrition and Meal Planning
Basic Home Management
Medication Administration.

