

Dear Senators HEIDER, Souza, Jordan, and  
Representatives WOOD, Packer, Chew:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of  
the Department of Health and Welfare:

IDAPA 16.07.50 - Minimum Standards for Nonhospital, Medically Monitored Detoxification/Mental  
Health Diversion Units - Proposed Rule (Docket No. 16-0750-1801).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the  
cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research  
and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative  
Services. The final date to call a meeting on the enclosed rules is no later than 09/21/2018. If a meeting is  
called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis  
from Legislative Services. The final date to hold a meeting on the enclosed rules is 10/22/2018.

The germane joint subcommittee may request a statement of economic impact with respect to a  
proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement,  
and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has  
been held.

To notify Research and Legislation, call 334-4834, or send a written request to the address on the  
memorandum attached below.



Eric Milstead  
Director

# Legislative Services Office

## Idaho State Legislature

*Serving Idaho's Citizen Legislature*

### MEMORANDUM

**TO:** Rules Review Subcommittee of the Senate Health & Welfare Committee and the House Health & Welfare Committee

**FROM:** Principal Legislative Research Analyst - Elizabeth Bowen

**DATE:** September 04, 2018

**SUBJECT:** Department of Health and Welfare

IDAPA 16.07.50 - Minimum Standards for Nonhospital, Medically Monitored Detoxification/Mental Health Diversion Units - Proposed Rule (Docket No. 16-0750-1801)

#### Summary and Stated Reasons for the Rule

In response to feedback from health care providers, this proposed rule significantly revises existing rules in order to modernize terms and reflect current best practices. The proposed rule also updates incorporations by reference to include the most recent versions of various documents, including the fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

#### Negotiated Rulemaking / Fiscal Impact

Negotiated rulemaking was conducted. Any fiscal impact on the state general fund is anticipated to be negligible.

#### Statutory Authority

I.C. 56-1003, 56-1004, 56-1004A, 56-1007, and 56-1009.

cc: Department of Health and Welfare  
Frank Powell and Trinette Middlebrook

#### \*\*\* PLEASE NOTE \*\*\*

Per the Idaho Constitution, all administrative rules must be reviewed by the Legislature during the next legislative session. The Legislature has 3 options with this rulemaking docket: **1)** Approve the docket in its entirety; **2)** Reject the docket in its entirety; or **3)** Reject the docket in part.

## IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

### 16.07.50 – MINIMUM STANDARDS FOR NONHOSPITAL, MEDICALLY MONITORED DETOXIFICATION/MENTAL HEALTH DIVERSION UNITS

DOCKET NO. 16-0750-1801

#### NOTICE OF RULEMAKING – PROPOSED RULE

**AUTHORITY:** In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1003, 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code.

**PUBLIC HEARING SCHEDULE:** Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 19, 2018.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

**DESCRIPTIVE SUMMARY:** The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The Division has received feedback from providers approved under this rule, who indicate portions of the rules are over-prescriptive, use archaic terms and do not reflect current best practices. Internally, a policy unit rule analysis indicates that this chapter is not in alignment with other Division of Behavioral Health rules and approval practices.

**FEE SUMMARY:** The following is a specific description of the fee or charge imposed or increased: N/A

**FISCAL IMPACT:** The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year resulting from this rulemaking:

These proposed changes include the fee structure to align with other Division of Behavioral Health rules and approval practices. The current structure is an initial \$500 application fee for programs seeking approval under the rule and an annual renewal fee of \$96 per bed. The proposed rule will reduce the initial application fee from \$500 to \$100. It will also change from an annual renewal fee of \$96 per bed to a flat \$100 renewal fee that is paid every three years. The Division has not had a new application for approval under these rules since 2015. Renewal fees for the last two SFY have been consistent at \$3,648 per year. The impact of this rule change is negligible.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules – Negotiated Rulemaking was published in the July 4, 2018 Idaho Administrative Bulletin, [Vol. 18-7, pages 129-130](#).

**INCORPORATION BY REFERENCE:** Pursuant to Section 67-5229(2)(a), Idaho Code, the ASAM Criteria, Third Edition, the DSM-5, 2013 Edition, and the National Electrical Code, 2017 Edition are being incorporated by reference into these rules to give them the force and effect of law. The document is not being published in this chapter of rules due to its length and format, but it is available upon request from Division of Behavioral Health.

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Adam Panitch, (208) 334-4916.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 26, 2018.

Dated this 3rd day of August, 2018.

Tamara Prisock  
DHW – Administrative Rules Unit  
450 W. State Street – 10th Floor  
P.O. Box 83720, Boise, ID 83720-0036  
Phone: (208) 334-5500 / Fax: (208) 334-6558  
E-mail: [dhwrules@dhw.idaho.gov](mailto:dhwrules@dhw.idaho.gov)

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0750-1801  
(Only Those Sections With Amendments Are Shown.)

**000. LEGAL AUTHORITY.**

~~Under Title 39, Chapter 3, Idaho Code, the Board of Health and Welfare has authority to adopt minimum standards, rules, and regulations for the development, construction, and operation of nonhospital, medically monitored detoxification/mental health diversion units in Idaho.~~ The Idaho Legislature has designated delegated to the Department of Health and Welfare as the State Mental Behavioral Health Authority ~~and the State Substance Abuse Authority.~~ ~~The Department's responsibility is to assure that mental health and substance use disorders treatment and services are available throughout the state to individuals who need such care and who meet the eligibility criteria under~~ the authority to promulgate and enforce rules to carry out the purposes and intent of the Regional Mental Behavioral Health Services Act and the Alcoholism and Intoxication Treatment Act. Sections 56-1003, 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code, authorize the Board of Health and Welfare and the Director of the Department to adopt and enforce rules to promote safe and adequate services and treatment of individuals within nonhospital, medically monitored detoxification/mental health diversion units. (3-29-10)(    )

**(BREAK IN CONTINUITY OF SECTIONS)**

**004. INCORPORATION BY REFERENCE.**

The Department has incorporated by reference the following documents in these rules. (3-29-10)

**01. AIA Guidelines for Design and Construction of Health Care Facilities, (AII) 2006.** AIA Guidelines for Design and Construction of Health Care Facilities, (AII) 2006, are applicable to airborne infection isolation rooms ~~for facilities operating a sobering station.~~ The guidelines are available online at <http://www.aia.org/>. (3-29-10)(    )

**02. American National Standard Specifications for Making Buildings and Facilities Accessible to and Usable by Physically Handicapped People (ANSI/ICC A117.1-2003).** These standards are available online at <http://www.ansi.org/>. (3-29-10)

**03. Americans with Disabilities Act Accessibility Guidelines.** 28 CFR Part 36, Appendix A. This code is available online at <http://www.ada.gov/publicat.htm>. Contact phone number is (800) 514-0301. (3-29-10)

**04. The ASAM ~~PPC-2R~~ Criteria.** American Society of Addiction Medicine (ASAM) Patient Placement Treatment Criteria for ~~the Treatment of Addictive~~ Substance-Related ~~Disorders, Second, and Co-Occurring Conditions Third~~ Edition ~~—Revised (ASAM-PPC-2R).~~ A copy of this manual is available by mail at the American Society of Addiction Medicine, 4601 North Park Ave., Suite 101, Chevy Chase, MD 20815; by telephone and fax, (301) 656-3920 and (301) 656-3815 (fax); or on the internet at <http://www.asam.org>. (3-29-10)(    )

**05. DSM-~~IV-TR~~5.** American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Fifth Edition, ~~Text Revision~~ (DSM-~~IV-TR~~5) Washington, D.C., American Psychiatric Association, ~~2000~~13. Copies of the manual are available from the American Psychiatric Association, ~~1400 K Street, N.W., Washington, DC, 20005~~ 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. (3-29-10)(    )

**06. Idaho Board of Nursing Rules.** IDAPA 23.01.01, “Rules of the Idaho Board of Nursing.” These rules are available online at <http://adminrules.idaho.gov/rules/current/23/230101.pdf>. (3-29-10)

**07. Idaho Diet Manual.** The Idaho Diet Manual, Ninth Edition, 2005, is available from the Idaho Dietetic Association, online at <http://eatrightidaho.org>. (3-29-10)

**08. Idaho Food Code.** IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments." These rules are available online at <http://adminrules.idaho.gov/rules/current/16/160219.pdf>. (3-29-10)

**09. International Building Code, ~~Edition 2003.~~** ~~This code is available from the International Code Council, 4051 West Flossmoor Rd., Country Club Hills, IL 60478-5795, phone: (888) 422-7233, and IDAPA 07.03.01, "Rules of Building Safety." These rules are available~~ online at ~~<http://www.icesafe.org>~~ ~~<https://adminrules.idaho.gov/rules/current/07/070301.pdf>~~. ~~Other building safety rules may be required.~~ (3-29-10)( )

**10. Life Safety Code.** National Fire Protection Association Standard 101, the Life Safety Code, 2000 Edition, including mandatory references. A copy of the code is available at 1 Batterymarch Park, Quincy, Massachusetts, 02169-7471. The telephone contact number is (800) 344-3555. The code is available online at <http://www.nfpa.org/catalog/product.asp?pid=10100>. (3-29-10)

**11. National Electrical Code.** ~~National Electric Code AKA: NFPA Standard 70, the National Electric Code, 2000 Edition~~ IDAPA 07.01.06, "Rules Governing the Use of National Electrical Code." ~~A copy of the code is~~ ~~These rules are~~ available online at ~~<http://www.nfpa.org/aboutthecodes/AboutTheCodes.asp?DocNum=70>~~ ~~<https://adminrules.idaho.gov/rules/current/07/070106.pdf>~~. ~~Other electrical rules may be required.~~ (3-29-10)( )

**12. National Fire Protection Association (NFPA) Documents.** The NFPA documents referenced in this chapter of rules are available from the National Fire Protection Association, 11 Tracy Drive, Avon, MA 02322-9908, (800) 344-3555, and online at <http://www.nfpa.org>. (3-29-10)

**13. National Sanitation Federation.** The National Sanitation Federation Standards. These standards may be found online at [http://www.nsf.org/business/about\\_NSF/](http://www.nsf.org/business/about_NSF/). (3-29-10)

**14. Occupational Safety and Health Act of 1970 (OSHA).** The OSHA Construction Standards may be obtained by contacting OSHA at 200 Constitution Avenue, NW, Washington, DC 20210. The internet website is <http://www.osha.gov/doc/index.html>. (3-29-10)

**005. OFFICE HOURS – MAILING ADDRESS – STREET ADDRESS – TELEPHONE – AND INTERNET WEBSITE.**

**01. Office Hours.** Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (3-29-10)

**02. Mailing Address.** The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (3-29-10)

**03. Street Address.** The business office of the Idaho Department of Health and Welfare is located at 450 West State St., Boise, Idaho 83702. (3-29-10)

**04. Telephone.** The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (3-29-10)

**05. Internet Website.** The Department's internet website at <http://www.healthandwelfare.idaho.gov>. (3-29-10)

**06. Substance Abuse Services Website.** The Substance Abuse Services internet website at <http://www.substanceabuse.idaho.gov>. (3-29-10)

**07. Mental Health Services Website.** ~~The Mental Health Services internet site is~~ ~~<http://www.mentalhealth.idaho.gov>~~. ( )

(BREAK IN CONTINUITY OF SECTIONS)

**010. DEFINITIONS AND ABBREVIATIONS A THROUGH K.**

For the purposes of this chapter of rules, the following definitions apply. (3-29-10)

**01. Administrator.** The person delegated the responsibility for the day-to-day operation and management of a detox/mental health diversion unit by the governing body. The administrator, owner, medical director, ~~lead nurse~~ director of nursing, or mental health program director may be the same individual. The term “administrator” is synonymous with the term “chief executive officer (CEO).” ~~(3-29-10)~~ ( )

**02. Adult.** An individual eighteen (18) years of age, or older. (3-29-10)

**03. Applicant.** An individual, firm, partnership, association, corporation, or governmental unit, acting separately or jointly, who is planning to operate or maintain a detox/mental health diversion unit in Idaho. (3-29-10)

**04. ASAM.** The American Society of Addiction Medicine. (3-29-10)

**05. Board.** The Idaho State Board of Health and Welfare. (3-29-10)

**06. Change of Ownership.** The sale, purchase, exchange, or lease of an existing facility by the present owner to a new owner. (3-29-10)

~~07. **Chemical Dependency Counselor.** A professional counselor licensed by the Idaho State Licensing Board of Professional Counselors and Marriage and Family Therapists under Title 54, Chapter 34, Idaho Code, who:~~

~~a. *Has specialized training, education, and experience in the treatment of persons with problems related to alcohol and drug use; and*~~ (3-29-10)

~~b. *Meets the requirements for certification as a alcohol and drug counselor under IDAPA 16.07.17, “Substance Use Disorders Services.”*~~ (3-29-10)

~~08. **Chemical Restraint.** The use of drugs that prevents a client from doing what he might do voluntarily on his own.~~ (3-29-10)

~~09. **Chief Executive Officer (CEO).** The individual delegated the responsibility for the day-to-day operation and management of a detox/mental health diversion unit by the governing body. The chief executive officer, owner, medical director, ~~lead nurse~~ director of nursing, or mental health program director may be the same individual. The term “chief executive officer (CEO)” is synonymous with the term “administrator.”~~ (3-29-10) ( )

~~10. **Client.** An adult, who is not the subject of involuntary commitment proceedings or detention without a hearing, as provided in Sections 18-212, 66-326, 66-329, 66-406, or 66-1305, Idaho Code, and who receives services at a detox/mental health diversion unit. The term “client” is synonymous with the terms: patient, participant, resident, consumer, or recipient of treatment.~~ (3-29-10)

~~11. **Department.** The Idaho Department of Health and Welfare. The Department is designated as the State Mental Health Authority under Section 39-3124, Idaho Code, and as the State Substance Abuse Authority under Section 39-304, Idaho Code.~~ (3-29-10)

~~12. **Director.** The Director of the Department of Health and Welfare, or his designee.~~ (3-29-10)

~~13. **Full Accreditation Certificate of Approval.** A certificate of approval issued for a period of ~~one~~ three (~~1~~) years to a facility that is in substantial compliance with these rules and minimum standards.~~ (3-29-10) ( )

~~14. **Governing Body.** The individual or individuals, board of directors, group, agency, or entity that~~



has ultimate authority and responsibility for the overall conduct and operation of the facility, and for full compliance with these rules and minimum standards. (3-29-10)

**154. Governmental Unit.** The state of Idaho, any county, municipality, or other political subdivision, or any department, division, board, or other agency thereof. (3-29-10)

**011. DEFINITIONS AND ABBREVIATIONS L THROUGH Z.**  
For the purposes of this chapter of rules, the following definitions apply. (3-29-10)

**01. ~~Lead Nurse~~ Director of Nursing.** A qualified licensed registered nurse (R.N.) licensed by the Idaho State Board of Nursing under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing," who is so designated by the governing body. The ~~lead nurse~~ director of nursing, administrator, or mental health program director may be the same individual. The ~~lead nurse~~ director of nursing is responsible for nursing care provided to clients and for supervising the nursing care and services provided by staff. ~~(3-29-10)( )~~

**02. ~~Level of Care Utilization System ("LOCUS").~~** ~~A clinical level of care placement tool for psychiatric and addictions services, developed by the American Association of Community Psychiatrists. (3-29-10)~~

**03. Licensed Clinical Social Worker (LCSW).** A clinical social worker licensed by the Idaho State Board of Social Work Examiners under Title 54, Chapter 32, Idaho Code, and IDAPA 24.14.01, "Rules of the Board of Social Work Examiners." (3-29-10)

**043. Licensed Marriage and Family Therapist (LMFT).** A person licensed to practice marriage and family therapy by the Idaho State Board of Professional Counselors and Marriage and Family Therapists, under Title 54, Chapter 34, Idaho Code, and IDAPA 24.14.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (3-29-10)

**054. Licensed Master's Level Social Worker (LMSW).** A master's level social worker licensed by the Idaho State Board of Social Work Examiners under Title 54, Chapter 32, Idaho Code, and IDAPA 24.14.01, "Rules of the Board of Social Work Examiners." (3-29-10)

**065. Licensed Practical Nurse (L.P.N.).** A practical nurse licensed by the Idaho State Board of Nursing under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-29-10)

**076. Licensed Professional Counselor (LPC).** A professional counselor licensed by the Idaho State Board of Professional Counselors and Marriage and Family Therapists, under Title 54, Chapter 32, Idaho Code, and IDAPA 24.14.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (3-29-10)

**087. Licensed Registered Nurse (R.N. or Licensed Registered Nurse).** A licensed registered nurse licensed by the Idaho State Board of Nursing under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-29-10)

**098. Mechanical Restraint.** Any apparatus that physically prevents a client from doing what he might do voluntarily on his own, including "safety belts." The term "mechanical restraint" is synonymous with the term "physical restraint." (3-29-10)

**109. Medical Director.** A qualified physician licensed by the Idaho State Board of Medicine in accordance with Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.01, "Rules of the Board of Medicine for the Licensure to Practice Medicine and Surgery and Osteopathic Medicine and Surgery in Idaho," who is so designated by the governing body. The medical director is responsible for providing medical care to clients and for supervising all of the medical care, services, and treatment provided by the medical staff. (3-29-10)

**110. Medical Staff.** Professional medical personnel employed, full-time or part-time, who are licensed under Title 54 or Title 56, Idaho Code, to provide medical care and services to clients in a Detox/Mental Health Diversion Unit. (3-29-10)

**121. Mental Health Clinical Staff.** Professional mental health personnel employed, full-time or part-time, who are licensed under Title 54, Idaho Code, to provide mental health counseling, treatment, and services to clients in a Detox/Mental Health Diversion Unit. (3-29-10)

**132. Mental Health Program Director.** A qualified psychiatrist, psychologist, licensed registered nurse, licensed clinical professional counselor, licensed clinical social worker, licensed professional counselor, licensed master's level social worker, or licensed marriage and family therapist, who is so designated by the governing body. The mental health program director is responsible for providing mental health counseling, treatment, and services provided to clients and for supervising mental health counseling, treatment, and services provided by mental health clinical staff. The mental health program director, administrator, ~~lead nurse~~ director of nursing, and medical director may be the same individual. (3-29-10)( )

~~14. MIS. The Department's computerized management information system designed to collect individual demographics and service information on persons who are suffering from a subacute psychiatric or alcohol/drug crisis. (3-29-10)~~

**153. Nonhospital, Medically Monitored Detoxification/Mental Health Diversion Unit.** A facility referred to in this rule as a "detox/mental health diversion unit," means a freestanding residential treatment facility, approved by the Department of Health and Welfare under these rules and minimum standards. Facilities owned, operated, or under the custody, control, or jurisdiction of the Department of Correction, Department of Juvenile Corrections, or state, city, or county law enforcement are excluded from this definition and are not required to meet these rules and minimum standards. (3-29-10)

**164. On-Call.** The scheduled state of availability to return to duty, work ready, within a specified period of time. (3-29-10)

**175. On-Duty.** Being awake, and actively carrying out assigned duties in the facility. (3-29-10)

**186. Owner.** An individual, firm, partnership, association, corporation, or governmental unit, acting separately or jointly, having legal ownership of the facility as an operating business, regardless of who owns the real property. An operator is synonymous with owner. (3-29-10)( )

**197. Physical Restraint.** An apparatus that physically prevents a client from doing what he might do voluntarily on his own including "safety belts." The term "physical restraint" is synonymous with the term "mechanical restraint." (3-29-10)

~~2018. Physician.~~ An individual who holds a license issued by the Idaho State Board of Medicine under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.01, "Rules of the Board of Medicine for the Licensure to Practice Medicine and Surgery and Osteopathic Medicine and Surgery in Idaho." (3-29-10)

**219. Provisional Certificate of Approval.** Pending satisfactory correction of all deficiencies, a certificate of approval issued for a period not to exceed six (6) months to a facility that is not in substantial compliance with these rules and minimum standards. A facility will not be issued more than one (1) provisional certificate of approval in any two (2) year period. (3-29-10)

**220. Psychiatrist.** An individual licensed by the Idaho State Board of Medicine to practice medicine under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.01, "Rules of the Board of Medicine for the Licensure to Practice Medicine and Surgery and Osteopathic Medicine and Surgery," who is certified by the American Board of Psychiatry and Neurology in psychiatry. (3-29-10)

**231. Psychologist.** An individual licensed by the Idaho State Board of Psychology to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (3-29-10)

22. Qualified Substance Use Disorders Professional. A qualified substance use disorders professional includes individuals with the following qualifications: ( )



- a. Idaho Board of Alcohol/Drug Counselor Certification - Certified Alcohol/Drug Counselor: ( )
- b. Idaho Board of Alcohol/Drug Counselor Certification - Advanced Certified Alcohol/Drug Counselor: ( )
- c. Northwest Indian Alcohol/Drug Specialist Certification - Counselor II or Counselor III: ( )
- d. National Board for Certified Counselors (NBCC) - Master Addictions Counselor (MAC): ( )
- e. “Licensed Clinical Social Worker” (LCSW) or a “Licensed Masters Social Worker” (LMSW) licensed under Title 54, Chapter 32, Idaho Code, and IDAPA 24.14.01, “Rules of the State Board of Social Work Examiners”: ( )
- f. “Marriage and Family Therapist” or “Associate Marriage and Family Therapist,” licensed under Title 54, Chapter 34, Idaho Code, and IDAPA 24.15.01, “Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists”: ( )
- g. “Nurse Practitioner” licensed under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, “Rules of the Idaho Board of Nursing”: ( )
- h. “Clinical Nurse Specialist” licensed under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, “Rules of the Idaho Board of Nursing”: ( )
- i. “Physician Assistant” licensed under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, “Rules for the Licensure of Physician Assistants”: ( )
- j. “Licensed Professional Counselor” (LPC) or a “Licensed Clinical Professional Counselor” (LCPC) licensed under Title 54, Chapter 34, Idaho Code, and IDAPA 24.15.01, “Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists”: ( )
- k. “Psychologist” or “Psychologist Extender” licensed under Title 54, Chapter 23, Idaho Code, and IDAPA 24.12.01, “Rules of the Idaho State Board of Psychologist Examiners”: ( )
- l. “Physician” licensed under Title 54, Chapter 18, Idaho Code; and ( )
- m. “Licensed Registered Nurse (RN)” licensed under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, “Rules of the Idaho Board of Nursing. ( )

**243.** **Serious Mental Illness (SMI).** Means any of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-~~IV~~ TR5), incorporated in Section 004 of these rules: (3-29-10)( )

- a. Schizophrenia- spectrum and other psychotic disorders: (3-29-10)( )
- b. ~~Paranoia and other psychotic disorders.~~ (3-29-10)
- e. Bipolar disorders (mixed, manic and depressive)-: (3-29-10)
- d.c. Major depressive disorders (single episode or recurrent)-: (3-29-10)
- e. ~~Schizoaffective disorders.~~ (3-29-10)
- f.l. Obsessive-compulsive disorders. (3-29-10)

**254.** **Serious and Persistent Mental Illness (SPMI).** A primary diagnosis under DSM-~~IV~~ TR5 of Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified (NOS) for a maximum of one

hundred twenty (120) days without a conclusive diagnosis. The psychiatric disorder must be of sufficient severity to cause a substantial disturbance in role performance or coping skills in at least two (2) of the following functional areas in the last six (6) months: ~~(3-29-10)~~( )

- a. Vocational or education, or both. (3-29-10)
- b. Financial. (3-29-10)
- c. Social relationships or support, or both. (3-29-10)
- d. Family. (3-29-10)
- e. Basic daily living skills. (3-29-10)
- f. Housing. (3-29-10)
- g. Community or legal, or both. (3-29-10)
- h. Health or medical, or both. (3-29-10)

**265. Social Worker.** An individual licensed by the Idaho State Board of Social Work Examiners to practice social work in Idaho under Title 54, Chapter 32, Idaho Code, and IDAPA 24.14.01, “Rules of the Idaho State Board of Social Worker Examiners.” (3-29-10)

**276. Substantial Compliance.** Substantial compliance means complying with the minimum standards and requirements of these rules, and the absence of any state or condition that could endanger the health, safety, or welfare of any client, employee, contractor, occupant, or volunteer. (3-29-10)

**012. -- 099. (RESERVED)**

**CERTIFICATE OF APPROVAL REQUIREMENTS**  
**(Sections 100 - 199)**

**100. CERTIFICATE OF APPROVAL.**

**01. Purpose.** The purpose of a certificate of approval issued by the Department is to assure, insofar as is reasonably practicable, that the care, services, treatment, and physical surroundings of each detox/mental health diversion unit are in substantial compliance with this chapter. The issuance of a certificate of approval does not guarantee adequacy of individual care, treatment, personal safety, fire safety, or the well-being of any client, employee, contractor, volunteer, or occupant of a facility. (3-29-10)

**02. Valid Certificate of Approval.** Under Sections 39-304, 39-305, 39-311, 39-3133, and 56-1003, Idaho Code, no individual, firm, partnership, association, corporation, or governmental unit, acting separately or jointly, can operate, establish, manage, conduct, or maintain, directly or indirectly, a detox/mental health diversion unit without a valid certificate of approval issued by the Department. (3-29-10)

a. No client may be admitted to, or cared for in, a detox/mental health diversion unit until a certificate of approval is issued by the Department. (3-29-10)

b. The application must include, at a minimum, all of the information, items, documents, and materials identified in Section 105 and 110 of these rules. Additional requirements found in the remainder of these rules must be supplied in a timely manner and prior to at least ninety (90) days prior to the planned opening date. ~~(3-29-10)~~( )

~~03. **Maximum Allowable Number of Beds.** A certificate of approval will specify the maximum allowable number of beds for detoxification, sobering, and mental health. Facilities are prohibited from exceeding~~

~~the maximum allowable number of beds for detoxification, sobering, and mental health as stated on the certificate of approval.~~ (3-29-10)

~~04.~~ **Apply for Certificate of Approval.** In addition to obtaining prior written approval of actual construction drawings, plans, and specifications in accordance with Section 600 through 699 of these rules, each individual, firm, partnership, association, corporation, or governmental unit, acting separately or jointly, planning to operate or maintain a detox/mental health diversion unit must apply for a certificate of approval on forms provided by the Department. (3-29-10)

a. The application and application fee must be submitted to the Department at least ninety (90) days prior to the planned opening date. The application must contain information required by the Department which includes affirmative evidence of the facility's ability to comply with these rules. (3-29-10)

b. Upon receipt of a completed application, the Department has up to sixty (60) days to notify the applicant of its determination. (3-29-10)

**101. -- 104. (RESERVED)**

**105. AGREEMENTS REQUIRED FOR CERTIFICATE OF APPROVAL FOR A DETOX/MENTAL HEALTH DIVERSION UNIT FACILITY.**

Each detox/mental health diversion unit must have and maintain at all times formal written agreements as provided in Subsections 105.01 through 105.05 of this rule before a certificate of approval can be issued. An individual filling more than one (1) of the following positions, must meet the qualifications under these rules for each position being filled by the individual. (3-29-10)

**01. Agreement with Licensed Hospital Required.** A formal written agreement must be maintained at all times for the provision of emergency medical services and ambulatory medical services with one (1) or more licensed hospitals serving the area in which the facility is located. The agreement must provide, at a minimum, for: (3-29-10)

a. Laboratory, x-ray, and other diagnostic services not otherwise available at the facility; (3-29-10)

b. Hospitalization for acutely ill clients; (3-29-10)

c. Specify hospital consents to accept all transfers for prompt medical evaluation, treatment, and admission; and (3-29-10)

d. Assurances for the exchange of information for clients. (3-29-10)

**02. Agreement with CEO or Administrator.** A formal written agreement must be maintained at all times with a qualified professional who is employed or contracted to serve as the CEO or administrator. The CEO or administrator is responsible for the day-to-day operations of the facility. (3-29-10)

**03. Agreement with Medical Director.** A formal written agreement must be maintained at all times with a qualified physician licensed in Idaho, who is employed or contracted to serve as the medical director. The medical director is responsible for the medical care provided to clients and for supervising all medical care, services, and treatment provided by the medical staff. (3-29-10)

**04. Agreement with ~~Lead Nurse~~ Director of Nursing.** A formal written agreement must be maintained at all times with a qualified R.N. licensed in Idaho, who is employed or contracted to serve as the ~~lead nurse~~ director of nursing. The ~~lead nurse~~ director of nursing is responsible for nursing care provided to clients and for supervising the nursing care, and services provided by staff. (3-29-10)( )

**05. Agreement with Mental Health Program Director.** A formal written agreement must be maintained at all times with a qualified professional licensed in Idaho, who is employed or contracted to serve as the Mental Health Program Director. The Mental Health Program Director is responsible for providing mental health counseling, treatment, and services to clients and for supervising mental health counseling, treatment and services

provided by the mental health staff.

(3-29-10)

~~06. Agreement with Chemical Dependency Counselor. A formal written agreement must be maintained at all times with a qualified professional counselor licensed in Idaho who is employed or contracted as a chemical dependency counselor. The chemical dependency counselor is responsible for developing an individualized treatment plan based on the treatment needs assessment for each client admitted to the detoxification unit or mental health unit, and for supervising all chemical dependency counseling provided by staff.~~ (3-29-10)

106. -- 109. (RESERVED)

#### 110. APPLICATION FOR CERTIFICATE OF APPROVAL.

**01. Completed and Signed Application.** The applicant must apply for a certificate of approval on forms provided by the Department, and must provide all of the information requested by the Department. Forms for a certificate of approval are available upon written request, or online at <http://www.healthandwelfare.idaho.gov>. (3-29-10)

**02. Initial Application and Building Evaluation Fee.** The applicant must make a request in writing for a certificate of approval and evaluation of existing buildings. The request must include: (3-29-10)

a. The physical address of the buildings that are to be evaluated; (3-29-10)

b. The name, address, and telephone number of the individual who is to receive the Department's determination and evaluation report; and (3-29-10)

c. A nonrefundable ~~five~~ one hundred (\$~~5~~100) dollar application and building evaluation fee. No application will be processed until the application fee is paid. (3-29-10)(    )

**03. Statement to Comply.** The applicant must provide a written statement that the applicant, owner, operator, proposed CEO or administrator, proposed medical director, proposed ~~lead nurse~~ director of nursing, and proposed mental health program director have thoroughly read, reviewed, and are prepared to comply with the provisions in IDAPA 16.07.50, "Minimum Standards for Nonhospital, Medically Monitored Detoxification/Mental Health Diversion Units." (3-29-10)(    )

**04. Statement Disclosing Revocation or Disciplinary Actions.** The applicant must provide a written statement regarding the applicant, owner, proposed CEO or administrator, proposed medical director, proposed ~~lead nurse~~ director of nursing, and proposed mental health program director that either: (3-29-10)(    )

a. Discloses any revocation or other disciplinary action taken against, or in the process of being taken against any of them, in Idaho or any other jurisdiction; or (3-29-10)

b. Affirms that no revocation or other disciplinary action has been taken against, or is in the process of being taken against any of them, in Idaho or any other jurisdiction. (3-29-10)

**05. Criminal History and Background Clearance.** The applicant must provide satisfactory evidence that the owner, applicant, all employees, transfers, reinstated former employees, student interns, contractors, volunteers, and any other individuals who provide care or services, or have access to clients, have successfully completed and received a clearance for a criminal history and background check that complies with Section 009 of these rules. (3-29-10)

**06. Electrical Inspection.** The applicant must provide a written statement from a licensed electrician or the local or state electrical inspector that all wiring in the facility complies with current electrical code as incorporated by reference in Section 004 of these rules. (3-29-10)

**07. Public Health District.** The applicant must provide a current written statement from the local health district that confirms the facility meets the local health codes for occupancy, and if the facility is not on a municipal water supply or sewage disposal system, that the water supply and sewage disposal system comply with

these rules and are in good working order. (3-29-10)

**08. Certificate of Occupancy, Fire Codes, and Building Codes.** The applicant must provide a written statement from the local zoning official, local building official, and local fire official, that confirms the facility complies with local zoning, local building codes, and local fire codes for occupancy. (3-29-10)

**09. Operational Policies and Procedures.** The applicant must provide a complete set of operational policies and procedures as required under these rules. (3-29-10)

**10. Proof of Insurance.** The applicant must provide proof of insurance. Each facility must maintain medical liability insurance at a minimum of one million dollars/three million dollars (\$1,000,000/\$3,000,000), and general liability insurance at a minimum of one million/three million dollars (\$1,000,000/\$3,000,000) or equivalent insurance. Copies of the declarations policy face-sheet must be included with the application. (3-29-10)

**11. Floor Plan.** The applicant must provide a detailed floor plan of the facility, including measurements of all rooms, or a copy of architectural drawings. (3-29-10)

**12. Purchase Agreement, Lease, or Deed.** The applicant must provide a copy of the purchase agreement, lease, or deed. (3-29-10)

**13. Identification of CEO or Administrator, Medical Director, ~~Lead Nurse~~ Director of Nursing, and Mental Health Program Director.** The applicant must provide a written statement that identifies the CEO or administrator, medical director, ~~lead nurse~~ director of nursing, and mental health program director along with documentation that establishes compliance with Sections 271 through 273, and 275 of these rules. ~~(3-29-10)~~( )

**14. Other Information as Requested.** The applicant must provide other information that may be requested by the Department for the proper administration and enforcement of these rules. (3-29-10)

**(BREAK IN CONTINUITY OF SECTIONS)**

**116. EXPIRATION AND RENEWAL OF CERTIFICATE OF APPROVAL.**

**01. Existing Certificate of Approval.** Each certificate of approval to operate a detox/mental health diversion unit will expire on the date designated on the certificate of approval, unless suspended or revoked prior to the certificate's expiration date. (3-29-10)

**02. Renewal of Certificate of Approval.** To renew a certificate of approval, the individual or governmental unit named on the certificate must submit a written request for renewal on a form approved by the Department at least ninety (90) days prior to the expiration of the certificate. The Department has up to thirty (30) days after receiving a completed renewal application to notify the applicant of its determination. (3-29-10)

**03. ~~Annual~~ Renewal Fee.** A ~~an annual~~ nonrefundable fee of ~~ninety six one hundred~~ (\$~~96~~100) dollars ~~per bed~~ must be submitted with the renewal application for certificate of approval. ~~This per bed annual renewal fee will be adjusted from time to time to cover the cost of licensing, enforcing, and regulating in accordance with these rules and minimum standards.~~ ~~(3-29-10)~~( )

**117. CERTIFICATE OF APPROVAL DURATION.**

A certificate of approval is effective for three (3) years from the date the Department issues the Certificate of Approval. The detox/mental health diversion unit's Certificate of Approval is subject to the unit maintaining compliance with these rules. ( )

**118. DETOX/MENTAL HEALTH DIVERSION UNIT - DEEMING.**

**01. National Accreditation.** The Department will deem a nationally accredited detox/mental health diversion unit to be in compliance with the minimum standards and rule requirements in these rules as long as the

national standards meet or exceed the standards of these rules. ( )

**02. Proof of Accreditation.** The applicant must submit a copy of accreditation results and reports regarding accreditation from the accrediting agency with their application. ( )

**03. Additional and Supplemental Information.** To address requirements for a state-approved detox/mental health diversion unit, the Department may require an applicant to provide additional or supplemental information not covered under the national accreditation or certification requirements. Additional documents may include: ( )

**a.** An organizational chart with verification that staff meet minimum certification standards; ( )

**b.** Satisfactory evidence that a criminal history and background check clearance, or waiver, has been issued by the Department for each individual required in Section 009 of these rules to have a criminal history check or whose position requires regular contact with clients. ( )

~~117.~~—119. (RESERVED)

**120. ISSUANCE OF CERTIFICATE OF APPROVAL BY DEPARTMENT.**

Upon completion of the application process, the Department may take any of the following actions in Subsections 120.01 through 120.03 of this rule. (3-29-10)

**01. Issue ~~Full Accreditation~~ Certificate of Approval.** Issue a ~~full accreditation~~ certificate of approval for a period of ~~one~~ three (+3) years if a facility is in substantial compliance with these rules and minimum standards. (~~3-29-10~~)( )

**02. Issue Provisional Certificate.** Issue a provisional certificate of approval for a period of six (6) months when a facility is not in substantial compliance with these rules and minimum standards. This provisional certificate is contingent on an approved plan to correct all deficiencies prior to the expiration of the provisional certificate being provided to the Department by the facility. A facility will not be issued more than one (1) provisional certificate of approval in any two-year period. (3-29-10)

**03. Deny Certificate.** The Department may ~~D~~deny a certificate of approval if it is determined that the detox/mental health diversion unit does not meet the requirements of these rules. The applicant will be notified of the denial, and the application returned with written recommendations for correction and completion of the recommendations. (~~3-29-10~~)( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**130. CHANGES REQUIRING NOTIFICATION TO THE DEPARTMENT.**

A detox/mental health diversion unit must notify the Department if any of the following changes in Subsections 130.01 through 130.05 of this rule occurs. (3-29-10)

**01. Change of Ownership, Operator, or Location.** The owner must notify the Department when there is a change of ownership, operator, or location. A new application for a certificate of approval must be submitted to the Department at least ninety (90) days prior to the proposed date of the change. (3-29-10)

**02. Change of Ownership, Operator, or Location Due to Facility in Litigation.** An application for a certificate of approval that is being suspended or revoked and a change of ownership, operator, or location due to a facility in litigation for failure to comply with these rules, must include evidence that there is a bona fide arms length agreement and relationship between the two (2) parties. An entity purchasing a facility with an enforcement action acquires the enforcement action. (3-29-10)

**03. Change of CEO or Administrator, Medical Director, or ~~Lead Nurse~~ Director of Nursing.** Any facility issued a certificate of approval must notify the Department in writing as soon as practicable prior to any the



following changes in Subsections 130.03.a. through 130.03.c of this rule, to permit the Department to determine whether any changes in certification status are necessary: ~~(3-29-10)~~( )

- a. Change in CEO or administrator; (3-29-10)
- b. Change in medical director; (3-29-10)
- c. Change in ~~lead nurse~~ **director of nursing**; or ~~(3-29-10)~~( )
- d. Change in mental health program director. (3-29-10)

**04. Change in Services or Closure of Facility.** A facility issued a certificate of approval must notify the Department in writing at least thirty (30) days prior to any of the following changes to permit the Department to determine whether any changes in certification status are necessary: (3-29-10)

- a. Material change in services or program classifications provided by the facility; or (3-29-10)
- b. Closure of the facility. (3-29-10)

**05. Change in Maximum Allowable Number of Beds.** A facility issued a certificate of approval must notify the Department in writing at least thirty (30) days prior to any proposed increase in the maximum allowable number of beds for detoxification, sobering, or mental health. (3-29-10)

**131. NOTIFICATION BY THE DEPARTMENT FOR PROPOSED CHANGES SUBMITTED BY THE FACILITY.**

**01. Notification on Submitted Applications for Proposed Changes.** The Department will notify the owner or operator of its determination with respect to a proposed change in ownership, operators, or location, within sixty (60) days of the submission of the application for the change as provided in Section 130 of these rules. (3-29-10)

~~**02. Notification of Changes in Maximum Number of Beds.** The Department will notify the owner or operator within thirty (30) days of its determination with respect to the proposed changes in the maximum allowable number of beds for detoxification, sobering, and mental health for the facility. (3-29-10)~~

**032. Notification of Changes in Operations.** The Department will notify the owner or operator within thirty (30) days of its determination with respect to any of the following proposed changes: ~~(3-29-10)~~( )

- a. Change of CEO or administrator; (3-29-10)
- b. Change of medical director; (3-29-10)
- c. Change of ~~lead nurse~~ **director of nursing**; ~~(3-29-10)~~( )
- d. Change of mental health program director; and (3-29-10)
- e. Material change in services or program classifications. (3-29-10)

**132. -- 149. (RESERVED)**

**150. DENIAL OF CERTIFICATE OF APPROVAL.**

**01. Denial of a Certificate of Approval for Lack of Substantial Compliance.** The Department may deny a certificate of approval when persuaded by a preponderance of the evidence that the facility is not in substantial compliance with these rules and minimum standards. (3-29-10)

**02. Denial of a Certificate of Approval Related to Key Individuals.** The Department may deny a

certificate of approval when persuaded by a preponderance of the evidence that any of the following individuals: applicant, owner, operator, CEO or administrator, medical director, ~~lead nurse~~ director of nursing, or mental health program director has: ~~(3-29-10)~~( )

- a. Violated any conditions of a certificate of approval; (3-29-10)
- b. Willfully misrepresented or omitted material information on the application or other documents pertaining to obtaining or renewing any certificate of approval; (3-29-10)
- c. Been found guilty of fraud, gross negligence, abuse assault, battery, or exploitation of children or vulnerable adults; (3-29-10)
- d. Been denied or has had revoked any license or certificate issued by the Department or under Title 54, Idaho Code; (3-29-10)
- e. Been convicted of operating any facility without a certificate of approval; (3-29-10)
- f. Been enjoined from operating any facility; (3-29-10)
- g. Been convicted of a criminal offense within the past five (5) years, other than a minor traffic violation or infraction; or (3-29-10)
- h. Directly been under the control or influence of any person who is described in Subsections 150.02.a. through 150.02.g. of this rule. (3-29-10)

**03. Denial of a Certificate of Approval for an Act Adversely Affecting Welfare of Client, Employee, Contractor, or Volunteer.** The Department may deny a certificate of approval when persuaded by a preponderance of the evidence that any act or omission adversely affecting the welfare of any client, employee, contractor, or volunteer is being permitted, aided, performed, or abetted by the facility, applicant, owner, operator, CEO or administrator, medical director, ~~lead nurse~~ director of nursing, or mental health program director. Such acts or omissions include neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights or exploitation of vulnerable adults. ~~(3-29-10)~~( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**160. ENFORCEMENT ACTION FOR SUSPENSION OR REVOCATION OF A CERTIFICATE AND LIMIT ON ADMISSIONS WITH NOTICE.**

The Department may suspend or revoke a certificate of approval, terminate or limit admissions, with or without a referral of clients, when persuaded by a preponderance of the evidence, that the facility is not in substantial compliance with these rules and minimum standards. Additional causes for suspension or revocation of a certificate of approval, for terminating or limiting admissions, with or without a referral of clients, may be issued for any of the reasons listed in this section of rule. (3-29-10)

**01. Act Adversely Affecting Welfare of Client.** Any act or omission adversely affecting the welfare of any client, employee, contractor, or volunteer is being permitted, aided, performed, or abetted by the facility, applicant, owner, operator, CEO or administrator, medical director, ~~lead nurse~~ director of nursing, or mental health program director. Such acts or omissions may include, but are not limited to, neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights or exploitation of vulnerable adults. ~~(3-29-10)~~( )

**02. Endangerment to Health and Safety.** Any state or condition exists at the facility which endangers the health or safety of any client. (3-29-10)

**03. Misrepresentation or Omission on Application.** The applicant, owner, operator, CEO or administrator, medical director, ~~lead nurse~~ director of nursing, or mental health program director has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining or renewing a

license. (3-29-10)( )

**04. Lack of Sound Judgment in Operation or Management.** The applicant, owner, operator, CEO or administrator, medical director, ~~lead-nurse~~ director of nursing, or mental health program director has demonstrated a lack of sound judgment in the operation or management of the facility. (3-29-10)( )

**05. Substantiated Deficiencies.** The facility has one (1) or more substantiated deficiencies as demonstrated by any one (1) of the following: (3-29-10)

**a.** Any deficiency that endangers the health and safety of any client, employee, contractor, or volunteer. (3-29-10)

**b.** Repeat violations of any requirement of these rules and minimum standards or of Idaho law. (3-29-10)

**c.** An accumulation of minor violations that when taken as a whole, would constitute a substantial deficiency. (3-29-10)

**06. Lack of Adequate Staffing.** The facility lacks adequate staff to properly care for the number and type of clients receiving care and treatment at the facility. (3-29-10)

**07. Acts of Key Individuals.** The facility, applicant, owner, CEO or administrator, medical director, ~~lead-nurse~~ director of nursing, or mental health program director: (3-29-10)( )

**a.** ~~Has~~ Violated any conditions of a certificate of approval. (3-29-10)( )

**b.** Willfully misrepresented or omitted material information on the application or other documents pertaining to obtaining or renewing any certificate of approval; ( )

**c.** Been found guilty of fraud, gross negligence, abuse assault, battery, or exploitation of children or vulnerable adults; ( )

**d.** ~~Has~~ Been denied or has had revoked any license issued under Title 54, Idaho Code, or by the Department; (3-29-10)( )

**e.** ~~Has~~ Been convicted of operating any facility without a license; (3-29-10)( )

**f.** ~~Has~~ Been enjoined from operating any facility; (3-29-10)( )

**g.** Been convicted of a criminal offense within the past five (5) years, other than a minor traffic violation or infraction; or ( )

**h.** ~~Is~~ Directly under the control or influence of any person who has been subject to the proceedings described in this Subsection of these rules; or (3-29-10)( )

**f.** ~~Fails to comply with the data gathering requirements of the MIS; or~~ (3-29-10)

**g.** Fails to substantially comply with these rules and minimum standards. (3-29-10)

**08. Violation of Client Confidentiality.** The applicant, owner, operator, CEO or administrator, medical director, ~~lead-nurse~~ director of nursing, mental health program director, or any employees, transfers, reinstated former employees, student interns, contractors, volunteers, or any other persons who provide care or services or have access to clients, violate client confidentiality. (3-29-10)( )

(BREAK IN CONTINUITY OF SECTIONS)

166. -- ~~169~~74. (RESERVED)

~~170. PENALTY FOR OPERATING A FACILITY WITHOUT A CERTIFICATE OF APPROVAL.~~

~~01. **Penalty for Operating Facility Without a Certificate of Approval.** Any person or entity establishing, conducting, managing, or operating a detox/mental health diversion unit without a certificate of approval issued by the Department is guilty of a misdemeanor. When a person is found guilty, the penalty is punishable by imprisonment in a county jail for a period of time not to exceed six (6) months, or by a fine not to exceed three hundred dollars (\$300), or both fine and imprisonment. Each day of continuing violation constitutes a separate offense. Under Section 39-1312, Idaho Code, the attorney general is authorized to prosecute any violations in the event the prosecuting attorney in the county where the alleged violation occurred fails or refuses to act within sixty (60) days of notification of the violation. (3-29-10)~~

~~02. **Injunction to Prevent Operation Without a Certificate of Approval.** Notwithstanding the existence or pursuit of any other remedy, the Department may in the manner provided by law maintain an action in the name of the State for injunctive relief or other process against any person or entity establishing, conducting, managing, or operating a detox/mental health diversion unit without a certificate of approval issued by the Department. (3-29-10)~~

~~171. PENALTY FOR OPERATING FACILITY NOT IN SUBSTANTIAL COMPLIANCE.~~

~~01. **Civil Monetary Penalties.** Civil monetary penalties are based upon one (1) or more deficiencies of substantial noncompliance. Nothing will prevent the Department from imposing this remedy for deficiencies which existed prior to inspection or complaint investigation through which they are identified. Actual harm to a client or clients does not need to be shown. A single act, omission or incident will not give rise to imposition of multiple penalties, even though such act, omission or incident may violate more than one (1) rule. (3-29-10)~~

~~02. **Assessment Amount for Civil Monetary Penalty.** When civil monetary penalties are imposed, such penalties are assessed for each day the facility is or was out of substantial compliance. The amounts below are multiplied by the total number of certified beds according to the records of the Department at the time substantial noncompliance is established. (3-29-10)~~

~~a. Initial deficiency is eight dollars (\$8). See following example:~~

<del>ASSESSMENT FOR CIVIL MONETARY PENALTY—INITIAL DEFICIENCY</del>				
<del>TABLE 171.02.a</del>				
<del>Number of Beds</del>	<del>Initial Deficiency</del>	<del>Times Number of Days Out of Substantial Compliance</del>	<del>Penalty Per Day</del>	<del>Amount of Penalty</del>
<del>41</del>	<del>\$8</del>	<del>45-Days</del>	<del>\$88</del>	<del>\$3,960</del>

~~(3-29-10)~~

~~b. Repeat deficiency is ten dollars (\$10). See following example:~~

<del>ASSESSMENT FOR CIVIL MONETARY PENALTY—REPEAT DEFICIENCY</del>				
<del>TABLE 171.02.b</del>				
<del>Number of Beds</del>	<del>Repeat Deficiency</del>	<del>Times Number of Days Out of Substantial Compliance</del>	<del>Penalty Per Day</del>	<del>Amount of Penalty</del>
<del>41</del>	<del>\$10</del>	<del>30-Days</del>	<del>\$110</del>	<del>\$3,300</del>

~~(3-29-10)~~

~~03. **Notice of Civil Monetary Penalties and Appeal Rights.** The Department will give written notice informing the facility of the amount of the penalty, the basis for its assessment, and the facility's appeal rights.~~

~~(3-29-10)~~

~~04. **Payment of Penalties.** The facility must pay the full amount of the penalty within thirty (30) calendar days from the date the notice is received. Interest accrues on all unpaid penalties at the legal rate of interest for judgments. Such interest accrualment will begin one (1) calendar day after the date of the initial assessment of the penalty.~~

~~(3-29-10)~~

~~05. **Failure to Pay.** Failure of a facility to timely pay the entire penalty, together with any interest, is cause for the Department to take any action described in Subsection 120 of these rules including but not limited to, revocation of the certificate of approval or offsetting and withholding any amounts due from Medicaid payments to the facility.~~

~~(3-29-10)~~

~~172.—174. (RESERVED)~~

**(BREAK IN CONTINUITY OF SECTIONS)**

**185. INSPECTIONS, INVESTIGATIONS, AND CONSULTATIONS.**

**01. Inspections or Investigations.** The Department will make or cause to be made such inspections and investigations as it deems necessary. Any holder of a certificate of approval, owner, operator, or applicant planning to alter, add to, or remodel an existing facility, to construct a new facility, or convert an existing structure is referred to Sections 600 through 699 of these rules for construction standards and review procedures that must occur prior to breaking ground or commencing any construction. (3-29-10)

**02. Initial Inspection.** Prior to commencing occupancy, the building or facility must be inspected and approved by the Department. The Department will make reasonable efforts to schedule an inspection within two (2) weeks of receiving a certificate of occupancy issued by the local governing authority, a city or county in Idaho or other evidence submitted by the applicant that the building or facility is ready for final inspection. (3-29-10)

**03. Intervals of Inspection Following Initial Inspection.** At the Department's discretion, the intervals of the inspection following the initial inspection will be at least one (1) every twelve (12) months or more frequently as needed. (3-29-10)

**04. Unannounced Inspections.** At the Department's discretion, inspections and investigations following the initial inspection are made unannounced and without prior notice. (3-29-10)

**05. Services of Others for Inspections and Investigations.** Under the provisions in these rules, the Department may use the services of any qualified person or organization, either public or private, to examine, survey, inspect, or investigate any person or entity holding a certificate of approval issued by the Department. (3-29-10)

**06. Access and Authority to Enter.** The Department or its designee must have full access and has the authority to examine: quality of care, services delivery, client records, facility records, physical premises, including the condition of buildings, grounds and equipment, food service, water supply, sanitation, maintenance, housekeeping practices, and any other areas necessary to determine compliance with these rules. (3-29-10)

**07. Authority to Interview.** The Department or its designee has the authority to interview any individual associated with the facility or the provision of care, including persons or governmental units named in the certificate, the complainant, CEO or administrator, medical director, ~~lead nurse~~ director of nursing, mental health program director, ~~chemical dependency counselor~~ qualified substance use disorders professional, staff, clients, clients' families, service providers, authorized provider or physician or other legally responsible person. Interviews are confidential and conducted privately unless otherwise specified by the Department or its designee.

~~(3-29-10)( )~~

- 08. Consultations.** Consultations may be provided at the option of the Department. (3-29-10)

**(BREAK IN CONTINUITY OF SECTIONS)**

**REQUIREMENTS APPLICABLE TO ALL DETOXIFICATION UNITS,  
~~SOBERING STATIONS,~~ AND MENTAL HEALTH DIVERSION UNITS**  
**(Sections 200 - 299)**

**(BREAK IN CONTINUITY OF SECTIONS)**

**210. PERSONNEL POLICIES AND PROCEDURES.**

Subject to the governing body's written approval, the CEO or administrator must establish the following policies, procedures, or plans. (3-29-10)

**01. Written Policies and Procedures for Personnel.** A written personnel policy concerning qualifications, responsibilities, and conditions of employment for each category of personnel must be maintained by the facility. The policy, procedures, or plans must contain at a minimum the following: (3-29-10)

- a.** The recruitment of qualified personnel, including consultants when utilized; (3-29-10)
  - b.** Documentation of orientation of all employees to policies, procedures, and objectives of the facility; (3-29-10)
  - c.** Competent supervision of all staff; (3-29-10)
  - d.** Job descriptions for all categories of personnel and uniform rules for each classification concerning hours of work, paydays, overtime, and other related personnel matters; (3-29-10)
  - e.** An ongoing, planned continuing educational program which maintains and upgrades the knowledge, skills, and abilities of the staff in relation to services provided and employee responsibilities, including the opportunity to attend outside educational programs. (3-29-10)
    - i.** A minimum of twenty-four (24) hours of training per year must be provided to staff; and (3-29-10)
    - ii.** Documentation of continuing education or in-service for all direct care personnel that is consistent with clients' needs and services offered. (3-29-10)
  - f.** Employee grievance procedures. (3-29-10)
  - g.** A written statement that the facility does not discriminate in employment in any manner prohibited by the laws of the United States or the state of Idaho. (3-29-10)
  - h.** A written statement that describes the facility's policy and procedure for recruiting and hiring all employees and interns. (3-29-10)
  - i.** Staff disciplinary, suspension, and termination policies and procedures. (3-29-10)
  - j.** Those facilities using volunteers must maintain written policies and procedures concerning volunteer services. Volunteers must receive orientation in accordance with Section 215 of these rules. (3-29-10)
- 02. Daily Work Schedules.** Daily work schedules must be maintained in writing that reflect: (3-29-10)



- a. Personnel on duty at any given time for the previous ~~twelve~~ **one** (12) months; ~~(3-29-10)~~( )
  - b. The first and last names of each employee, including professional designation; and (3-29-10)
  - c. Any adjustments made to the schedule. (3-29-10)
- 03. Job Descriptions.** Each employee must be given a current job description that is consistent with his classification, be initialed by the employee, and be retained on file in each employee's personnel record. Job descriptions must contain at a minimum the following: (3-29-10)
- a. The authority, responsibilities and duties of each classification; and (3-29-10)
  - b. Reporting and supervisory requirements for the classification. (3-29-10)
- 04. Organizational Chart.** An organizational chart that clearly reflects lines of authority within the facility's organizational structure must be posted or made available to all employees. (3-29-10)
- 05. Applicable Idaho and Federal Laws.** Applicable Idaho and federal laws must be observed in relation to the employment of any individual. (3-29-10)
- 06. Age Limitations.** No person who is under the age of eighteen (18) years can provide direct care to clients. (3-29-10)
- 07. Payroll Records.** Payroll records must be maintained by the facility that reflect an employee's hours of work, paydays, overtime, and other related matters. (3-29-10)
- 08. Personnel Files.** Personnel files must be maintained by the facility for each employee. This file must contain at a minimum the following: (3-29-10)
- a. An application for employment signed by the employee and a resume that must include pre-employment education, training and experience; (3-29-10)
  - b. Copies of all certification certificates, certification identification card, and all other health care licenses or certificates related to job duties; (3-29-10)
  - c. Copy of completed criminal history and background check; (3-29-10)
  - d. Position and qualifications of the position for which the employee is hired, including education and experience; (3-29-10)
  - e. Letter of hire or other documentation of the terms of employment and the employee's starting and termination date; (3-29-10)
  - f. Orientation and training documentation reflecting what type of training the employee received and the amount of time for each program; (3-29-10)
  - g. Verification of a tuberculin skin test upon employment and any subsequent test results; (3-29-10)
  - h. Copies of the employee's annual written job performance evaluation reviews including: (3-29-10)
  - i. Documentation of any disciplinary actions taken against the employee; and (3-29-10)
  - ii. Documentation of any commendations. (3-29-10)
- 211. EMPLOYEE HEALTH.** Personnel policies related to employee health must include: (3-29-10)

**01. Tuberculin Skin Test.** The current status of a tuberculin skin test, taken immediately prior to employment or within thirty (30) days after employment, must be recorded. (3-29-10)

**a.** If the skin test is positive, either by history or current test, personnel must seek a medical evaluation and chest x-ray or tuberculosis blood test to determine the presence or absence of active disease. Personnel who have active tuberculosis must be restricted from employment and attendance at the facility until it is determined by laboratory evaluation that the tuberculosis is noninfectious. ~~(3-29-10)~~( )

**b.** Personnel who have a negative reaction to the skin test, must be ~~tested annually if it is determined that they function in a high risk tuberculosis area~~ given an annual tuberculosis risk assessment checklist to screen for potential symptoms and infection. Employees who are screened as high risk must be given a tuberculin skin test within thirty (30) days. If the skin test is positive, personnel must seek a medical evaluation and chest x-ray or tuberculosis blood test to determine the presence or absence of active disease. Personnel who have active tuberculosis must be restricted from employment and attendance at the facility until it is determined by laboratory evaluation that the tuberculosis is noninfectious. ~~(3-29-10)~~( )

**02.** ~~Repeat Skin Test. A repeat skin test is also required if an employee is exposed to a client or other staff who develop tuberculosis.~~ (3-29-10)

~~03.~~ **Report Symptoms.** The facility must require that all personnel report immediately to their supervisor any signs or symptoms of personal illness. (3-29-10)

~~043.~~ **Policy for Communicable Disease Precautions.** Personnel who have a communicable disease, infectious wound, or other transmittable condition and who provide care or services to clients or have access to clients are required to implement protective infection control techniques in accordance with these rules and as required by the facility's operator or contractor through its CEO or administrator. Personnel may be required: (3-29-10)

**a.** Not to work until the infectious state is corrected and noninfectious; (3-29-10)

**b.** To work in other areas of the facility where contact with others is not expected and the likelihood of transmission of infection is absent; or (3-29-10)

**c.** To seek other remedies that will avoid spreading the infection. (3-29-10)

~~054.~~ **Documentation in Personnel File.** Documentation of compliance with health policy must be current, be initialed by each employee, and be retained on file in each employee's personnel file. (3-29-10)

212. -- 214. (RESERVED)

**215. ORIENTATION AND CONTINUING EDUCATION.**

The facility must provide a formalized, on-going educational program for all personnel, including a written structured orientation program designed to meet the training needs of new employees in relation to an employee's responsibilities. (3-29-10)

**01. Documentation of Education Program.** Documentation of compliance with orientation and continuing education program must be current, be initialed by each employee, and be retained on file in each employee's personnel file. (3-29-10)

**02. Content for Orientation and Continuing Education Program.** Orientation and continuing education in the facility must include at a minimum the following: (3-29-10)

**a.** All facility policies and procedures relevant to an employee's responsibilities; (3-29-10)

**b.** Basic procedures relative to client care; (3-29-10)

- c. Client rights and responsibilities; (3-29-10)
- d. Confidentiality; (3-29-10)
- e. Facility's code of ethics; (3-29-10)
- f. Use of mechanical and electrical equipment by an employee; (3-29-10)
- g. Fire safety and emergency evacuation; (3-29-10)
- h. Emergency procedures; (3-29-10)
- i. Organizational structure; (3-29-10)
- j. Measures to prevent cross infection, including aseptic and isolation techniques; (3-29-10)
- k. Special needs of the client population served; (3-29-10)
- l. Restorative care; (3-29-10)
- m. Proper maintenance and handling of client records; (3-29-10)
- n. Philosophical approach to treatment and the facility's goals; and (3-29-10)
- o. Policies and procedures for reporting cases of suspected abuse or neglect of vulnerable adults. (3-29-10)

**03. Continuing Education for Direct Care Staff.** Each direct care staff member must annually receive ~~twenty-four~~ **twelve** (12) hours of continuing education that includes an understanding of the nature of addiction, the withdrawal syndrome, group therapy, family therapy, and other treatment methodologies that are appropriate to the position held by each direct care staff member. Continuing education requirements may be met through in-house educational programs, outside continuing educational programs, or a combination thereof.

(3-29-10)( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**230. POLICIES AND PROCEDURES APPLICABLE TO ALL DETOXIFICATION UNITS, ~~SOBERING STATIONS,~~ AND MENTAL HEALTH DIVERSION UNITS.**

Subject to the governing body's written approval, the CEO or administrator must develop a set of physician approved written policies and procedures in accordance with these rules that are available at all times to clients, staff, and the public.

(3-29-10)( )

**231. PHYSICIAN APPROVED ADMISSIONS POLICY, INTAKE PROCEDURES, AND DISCHARGE PLANNING.**

Each detox/mental health diversion unit must have written physician-approved admission policies and procedures that at a minimum meet the following requirements in Subsections 231.01 through 231.10 of this rule. (3-29-10)

**01. Admissions Policy.** A client will be admitted, accepted, or retained only when the facility has the capability, capacity, and services to provide appropriate care, and the client does not require a type of service for which the facility is not approved to provide, or for which the facility does not provide or arrange for, or in which the facility does not have the personnel, appropriate in numbers and with appropriate knowledge and skills to provide such services. (3-29-10)

**02. Criteria for Admissions.** Written criteria for admissions, uniformly applied to all prospective clients, must be provided in accordance with these rules. (3-29-10)

**03. Criteria for Rejecting Admissions.** Written criteria for rejecting admission requests, uniformly applied to all prospective clients, must be provided in accordance with these rules, and that includes a statement that the following persons are not eligible for admission: (3-29-10)

- a. Any person who is violent, charged with a crime, or otherwise needs a secure holding facility; (3-29-10)
- b. Any person who is under the age of eighteen (18) years; (3-29-10)
- c. Any person who is the subject of involuntary commitment proceedings or detention without a hearing under Sections 18-212, 66-326, 66-329, 66-406, or 66-1305, Idaho Code; (3-29-10)
- d. Any person who requires specialized care not available at the facility; (3-29-10)
- e. Any person who has a physical or medical condition that is unstable or can only be safely treated in a hospital; (3-29-10)
- f. ~~Any person whose primary problem is social, economic, or one of physical health such as epilepsy, an intellectual disability, dementia, a developmental disability, or, chronic alcoholism, drug abuse, physical disability, or aged, unless in addition to such condition, he meets the admission criteria provided in Sections 320, 420, or 520 of these rules;~~ (3-29-10)

~~g.~~ Any person who fails to meet the admission criteria in Sections 320, 420, or 520 of these rules; (3-29-10)

~~h.~~ Any person who can be safely maintained and effectively treated in a less restrictive or intensive level of care; or (3-29-10)

~~i.~~ Any person who does not voluntarily consent to admission or treatment. (3-29-10)

**04. Intake Procedures.** Written intake procedures must be provided that include a determination that the facility's services are or are not appropriate to meet the needs of the client. (3-29-10)

**05. Referrals For Individuals Not Admitted.** Written policies must be provided for making referrals of individuals not admitted to the facility and written policies for accepting referrals from outside facilities. (3-29-10)

**06. Initial Client Assessments Procedures.** Written procedures must be provided that require a completed initial client assessment on every proposed client prior to admission. (3-29-10)

**07. Medical Orders.** Written, verbal, and telephone orders from persons authorized to give medical orders under Idaho law and written policies and procedures established by the governing body will be accepted by the medical staff empowered to do so under Idaho law. (3-29-10)

a. Verbal and telephone orders must contain the name of the person giving the order, the first initial and last name and professional designation of the medical staff receiving the order. (3-29-10)

b. The order must be promptly signed or otherwise authenticated by the prescribing person in accordance with written policies and procedures established by the governing body. (3-29-10)

**08. Services Orientation Procedures for Clients Admitted to a Detoxification Unit or Mental Health Diversion Unit.** Written services orientation information must be recorded in each client's record as soon as practicable. This orientation information must include: (3-29-10)

a. The facility's philosophical approach to treatment; (3-29-10)

b. Information on client's rights and responsibilities while receiving services at the facility; (3-29-10)

- c. The services available; and (3-29-10)
- d. Information on the rules governing client's behavior and those infractions, if any, that may result in discharge or other disciplinary actions. (3-29-10)

~~09. **Criteria for Appropriate Rehabilitative Services.** Written criteria must be provided that assures appropriate rehabilitative services are provided whereby each client is assigned a primary addiction therapist or primary mental health professional, depending upon need, who will follow the client's progress during his admission to the detoxification or mental health unit, or both. The client's progress must be documented in the client's record. (3-29-10)~~

~~10. **Criteria for Assuring Clients Remain in Program.** Written criteria must be provided that assures clients will remain in a medical detoxification program, *sobering program*, or mental health diversion program for the period of time deemed medically necessary and documented by the attending physician. Coercion or force cannot be used to induce any client to remain in treatment. (3-29-10)( )~~

~~11. **Discharge Criteria and Planning.** Written criteria for discharge, uniformly applied to all prospective clients, must be established in accordance with these rules, including a procedure to screen each client for discharge planning needs. (3-29-10)~~

**(BREAK IN CONTINUITY OF SECTIONS)**

**235. MEDICATION POLICIES AND PROCEDURES.**

Each detox/mental health diversion unit must have written policies and procedures that govern the safe storage, dispensing, and administration of medication. Written policies and procedures must include at a minimum the following requirements in Subsection 235.01 through 235.07 of this rule. (3-29-10)

**01. Physician's Order.** Each client of a detox/mental health diversion unit must have a written order signed by a physician, a physician's standing order, or a physician's order received by phone and signed by the physician at the earliest opportunity before any medication is administered to a client. (3-29-10)

**02. Administration of Medication.** Medications can only be provided to a client by licensed nursing staff in accordance with written policies and procedures established by the governing body, which must include at least the following: (3-29-10)

- a. Administered in accordance with a physician's, dentists', nurse practitioner's, or physician assistant's written orders; (3-29-10)
- b. The client is identified prior to administering the medication; (3-29-10)
- c. Medications are administered as soon as possible after preparation; (3-29-10)
- d. Medications are administered only if properly identified; (3-29-10)
- e. Medications are administered by the person preparing the medication for delivery to the client; (3-29-10)
- f. Clients are observed for reactions to medications and if a reaction occurs, it is immediately reported to the on-duty nurse and *lead nurse director of nursing*; and (3-29-10)( )
- g. Each client's medication is properly recorded on his individual medication record. (3-29-10)

**03. Storage and Distribution of Medication.** Storage and distribution policies and procedures must describe the following: (3-29-10)

- a. Receiving of medication; (3-29-10)
  - b. Storage of medication, including assurances that all prescription drugs stored in the facility must be kept in a double locked container. Only those medications requiring refrigeration can be stored in a refrigerator; and (3-29-10)
  - c. Medication distribution system to be used including assurances that medications prescribed for one client will not be administered to or by another client or employee. (3-29-10)
- 04. Disposal of Unused, Outdated, or Recalled Drugs.** Policy and procedures for documentation and disposal of unused drugs must provide assurances that no unused, outdated, or recalled drugs are kept in the facility. All unused, outdated, or recalled drugs must be disposed of in a manner that assures that they cannot be retrieved. (3-29-10)
- 05. Written Records of Disposals.** A written record of all disposals of drugs must be maintained in the facility and must include at a minimum the following: (3-29-10)
- a. A description of the drug, including the amount; (3-29-10)
  - b. The client for whom the medication was prescribed; (3-29-10)
  - c. The reason for disposal; and (3-29-10)
  - d. The method of disposal. (3-29-10)
- 06. Medication Policies and Procedures for Staff Response.** How staff are to respond if: (3-29-10)
- a. A client refuses a medication; (3-29-10)
  - b. A client misses a medication and the reasons; (3-29-10)
  - c. A client medication is not available; (3-29-10)
  - d. Medications are missing; (3-29-10)
  - e. A client receives an incorrect medication or dosage. (3-29-10)
- 07. Written Medication Record.** Each client's medication must be properly recorded on his individual medication record by the person administering the medication. The written record must include: (3-29-10)
- a. Client's name; (3-29-10)
  - b. Prescribing physician's name; (3-29-10)
  - c. Description of medication, including prescribed dosage; (3-29-10)
  - d. Verification in writing by staff that medication was taken, not taken, missed, not available, or refused, and the times and dates administered; (3-29-10)
  - e. Method of administration; (3-29-10)
  - f. Date and time of administration; (3-29-10)
  - g. Injection sites; (3-29-10)



- h. Name or initial of person administering the medication; and (3-29-10)
- i. Any adverse reactions to the medication. (3-29-10)

**(BREAK IN CONTINUITY OF SECTIONS)**

**245. INFECTION CONTROL.**

Each detox/mental health diversion unit must develop and implement written plans consistent with recognized standards for the prevention and control of infection for both staff and clients. (3-29-10)

**01. Infection Control Program.** The program must include, at minimum, the following elements: (3-29-10)

- a. Methods of maintaining sanitary conditions in the facility; (3-29-10)
- b. Employee infection surveillance and actions; and (3-29-10)
- c. Isolation procedures; (3-29-10)

**02. Report for Monitoring Infections.** Specifics for monitoring the course of infections must include, at minimum, a prepared written quarterly report describing the status of each infection. This report must include: (3-29-10)

- a. Diagnosis; (3-29-10)
- b. Description of the infection; (3-29-10)
- c. Causative organism, if identified; (3-29-10)
- d. Date of onset; (3-29-10)
- e. Treatment and date initiated; (3-29-10)
- f. ~~Client's progress;~~ ~~(3-29-10)~~
- ~~g.~~ Control techniques utilized; and (3-29-10)
- ~~h.g.~~ Diagnostic tests employed. (3-29-10)

**03. Infection Control and Prevention Procedures.** There must be a written infection control procedure that includes aseptic techniques, cleaning, sanitizing, and disinfection of all instruments, equipment, and surfaces, for all departments and services where client care is delivered. (3-29-10)

**246. CONTROL OF TUBERCULOSIS.**

In order to assure the control of tuberculosis in the facility, there must be a planned, organized program of prevention through written and implemented procedures that are consistent with current accepted practices and include the following in Subsections 246.01 through 246.05 of this rule. (4-7-11)

**01. Tuberculosis Risk Assessment.** Each client must be given a tuberculosis risk assessment checklist immediately prior to admission to screen for potential symptoms and infection. Clients who are screened as high risk must be given a tuberculin skin test prior to admission or provide proof of the results of a tuberculin skin test given within six (6) months prior to admission. ( )

**02. Tuberculin Skin Tests.** The results of a tuberculin skin test, taken immediately prior to admission or within six (6) months prior to admission, must be established for ~~each~~ any client who is screened at high risk. ~~If the~~

~~status is not known upon admission, a tuberculin skin test must be done as soon as possible.~~ (3-29-10)( )

a. If the tuberculin skin test is negative, the test does not have to be repeated prior to discharge. (3-29-10)

b. If the tuberculin skin test is positive, the client must have a chest x-ray or tuberculosis blood test to rule out the presence of infectious pulmonary tuberculosis. (3-29-10)( )

**023. Protective Infection Control Techniques.** If any x-ray is suggestive of infectious pulmonary tuberculosis, the facility is required to implement protective infection control techniques in accordance with these rules and as required by the facility's governing body through its CEO or administrator. (3-29-10)

**034. Transfer of Client Suspected or Diagnosed.** Arrangements for transfer to an appropriate facility must be made for any client suspected or diagnosed with infectious pulmonary tuberculosis. These arrangements must be made in accordance with these rules and as required by the facility's governing body through its CEO or administrator. (3-29-10)

**045. Discharge Prior to Availability of Test Result.** A client, discharged prior to sufficient time elapsing for the tuberculin skin test to be read, will be instructed regarding the appropriate time frame and protocol for return to the facility to have the tuberculin skin test read. (4-7-11)

~~05. Sobering Station Exclusion. The tuberculin skin tests required in Subsection 246.01 of this rule, is not required for clients receiving services from a sobering station.~~ (4-7-11)

247. -- 249. (RESERVED)

## 250. FOOD AND NUTRITIONAL CARE POLICIES AND PROCEDURES.

Each detox/mental health diversion unit must develop written policies and procedures for providing proper nutritional care for each client that includes procedures to follow if a client refuses food or to follow the prescribed diet. The acquisition, preparation, storage, and serving of all food and drink in a facility must comply with IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments." (3-29-10)

**01. Three Nutritious Meals Per Day.** At least three nutritious meals per day and nutritional snacks, must be provided to each client present at meal times in the detoxification or mental health diversion units. No more than fourteen (14) hours may elapse between the end of an evening meal and the beginning of the morning meal. Physician approved special diets must be provided upon request by a client. Under no circumstances may food be withheld for disciplinary reasons. Menus must be reviewed and approved in advance by a registered dietitian in Idaho in accordance with the Idaho Diet Manual from the Idaho Dietetic Association. Nourishments must be made available to a client in a sobering station. (3-29-10)( )

**02. On-Site Food Service.** On-site food service must comply with all provisions of IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments." (3-29-10)

**03. Third-Party Food Service.** When food service is provided by a third-party, the provider must meet all the conditions of these rules pertaining to food service and be in compliance with IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments." Each detox/mental health diversion unit must maintain a written agreement at all times with a food service provider containing assurances that the provider will meet all food service and dietary standards imposed by this rule. (3-29-10)

**04. Reports for Sanitation and Food Service.** Sanitation reports and food service reports must be maintained on file in the facility. (3-29-10)

251. -- 259. (RESERVED)

## 260. CLIENT RECORDS POLICIES AND PROCEDURES.

Each detox/mental health diversion unit must develop written policies and procedures to assure accurate and authentic records are maintained for each client in the facility. (3-29-10)

01. **Complete and Accurate Records.** Each facility must implement written policies and procedures to assure complete, accurate, and authentic records in accordance with professional standards and practices. (3-29-10)

02. ~~Responsible Staff~~ **Client Record Required.** ~~The CEO or administrator must designate to a staff member the responsibility for the accurate maintenance of client records. If this person is not a Registered Records Administrator (RRA) or an Accredited Records Technician (ART), consultation from such a qualified individual must be provided periodically to the designated staff person~~ Each detox/mental health diversion unit must maintain a client record on each client. All entries into the client's record must be signed and dated. (3-29-10)(    )

03. ~~Individual Client Record~~ **Content of Client Record.** ~~An individual record must be maintained for each admission with all entries kept current, dated, and signed. Client records must, at a minimum, contain the following~~ The client record must describe the client's situation at the time of admission and include the services provided, all progress notes, and the client's status at the time of discharge. At a minimum the record must contain: (3-29-10)(    )

a. ~~Client's name, date and time of admission; previous address; home telephone; sex; date of birth; place of birth; ethnicity; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service; name, address, and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; and date and time of discharge. The client's name, address, contact information, date of birth, gender, marital status, race or ethnic origin, next of kin or person to contact, educational level, type and place of employment, date of initial contact or admission to the unit, source of any referral, legal status including relevant legal documents, name of personal physician, record of any known drug reactions or allergies, and other identifying data as indicated;~~ (3-29-10)(    )

b. ~~Biopsychosocial assessment, including medical history and physical examination that evaluates an individual's strengths, weaknesses, problems, and needs. Any staffing notes pertaining to the client;~~ (3-29-10)(    )

c. ~~Transfer or referral report, where applicable. Any medical records obtained regarding the client;~~ (3-29-10)(    )

d. ~~Special reports dated and signed by the person making the report such as laboratory, x-ray, social services, mental health, consultation, and other special reports. Any assessments; and~~ (3-29-10)(    )

e. ~~Individualized treatment plan based on a biopsychosocial assessment of the client's alcohol or substance use disorder treatment needs, including treatment goals based on client input~~ The initial and updated service plans. (3-29-10)(    )

f. ~~Physician's orders containing the physician's authorization for required medications, tests, treatments, and diet. Each entry must be dated and signed or counter-signed by the physician.~~ (3-29-10)

g. ~~Progress notes by physicians, nurses, therapists, social workers, and other health care personnel must be recorded indicating observations to provide a full descriptive, chronological picture of the client during his admission. The author must date and sign his entry~~ (3-29-10)

h. ~~The final diagnosis on discharge or cause of death, condition on discharge, and disposition signed and dated by the attending physician.~~ (3-29-10)

i. ~~Nurses' entries must include the following information:~~ (3-29-10)

i. ~~Date, time and mode of admission; documentation of the client's general physical and emotional condition as well as mental attitude on admission.~~ (3-29-10)

ii. ~~Medication administration record.~~ (3-29-10)

- ~~iii. Date and times of all treatments. (3-29-10)~~
- ~~iv. Any change in the client's physical or mental status. (3-29-10)~~
- ~~v. Any incident or accident occurring while the client is in the facility. (3-29-10)~~
- ~~vi. The signature of the on-duty nurse for each shift indicating the assumption of responsibility for all entries made by nonprofessional nursing personnel. (3-29-10)~~

**04. Maintenance of Client Records.** Each detox/mental health diversion unit must develop written policies and procedures governing the maintenance, compilation, storage, dissemination, and accessibility of client records. ( )

**05. Retention and Destruction of Client Records.** Each detox/mental health diversion unit must develop written policies and procedures governing the retention and destruction of client records. ( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**270. MINIMUM STAFFING POLICIES AND PROCEDURES.**

Each detox/mental health diversion unit must develop, implement, and comply with written staffing policies and procedures based on the number of beds, number of clients, client needs, services provided, and configuration of the facility as described in Subsections 270.01 through 270.06 of this rule. In a facility with both detoxification and mental health diversion units, the facility may divide a staff member's time to provide direct care in both units provided the staffing ratios for each unit are met. (3-29-10)

**01. Staff Trained for Emergencies.** A staff member trained to respond to fires and other natural disasters, as well as to administer emergency first aid and CPR must be on duty twenty-four (24) hours per day, seven (7) days per week. Training and annual training updates in each of these areas must be documented in personnel files. (3-29-10)

**02. Direct Care Staff.** The facility must have adequate nursing personnel and direct care staff in sufficient numbers to plan, administer, and provide client bedside care. At a minimum, two (2) staff, one of whom must be an R.N. or L.P.N., must be on duty twenty-four (24) hours per day, seven (7) days per week. In the absence of the ~~lead nurse~~ **director of nursing**, an R.N. or L.P.N. must be designated to assume the ~~lead nurse~~ **director of nursing's** duties. No person may be assigned nursing duties, including aides and orderlies, who has been on duty in the facility during the preceding twelve (12) hours, except in an emergency. (3-29-10)( )

**03. Monthly Staffing Pattern.** Monthly staffing patterns indicating daily staff, staff titles, and client census must be kept for the previous ~~twelve one~~ (12) months. A written staffing plan must be developed to ensure appropriate and adequate staff coverage for emergency or high demand situations. (3-29-10)( )

**04. ~~Clinical Supervision and Consultation for Staff~~ **Supervision.**** ~~A written staffing plan that specifies a minimum of one (1) hour per month of personal clinical supervision and consultation for each staff person and volunteer who is responsible for the delivery of direct care services must be maintained. The clinical supervision must relate to the individual's skill level with the objective of assisting direct care staff and volunteers to increase their treatment skill and the quality of services delivered to clients.~~ **Each detox/mental health diversion unit must ensure that:** (3-29-10)( )

**a. Staff have access to regularly scheduled supervision with detox/mental health diversion unit supervisors: and** ( )

**b. Staff members practice only within the scope of their credentials.** ( )

**05. ~~Staffing of Certified Alcohol and Drug Counselor~~ **Clinical Supervision.**** ~~The services of a certified alcohol and drug counselor must be available to each client.~~ **Each detox/mental health diversion unit must**

provide for regular and ongoing supervision of clinical activities. The detox/mental health diversion unit must establish a written supervisory protocol that addresses: (3-29-10)( )

a. Management and oversight of the provision of professional services offered by the detox/mental health diversion unit; and ( )

b. Supervision centered on the evaluation and improvement of clinician skills, knowledge, and attitudes. ( )

**06. Staff Trained in Substance Abuse Withdrawal.** The facility, at a minimum, must have at least one (1) staff member on duty twenty-four (24) hours per day, seven (7) days per week trained in the following areas: (3-29-10)

a. Substance abuse withdrawal symptoms, including delirium tremens; and (3-29-10)

b. Symptoms of secondary complications to substance abuse. (3-29-10)

**271. QUALIFICATIONS AND RESPONSIBILITIES FOR CEO OR ADMINISTRATOR.**

**01. CEO or Administrator.** Each detox/mental health diversion unit must maintain at all times, through employment or contract, a CEO or administrator who is responsible for carrying out the policies established by the governing body and the day-to-day conduct and operations of the facility. ~~This individual must have the qualifications required in Subsections 271.03 and 271.04 of this rule at the time of hire and throughout the duration of employment or contract.~~ (3-29-10)( )

**02. CEO's or Administrator's Responsibilities.** The CEO or administrator is responsible for assuring that policies, procedures, conduct and operations required by Title 39, Chapter 3, Idaho Code, Title 39, Chapter 31, Idaho Code, and IDAPA 16.07.50, "Rules and Minimum Standards Governing Nonhospital, Medically Monitored Detoxification/Mental Health Diversion Units," are developed and implemented. (3-29-10)

~~**03. Required License or Degree.** Each CEO or administrator of a Detox/Mental Health Diversion Unit must, at a minimum, have one (1) or more of the following Idaho licensures or degrees at the time of hire or contract and throughout the duration of employment or contract:~~ (3-29-10)

~~a. Licensed Physician;~~ (3-29-10)

~~b. Licensed Psychologist;~~ (3-29-10)

~~c. Licensed Master's Level Nurse;~~ (3-29-10)

~~d. Licensed Clinical Professional Counselor (LCPC);~~ (3-29-10)

~~e. Licensed Clinical Social Worker (LCSW);~~ (3-29-10)

~~f. Licensed Professional Counselor (LPC);~~ (3-29-10)

~~g. Licensed Master's Level Social Worker (LMSW);~~ (3-29-10)

~~h. Licensed Bachelor's Level Nurse; or~~ (3-29-10)

~~i. Master's degree in the field of alcoholism, substance use disorders, or mental health.~~ (3-29-10)

~~**04. Required Experience and Abilities.** Each CEO or administrator of a detox/mental health diversion unit must, at a minimum have and demonstrate the following experience and abilities at the time of hire or contract:~~ (3-29-10)

~~a. At least two (2) years of paid full-time experience must be in the field of alcoholism, substance use~~

~~disorders and mental health.~~

~~(3-29-10)~~

~~b. At least one (1) year of the two (2) years' full-time experience must be in an administrative capacity that includes knowledge and experience demonstrating competence in planning and budgeting, fiscal management, supervision, personnel management, employee performance assessment, data collection, and reporting. (3-29-10)~~

~~05. Availability of CEO or Administrator. The facility's CEO or administrator must, at a minimum, be full-time forty (40) hours per week to provide for safe and adequate care of clients and staff. The facility's CEO or Administrator, or his designee must be available to be on-site at the facility within two (2) hours and must be on-call at all times. (3-29-10)~~

## 272. QUALIFICATIONS AND RESPONSIBILITIES FOR MEDICAL DIRECTOR.

**01. Medical Director.** Each detox/mental health diversion unit must maintain at all times through employment, or contract a medical director who is responsible for providing medical care to clients and for supervising all medical care, services, and treatment provided by the medical staff. This individual must have the qualifications required in Subsections 272.03 and 272.04 of this rule at the time of hire and throughout the duration of employment or contract. (3-29-10)

**02. Medical Director's Responsibilities.** The medical director's responsibilities include, at a minimum, the following: (3-29-10)

- a. The provision of advice on health-related policies and issues; (3-29-10)
- b. The provision of emergency medical care to admitted clients; (3-29-10)
- c. The supervision of the performance of the medical examination and laboratory tests required upon the client's admission and the evaluation of the resultant test results; and (3-29-10)
- d. The supervision of the medical treatment provided to clients. (3-29-10)

**03. Required License.** Each medical director of a detox/mental health diversion unit must be a licensed physician by the Idaho Board of Medicine at the time of hire or contract and throughout the duration of employment or contract. (3-29-10)

**04. Required Experience and Abilities.** Each medical director of a detox/mental health diversion unit must, at a minimum, have and demonstrate the following experience and abilities at the time of hire or contract: (3-29-10)

a. At least two (2) years of paid full-time experience in the field of alcoholism, substance use disorders and mental health. (3-29-10)

b. At least one (1) of the two (2) years' full-time experience must be in a clinical mental health setting which includes: (3-29-10)

i. Assessment of the likelihood of danger to self or others, grave disability, capacity to give informed consent, and capacity to understand legal proceedings; (3-29-10)

ii. Diagnosis using DSM-~~IV~~-TR5 criteria; and ~~(3-29-10)~~ ( )

iii. Treatment of mental health disorders including knowledge of treatment modalities and experience applying treatment modalities in a clinical setting. (3-29-10)

d. At least one (1) of the two (2) years' full-time experience must be in an administrative capacity that includes: (3-29-10)

i. Knowledge and experience demonstrating competence in planning and budgeting, fiscal

management, supervision, personnel management, employee performance assessment, data collection, and reporting;  
and (3-29-10)

ii. An understanding of and adherence to the ethical standards of the respective license adopted by the governing board for licensure. (3-29-10)

**05. Availability of Medical Director.** The facility's medical director or his designee must be available to be on-site at the facility within two (2) hours and must be on-call at all times. (3-29-10)

**273. QUALIFICATIONS AND RESPONSIBILITIES FOR ~~LEAD-NURSE~~ **DIRECTOR OF NURSING.****

**01. ~~Lead-Nurse~~ Director of Nursing.** Each detox/mental health diversion unit must maintain at all times, through employment or contract, an R.N. licensed in Idaho to serve as the ~~lead-nurse~~ director of nursing. This individual must have the qualifications required in Subsections 273.03 and 273.04 of this rule at the time of hire and throughout the duration of employment or contract. (~~3-29-10~~)(    )

**02. ~~Lead-Nurse~~ Director of Nursing's Responsibilities.** The ~~lead-nurse~~ director of nursing is responsible for all nursing services provided to clients and for supervising all of the nursing services provided by staff. The ~~lead-nurse~~ director of nursing's responsibilities include, at a minimum, the following: (~~3-29-10~~)(    )

- a. To organize, coordinate, and evaluate nursing service functions and staff; (3-29-10)
- b. To be responsible for development and implementation of client care policies and procedures; (3-29-10)
- c. To select, supervise, direct, promote, and terminate nursing staff; (3-29-10)
- d. To establish procedures to insure that staff licenses are valid and current; and (3-29-10)
- e. To participate with the CEO or administrator and medical director in planning and budgeting for nursing care. (3-29-10)

**03. Required License.** Each ~~lead-nurse~~ director of nursing must be an R.N. licensed by the Idaho Board of Nursing at the time of hire or contract and throughout the duration of employment or contract. (~~3-29-10~~)(    )

**04. Required Experience and Abilities.** Each ~~lead-nurse~~ director of nursing must, at a minimum, have and demonstrate the following experience and abilities at the time of hire or contract (~~3-29-10~~)(    )

- a. At least two (2) years of paid full-time experience in the field of alcoholism, substance use disorders, and mental health. (3-29-10)
- b. At least one (1) of the two (2) years' full-time experience must be in a clinical mental health setting. (3-29-10)
- c. At least one (1) of the two (2) years' full-time experience must be in an administrative capacity that includes: (3-29-10)
  - i. Knowledge and experience demonstrating competence in planning and budgeting, fiscal management, supervision, personnel management, employee performance assessment, data collection, and reporting; and (3-29-10)
  - ii. An understanding of and adherence to the ethical standards of the respective license adopted by the governing board for licensure. (3-29-10)

**05. Availability of ~~Lead-Nurse~~ Director of Nursing.** The facility's ~~lead-nurse~~ director of nursing must, at a minimum, be full-time forty (40) hours per week. (~~3-29-10~~)(    )



274. ~~QUALIFICATIONS AND RESPONSIBILITIES FOR CHEMICAL DEPENDENCY COUNSELORS.~~  
~~(RESERVED)~~

~~01. Chemical Dependency Counselor. Each detox/mental health diversion unit must maintain at all times through employment or contract a chemical dependency counselor. This individual must have the qualifications required in Subsections 274.03 and 274.04 of this rule at the time of hire and throughout the duration of employment or contract. (3-29-10)~~

~~02. Chemical Dependency Counselor's Responsibilities. A chemical dependency counselor's responsibilities include at a minimum, the following: (3-29-10)~~

~~a. Case staffing; (3-29-10)~~

~~b. Individual case supervision; (3-29-10)~~

~~c. Consultation with other clinical professionals; (3-29-10)~~

~~d. Review of case record maintenance; and (3-29-10)~~

~~e. Other clinically appropriate services determined by the facility. (3-29-10)~~

~~03. Chemical Dependency Counselor License or Certification. Each chemical dependency counselor must be certified in Idaho to meet the standards and requirements under IDAPA 16.07.17, "Substance Use Disorders Services," at the time of hire or contract and throughout the duration of employment or contract. (3-29-10)~~

~~04. Required Experience and Abilities. Each chemical dependency counselor must, at a minimum, have and demonstrate the following experience and abilities at the time of hire or contract: (3-29-10)~~

~~a. At least two (2) years of paid full-time experience in the field of alcoholism, substance use disorders, and mental health. (3-29-10)~~

~~b. At least one (1) of the two (2) years' full-time experience must be in a clinical mental health setting. (3-29-10)~~

~~c. At least one (1) of the two (2) years' full-time experience must be in an administrative capacity that includes: (3-29-10)~~

~~i. Knowledge and experience demonstrating competence in planning and budgeting, fiscal management, supervision, personnel management, employee performance assessment, data collection, and reporting; and (3-29-10)~~

~~ii. An understanding of and adherence to the ethical standards of the respective license adopted by the governing board for licensure. (3-29-10)~~

~~05. Availability of Chemical Dependency Counselor. The facility must have at least one (1) chemical dependency counselor; at a minimum, be full-time forty (40) hours per week. (3-29-10)~~

(BREAK IN CONTINUITY OF SECTIONS)

295. AVAILABILITY OF ON-SITE ALCOHOL AND DRUG **SCREENING AND** TESTING.

01. On-Site **Testing Screening**. Each facility must have **testing screening** available on-site for the purpose of detecting the presence of alcohol or any controlled substances in clients. (3-29-10)(    )

**02. Quality of ~~Tests~~ Screening.** The facility must use testing screening instruments that are widely recognized as possessing sufficient sensitivity to detect the presence of substances in low quantities a Clinical Laboratory Improvement Amendments (CLIA) waiver. (3-29-10)( )

**03. ~~Policies for Collection and Handling Specimens~~ Drug Screening and Testing Policies and Procedures.** ~~The facility must establish and enforce policies to govern the collection and handling of urine specimens when such testing is indicated~~ Each facility must have policies and procedures regarding the collection, handling, testing, and reporting of drug-screening and drug-testing specimens. Policies and procedures must include elements contributing to the reliability and validity of the screening and testing process. (3-29-10)( )

- a.** Direct observation of specimen collection (as instructed by the Medical Director); ( )
- b.** Verification temperature; ( )
- c.** Specific, detailed, written procedures regarding all aspects of specimen collection, specimen evaluation, and result reporting; ( )
- d.** A documented chain of custody for each specimen collected; ( )
- e.** Quality control and quality assurance procedures for ensuring the integrity of the process; and ( )
- f.** Procedures for verifying accuracy when drug test results are contested. ( )

**04. ~~Documentation of Test Results~~ Release of Results.** ~~All test results must be documented in the client's record according to the requirements of the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164, 42 U.S.C. Sections 290 dd-3 and ee-3, and 42 C.F.R., Part 2 (June 9, 1987)~~ The facility must have a policy and procedures for releasing the results of an alcohol and drug screening or test. (3-29-10)( )

**05. On-Site Testing.** A program performing on-site testing must use alcohol and drug screening tests approved by the U.S. Food and Drug Administration. ( )

**06. Laboratory Used for Testing.** Each laboratory used for lab-based confirmation or lab-based testing must meet the requirements in and be approved under IDAPA 16.02.06, "Rules Governing Quality Assurance for Idaho Clinical Laboratories." ( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**301. REQUIRED MINIMUM STAFFING STANDARDS APPLICABLE TO DETOXIFICATION UNITS.** Each detoxification unit must develop and implement policies and procedures to provide necessary and qualified staff in sufficient numbers to assure the health and safety of clients. The program's policies must define the types and numbers of clinical, direct care, and managerial staff needed to provide clients with treatment services in a safe and therapeutic environment. Each detoxification unit must, at a minimum, meet the following standards for staffing in the detoxification unit for direct care staff. (3-29-10)

**01. Nurse.** At least one (1) R.N. or L.P.N. must be on duty twenty-four (24) hours per day, seven (7) days per week. (3-29-10)

**02. Direct Care Staff.** (3-29-10)

**a.** A detoxification unit with one (1) through six (6) clients must have one (1) direct care staff member on duty twenty-four (24) hours per day, seven (7) days per week. (3-29-10)

**b.** A detoxification unit with seven (7) through twelve (12) clients must have two (2) direct care staff members on duty twenty-four (24) hours per day, seven (7) days per week. (3-29-10)

c. A detoxification unit with thirteen (13) through eighteen (18) clients must have three (3) direct care staff members on duty twenty-four (24) hours per day, seven (7) days per week. (3-29-10)

d. A detoxification unit with nineteen (19) ~~clients~~ or more ~~clients~~ must have ~~at least one three (3)~~ ~~additional~~ direct care staff members on duty twenty-four (24) hours per day, seven (7) days per week, ~~beyond the three (3) staff required in Subsection 301.02.e of this rule for each additional six (6) clients or fraction thereof. Based on client acuity, the Medical Director must determine and document if additional direct care staff members are needed.~~ (3-29-10)( )

03. **Physician Supervision.** The treatment of each client must be under the supervision of a physician. (3-29-10)

**(BREAK IN CONTINUITY OF SECTIONS)**

**320. REQUIRED MINIMUM ADMISSION CRITERIA TO DETOXIFICATION UNITS.**

According to physician-approved written admission criteria, policies, and procedures, each detoxification unit must develop and implement written admission criteria that are uniformly applied to all clients. (3-29-10)

01. **Admission to Detoxification Unit.** A prospective client will be admitted or retained only if he meets the following admission criteria: (3-29-10)

a. Must be eighteen (18) years of age or older; (3-29-10)

b. Demonstrates a need for detoxification services; (3-29-10)

c. Has alcohol or other addictive controlled substance intake of sufficient amount and duration to create a reasonable expectation of withdrawal upon cessation of use; (3-29-10)

d. Is medically stable prior to admission and if seeking detoxification from alcohol has a blood alcohol level no greater than point twenty-four (.24) as measured by an accurately calibrated Breathalyzer or as determined by another equivalent laboratory test. A client who has a blood alcohol content in excess of point twenty-four (.24) may be admitted with approval granted by the medical director or his designee; (4-7-11)

e. ~~Meets admission criteria specifications that do not exceed ASAM Level III.7-D; and~~ (3-29-10)

f. Demonstrates the capacity to benefit from short-term stabilization and the services available at the facility may reduce the prospective client's acute symptoms and may prevent the client from detoxification hospitalization. (3-29-10)

02. **Detoxification Unit Able to Provide Services.** The detoxification unit must have the capability, capacity, personnel, and services to provide appropriate care to the prospective client. The client cannot require a type of service for which the detoxification unit is not approved to provide. (3-29-10)

03. **Monitoring Clients in Detoxification Unit.** The level of monitoring in the detoxification unit of the client or the physical restrictions of the environment must be adequate to prevent the client from causing serious harm to self or others. (3-29-10)

04. ~~Notification of Admission of Opiate/Methadone Client. The lead nurse must be notified that an opiate/methadone client was admitted to the detoxification unit. The name of the clinic where the client received the methadone must be documented in the client's record.~~ (3-29-10)

**(BREAK IN CONTINUITY OF SECTIONS)**

**330. REQUIRED MINIMUM TREATMENT NEEDS ASSESSMENT FOR CLIENTS OF DETOXIFICATION UNITS.**

**01. Client Treatment Needs Assessment.** A ~~chemical dependency counselor~~ qualified substance use disorders professional, within twenty-four (24) hours of admission, or as soon as a client is able, must complete a treatment needs assessment for each client admitted to the detoxification unit. The assessment must establish the historical development and dysfunctional nature of the client's alcohol and drug abuse or dependence and must evaluate the client's treatment needs. ~~(3-29-10)~~( )

**02. Treatment Needs Assessment Content.** The treatment needs assessment must be recorded in the client's record and must include, at a minimum, the following: (3-29-10)

**a.** A summary of the client's alcohol or drug abuse history including substances used, date of last use, amounts used, frequency, duration, age of first use, patterns, and consequences of use; types of and responses to previous treatment, periods of sobriety, and any other information supporting any diagnostic recommendations or diagnosis made; (3-29-10)

**b.** A summary of the client's family, including family background, current family composition, substance use and abuse by family members, supportive or dysfunctional relationships, and other family-related issues; (3-29-10)

**c.** A summary of the client's educational background, including current educational status, levels of achievement, and educational problems or difficulties; (3-29-10)

**d.** A summary of the client's vocational and employment status including skills or trades learned, work record, and current vocational or employment problems; (3-29-10)

**e.** A summary of the client's past and current involvement with the criminal justice system; (3-29-10)

**f.** A general summary of the client's medical history including past or current major illnesses or injuries, afflictions with communicable diseases, or known health problems or needs; (3-29-10)

**g.** A summary of the client's financial status, including current income sources, family income, ability to pay for services, and insurance coverage; (3-29-10)

**h.** A social assessment of the client, including a summarization of the nature of and problems with the client's social relationships outside the family unit; (3-29-10)

**i.** Any history of emotional or behavioral problems, including any history of psychological or psychiatric treatment; (3-29-10)

**j.** A master problem list developed from client input and identified clinical problems; and (3-29-10)

**k.** A diagnostic summary and master problem list. (3-29-10)

**331. -- 334. (RESERVED)**

**335. MINIMUM REQUIREMENTS FOR INDIVIDUALIZED DETOXIFICATION TREATMENT PLAN FOR CLIENTS OF DETOXIFICATION UNITS.**

**01. Develop Detoxification Treatment Plan.** A ~~chemical dependency counselor~~ qualified substance use disorders professional must develop an individualized treatment plan based upon the treatment needs assessment for each client admitted to the detoxification unit. ~~(3-29-10)~~( )

**02. Written Detoxification Treatment Plan.** The individualized detoxification treatment plan must be

signed and dated by both the client and the ~~chemical dependency counselor~~ qualified substance use disorders professional. The signature of the counselor must be followed by the counselor's credentials. (3-29-10)(    )

**03. Client Records for Detoxification Treatment.** The treatment plan must be recorded in the client's record and must include at a minimum the following: (3-29-10)

- a. A statement of the client's current strengths. (3-29-10)
- b. A statement of specific clinical problems to be addressed during treatment. (3-29-10)
- c. A diagnostic statement and a statement of measurable treatment goals based on client input that relate to the problems identified. (3-29-10)
- d. Measurable short-term objectives based on client input leading to the completion of goals including: (3-29-10)
  - i. Time frames for the anticipated dates of achievement or completion of each objective, or for reviewing progress towards objectives; and (3-29-10)
  - ii. Specification and description of the indicators to be used to assess progress based on client input. (3-29-10)
- e. A description of the methods or treatment procedures proposed to assist the client in achieving the objectives, including: (3-29-10)
  - i. Type and frequency of services or assigned activities to be provided; (3-29-10)
  - ii. Referrals for needed services that are not provided directly by the facility; and (3-29-10)
- f. A statement identifying the staff member responsible for facilitating the methods or treatment procedures. (3-29-10)

**04. Detoxification Treatment Plan Review.** The detoxification treatment plan must be reviewed by a ~~chemical dependency counselor~~ qualified substance use disorders professional every three (3) days and documented in each client's record. The treatment plan review must include, at a minimum, the following: (3-29-10)(    )

- a. A statement of the client's progress or regress as it relates to the measurable goals and measurable objectives identified in the client's individualized treatment plan. (3-29-10)
- b. Any additional clinical problems identified. (3-29-10)
- c. A statement of the planned actions to be taken to address the identified clinical problems. (3-29-10)

**336. -- 339. (RESERVED)**

**340. REQUIRED MINIMUM DISCHARGE PLANNING FOR CLIENTS OF DETOXIFICATION UNIT.** According to physician-approved written discharge criteria, policies, and procedures, each detoxification unit must provide each client with a discharge plan that must include, at a minimum, the following. (3-29-10)

~~**01. Discharge Criteria.** A client with stable vital signs and stable laboratory results can be discharged from a detoxification unit when the client meets the discharge criteria specifications of the dimensions in Level III.2-D of the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders of the American Society of Addiction Medicine incorporated by reference in Section 004 of these rules. (3-29-10)~~

~~**02. Client Referral.** Each client must be referred to the appropriate level of care upon discharge which may include community resources or state substance use disorders programs. (3-29-10)~~

- ~~032.~~ **Discharge Summary Content.** The discharge summary must include: (3-29-10)
- a. The reason for admission and original diagnosis; (3-29-10)
  - b. A summary of the client's clinical problems, course of treatment, and progress toward planned goals and objectives identified in the treatment plan; (3-29-10)
  - c. The reason for discharge and diagnoses at discharge; (3-29-10)
  - d. A continued care treatment plan and documentation of referrals made; and (3-29-10)
  - e. An inventory and proper accounting for all clothing and personal property returned to the client upon discharge. (3-29-10)

341. -- ~~400~~**99.** (RESERVED)

~~**ADDITIONAL REQUIREMENTS APPLICABLE TO SOBERING STATIONS**~~  
~~(Sections 400—499)~~

~~**401. REQUIRED MINIMUM STAFFING STANDARDS APPLICABLE TO SOBERING STATIONS.**~~

~~Each detox/mental health diversion unit that chooses to maintain or operate a sobering station must, at a minimum, meet the following standards for staffing in the sobering station for direct care staff. (3-29-10)~~

- ~~**01. Nurse.** At least one (1) R.N. or L.P.N. must be on duty during posted hours of operation. (3-29-10)~~
- ~~**02. Direct Care Staff.** (3-29-10)~~
  - ~~**a.** A sobering station with one (1) through eight (8) clients must have one (1) direct care staff member on duty during posted hours of operation. (3-29-10)~~
  - ~~**b.** A sobering station with nine (9) through eighteen (18) clients must have two (2) direct care staff members on duty during posted hours of operation. (3-29-10)~~
  - ~~**c.** A sobering station with nineteen (19) through thirty (30) clients must have three (3) direct care staff members on duty during posted hours of operation. (3-29-10)~~
  - ~~**d.** A sobering station with more than thirty (30) clients must have one (1) additional direct care staff member beyond the three (3) staff required in Subsection 401.02.e of this rule for each additional ten (10) clients or fraction thereof during posted hours of operation. (3-29-10)~~
- ~~**03. Physician Supervision.** The services provided to each client must be under the supervision of a physician. (3-29-10)~~

~~**402.—409. (RESERVED)**~~

~~**410. REQUIRED MINIMUM SERVICES APPLICABLE TO SOBERING STATIONS.**~~

~~Each detox/mental health diversion unit that chooses to maintain or operate a sobering station must provide the following services. (3-29-10)~~

- ~~**01. Services to Reduce Acute Symptoms and to Monitor.** A sobering station must provide services that reduce the client's acute symptoms in a safe structured setting. (3-29-10)~~
- ~~**02. Planning Services on Release.** A sobering station must provide a procedure to screen each client for planning needs on release. (3-29-10)~~

~~411. — 419. (RESERVED)~~

~~420. REQUIRED MINIMUM INTAKE CRITERIA APPLICABLE TO SOBERING STATIONS.~~

~~Each detox/mental health diversion unit that maintains or operates a sobering station must develop and implement physician approved written intake criteria, policies, and procedures that are uniformly applied to all clients. (3-29-10)~~

~~01. Intake to Sobering Station. A prospective client will be accepted into or retained only if he meets the following intake criteria: (3-29-10)~~

~~a. Must be brought to the sobering station by law enforcement or referred by a hospital or other medical care provider. (3-29-10)~~

~~b. Must be eighteen (18) years of age or older; and (3-29-10)~~

~~c. Demonstrates the capacity to benefit from sobering; (3-29-10)~~

~~d. The services available in the sobering station may reduce the prospective client's acute symptoms and may prevent the client from detoxification hospitalization. (3-29-10)~~

~~02. Sobering Station Able to Provide Services. The sobering station must have the capability, capacity, personnel, and services to provide appropriate care to the prospective client. (3-29-10)~~

~~a. The client does not require a type of service for which the facility is not approved to provide; and (3-29-10)~~

~~b. The level of monitoring of the client in the unit or the physical restrictions of the environment of the facility are adequate to prevent the patient from causing serious harm to self or others. (3-29-10)~~

~~03. Monitoring Clients in Sobering Station. A client admitted to a sobering station must be closely monitored. (3-29-10)~~

~~a. Qualified staff must check each client's vital signs upon entry and throughout the client's stay in the sobering station according to the written policies and procedures approved and signed by the medical director. (3-29-10)~~

~~b. The lead nurse must be notified that an opiate/methadone client was admitted to the sobering station and the name of the clinic where the client received the methadone must be documented. (3-29-10)~~

~~421. — 424. (RESERVED)~~

~~425. REQUIRED MINIMUM PLANNING ON RELEASE APPLICABLE TO SOBERING STATIONS.~~

~~According to physician approved written criteria, policies, and procedures, each sobering station must provide each client with a plan on release that must include, at a minimum, the following. (3-29-10)~~

~~01. Planning on Release. The facility must provide a procedure to screen each client for planning needs on release. (3-29-10)~~

~~a. A client must be released from a sobering station according to the criteria in Subsection 425.02 of this rule. (3-29-10)~~

~~b. A client must be referred to the appropriate level of care upon release which may include community resources and state substance use disorders programs. (3-29-10)~~

~~02. Summary on Release Content. The summary on release must include: (3-29-10)~~

~~a. Documented signs of being sober such as clear speech, steady gait, clear thinking, and appropriate~~



~~behavior, including stable vital signs and stable laboratory results. (3-29-10)~~

~~b. Documented signs that the client is able to care for self or released as sober and responsible to a third party adult. (3-29-10)~~

~~c. A release executed by a sober third party adult into whose care the client has been discharged, if the client is not sober, and the sober third party adult has requested and agreed to assume responsibility for the client's well being. (3-29-10)~~

~~d. Documentation that the client was encouraged to enter programs for ongoing recovery. (3-29-10)~~

~~e. An inventory and proper accounting for all clothing and personal property returned to the client upon discharge. (3-29-10)~~

~~426. — 499. (RESERVED)~~

### ADDITIONAL REQUIREMENTS APPLICABLE TO MENTAL HEALTH DIVERSION UNITS

(Sections 500 - 599)

#### 500. REQUIRED MINIMUM POLICY STANDARDS APPLICABLE TO MENTAL HEALTH DIVERSION UNITS.

~~01. **Crisis Stabilization for Mental Health Diversion Unit.** Each mental health diversion unit issued a certificate of approval under these rules must offer intensive mental health services twenty-four (24) hours per day, seven (7) days per week, to persons **eighteen (18) years of age or older** with an urgent or emergent need for crisis stabilization services in a safe, structured setting. (3-29-10)(    )~~

~~02. **Focus of Mental Health Diversion Unit.** Mental health diversion units are focused on short term stabilization for up to a maximum of seven (7) days. In order to assure that adequate arrangements are in place to allow for a safe discharge of a client, the length of stay may be extended up to twenty four (24) hours. (3-29-10)~~

~~03. **Alternative to Inpatient Hospitalization.** Services at this level of care are used as an alternative to inpatient hospitalization and include crisis stabilization, initial and continuing biopsychosocial assessment, care management, medication management, and mobilization of family or significant other support, and community resources. (3-29-10)~~

~~04. **Initial Assessment.** This level of care provides for an initial assessment by a licensed mental health professional followed by a face-to-face psychiatric evaluation within twenty four (24) hours of admission or as soon as a client is able. (3-29-10)~~

~~05. **Primary Diagnoses.** The primary diagnoses treated in a mental health diversion unit are active symptomatology consistent with a DSM-IV-TR diagnosis (Axes I-V) as the principle diagnosis however, patients may have additional physical, medical, or co-dependency issues. (3-29-10)~~

#### (BREAK IN CONTINUITY OF SECTIONS)

#### 520. MINIMUM REQUIREMENTS FOR ADMISSION CRITERIA APPLICABLE TO MENTAL HEALTH DIVERSION UNITS.

According to physician-approved written admission criteria, policies, and procedures, each mental health diversion unit must develop and implement written admission criteria that are uniformly applied to all clients. (3-29-10)

**01. Admission to Mental Health Diversion Unit.** A prospective client will be admitted or retained only if he meets the following admission criteria: (3-29-10)

a. Demonstrates active symptomatology consistent with a DSM-~~IV~~<sup>TR</sup>5 diagnosis (~~Axis I-V~~) as the principle diagnosis and demonstrates significant functional impairment related to his diagnosis such as self-injurious behavior or threats, current suicidal ideation with expressed intentions or a past history of self-destructive, impulsive, or parasuicidal behavior, or grave disability; (3-29-10)(    )

b. ~~His symptoms do not exceed Level V of LOCUS Criteria;~~ (3-29-10)

~~e~~ Must be eighteen (18) years of age or older; and (3-29-10)

~~d.c.~~ Demonstrates the capacity to benefit from short-term stabilization and the services available at the facility may reduce the prospective client's acute symptoms and may prevent the client from psychiatric hospitalization. (3-29-10)

**02. Mental Health Diversion Unit Able to Provide Services.** The mental health diversion unit must have the capability, capacity, personnel, and services to provide appropriate care to the prospective client. The client cannot require a type of service for which the mental health diversion unit is not approved to provide. (3-29-10)

**03. Monitoring Clients in Mental Health Diversion Unit.** The level of monitoring the client in the mental health diversion unit or the physical restrictions of the environment of the unit must be adequate to prevent the client from causing serious harm to self or others. (3-29-10)

**(BREAK IN CONTINUITY OF SECTIONS)**

**601. CODES AND STANDARDS.**

Each detox/mental health diversion unit must comply with all state and local building, fire, electrical, plumbing, zoning, heating, or other applicable codes in which the facility is located and that are in effect when construction is begun. Written evidence of compliance must be kept in the facility. (3-29-10)

**01. Code Conflict.** In the event of a conflict between codes, the most restrictive code requirements will apply. (3-29-10)

**02. Compliance with Codes and Standards.** Each detox/mental health diversion unit must be in compliance with the applicable provisions of the following codes and standards in Subsection 601.02.a. through 601.02.h. of this rule. (3-29-10)

a. 2000 Edition of the Life Safety Code, including mandatory references. (3-29-10)

b. American National Standard Specifications for Making Buildings and Facilities Accessible to and Usable by Physically Handicapped People (ANSI/ICC A117.1-2003). (3-29-10)

c. Idaho Department of Health and Welfare Rules, IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments," also known as the Idaho Food Code. (3-29-10)

d. National Electrical Code. (3-29-10)(    )

e. International Fire Code. (3-29-10)

f. Occupational Safety and Health Act of 1970 (OSHA). (3-29-10)

g. National Sanitation Federation. (3-29-10)

~~h. For facilities operating a sobering station, at least one (1) airborne infection isolation room must comply with (AIA) 2006 AIA Guidelines for Design and Construction of Health Care Facilities. (3-29-10)~~

**03. Evidence of Compliance with Local Building Codes.** No facility will be approved unless the applicant provides evidence to the Department that responsible local officials (planning, zoning, and building) have approved the facility/building for code compliance. (3-29-10)

**(BREAK IN CONTINUITY OF SECTIONS)**

**620. BEDS AND SLEEPING AREAS FOR MEDICALLY MONITORED RESIDENTIAL DETOXIFICATION UNIT.**

Each medically monitored residential detoxification unit must be in compliance with Subsections 620.01 through 620.11 of this rule. (3-29-10)

**01. ~~Number of Approved Beds for Detoxification Unit.~~ ~~The number of approved beds for detoxification is limited to the number stated on the certificate of approval.~~** (3-29-10)(    )

**a.** Each ~~approved~~ bed for detoxification must have, at a minimum, a single bed mattress in good repair with moisture-proof cover, sheets, blankets, bedspread, pillow and pillow cases. (3-29-10)(    )

**b.** Roll-away type beds, cots, bunk-beds, and folding beds cannot be used and will not be approved. (3-29-10)

**02. Location of Beds.** Client beds for medical detoxification may be located within an area suitable for multiple beds (“suite”), provided the suite is surrounded by solid walls, floor to ceiling, and is constructed and maintained in accordance with Chapter 18 of the 2000 Edition of the Life Safety Code. (3-29-10)

**03. Cubicle Curtains.** Cubicle curtains of fire retardant material, capable of enclosing each approved bed must be provided in multiple-bed rooms or suites to ensure privacy for clients. (3-29-10)

**04. Unacceptable Location of Beds.** Client beds for detoxification must not be located in hallways, closets, attics, corridors, trailer houses, or in any room other than one approved for clients. (3-29-10)

**05. Numbered Beds.** Client beds for detoxification must be numbered. (3-29-10)

**06. Square Footage Requirements.** Square footage requirements for client sleeping areas must, at a minimum, provide not less than sixty (60) square feet of floor space per client. (3-29-10)

**07. Visibility of Client Beds.** Client beds for detoxification must be visible at all times to staff in the staff station. (3-29-10)

**08. Occupants of Sleeping Areas.** Solid walls or movable partitions, floor to ceiling, must be used to ensure that sleeping areas and suites for detoxification are only occupied by individuals of the same sex. (3-29-10)

**09. Safe and Secure Sleeping Areas.** Sleeping areas for detoxification must be free of safety hazards, and appropriately lighted with no items or articles that a client might use to injure self or others. (3-29-10)

**10. Separate and Distinct Client Areas.** Solid walls, floor to ceiling, must be used to ensure that client areas for medically monitored detoxification are separate and distinct from client areas for ~~sobering and~~ mental health. (3-29-10)(    )

**11. Prior Approval Needed for Reallocated or Relocated Beds.** Once the Department has approved the actual construction drawings, plans, and specifications, approved beds for detoxification cannot be reallocated or relocated unless prior written approval has been obtained from the Department. (3-29-10)

**621. -- 629. (RESERVED)**

**630. BEDS AND BEDROOMS FOR MENTAL HEALTH DIVERSION UNIT.**

Each mental health diversion unit must be in compliance with the following Subsections 630.01 through 630.14 of this rule. (3-29-10)

**01. ~~Number of Approved Beds for Mental Health Diversion Unit.~~ ~~The number of approved beds for mental health diversion is limited to the number stated on the certificate of approval.~~ (3-29-10)( )**

**a.** Each ~~approved~~ bed for mental health diversion treatment must have, at a minimum, a single bed mattress in good repair with moisture-proof cover, sheets, blankets, bedspread, pillow and pillowcases. (3-29-10)( )

**b.** Roll away type beds, cots, bunk beds, and folding beds cannot be used and will not be approved. (3-29-10)

**02. Cubicle Curtains.** Cubicle curtains of fire retardant material, capable of enclosing each approved bed must be provided in multiple-bed rooms to ensure privacy for clients. (3-29-10)

**03. Maximum Room Capacity.** The maximum room capacity in each bedroom is two (2) clients. (3-29-10)

**04. Staff Calling System.** A staff calling system for each client must be installed in each bedroom and in each toilet, bath, and shower room. A staff call must be considered an emergency call and must register at the staff station. The staff calling system must be designed so that a signal light activated by the client will remain lit until turned off by a staff member at the client's calling station - bed, bath, or shower room. The staff calling system is not a substitute for supervision. (3-29-10)

**05. Location of Client Beds.** Client beds must not be located in hallways, closets, attics, corridors, trailer houses, or in any room other than one approved for clients. (3-29-10)

**06. Numbered Bedrooms and Beds.** Client bedrooms and beds must be numbered. (3-29-10)

**07. Size of Client Sleeping Areas.** Square footage requirements for client sleeping areas must provide for not less than sixty (60) square feet of floor space per client. (3-29-10)

**08. Entrances to Client Bedrooms.** Entrances to each client bedroom must be visible at all times to staff in the staff station. (3-29-10)

**09. Ceiling Height.** Ceiling heights must be a minimum of seven (7) feet, six (6) inches. (3-29-10)

**10. Occupants of Bedrooms.** A client bedroom used for mental health diversion must only be occupied by individuals of the same sex. (3-29-10)

**11. Bedroom Door Requirements.** Each client bedroom must have a ninety-degree (90°) swinging door, at a minimum, that will not block any corridor or hallway, that is no less than thirty-two (32) inches in width, with a vision window, and that opens out directly into a corridor visible at all times to staff in the staff station. (3-29-10)

**12. Safe and Secure Client Bedrooms.** Each client bedroom must be free of safety hazards, and appropriately lighted with no items or articles that a client might use to injure self or others. (3-29-10)

**13. Separate and Distinct Client Areas.** Solid walls, floor to ceiling, must be used to ensure that client areas for mental health diversion are separate and distinct from client areas for ~~sobering and~~ medically monitored detoxification. (3-29-10)( )

**14. Prior Approval Needed for Reallocated or Relocated Beds.** Once the Department has approved the actual construction drawings, plans, and specifications, approved beds for mental health diversion cannot be reallocated or relocated unless prior written approval has been obtained from the Department. (3-29-10)

631. -- ~~6349.~~ (RESERVED)

~~640. SOBERING STATION.~~

~~A sobering station is an optional service that may be provided in a detox/mental health diversion unit. When a sobering station is provided it must be in compliance with Subsections 640.01 through 640.16 of this rule. (3-29-10)~~

~~01. Number of Clients in a Sobering Station. The number of clients that may be housed in the sobering station is limited to the number stated on the certificate of approval. (3-29-10)~~

~~02. Visible Client Areas. Client areas for sobering must be visible at all times to staff at the staff station. If vision windows are used they must provide for one way vision into client areas for staff at the staff station and must be made of tempered, shatterproof glass. The Department will consider alternative design solutions to one way vision which will accommodate the requirements for client area accessibility and monitoring. (3-29-10)~~

~~03. Disease Protection of Clients. Client areas must provide for disease protection and be maintained in a clean sanitary condition at all times. (3-29-10)~~

~~04. Furniture. Furniture located in client areas must be weighted or secured to the floor to ensure safety of staff and clients. (3-29-10)~~

~~05. Location of Client Areas. Client areas in a sobering station must not be located in hallways, closets, attics, corridors, trailer houses, or in any room other than one approved for clients. (3-29-10)~~

~~06. Numbered Rooms. Client rooms for a sobering station must be numbered. (3-29-10)~~

~~07. Size of Client Rooms. Square footage requirements for client rooms in a sobering station must provide for not less than thirty (30) square feet of floor space per client. (3-29-10)~~

~~08. Entrances to Client Rooms. Entrances to all sobering station client rooms must be visible at all times to staff at the staff station. (3-29-10)~~

~~09. Ceiling Height of Client Rooms. Ceiling heights for client rooms must be a minimum of seven (7) feet, six (6) inches. (3-29-10)~~

~~10. Floor Drain in Client Room. Client rooms in a sobering station must have at least one tamper resistant floor drain installed. (3-29-10)~~

~~11. Doors on Client Rooms. Client rooms in a sobering station must have a ninety degree (90°) swinging door, at a minimum, that will not block any corridor or hallway, that is no less than thirty two (32) inches in width, with a vision window, and that opens out directly into a corridor visible at all times to staff at the staff station. The Department will consider alternative design solutions to one way vision which will accommodate the requirements for client area accessibility and monitoring. (3-29-10)~~

~~12. Utilities in Client Rooms. Client rooms in a sobering station must have a toilet and hand washing sink with solid walls or partitions to separate the toilet from the sleeping area, and have mechanical ventilation to the outside. (3-29-10)~~

~~13. Client Rooms Free of Hazards. Client rooms and areas in a sobering station must be free of safety hazards, and appropriately lighted with no items or articles that a client might use to injure self or others. (3-29-10)~~

~~14. Airborne Infection Isolation Room. Each sobering station must have at least one (1) private airborne infection isolation room with a toilet, hand washing sink, and other accessory facilities that complies with (AIA) 2006 AIA Guidelines for Design and Construction of Health Care Facilities. Private airborne infection isolation rooms must have no hardware, equipment, or furnishings that obstruct observation of a client, or that present a physical hazard, or a suicide risk. Private airborne infection isolation rooms must have at least sixty (60) square feet of floor space and a ceiling height of seven (7) feet, six (6) inches. (3-29-10)~~

~~15. **Separate and Distinct Client Areas.** Solid walls, floor to ceiling, must be used to ensure that client areas for sobering are separate and distinct from client areas for medically monitored detoxification and mental health diversion. (3-29-10)~~

~~16. **Prior Approval Needed for Reallocated or Relocated Beds.** Once the Department has approved the actual construction drawings, plans, and specifications, approved beds for a sobering station cannot be reallocated or relocated unless prior approval has been obtained from the Department. (3-29-10)~~

~~641.—649. (RESERVED)~~

**(BREAK IN CONTINUITY OF SECTIONS)**

**655. ADMINISTRATIVE AREAS.**

The following administrative areas must be located in the facility, or readily available to staff. The size and disposition of each administrative area will depend upon the number and types of approved beds to be served. Depending on the size of the facility and the number of clients served, there may be a need for more than one of the administrative areas listed below. Although identifiable spaces are required to be provided for each of the indicated functions, consideration will be given to design solutions which would accommodate some functions without specific designation of areas or rooms. Details of such proposals must be submitted to the Department for prior approval. Each administrative area must be in compliance with Subsections 655.01 through 655.10 of this rule. (3-29-10)

**01. Staff Station.** The facility must have one (1) or more staff stations centrally located in each distinct service area for ~~the sobering station~~, the medically monitored detoxification unit, and the mental health diversion unit, with adequate space for charting and storage for administrative supplies. ~~(3-29-10)~~ ( )

**02. Lounge and Toilets for Staff.** The facility must have lounge and toilet rooms for staff. The toilet rooms may be unisex. (3-29-10)

**03. Closets and Compartments.** Individual closets or compartments, for the safekeeping of coats and personal effects of personnel, must be located convenient to the staff station or in a central location close to personnel. (3-29-10)

**04. Clean Workroom or Clean Holding Room.** If the room is used for work, it must contain a counter and hand-washing facilities. When the room is used only for storage as part of a system for distributing clean and sterile supplies, the work counter and hand-washing facilities can be omitted. (3-29-10)

**05. Soiled Workroom and Soiled Holding Room.** The soiled workroom must contain a clinical sink or equivalent flushing rim fixture and a sink for hand-washing, towel dispenser, work counter, waste receptacle, and soiled linen receptacle. (3-29-10)

**06. Drug Distribution Station.** The drug distribution station must be secure and convenient, with prompt twenty-four (24) hour availability of medicine. A secure medicine preparation area must be available and under the nursing staff's visual control and contain a work counter, refrigerator, and locked storage for controlled drugs, convenient to hand washing station and have a minimum area of fifty (50) square feet. A medicine dispensing unit can be located at the staff station, in the clean workroom, or in an alcove or other space convenient to staff and under staff control. (3-29-10)

**07. Nourishment Station.** The nourishment station must contain a sink equipped for hand-washing, towel dispenser, equipment for serving nourishment between scheduled meals, refrigerator, and storage cabinets. Ice for clients' must be provided only by icemaker-dispenser units. (3-29-10)

**08. Equipment Storage Rooms.** Rooms must be available for storage of equipment. (3-29-10)

**09. Janitor's Closet.** Rooms must be available for storage of janitorial supplies and equipment.

(3-29-10)

**10. Lockable Storage Area.** A storage area of at least sixty-four (64) cubic feet (4x4x4), with segregated lockable storage compartments for client personal effects, must be maintained on-site. This storage area for client personal effects may be located in a separate area inside or outside of the facility's buildings. (3-29-10)

**(BREAK IN CONTINUITY OF SECTIONS)**

**685. VENTILATION.**

~~**01. Detox/Mental Health Diversion Unit Ventilation.** Each detox/mental health diversion unit must be adequately ventilated and precautions must be taken to prevent offensive odors in compliance with the minimum requirements of the Uniform Mechanical Code. (3-29-10)( )~~

~~**02. Sobering Station Ventilation.** A facility with a sobering station, must have private airborne infection isolation rooms that are adequately ventilated and precautions must be taken to prevent offensive odors in compliance with the following minimum requirements of the 2006 AIA Guidelines for Design and Construction of Health Care Facilities:~~

<b>TABLE 685.02—MINIMUM REQUIREMENTS OF THE 2006 AIA GUIDELINES FOR DESIGN AND CONSTRUCTION OF HEALTH CARE FACILITIES—VENTILATION PRECAUTIONS FOR SOBERING STATIONS</b>				
<i>Area</i>	<i>Air Movement/Relation</i>	<i>Minimum Outdoor Air Changes/Hr</i>	<i>Total Air Changes/Hr</i>	<i>Exhausted</i>
<i>Isolation Room</i>	<i>In</i>	<i>2</i>	<i>12</i>	<i>Yes</i>

(3-29-10)



## INCORPORATION BY REFERENCE SYNOPSIS

**In compliance with Section 67-5223(4), Idaho Code**, the following is a synopsis of the differences between the materials previously incorporated by reference in this rule that are currently in full force and effect and newly revised or amended versions of these same materials that are being proposed for incorporation by reference under this rulemaking.

The following agency of the State of Idaho has prepared this synopsis as part of the proposed rulemaking for the chapter cited here under the docket number specified:

**DEPARTMENT OF HEALTH AND WELFARE  
IDAPA 16.07.50 -- Minimum Standards for Nonhospital,  
Detox/Mental Health Diversion Units  
Proposed Rulemaking -- Docket No. 16-0750-1801**

*(Include a brief description that explains the differences between the version of the materials or documents that are currently incorporated by reference and the materials or documents that are being proposed for adoption in this rulemaking.)*

*(You may use the following table or write a brief summary of the differences)*

<b>Incorporated Document Version/URL</b>	<b>IDAPA Section Number</b>	<b>Current Version of Incorporated Document</b>	<b>Substantive Changes in New Incorporation by Reference Version</b>
The ASAM Criteria 4 <sup>th</sup> Ed.	004	The ASAM Criteria 5 <sup>th</sup> Ed.	See attachment.

at <http://www.asam.org/for-the-public/definition-of-addiction>), which serves as more of a description of the condition.<sup>3</sup> In April of 2011, these two versions were unanimously adopted as official ASAM statements.

Notice how the “short version” definition uses the singular term “addiction” to describe

a condition that is “primary” and “chronic.” So although this definition explains how compulsive, impulsive, or out-of-control substance use can be present, addiction can also involve impaired control over behaviors (such as gambling) that do not involve psychoactive substance use.

## What’s New in *The ASAM Criteria*

While relying on the same principles that have guided previous editions, *The ASAM Criteria* now expands on prior understanding and applications to serve a wider and more diverse population. This broader population includes people with addiction who are older adults, parents with children, and also those working in safety-sensitive occupations. The current edition also branches out to explore addiction services within criminal justice settings.

In addition, new information has been included to assist in applying *The ASAM Criteria* in managed care, in utilization management, and in the context of mental health and addiction parity and federal health care reform. Finally, additional sections have been added to this edition to respond to the request of users of the criteria—clinicians, care managers, and public and private sector payers—to make information more applicable to the “real world” in which providers deliver care and payers and third parties authorize and manage care.

Other key highlights of this new edition include, but are not limited to...

- » **Synchronization with *The ASAM Criteria Software***, such that the definitions and specifications in this text for the dimensions, levels of care, and admissions decision rules serve as the reference manual for *The ASAM Criteria Software*, developed with the support of SAMHSA.
- » **Combining adult and adolescent treatment information** in order to show overarching alignment with the guiding principles and applications of *The ASAM Criteria*. At the same time, *The ASAM Criteria* continues to distinguish between adult and adolescent populations, and presents separate diagnostic and dimensional admission criteria within each level of care.
- » **Incorporation of the latest understanding of Co-Occurring Disorders Capability** (formerly termed Dual Diagnosis Capability), and what might better be termed “complexity capability,” to acknowledge the range of service needs beyond just addiction and mental health treatment. The need for persons with substance



***The ASAM Criteria Software*** is a standardized, computer-assisted implementation of the adult admission decision rules in this book to provide a direct mechanism for linking the addiction specialty care system with general medical systems in the era of three intersecting legislative initiatives in the U.S.: health care reform, parity, and health information technology. It does not address specialized treatment services for adolescents.



## BRAND NEW CHAPTERS IN THE ASAM CRITERIA

### Application to Adult Special Populations

- » Older Adults
- » Parents or Prospective Parents Receiving Addiction Treatment Concurrently with Their Children
- » Persons in Safety-Sensitive Occupations
- » Persons in Criminal Justice Settings

### Emerging Understandings of Addiction

- » Gambling Disorder
- » Tobacco Use Disorder

use disorders to be assessed and treated for co-occurring infectious diseases is but one clear example of this concept. Programs and practitioners increasingly understand the need for trauma-informed care and primary health/behavioral health integration as core features of all addiction treatment programs.

As the treatment field has learned more about the complexities of the people we serve, it increasingly is becoming more trauma informed and responsive to the needs of people with co-occurring mental and substance use disorders. Services that are “co-occurring capable or enhanced” and “complexity capable” are described within this edition.

- » **Inclusion of the conceptual framework of Recovery-Oriented Systems of Care** to facilitate understanding of addiction treatment

services within a recovery-oriented “chronic disease management” continuum, rather than as repeated and disconnected “acute episodes of treatment” for the acute complications of addiction; and/or repeated and disconnected readmissions to addiction or mental health programs that employ rigid lengths of stay into which patients are “placed.”

- » **Further expansion on the role of the physician.** The role of physicians within interdisciplinary teams, in various levels of care, deserves attention, which work-group members, authors, and editors have attempted to recognize and articulate. There are physicians working in more traditional medical practices (outpatient clinic settings described as Outpatient Services or Level 1 settings by *The ASAM Criteria*) and not necessarily in interdisciplinary teams. It is hoped that, in their own offices, they will increasingly meet patient needs through the use of pharmacotherapies as well as psychosocial therapies, as these are indicated in individual cases. More change is occurring in mental health settings where psychiatrists and other mental health clinicians are screening for and treating addiction, and are more open to co-occurring disorders treatment. ASAM is committed, through the publication of this and future editions of *The ASAM Criteria*, to be relevant to an ever-evolving health care service delivery landscape.

The “Staff” sections at the beginning of each treatment level of care in *The ASAM Criteria* indicate physician involvement. In the ASAM PPC-2R (2001), there was mention of physician involvement without noting whether the physician is an addiction specialist or simply any licensed physician. This was based, at least to some extent, upon the *status quo*, specifically the availability or lack of specially trained and certified physicians with respect to addiction treatment. Even if there were an unlimited availability of such treatment, economic considerations would still play a role in which one would want the least expensive

alternative to obtain identical outcomes. In *The ASAM Criteria*, Third Edition, authors and editors have indicated where specialist and non-specialist physicians must be involved in services for addiction, which for most people is a lifelong illness.

This edition also has continued to describe “Medically Monitored,” versus “Medically Managed,” intensive addiction services (Level 3.7 vs. Level 4) but medical management can apply in outpatient care (Level 1 and Level 2) as well. Even when care is medically monitored (provided to the patient primarily by non-physicians as part of a team supervised by a physician), the physician will be in the position to offer service components that contribute to the care experience of the patient.

Federal agencies have made policy decisions to promote office-based (Level 1) care by generalist physicians as the prescribers. There has been insufficient research on the specific utilization of addiction specialist physicians compared with general medical or general psychiatric physicians in the Level 1 management of opioid addiction involving pharmacotherapy. In this edition of the criteria, authors and editors offer suggestions regarding the utilization of physicians in the care of patients in various levels of care, including suggestions on the utilization of physicians specifically trained and certified in the care of addiction. These suggestions have been generated via the expert consensus of the authors, field reviewers, and editors of *The ASAM Criteria*. The empirical validation of these suggestions awaits future analysis by competent and experienced health services researchers.

- » **Updated diagnostic admission criteria for the levels of care** to be consistent with the American Psychiatric Association’s 2013 publication of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*.
- » **A new section on gambling disorder** that is consistent with ASAM’s definition of

addiction, asserting that the pathological pursuit of reward or relief can involve not just the use of psychoactive substances, but also the engagement in certain behaviors. The inclusion of a gambling disorder section also reflects shifts in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, which includes gambling disorder in the Substance Use and Addictive Disorders chapter.

- » **A new section on tobacco use disorder** reflects a decision to address the treatment field’s inconsistencies in, and even ambivalence about, viewing this condition as similar to alcohol and other substance use disorders.
- » **An updated opioid treatment section** to incorporate new advances, named Opioid Treatment Services (addressing opioid antagonist pharmacotherapy in addition to opioid agonist pharmacotherapy).

Previous editions and supplements of ASAM’s criteria have described care offered in what this edition is naming Opioid Treatment Programs (utilizing methadone to treat opioid use disorder in Level 1 and previously called Opioid Maintenance Therapy, OMT.) *The ASAM Criteria*, Third Edition, is the first edition to address the growing use of office-based opioid treatment, utilizing buprenorphine products to treat opioid addiction.

- » **Updates to better assess, understand, and provide services for all six ASAM criteria dimensions** to reflect current science and research. This can be seen in Chapter 6: Addressing Withdrawal Management and Intoxication Management, and Appendix B: Special Considerations for Dimension 5 Criteria, for example.
- » **Revised terminology** reflects contemporary usage and a strength-based, recovery-oriented, trauma-informed, and culturally competent approach. See Chapter 3: Intake and Assessment for more information.

» **Reformatted level of care numbers.** Listed in previous editions of the criteria using Roman numerals, levels of care have been reformatted using Arabic numbers.

» **A user-friendly format.** In the publication design and delivery of the content in this edition, much attention has been paid to make *The ASAM Criteria* book user-friendly so that information is more easily retrieved and cross-referenced.

THEN AND NOW  
1

## New Terminology

*The ASAM Criteria* uses new terminology and language in its attempt to embrace a broader view of the conditions addressed by health care professionals. Specifically, addiction care professionals may notice content and terminology addressing substance use disorders not covered in previous editions (eg, tobacco use disorder),

other addictive disorders (eg, gambling disorder), and references to the definition of addiction adopted by ASAM in 2011. Other references to specific terminology revisions have been briefly explained below. For a more comprehensive list of terms used in this edition, consult the Glossary provided in Appendix C.



### NEW TERMINOLOGY IN THE ASAM CRITERIA

- » The individuals served in treatment are now most often referred to as “individual,” “person,” “participant,” or “patient,” and these are used interchangeably in this publication
- » Book title and concept is now “*The ASAM Criteria*”
- » Terms such as “**dual diagnosis**” and “**dual disorders**” are now described in the spectrum of “co-occurring disorders or conditions”
- » “**Detoxification services**” are referred to in this edition as “withdrawal management”
- » “**Opioid Maintenance Therapy (OMT)**” is now discussed as Opioid Treatment Programs (OTP) and Office-Based Opioid Treatment (OBOT) within “Opioid Treatment Services (OTS)”
- » “**Level III.3: Clinically Managed Medium-Intensity Residential Treatment**” is now “Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services”

## New Terminology Explained

See the following boxes for further explanations of some of the key terminology changes introduced in *The ASAM Criteria*, Third Edition.

### "INDIVIDUAL," "PERSON," "PARTICIPANT," "PATIENT"

In addiction and mental health services, there is a wide variety of terminology used to describe the people served: patients, clients, consumers, participants, residents, persons, individuals, customers, etc. In *The ASAM Criteria*, various terms will be used at different times, depending on what seems to flow best in the context. "Individual," "person," "participant," and "patient" will be used most often. The use of the term "patient" implies the highest biopsychosocial values of the helping professions: to serve as the patient's agent and support, to care for the patient as we would want ourselves and our loved ones to be treated, healing where possible but always seeking to reduce suffering.

In order to limit complexity in terms, "client," "consumer," and "customer" will not be used. It should be noted, however, that regardless of the term given, *The ASAM Criteria* always supports and promotes a collaborative, participatory process of assessment and service planning. This approach is consistent with evidence-based practices and the outcomes research that finds the quality of the therapeutic alliance with the participant to have a significant impact on achieving effective outcomes, and that finds person-centered services to improve the adherence to treatment.

### "THE ASAM CRITERIA"

The title of this 2013 edition is *The ASAM Criteria* with the subtitle, *Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. This is the third edition of ASAM's criteria. The 2001 edition was named *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R)*, which was seen as so long and complicated that many would say "Do you use the ASAM?" Suggested terminology for this edition is the following:

"**The ASAM Criteria**," to reinforce that these criteria are the official, accepted criteria of ASAM and not associated with any of the various state adaptations or interpretations also in existence. Also, *The ASAM Criteria*, Third Edition, now directly and specifically relates to and supports *The ASAM Criteria Software*, which is the only authorized implementation of these decision rules.

The new title broadens the reach of the criteria beyond "patients" and "placement" to speak to and encourage other non-medical disciplines to use *The ASAM Criteria*. It is this movement beyond "placement" which will challenge the perpetuated idea that placing people in programs is a primary and sufficient goal. The essential focus is on matching services to each patient's unique multidimensional needs. Placement is simply where this individualized treatment can efficiently and effectively be delivered. (See the arrangement of later sections which move from assessment through service planning and placement.)

The subtitle connotes that these criteria address conditions related to addiction and other substance-related disorders. However, not every person is suffering from the disease of addiction. Certain people may just need Early Intervention (Level 0.5) or Screening, Brief Intervention, Referral, and Treatment (SBIRT).

In addition, there are other health conditions that are not necessarily related to substance use or gambling, but that co-occur and need physical and/or mental health services. Some of these may be sub-diagnostic and therefore "conditions" rather than disorders. Thus the subtitle of *The ASAM Criteria* is intended to cover the broader range of conditions to help with integration into general health care (under health care reform) and into behavioral health with co-occurring disorders.

## **"CO-OCCURRING DISORDERS OR CONDITIONS"**

The addiction and mental health fields have made progress on developing a consensus on terminology to describe individuals who are experiencing simultaneous mental health and substance use conditions. Terms previously in use include "dual diagnosis," "dual disorders," "mentally ill chemically addicted" (MICA), "chemically addicted mentally ill" (CAMI), "mentally ill substance abusers" (MISA), "mentally ill chemically dependent" (MICD), "co-occurring disorders," "coexisting disorders," "comorbid disorders," "concurrent disorders" (Canada), and "individuals with co-occurring psychiatric and substance symptomatology" (ICOPSS). Many of these terms are historical terms, no longer in routine use.

For the sake of consistency with national trends, *The ASAM Criteria* has adopted the term "co-occurring mental health and substance-related conditions and disorders." Throughout the text, the term "co-occurring disorders or conditions" refers to mental health and substance-related conditions, unless specifically otherwise stated. A more extensive discussion related to co-occurring disorders or conditions, including expanded definitions for terms such as "Co-Occurring Capability," "Co-Occurring Enhanced," and "Complexity Capability," can be found in the "Integrated Services" sections of Chapter 2.

## **"WITHDRAWAL MANAGEMENT"**

This refers to the services required for Dimension 1: Acute Intoxication and/or Withdrawal Potential. Previously referred to as "detoxification services," *The ASAM Criteria*, Third Edition, more accurately describes services to assist a patient's withdrawal. The liver detoxifies, but clinicians manage withdrawal. If the person is intoxicated and not yet in withdrawal, the Dimension 1 services needed would be termed "Intoxication Management."

## **"OPIOID TREATMENT SERVICES"**

In the *ASAM PPC-2R* (2001), a chapter titled "Opioid Maintenance Therapy" was focused solely on opioid agonist medications—methadone and LAAM (levo-alpha-acetylmethadol). LAAM is no longer used in the United States, and buprenorphine is now available as a pharmacological therapy for opioid addiction. In addition, previous editions of ASAM's criteria did not address opioid antagonist medications to treat opioid addiction, such as naltrexone (which has been available in an oral tablet form since the 1970s). The new title for this chapter, "Opioid Treatment Services," is intended to broaden the term to include all medications used to treat opioid use disorders and the psychosocial services that are offered concurrently with these pharmacotherapies.

Within this chapter, Opioid Treatment Programs (OTP) and Office-Based Opioid Treatment (OBOT) are explained.

## **"LEVEL 3.3: CLINICALLY MANAGED POPULATION-SPECIFIC HIGH-INTENSITY RESIDENTIAL SERVICES"**

The adult level of care, Level 3.3, has been renamed and changed from its original description as "Clinically Managed Medium-Intensity Residential Treatment." Treatment is specific to persons with cognitive difficulties needing more specialized, individualized services. The cognitive impairments manifested in patients most appropriately treated in Level 3.3 services can be due to aging, traumatic brain injury, acute but lasting injury, or due to illness. Level 3.3 is described in more detail in Chapter 7.



## INCORPORATION BY REFERENCE SYNOPSIS

**In compliance with Section 67-5223(4), Idaho Code**, the following is a synopsis of the differences between the materials previously incorporated by reference in this rule that are currently in full force and effect and newly revised or amended versions of these same materials that are being proposed for incorporation by reference under this rulemaking.

The following agency of the State of Idaho has prepared this synopsis as part of the proposed rulemaking for the chapter cited here under the docket number specified:

**DEPARTMENT OF HEALTH AND WELFARE**  
**IDAPA 16.07.50, “Minimum Standards for Nonhospital, Medically Monitored**  
**Detoxification/Mental Health Diversion Units”**  
**Docket No. 16-0750-1801**

*(Include a brief description that explains the differences between the version of the materials or documents that are currently incorporated by reference and the materials or documents that are being proposed for adoption in this rulemaking.)*

*(You may use the following table or write a brief summary of the differences)*

Incorporated Document Version/URL	IDAPA Section Number	Current Version of Incorporated Document	Substantive Changes in New Incorporation by Reference Version
DSM-IV-TR (no URL available)	004.	American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, DSM-IV- TR (2000)	See attached for summary of changes to the Fifth Edition of the DSM to be incorporated by reference, effective July 1, 2019.



# Highlights of Changes from DSM-IV-TR to DSM-5



Changes made to the DSM-5 diagnostic criteria and texts are outlined in this chapter in the same order in which they appear in the DSM-5 classification. This is not an exhaustive guide; minor changes in text or wording made for clarity are not described here. It should also be noted that Section I of DSM-5 contains a description of changes pertaining to the chapter organization in DSM-5, the multiaxial system, and the introduction of dimensional assessments (in Section III).

## Terminology

The phrase “general medical condition” is replaced in DSM-5 with “another medical condition” where relevant across all disorders.

## Neurodevelopmental Disorders

### Intellectual Disability (Intellectual Developmental Disorder)

Diagnostic criteria for intellectual disability (intellectual developmental disorder) emphasize the need for an assessment of both cognitive capacity (IQ) and adaptive functioning. Severity is determined by adaptive functioning rather than IQ score. The term mental retardation was used in DSM-IV. However, *intellectual disability* is the term that has come into common use over the past two decades among medical, educational, and other professionals, and by the lay public and advocacy groups. Moreover, a federal statute in the United States (Public Law 111-256, Rosa’s Law) replaces the term “mental retardation with intellectual disability. Despite the name change, the deficits in cognitive capacity beginning in the developmental period, with the accompanying diagnostic criteria, are considered to constitute a mental disorder. The term *intellectual developmental disorder* was placed in parentheses to reflect the World Health Organization’s classification system, which lists “disorders” in the International Classification of Diseases (ICD; ICD-11 to be released in 2015) and bases all “disabilities” on the International Classification of Functioning, Disability, and Health (ICF). Because the ICD-11 will not be adopted for several years, *intellectual disability* was chosen as the current preferred term with the bridge term for the future in parentheses.

### Communication Disorders

The DSM-5 communication disorders include language disorder (which combines DSM-IV expressive and mixed receptive-expressive language disorders), speech sound disorder (a new name for phonological disorder), and childhood-onset fluency disorder (a new name for stuttering). Also included is social (pragmatic) communication disorder, a new condition for persistent difficulties in the social uses of verbal and nonverbal communication. Because social communication deficits are one component of autism spectrum disorder (ASD), it is important to note that social (pragmatic) communication disorder cannot be diagnosed in the presence of restricted repetitive behaviors, interests, and activities (the other component of ASD). The symptoms of some patients diagnosed with DSM-IV pervasive developmental disorder not otherwise specified may meet the DSM-5 criteria for social communication disorder.

### Autism Spectrum Disorder

Autism spectrum disorder is a new DSM-5 name that reflects a scientific consensus that four previously separate disorders are actually a single condition with different levels of symptom severity in two core

domains. ASD now encompasses the previous DSM-IV autistic disorder (autism), Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. ASD is characterized by 1) deficits in social communication and social interaction and 2) restricted repetitive behaviors, interests, and activities (RRBs). Because both components are required for diagnosis of ASD, social communication disorder is diagnosed if no RRBs are present.

### **Attention-Deficit/Hyperactivity Disorder**

The diagnostic criteria for attention-deficit/hyperactivity disorder (ADHD) in DSM-5 are similar to those in DSM-IV. The same 18 symptoms are used as in DSM-IV, and continue to be divided into two symptom domains (inattention and hyperactivity/impulsivity), of which at least six symptoms in one domain are required for diagnosis. However, several changes have been made in DSM-5: 1) examples have been added to the criterion items to facilitate application across the life span; 2) the cross-situational requirement has been strengthened to "several" symptoms in each setting; 3) the onset criterion has been changed from "symptoms that caused impairment were present before age 7 years" to "several inattentive or hyperactive-impulsive symptoms were present prior to age 12"; 4) subtypes have been replaced with presentation specifiers that map directly to the prior subtypes; 5) a comorbid diagnosis with autism spectrum disorder is now allowed; and 6) a symptom threshold change has been made for adults, to reflect their substantial evidence of clinically significant ADHD impairment, with the cutoff for ADHD of five symptoms, instead of six required for younger persons, both for inattention and for hyperactivity and impulsivity. Finally, ADHD was placed in the neurodevelopmental disorders chapter to reflect brain developmental correlates with ADHD and the DSM-5 decision to eliminate the DSM-IV chapter that includes all diagnoses usually first made in infancy, childhood, or adolescence.

### **Specific Learning Disorder**

Specific learning disorder combines the DSM-IV diagnoses of reading disorder, mathematics disorder, disorder of written expression, and learning disorder not otherwise specified. Because learning deficits in the areas of reading, written expression, and mathematics commonly occur together, coded specifiers for the deficit types in each area are included. The text acknowledges that specific types of reading deficits are described internationally in various ways as dyslexia and specific types of mathematics deficits as dyscalculia.

### **Motor Disorders**

The following motor disorders are included in the DSM-5 neurodevelopmental disorders chapter: developmental coordination disorder, stereotypic movement disorder, Tourette's disorder, persistent (chronic) motor or vocal tic disorder, provisional tic disorder, other specified tic disorder, and unspecified tic disorder. The tic criteria have been standardized across all of these disorders in this chapter. Stereotypic movement disorder has been more clearly differentiated from body-focused repetitive behavior disorders that are in the DSM-5 obsessive-compulsive disorder chapter.

## **Schizophrenia Spectrum and Other Psychotic Disorders**

### **Schizophrenia**

Two changes were made to DSM-IV Criterion A for schizophrenia. The first change is the elimination of the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations (e.g., two or more voices conversing). In DSM-IV, only one such symptom was needed to meet the diagnostic requirement for Criterion A, instead of two of the other listed symptoms. This special attribution was

removed due to the nonspecificity of Schneiderian symptoms and the poor reliability in distinguishing bizarre from nonbizarre delusions. Therefore, in DSM-5, two Criterion A symptoms are required for any diagnosis of schizophrenia. The second change is the addition of a requirement in Criterion A that the individual must have at least one of these three symptoms: delusions, hallucinations, and disorganized speech. At least one of these core “positive symptoms” is necessary for a reliable diagnosis of schizophrenia.

### **Schizophrenia subtypes**

The DSM-IV subtypes of schizophrenia (i.e., paranoid, disorganized, catatonic, undifferentiated, and residual types) are eliminated due to their limited diagnostic stability, low reliability, and poor validity. These subtypes also have not been shown to exhibit distinctive patterns of treatment response or longitudinal course. Instead, a dimensional approach to rating severity for the core symptoms of schizophrenia is included in Section III to capture the important heterogeneity in symptom type and severity expressed across individuals with psychotic disorders.

### **Schizoaffective Disorder**

The primary change to schizoaffective disorder is the requirement that a major mood episode be present for a majority of the disorder’s total duration after Criterion A has been met. This change was made on both conceptual and psychometric grounds. It makes schizoaffective disorder a longitudinal instead of a cross-sectional diagnosis—more comparable to schizophrenia, bipolar disorder, and major depressive disorder, which are bridged by this condition. The change was also made to improve the reliability, diagnostic stability, and validity of this disorder, while recognizing that the characterization of patients with both psychotic and mood symptoms, either concurrently or at different points in their illness, has been a clinical challenge.

### **Delusional Disorder**

Criterion A for delusional disorder no longer has the requirement that the delusions must be non-bizarre. A specifier for bizarre type delusions provides continuity with DSM-IV. The demarcation of delusional disorder from psychotic variants of obsessive-compulsive disorder and body dysmorphic disorder is explicitly noted with a new exclusion criterion, which states that the symptoms must not be better explained by conditions such as obsessive-compulsive or body dysmorphic disorder with absent insight/delusional beliefs. DSM-5 no longer separates delusional disorder from shared delusional disorder. If criteria are met for delusional disorder then that diagnosis is made. If the diagnosis cannot be made but shared beliefs are present, then the diagnosis “other specified schizophrenia spectrum and other psychotic disorder” is used.

### **Catatonia**

The same criteria are used to diagnose catatonia whether the context is a psychotic, bipolar, depressive, or other medical disorder, or an unidentified medical condition. In DSM-IV, two out of five symptom clusters were required if the context was a psychotic or mood disorder, whereas only one symptom cluster was needed if the context was a general medical condition. In DSM-5, all contexts require three catatonic symptoms (from a total of 12 characteristic symptoms). In DSM-5, catatonia may be diagnosed as a specifier for depressive, bipolar, and psychotic disorders; as a separate diagnosis in the context of another medical condition; or as an other specified diagnosis.

## Bipolar and Related Disorders

### Bipolar Disorders

To enhance the accuracy of diagnosis and facilitate earlier detection in clinical settings, Criterion A for manic and hypomanic episodes now includes an emphasis on changes in activity and energy as well as mood. The DSM-IV diagnosis of bipolar I disorder, mixed episode, requiring that the individual simultaneously meet full criteria for both mania and major depressive episode, has been removed. Instead, a new specifier, “with mixed features,” has been added that can be applied to episodes of mania or hypomania when depressive features are present, and to episodes of depression in the context of major depressive disorder or bipolar disorder when features of mania/hypomania are present.

### Other Specified Bipolar and Related Disorder

DSM-5 allows the specification of particular conditions for other specified bipolar and related disorder, including categorization for individuals with a past history of a major depressive disorder who meet all criteria for hypomania except the duration criterion (i.e., at least 4 consecutive days). A second condition constituting an other specified bipolar and related disorder is that too few symptoms of hypomania are present to meet criteria for the full bipolar II syndrome, although the duration is sufficient at 4 or more days.

### Anxious Distress Specifier

In the chapter on bipolar and related disorders and the chapter on depressive disorders, a specifier for anxious distress is delineated. This specifier is intended to identify patients with anxiety symptoms that are not part of the bipolar diagnostic criteria.

## Depressive Disorders

DSM-5 contains several new depressive disorders, including disruptive mood dysregulation disorder and premenstrual dysphoric disorder. To address concerns about potential overdiagnosis and overtreatment of bipolar disorder in children, a new diagnosis, disruptive mood dysregulation disorder, is included for children up to age 18 years who exhibit persistent irritability and frequent episodes of extreme behavioral dyscontrol. Based on strong scientific evidence, premenstrual dysphoric disorder has been moved from DSM-IV Appendix B, “Criteria Sets and Axes Provided for Further Study,” to the main body of DSM-5. Finally, DSM-5 conceptualizes chronic forms of depression in a somewhat modified way. What was referred to as dysthymia in DSM-IV now falls under the category of persistent depressive disorder, which includes both chronic major depressive disorder and the previous dysthymic disorder. An inability to find scientifically meaningful differences between these two conditions led to their combination with specifiers included to identify different pathways to the diagnosis and to provide continuity with DSM-IV.

### Major Depressive Disorder

Neither the core criterion symptoms applied to the diagnosis of major depressive episode nor the requisite duration of at least 2 weeks has changed from DSM-IV. Criterion A for a major depressive episode in DSM-5 is identical to that of DSM-IV, as is the requirement for clinically significant distress or impairment in social, occupational, or other important areas of life, although this is now listed as Criterion B rather than Criterion C. The coexistence within a major depressive episode of at least three manic symptoms (insufficient to satisfy criteria for a manic episode) is now acknowledged by the specifier “with mixed features.” The presence of mixed features in an episode of major depressive disorder in-

creases the likelihood that the illness exists in a bipolar spectrum; however, if the individual concerned has never met criteria for a manic or hypomanic episode, the diagnosis of major depressive disorder is retained.

### **Bereavement Exclusion**

In DSM-IV, there was an exclusion criterion for a major depressive episode that was applied to depressive symptoms lasting less than 2 months following the death of a loved one (i.e., the bereavement exclusion). This exclusion is omitted in DSM-5 for several reasons. The first is to remove the implication that bereavement typically lasts only 2 months when both physicians and grief counselors recognize that the duration is more commonly 1–2 years. Second, bereavement is recognized as a severe psychosocial stressor that can precipitate a major depressive episode in a vulnerable individual, generally beginning soon after the loss. When major depressive disorder occurs in the context of bereavement, it adds an additional risk for suffering, feelings of worthlessness, suicidal ideation, poorer somatic health, worse interpersonal and work functioning, and an increased risk for persistent complex bereavement disorder, which is now described with explicit criteria in Conditions for Further Study in DSM-5 Section III. Third, bereavement-related major depression is most likely to occur in individuals with past personal and family histories of major depressive episodes. It is genetically influenced and is associated with similar personality characteristics, patterns of comorbidity, and risks of chronicity and/or recurrence as non-bereavement-related major depressive episodes. Finally, the depressive symptoms associated with bereavement-related depression respond to the same psychosocial and medication treatments as non-bereavement-related depression. In the criteria for major depressive disorder, a detailed footnote has replaced the more simplistic DSM-IV exclusion to aid clinicians in making the critical distinction between the symptoms characteristic of bereavement and those of a major depressive episode. Thus, although most people experiencing the loss of a loved one experience bereavement without developing a major depressive episode, evidence does not support the separation of loss of a loved one from other stressors in terms of its likelihood of precipitating a major depressive episode or the relative likelihood that the symptoms will remit spontaneously.

### **Specifiers for Depressive Disorders**

Suicidality represents a critical concern in psychiatry. Thus, the clinician is given guidance on assessment of suicidal thinking, plans, and the presence of other risk factors in order to make a determination of the prominence of suicide prevention in treatment planning for a given individual. A new specifier to indicate the presence of mixed symptoms has been added across both the bipolar and the depressive disorders, allowing for the possibility of manic features in individuals with a diagnosis of unipolar depression. A substantial body of research conducted over the last two decades points to the importance of anxiety as relevant to prognosis and treatment decision making. The “with anxious distress” specifier gives the clinician an opportunity to rate the severity of anxious distress in all individuals with bipolar or depressive disorders.

## **Anxiety Disorders**

The DSM-5 chapter on anxiety disorder no longer includes obsessive-compulsive disorder (which is included with the obsessive-compulsive and related disorders) or posttraumatic stress disorder and acute stress disorder (which is included with the trauma- and stressor-related disorders). However, the sequential order of these chapters in DSM-5 reflects the close relationships among them.



### **Agoraphobia, Specific Phobia, and Social Anxiety Disorder (Social Phobia)**

Changes in criteria for agoraphobia, specific phobia, and social anxiety disorder (social phobia) include deletion of the requirement that individuals over age 18 years recognize that their anxiety is excessive or unreasonable. This change is based on evidence that individuals with such disorders often overestimate the danger in “phobic” situations and that older individuals often misattribute “phobic” fears to aging. Instead, the anxiety must be out of proportion to the actual danger or threat in the situation, after taking cultural contextual factors into account. In addition, the 6-month duration, which was limited to individuals under age 18 in DSM-IV, is now extended to all ages. This change is intended to minimize overdiagnosis of transient fears.

### **Panic Attack**

The essential features of panic attacks remain unchanged, although the complicated DSM-IV terminology for describing different types of panic attacks (i.e., situationally bound/cued, situationally predisposed, and unexpected/uncued) is replaced with the terms unexpected and expected panic attacks. Panic attacks function as a marker and prognostic factor for severity of diagnosis, course, and comorbidity across an array of disorders, including but not limited to anxiety disorders. Hence, panic attack can be listed as a specifier that is applicable to all DSM-5 disorders.

### **Panic Disorder and Agoraphobia**

Panic disorder and agoraphobia are unlinked in DSM-5. Thus, the former DSM-IV diagnoses of panic disorder with agoraphobia, panic disorder without agoraphobia, and agoraphobia without history of panic disorder are now replaced by two diagnoses, panic disorder and agoraphobia, each with separate criteria. The co-occurrence of panic disorder and agoraphobia is now coded with two diagnoses. This change recognizes that a substantial number of individuals with agoraphobia do not experience panic symptoms. The diagnostic criteria for agoraphobia are derived from the DSM-IV descriptors for agoraphobia, although endorsement of fears from two or more agoraphobia situations is now required, because this is a robust means for distinguishing agoraphobia from specific phobias. Also, the criteria for agoraphobia are extended to be consistent with criteria sets for other anxiety disorders (e.g., clinician judgment of the fears as being out of proportion to the actual danger in the situation, with a typical duration of 6 months or more).

### **Specific Phobia**

The core features of specific phobia remain the same, but there is no longer a requirement that individuals over age 18 years must recognize that their fear and anxiety are excessive or unreasonable, and the duration requirement (“typically lasting for 6 months or more”) now applies to all ages. Although they are now referred to as specifiers, the different types of specific phobia have essentially remained unchanged.

### **Social Anxiety Disorder (Social Phobia)**

The essential features of social anxiety disorder (social phobia) (formerly called social phobia) remain the same. However, a number of changes have been made, including deletion of the requirement that individuals over age 18 years must recognize that their fear or anxiety is excessive or unreasonable, and duration criterion of “typically lasting for 6 months or more” is now required for all ages. A more significant change is that the “generalized” specifier has been deleted and replaced with a “performance only” specifier. The DSM-IV generalized specifier was problematic in that “fears include most social situations” was difficult to operationalize. Individuals who fear only performance situations (i.e., speaking



or performing in front of an audience) appear to represent a distinct subset of social anxiety disorder in terms of etiology, age at onset, physiological response, and treatment response.

### **Separation Anxiety Disorder**

Although in DSM-IV, separation anxiety disorder was classified in the section “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence,” it is now classified as an anxiety disorder. The core features remain mostly unchanged, although the wording of the criteria has been modified to more adequately represent the expression of separation anxiety symptoms in adulthood. For example, attachment figures may include the children of adults with separation anxiety disorder, and avoidance behaviors may occur in the workplace as well as at school. Also, in contrast to DSM-IV, the diagnostic criteria no longer specify that age at onset must be before 18 years, because a substantial number of adults report onset of separation anxiety after age 18. Also, a duration criterion—“typically lasting for 6 months or more”—has been added for adults to minimize overdiagnosis of transient fears.

### **Selective Mutism**

In DSM-IV, selective mutism was classified in the section “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.” It is now classified as an anxiety disorder, given that a large majority of children with selective mutism are anxious. The diagnostic criteria are largely unchanged from DSM-IV.

## **Obsessive-Compulsive and Related Disorders**

The chapter on obsessive-compulsive and related disorders, which is new in DSM-5, reflects the increasing evidence that these disorders are related to one another in terms of a range of diagnostic validators, as well as the clinical utility of grouping these disorders in the same chapter. New disorders include hoarding disorder, excoriation (skin-picking) disorder, substance-/medication-induced obsessive-compulsive and related disorder, and obsessive-compulsive and related disorder due to another medical condition. The DSM-IV diagnosis of trichotillomania is now termed trichotillomania (hair-pulling disorder) and has been moved from a DSM-IV classification of impulse-control disorders not elsewhere classified to obsessive-compulsive and related disorders in DSM-5.

### **Specifiers for Obsessive-Compulsive and Related Disorders**

The “with poor insight” specifier for obsessive-compulsive disorder has been refined in DSM-5 to allow a distinction between individuals with good or fair insight, poor insight, and “absent insight/delusional” obsessive-compulsive disorder beliefs (i.e., complete conviction that obsessive-compulsive disorder beliefs are true). Analogous “insight” specifiers have been included for body dysmorphic disorder and hoarding disorder. These specifiers are intended to improve differential diagnosis by emphasizing that individuals with these two disorders may present with a range of insight into their disorder-related beliefs, including absent insight/delusional symptoms. This change also emphasizes that the presence of absent insight/delusional beliefs warrants a diagnosis of the relevant obsessive-compulsive or related disorder, rather than a schizophrenia spectrum and other psychotic disorder. The “tic-related” specifier for obsessive-compulsive disorder reflects a growing literature on the diagnostic validity and clinical utility of identifying individuals with a current or past comorbid tic disorder, because this comorbidity may have important clinical implications.

### **Body Dysmorphic Disorder**

For DSM-5 body dysmorphic disorder, a diagnostic criterion describing repetitive behaviors or mental

acts in response to preoccupations with perceived defects or flaws in physical appearance has been added, consistent with data indicating the prevalence and importance of this symptom. A “with muscle dysmorphia” specifier has been added to reflect a growing literature on the diagnostic validity and clinical utility of making this distinction in individuals with body dysmorphic disorder. The delusional variant of body dysmorphic disorder (which identifies individuals who are completely convinced that their perceived defects or flaws are truly abnormal appearing) is no longer coded as both delusional disorder, somatic type, and body dysmorphic disorder; in DSM-5 this presentation is designated only as body dysmorphic disorder with the absent insight/delusional beliefs specifier.

### **Hoarding Disorder**

Hoarding disorder is a new diagnosis in DSM-5. DSM-IV lists hoarding as one of the possible symptoms of obsessive-compulsive personality disorder and notes that extreme hoarding may occur in obsessive-compulsive disorder. However, available data do not indicate that hoarding is a variant of obsessive-compulsive disorder or another mental disorder. Instead, there is evidence for the diagnostic validity and clinical utility of a separate diagnosis of hoarding disorder, which reflects persistent difficulty discarding or parting with possessions due to a perceived need to save the items and distress associated with discarding them. Hoarding disorder may have unique neurobiological correlates, is associated with significant impairment, and may respond to clinical intervention.

### **Trichotillomania (Hair-Pulling Disorder)**

Trichotillomania was included in DSM-IV, although “hair-pulling disorder” has been added parenthetically to the disorder’s name in DSM-5.

### **Excoriation (Skin-Picking) Disorder**

Excoriation (skin-picking) disorder is newly added to DSM-5, with strong evidence for its diagnostic validity and clinical utility.

### **Substance/Medication-Induced Obsessive-Compulsive and Related Disorder and Obsessive-Compulsive and Related Disorder Due to Another Medical Condition**

DSM-IV included a specifier “with obsessive-compulsive symptoms” in the diagnoses of anxiety disorders due to a general medical condition and substance-induced anxiety disorders. Given that obsessive-compulsive and related disorders are now a distinct category, DSM-5 includes new categories for substance-/medication-induced obsessive-compulsive and related disorder and for obsessive-compulsive and related disorder due to another medical condition. This change is consistent with the intent of DSM-IV, and it reflects the recognition that substances, medications, and medical conditions can present with symptoms similar to primary obsessive-compulsive and related disorders.

### **Other Specified and Unspecified Obsessive-Compulsive and Related Disorders**

DSM-5 includes the diagnoses other specified obsessive-compulsive and related disorder, which can include conditions such as body-focused repetitive behavior disorder and obsessional jealousy, or unspecified obsessive-compulsive and related disorder. Body-focused repetitive behavior disorder is characterized by recurrent behaviors other than hair pulling and skin picking (e.g., nail biting, lip biting, cheek chewing) and repeated attempts to decrease or stop the behaviors. Obsessional jealousy is characterized by nondelusional preoccupation with a partner’s perceived infidelity.

## Trauma- and Stressor-Related Disorders

### Acute Stress Disorder

In DSM-5, the stressor criterion (Criterion A) for acute stress disorder is changed from DSM-IV. The criterion requires being explicit as to whether qualifying traumatic events were experienced directly, witnessed, or experienced indirectly. Also, the DSM-IV Criterion A2 regarding the subjective reaction to the traumatic event (e.g., “the person’s response involved intense fear, helplessness, or horror”) has been eliminated. Based on evidence that acute posttraumatic reactions are very heterogeneous and that DSM-IV’s emphasis on dissociative symptoms is overly restrictive, individuals may meet diagnostic criteria in DSM-5 for acute stress disorder if they exhibit any 9 of 14 listed symptoms in these categories: intrusion, negative mood, dissociation, avoidance, and arousal.

### Adjustment Disorders

In DSM-5, adjustment disorders are reconceptualized as a heterogeneous array of stress-response syndromes that occur after exposure to a distressing (traumatic or nontraumatic) event, rather than as a residual category for individuals who exhibit clinically significant distress without meeting criteria for a more discrete disorder (as in DSM-IV). DSM-IV subtypes marked by depressed mood, anxious symptoms, or disturbances in conduct have been retained, unchanged.

### Posttraumatic Stress Disorder

DSM-5 criteria for posttraumatic stress disorder differ significantly from those in DSM-IV. As described previously for acute stress disorder, the stressor criterion (Criterion A) is more explicit with regard to how an individual experienced “traumatic” events. Also, Criterion A2 (subjective reaction) has been eliminated. Whereas there were three major symptom clusters in DSM-IV—reexperiencing, avoidance/numbing, and arousal—there are now four symptom clusters in DSM-5, because the avoidance/numbing cluster is divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood. This latter category, which retains most of the DSM-IV numbing symptoms, also includes new or reconceptualized symptoms, such as persistent negative emotional states. The final cluster—alterations in arousal and reactivity—retains most of the DSM-IV arousal symptoms. It also includes irritable or aggressive behavior and reckless or self-destructive behavior. Posttraumatic stress disorder is now developmentally sensitive in that diagnostic thresholds have been lowered for children and adolescents. Furthermore, separate criteria have been added for children age 6 years or younger with this disorder.

### Reactive Attachment Disorder

The DSM-IV childhood diagnosis reactive attachment disorder had two subtypes: emotionally withdrawn/inhibited and indiscriminately social/disinhibited. In DSM-5, these subtypes are defined as distinct disorders: reactive attachment disorder and disinhibited social engagement disorder. Both of these disorders are the result of social neglect or other situations that limit a young child’s opportunity to form selective attachments. Although sharing this etiological pathway, the two disorders differ in important ways. Because of dampened positive affect, reactive attachment disorder more closely resembles internalizing disorders; it is essentially equivalent to a lack of or incompletely formed preferred attachments to caregiving adults. In contrast, disinhibited social engagement disorder more closely resembles ADHD; it may occur in children who do not necessarily lack attachments and may have established or even secure attachments. The two disorders differ in other important ways, including correlates, course, and response to intervention, and for these reasons are considered separate disorders.

## Dissociative Disorders

Major changes in dissociative disorders in DSM-5 include the following: 1) derealization is included in the name and symptom structure of what previously was called depersonalization disorder and is now called *depersonalization/derealization disorder*, 2) dissociative fugue is now a specifier of dissociative amnesia rather than a separate diagnosis, and 3) the criteria for dissociative identity disorder have been changed to indicate that symptoms of disruption of identity may be reported as well as observed, and that gaps in the recall of events may occur for everyday and not just traumatic events. Also, experiences of pathological possession in some cultures are included in the description of identity disruption.

### Dissociative Identity Disorder

Several changes to the criteria for dissociative identity disorder have been made in DSM-5. First, Criterion A has been expanded to include certain possession-form phenomena and functional neurological symptoms to account for more diverse presentations of the disorder. Second, Criterion A now specifically states that transitions in identity may be observable by others or self-reported. Third, according to Criterion B, individuals with dissociative identity disorder may have recurrent gaps in recall for everyday events, not just for traumatic experiences. Other text modifications clarify the nature and course of identity disruptions.

## Somatic Symptom and Related Disorders

In DSM-5, somatoform disorders are now referred to as somatic symptom and related disorders. In DSM-IV, there was significant overlap across the somatoform disorders and a lack of clarity about their boundaries. These disorders are primarily seen in medical settings, and nonpsychiatric physicians found the DSM-IV somatoform diagnoses problematic to use. The DSM-5 classification reduces the number of these disorders and subcategories to avoid problematic overlap. Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed.

### Somatic Symptom Disorder

DSM-5 better recognizes the complexity of the interface between psychiatry and medicine. Individuals with somatic symptoms plus abnormal thoughts, feelings, and behaviors *may or may not* have a diagnosed medical condition. The relationship between somatic symptoms and psychopathology exists along a spectrum, and the arbitrarily high symptom count required for DSM-IV somatization disorder did not accommodate this spectrum. The diagnosis of somatization disorder was essentially based on a long and complex symptom count of medically unexplained symptoms. Individuals previously diagnosed with somatization disorder will usually meet DSM-5 criteria for somatic symptom disorder, but only if they have the maladaptive thoughts, feelings, and behaviors that define the disorder, in addition to their somatic symptoms.

In DSM-IV, the diagnosis undifferentiated somatoform disorder had been created in recognition that somatization disorder would only describe a small minority of “somatizing” individuals, but this disorder did not prove to be a useful clinical diagnosis. Because the distinction between somatization disorder and undifferentiated somatoform disorder was arbitrary, they are merged in DSM-5 under somatic symptom disorder, and no specific number of somatic symptoms is required.

### Medically Unexplained Symptoms

DSM-IV criteria overemphasized the importance of an absence of a medical explanation for the somatic symptoms. Unexplained symptoms are present to various degrees, particularly in conversion disorder,

but somatic symptom disorders can also accompany diagnosed medical disorders. The reliability of medically unexplained symptoms is limited, and grounding a diagnosis on the absence of an explanation is problematic and reinforces mind-body dualism. The DSM-5 classification defines disorders on the basis of positive symptoms (i.e., distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms). Medically unexplained symptoms do remain a key feature in conversion disorder and pseudocyesis because it is possible to demonstrate definitively in such disorders that the symptoms are not consistent with medical pathophysiology.

### **Hypochondriasis and Illness Anxiety Disorder**

Hypochondriasis has been eliminated as a disorder, in part because the name was perceived as pejorative and not conducive to an effective therapeutic relationship. Most individuals who would previously have been diagnosed with hypochondriasis have significant somatic symptoms in addition to their high health anxiety, and would now receive a DSM-5 diagnosis of somatic symptom disorder. In DSM-5, individuals with high health anxiety without somatic symptoms would receive a diagnosis of illness anxiety disorder (unless their health anxiety was better explained by a primary anxiety disorder, such as generalized anxiety disorder).

### **Pain Disorder**

DSM-5 takes a different approach to the important clinical realm of individuals with pain. In DSM-IV, the pain disorder diagnoses assume that some pains are associated solely with psychological factors, some with medical diseases or injuries, and some with both. There is a lack of evidence that such distinctions can be made with reliability and validity, and a large body of research has demonstrated that psychological factors influence all forms of pain. Most individuals with chronic pain attribute their pain to a combination of factors, including somatic, psychological, and environmental influences. In DSM-5, some individuals with chronic pain would be appropriately diagnosed as having somatic symptom disorder, with predominant pain. For others, psychological factors affecting other medical conditions or an adjustment disorder would be more appropriate.

### **Psychological Factors Affecting Other Medical Conditions and Factitious Disorder**

Psychological factors affecting other medical conditions is a new mental disorder in DSM-5, having formerly been included in the DSM-IV chapter “Other Conditions That May Be a Focus of Clinical Attention.” This disorder and factitious disorder are placed among the somatic symptom and related disorders because somatic symptoms are predominant in both disorders, and both are most often encountered in medical settings. The variants of psychological factors affecting other medical conditions are removed in favor of the stem diagnosis.

### **Conversion Disorder (Functional Neurological Symptom Disorder)**

Criteria for conversion disorder (functional neurological symptom disorder) are modified to emphasize the essential importance of the neurological examination, and in recognition that relevant psychological factors may not be demonstrable at the time of diagnosis.

## **Feeding and Eating Disorders**

In DSM-5, the feeding and eating disorders include several disorders included in DSM-IV as feeding and eating disorders of infancy or early childhood in the chapter “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.” In addition, brief descriptions and preliminary diagnostic criteria are provided for several conditions under other specified feeding and eating disorder; insufficient informa-

tion about these conditions is currently available to document their clinical characteristics and validity or to provide definitive diagnostic criteria.

### **Pica and Rumination Disorder**

The DSM-IV criteria for pica and for rumination disorder have been revised for clarity and to indicate that the diagnoses can be made for individuals of any age.

### **Avoidant/Restrictive Food Intake Disorder**

DSM-IV feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder, and the criteria have been significantly expanded. The DSM-IV disorder was rarely used, and limited information is available on the characteristics, course, and outcome of children with this disorder. Additionally, a large number of individuals, primarily but not exclusively children and adolescents, substantially restrict their food intake and experience significant associated physiological or psychosocial problems but do not meet criteria for any DSM-IV eating disorder. Avoidant/restrictive food intake disorder is a broad category intended to capture this range of presentations.

### **Anorexia Nervosa**

The core diagnostic criteria for anorexia nervosa are conceptually unchanged from DSM-IV with one exception: the requirement for amenorrhea has been eliminated. In DSM-IV, this requirement was waived in a number of situations (e.g., for males, for females taking contraceptives). In addition, the clinical characteristics and course of females meeting all DSM-IV criteria for anorexia nervosa except amenorrhea closely resemble those of females meeting all DSM-IV criteria. As in DSM-IV, individuals with this disorder are required by Criterion A to be at a significantly low body weight for their developmental stage. The wording of the criterion has been changed for clarity, and guidance regarding how to judge whether an individual is at or below a significantly low weight is now provided in the text. In DSM-5, Criterion B is expanded to include not only overtly expressed fear of weight gain but also persistent behavior that interferes with weight gain.

### **Bulimia Nervosa**

The only change to the DSM-IV criteria for bulimia nervosa is a reduction in the required minimum average frequency of binge eating and inappropriate compensatory behavior frequency from twice to once weekly. The clinical characteristics and outcome of individuals meeting this slightly lower threshold are similar to those meeting the DSM-IV criterion.

### **Binge-Eating Disorder**

Extensive research followed the promulgation of preliminary criteria for binge eating disorder in Appendix B of DSM-IV, and findings supported the clinical utility and validity of binge-eating disorder. The only significant difference from the preliminary DSM-IV criteria is that the minimum average frequency of binge eating required for diagnosis has been changed from at least twice weekly for 6 months to at least once weekly over the last 3 months, which is identical to the DSM-5 frequency criterion for bulimia nervosa.

### **Elimination Disorders**

No significant changes have been made to the elimination disorders diagnostic class from DSM-IV to DSM-5. The disorders in this chapter were previously classified under disorders usually first diagnosed in infancy, childhood, or adolescence in DSM-IV and exist now as an independent classification in DSM-5.



## Sleep-Wake Disorders

Because of the DSM-5 mandate for concurrent specification of coexisting conditions (medical and mental), sleep disorders related to another mental disorder and sleep disorder related to a general medical condition have been removed from DSM-5, and greater specification of coexisting conditions is provided for each sleep-wake disorder. This change underscores that the individual has a sleep disorder warranting independent clinical attention, in addition to any medical and mental disorders that are also present, and acknowledges the bidirectional and interactive effects between sleep disorders and coexisting medical and mental disorders. This reconceptualization reflects a paradigm shift that is widely accepted in the field of sleep disorders medicine. It moves away from making causal attributions between coexisting disorders. Any additional relevant information from the prior diagnostic categories of sleep disorder related to another mental disorder and sleep disorder related to another medical condition has been integrated into the other sleep-wake disorders where appropriate.

Consequently, in DSM-5, the diagnosis of primary insomnia has been renamed insomnia disorder to avoid the differentiation of primary and secondary insomnia. DSM-5 also distinguishes narcolepsy, which is now known to be associated with hypocretin deficiency, from other forms of hypersomnolence. These changes are warranted by neurobiological and genetic evidence validating this reorganization. Finally, throughout the DSM-5 classification of sleep-wake disorders, pediatric and developmental criteria and text are integrated where existing science and considerations of clinical utility support such integration. This developmental perspective encompasses age-dependent variations in clinical presentation.

### Breathing-Related Sleep Disorders

In DSM-5, breathing-related sleep disorders are divided into three relatively distinct disorders: obstructive sleep apnea hypopnea, central sleep apnea, and sleep-related hypoventilation. This change reflects the growing understanding of pathophysiology in the genesis of these disorders and, furthermore, has relevance to treatment planning.

### Circadian Rhythm Sleep-Wake Disorders

The subtypes of circadian rhythm sleep-wake disorders have been expanded to include advanced sleep phase syndrome, irregular sleep-wake type, and non-24-hour sleep-wake type, whereas the jet lag type has been removed.

### Rapid Eye Movement Sleep Behavior Disorder and Restless Legs Syndrome

The use of DSM-IV “not otherwise specified” diagnoses has been reduced by designating rapid eye movement sleep behavior disorder and restless legs syndrome as independent disorders. In DSM-IV, both were included under dyssomnia not otherwise specified. Their full diagnostic status is supported by research evidence.

## Sexual Dysfunctions

In DSM-IV, sexual dysfunctions referred to sexual pain or to a disturbance in one or more phases of the sexual response cycle. Research suggests that sexual response is not always a linear, uniform process and that the distinction between certain phases (e.g., desire and arousal) may be artificial. In DSM-5, gender-specific sexual dysfunctions have been added, and, for females, sexual desire and arousal disorders have been combined into one disorder: female sexual interest/arousal disorder.

To improve precision regarding duration and severity criteria and to reduce the likelihood of overdiag-



nosis, all of the DSM-5 sexual dysfunctions (except substance-/medication-induced sexual dysfunction) now require a minimum duration of approximately 6 months and more precise severity criteria. These changes provide useful thresholds for making a diagnosis and distinguish transient sexual difficulties from more persistent sexual dysfunction.

### **Genito-Pelvic Pain/Penetration Disorder**

Genito-pelvic pain/penetration disorder is new in DSM-5 and represents a merging of the DSM-IV categories of vaginismus and dyspareunia, which were highly comorbid and difficult to distinguish. The diagnosis of sexual aversion disorder has been removed due to rare use and lack of supporting research.

### **Subtypes**

DSM-IV included the following subtypes for all sexual disorders: lifelong versus acquired, generalized versus situational, and due to psychological factors versus due to combined factors. DSM-5 includes only lifelong versus acquired and generalized versus situational subtypes. Sexual dysfunction due to a general medical condition and the subtype due to psychological versus combined factors have been deleted due to findings that the most frequent clinical presentation is one in which both psychological and biological factors contribute. To indicate the presence and degree of medical and other nonmedical correlates, the following associated features are described in the accompanying text: partner factors, relationship factors, individual vulnerability factors, cultural or religious factors, and medical factors.

## **Gender Dysphoria**

Gender dysphoria is a new diagnostic class in DSM-5 and reflects a change in conceptualization of the disorder's defining features by emphasizing the phenomenon of "gender incongruence" rather than cross-gender identification per se, as was the case in DSM-IV gender identity disorder. In DSM-IV, the chapter "Sexual and Gender Identity Disorders" included three relatively disparate diagnostic classes: gender identity disorders, sexual dysfunctions, and paraphilias. Gender identity disorder, however, is neither a sexual dysfunction nor a paraphilia. Gender dysphoria is a unique condition in that it is a diagnosis made by mental health care providers, although a large proportion of the treatment is endocrinological and surgical (at least for some adolescents and most adults). In contrast to the dichotomized DSM-IV gender identity disorder diagnosis, the type and severity of gender dysphoria can be inferred from the number and type of indicators and from the severity measures.

The experienced gender incongruence and resulting gender dysphoria may take many forms. Gender dysphoria thus is considered to be a multcategory concept rather than a dichotomy, and DSM-5 acknowledges the wide variation of gender -incongruent conditions. Separate criteria sets are provided for gender dysphoria in children and in adolescents and adults. The adolescent and adult criteria include a more detailed and specific set of polythetic symptoms. The previous Criterion A (cross-gender identification) and Criterion B (aversion toward one's gender) have been merged, because no supporting evidence from factor analytic studies supported keeping the two separate. In the wording of the criteria, "the other sex" is replaced by "some alternative gender." Gender instead of sex is used systematically because the concept "sex" is inadequate when referring to individuals with a disorder of sex development.

In the child criteria, "strong desire to be of the other gender" replaces the previous "repeatedly stated desire" to capture the situation of some children who, in a coercive environment, may not verbalize the desire to be of another gender. For children, Criterion A1 ("a strong desire to be of the other gender or

an insistence that he or she is the other gender . . .)” is now necessary (but not sufficient), which makes the diagnosis more restrictive and conservative.

### **Subtypes and Specifiers**

The subtyping on the basis of sexual orientation has been removed because the distinction is not considered clinically useful. A posttransition specifier has been added because many individuals, after transition, no longer meet criteria for gender dysphoria; however, they continue to undergo various treatments to facilitate life in the desired gender. Although the concept of posttransition is modeled on the concept of full or partial remission, the term remission has implications in terms of symptom reduction that do not apply directly to gender dysphoria.

## **Disruptive, Impulse-Control, and Conduct Disorders**

The chapter on disruptive, impulse-control, and conduct disorders is new to DSM-5. It brings together disorders that were previously included in the chapter “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence” (i.e., oppositional defiant disorder; conduct disorder; and disruptive behavior disorder not otherwise specified, now categorized as other specified and unspecified disruptive, impulse-control, and conduct disorders) and the chapter “Impulse-Control Disorders Not Otherwise Specified” (i.e., intermittent explosive disorder, pyromania, and kleptomania). These disorders are all characterized by problems in emotional and behavioral self-control. Because of its close association with conduct disorder, antisocial personality disorder has dual listing in this chapter and in the chapter on personality disorders. Of note, ADHD is frequently comorbid with the disorders in this chapter but is listed with the neurodevelopmental disorders.

### **Oppositional Defiant Disorder**

Four refinements have been made to the criteria for oppositional defiant disorder. First, symptoms are now grouped into three types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness. This change highlights that the disorder reflects both emotional and behavioral symptomatology. Second, the exclusion criterion for conduct disorder has been removed. Third, given that many behaviors associated with symptoms of oppositional defiant disorder occur commonly in normally developing children and adolescents, a note has been added to the criteria to provide guidance on the frequency typically needed for a behavior to be considered symptomatic of the disorder. Fourth, a severity rating has been added to the criteria to reflect research showing that the degree of pervasiveness of symptoms across settings is an important indicator of severity.

### **Conduct Disorder**

The criteria for conduct disorder are largely unchanged from DSM-IV. A descriptive features specifier has been added for individuals who meet full criteria for the disorder but also present with limited prosocial emotions. This specifier applies to those with conduct disorder who show a callous and unemotional interpersonal style across multiple settings and relationships. The specifier is based on research showing that individuals with conduct disorder who meet criteria for the specifier tend to have a relatively more severe form of the disorder and a different treatment response.

### **Intermittent Explosive Disorder**

The primary change in DSM-5 intermittent explosive disorder is the type of aggressive outbursts that should be considered: physical aggression was required in DSM-IV, whereas verbal aggression and non-destructive/noninjurious physical aggression also meet criteria in DSM-5. DSM-5 also provides more

specific criteria defining frequency needed to meet criteria and specifies that the aggressive outbursts are impulsive and/or anger based in nature, and must cause marked distress, cause impairment in occupational or interpersonal functioning, or be associated with negative financial or legal consequences. Furthermore, because of the paucity of research on this disorder in young children and the potential difficulty of distinguishing these outbursts from normal temper tantrums in young children, a minimum age of 6 years (or equivalent developmental level) is now required. Finally, especially for youth, the relationship of this disorder to other disorders (e.g., ADHD, disruptive mood dysregulation disorder) has been further clarified.

## Substance-Related and Addictive Disorders

### Gambling Disorder

An important departure from past diagnostic manuals is that the substance-related disorders chapter has been expanded to include gambling disorder. This change reflects the increasing and consistent evidence that some behaviors, such as gambling, activate the brain reward system with effects similar to those of drugs of abuse and that gambling disorder symptoms resemble substance use disorders to a certain extent.

### Criteria and Terminology

DSM-5 does not separate the diagnoses of substance abuse and dependence as in DSM-IV. Rather, criteria are provided for substance use disorder, accompanied by criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, where relevant. The DSM-5 substance use disorder criteria are nearly identical to the DSM-IV substance abuse and dependence criteria combined into a single list, with two exceptions. The DSM-IV recurrent legal problems criterion for substance abuse has been deleted from DSM-5, and a new criterion, craving or a strong desire or urge to use a substance, has been added. In addition, the threshold for substance use disorder diagnosis in DSM-5 is set at two or more criteria, in contrast to a threshold of one or more criteria for a diagnosis of DSM-IV substance abuse and three or more for DSM-IV substance dependence. Cannabis withdrawal is new for DSM-5, as is caffeine withdrawal (which was in DSM-IV Appendix B, “Criteria Sets and Axes Provided for Further Study”). Of note, the criteria for DSM-5 tobacco use disorder are the same as those for other substance use disorders. By contrast, DSM-IV did not have a category for tobacco abuse, so the criteria in DSM-5 that are from DSM-IV abuse are new for tobacco in DSM-5. Severity of the DSM-5 substance use disorders is based on the number of criteria endorsed: 2–3 criteria indicate a mild disorder; 4–5 criteria, a moderate disorder; and 6 or more, a severe disorder. The DSM-IV specifier for a physiological subtype has been eliminated in DSM-5, as has the DSM-IV diagnosis of polysubstance dependence. Early remission from a DSM-5 substance use disorder is defined as at least 3 but less than 12 months without substance use disorder criteria (except craving), and sustained remission is defined as at least 12 months without criteria (except craving). Additional new DSM-5 specifiers include “in a controlled environment” and “on maintenance therapy” as the situation warrants.

## Neurocognitive Disorders

### Delirium

The criteria for delirium have been updated and clarified on the basis of currently available evidence.

### Major and Mild Neurocognitive Disorder

The DSM-IV diagnoses of dementia and amnesic disorder are subsumed under the newly named entity

major neurocognitive disorder (NCD). The term dementia is not precluded from use in the etiological subtypes where that term is standard. Furthermore, DSM-5 now recognizes a less severe level of cognitive impairment, mild NCD, which is a new disorder that permits the diagnosis of less disabling syndromes that may nonetheless be the focus of concern and treatment. Diagnostic criteria are provided for both major NCD and mild NCD, followed by diagnostic criteria for the different etiological subtypes. An updated listing of neurocognitive domains is also provided in DSM-5, as these are necessary for establishing the presence of NCD, distinguishing between the major and mild levels of impairment, and differentiating among etiological subtypes.

Although the threshold between mild NCD and major NCD is inherently arbitrary, there are important reasons to consider these two levels of impairment separately. The major NCD syndrome provides consistency with the rest of medicine and with prior DSM editions and necessarily remains distinct to capture the care needs for this group. Although the mild NCD syndrome is new to DSM-5, its presence is consistent with its use in other fields of medicine, where it is a significant focus of care and research, notably in individuals with Alzheimer's disease, cerebrovascular disorders, HIV, and traumatic brain injury.

### **Etiological Subtypes**

In DSM-IV, individual criteria sets were designated for dementia of the Alzheimer's type, vascular dementia, and substance-induced dementia, whereas the other neurodegenerative disorders were classified as dementia due to another medical condition, with HIV, head trauma, Parkinson's disease, Huntington's disease, Pick's disease, Creutzfeldt-Jakob disease, and other medical conditions specified. In DSM-5, major or mild vascular NCD and major or mild NCD due to Alzheimer's disease have been retained, whereas new separate criteria are now presented for major or mild NCD due to frontotemporal NCD, Lewy bodies, traumatic brain injury, Parkinson's disease, HIV infection, Huntington's disease, prion disease, another medical condition, and multiple etiologies. Substance/medication-induced NCD and unspecified NCD are also included as diagnoses.

### **Personality Disorders**

The criteria for personality disorders in Section II of DSM-5 have not changed from those in DSM-IV. An alternative approach to the diagnosis of personality disorders was developed for DSM-5 for further study and can be found in Section III. For the general criteria for personality disorder presented in Section III, a revised personality functioning criterion (Criterion A) has been developed based on a literature review of reliable clinical measures of core impairments central to personality pathology. Furthermore, the moderate level of impairment in personality functioning required for a personality disorder diagnosis in DSM-5 Section III was set empirically to maximize the ability of clinicians to identify personality disorder pathology accurately and efficiently. With a single assessment of level of personality functioning, a clinician can determine whether a full assessment for personality disorder is necessary. The diagnostic criteria for specific DSM-5 personality disorders in the alternative model are consistently defined across disorders by typical impairments in personality functioning and by characteristic pathological personality traits that have been empirically determined to be related to the personality disorders they represent. Diagnostic thresholds for both Criterion A and Criterion B have been set empirically to minimize change in disorder prevalence and overlap with other personality disorders and to maximize relations with psychosocial impairment. A diagnosis of personality disorder—trait specified, based on moderate or greater impairment in personality functioning and the presence of pathological personality traits, replaces personality disorder not otherwise specified and provides a much more

informative diagnosis for patients who are not optimally described as having a specific personality disorder. A greater emphasis on personality functioning and trait-based criteria increases the stability and empirical bases of the disorders.

Personality functioning and personality traits also can be assessed whether or not an individual has a personality disorder, providing clinically useful information about all patients. The DSM-5 Section III approach provides a clear conceptual basis for all personality disorder pathology and an efficient assessment approach with considerable clinical utility.

## Paraphilic Disorders

### Specifiers

An overarching change from DSM-IV is the addition of the course specifiers “in a controlled environment” and “in remission” to the diagnostic criteria sets for all the paraphilic disorders. These specifiers are added to indicate important changes in an individual’s status. There is no expert consensus about whether a long-standing paraphilia can entirely remit, but there is less argument that consequent psychological distress, psychosocial impairment, or the propensity to do harm to others can be reduced to acceptable levels. Therefore, the “in remission” specifier has been added to indicate remission from a paraphilic disorder. The specifier is silent with regard to changes in the presence of the paraphilic interest per se. The other course specifier, “in a controlled environment,” is included because the propensity of an individual to act on paraphilic urges may be more difficult to assess objectively when the individual has no opportunity to act on such urges.

### Change to Diagnostic Names

In DSM-5, paraphilias are not ipso facto mental disorders. There is a distinction between paraphilias and paraphilic disorders. A paraphilic disorder is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others. A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not automatically justify or require clinical intervention.

The distinction between paraphilias and paraphilic disorders was implemented without making any changes to the basic structure of the diagnostic criteria as they had existed since DSM-III-R. In the diagnostic criteria set for each of the listed paraphilic disorders, Criterion A specifies the qualitative nature of the paraphilia (e.g., an erotic focus on children or on exposing the genitals to strangers), and Criterion B specifies the negative consequences of the paraphilia (distress, impairment, or harm—or risk of harm—to others).

The change for DSM-5 is that individuals who meet both Criterion A and Criterion B would now be diagnosed as having a paraphilic disorder. A diagnosis would not be given to individuals whose symptoms meet Criterion A but not Criterion B—that is, to those individuals who have a paraphilia but not a paraphilic disorder.

The distinction between paraphilias and paraphilic disorders is one of the changes from DSM-IV that applies to all atypical erotic interests. This approach leaves intact the distinction between normative and nonnormative sexual behavior, which could be important to researchers or to persons who have nonnormative sexual preferences, but without automatically labeling nonnormative sexual behavior as

psychopathological. This change in viewpoint is reflected in the diagnostic criteria sets by the addition of the word disorder to all the paraphilias. Thus, for example, DSM-IV pedophilia has become DSM-5 pedophilic disorder.

DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish DSM-5 in 2013, culminating a 14-year revision process. For more information, go to [www.DSM5.org](http://www.DSM5.org).

APA is a national medical specialty society whose more than 36,000 physician members specialize in the diagnosis, treatment, prevention and research of mental illnesses, including substance use disorders. Visit the APA at [www.psychiatry.org](http://www.psychiatry.org). For more information, please contact Eve Herold at 703-907-8640 or [press@psych.org](mailto:press@psych.org).

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## INCORPORATION BY REFERENCE SYNOPSIS

**In compliance with Section 67-5223(4), Idaho Code**, the following is a synopsis of the differences between the materials previously incorporated by reference in this rule that are currently in full force and effect and newly revised or amended versions of these same materials that are being proposed for incorporation by reference under this rulemaking.

The following agency of the State of Idaho has prepared this synopsis as part of the proposed rulemaking for the chapter cited here under the docket number specified:

**DEPARTMENT OF HEALTH AND WELFARE  
IDAPA 16.07.50 -- Minimum Standards for Nonhospital,  
Detox/Mental Health Diversion Units  
Proposed Rulemaking -- Docket No. 16-0750-1801**

*(Include a brief description that explains the differences between the version of the materials or documents that are currently incorporated by reference and the materials or documents that are being proposed for adoption in this rulemaking.)*

*(You may use the following table or write a brief summary of the differences)*

<b>Incorporated Document Version/URL</b>	<b>IDAPA Section Number</b>	<b>Current Version of Incorporated Document</b>	<b>Substantive Changes in New Incorporation by Reference Version</b>
National Electrical Code 2017	004	National Electrical Code 2000	See attachment.



## Summary of the Changes – 2017 National Electrical Code®

Every three years, the *National Electrical Code*® (NEC®) is revised and expanded. Initially the NFPA® received 4,012 public suggestions for changes, which resulted in 1,235 first revisions. There were 1,513 public comments submitted in response to these 1,235 first revisions, resulting in 559 second revisions. Changes included editorial clarification, expanded requirements, new requirements, deleted requirements, and the relocation of other requirements. Nine new articles were proposed, and five new articles were added to the 2017 NEC.

With the fast pace of technology, it's more important than ever for anyone participating in the electrical industry to get up to speed with all the changes. Make sure that you get a copy of the 2017 NEC; then get a copy of Mike Holt's *Illustrated Guide to Changes to the National Electrical Code 2017* textbook that will help you understand the changes. With your *Code* book and Mike's textbook, watch and listen to the DVDs – Mike and his outstanding team of *Code* experts, provide feedback and insight on the topics being discussed, bringing to life the rules, their application, and what impact they will have on your work.

### Article 90—Introduction to the *National Electrical Code*

**90.2 Scope of the NEC.** Changes to this section include the removal of conductors, equipment and raceways, as well as clarifying that utility energy storage equipment isn't covered by the NEC.

**90.3 Code Arrangement.** Editorial revisions to the arrangement of the *Code* clarify how the different chapters in the NEC apply, supplement or modify each other.

## Chapter 1—General Rules

### 100 Definitions

This article contains definitions essential to the application of this *Code*; it does not include general terms or technical terms from other codes and standards. In general, only those terms are used in two or more articles are defined in Article 100.

**Accessible, Readily.** This definition was editorially revised; the language about “whom access is requisite” was removed, and a clarification about the use of keys to gain access clarified.

**Building.** Changes to this definition ensure that building codes, not the NEC, are the appropriate place to define a “building.”

**Communications Equipment.** Revisions clarify what Communications Equipment is.

**Communications Raceway.** The definition now indicates which cable types you're likely to see in a Communications Raceway.

**Coordination, Selective (Selective Coordination).** “Coordination, (Selective)” is now “Coordination, (Selective) (Selective Coordination).”

## Summary of the Changes – 2017 National Electrical Code®

**Electric Sign [Article 600].** The definition of “electric sign” is a bit more accurate, though not likely to change anyone’s worldview.

**Interactive Inverter.** This term used to be “Utility Interactive Inverter.”

**Photovoltaic (PV) System.** A change to this definition removes any arguments about whether or not the energy created is “suitable” for connecting to load.

**Raceway.** The definition of “raceway” no longer contains construction specifications, such as “metallic” or “nonmetallic.”

**Receptacle.** A small change was made in order to comply with the *NEC* style manual, and new text regarding a new type of receptacle was added.

**Structure.** A change to this definition clarifies that stand-alone equipment is no longer considered a structure.

### Article 110—Requirements for Electrical Installations

**110.3 Examination, Identification, Installation, Use, and Listing of Equipment.** Changes to this section of the *Code* include addressing reconditioned, refurbished, or remanufactured equipment and providing rules for who may list electrical equipment.

**110.5 Copper Conductors.** A Change to this rule helps to remove misapplication of the *Code*.

**110.9 Interrupting Overcurrent Protection Rating.** A change to this very important rule creates enforceable language.

**110.11 Deteriorating Agents.** New Informational Note intended to make *Code* users aware that there are minimum flood provisions contained in other building codes as they related to electrical installations.

**110.14 Conductor Termination and Splicing.** A properly calibrated tool must be used when torquing terminal connections.

**110.16 Arc-Flash Hazard Warning.** The requirements for warning qualified persons about arc-flash hazards have been increased, again.

**110.21 Markings.** New marking requirements for reconditioned equipment have been added, and the warning signage requirements have been editorially revised.

**110.24 Available Fault Current.** The available fault current calculation required by this section must now be made available upon request.

**110.26 Spaces About Electrical Equipment.** Changes to 110.26 include a new Informational Note refers to NFPA 70E, Standard for Electrical Safety in the Workplace, new requirements for spaces with “limited access”, and clarification of the outdoor dedicated space rules.

## Chapter 2—Wiring and Protection

### Article 210—Branch Circuits

**210.1 Scope.** Article 210 provides the general requirements for branch circuits such as, conductor sizing, overcurrent protection, identification, GFCI and AFCI protection, as well as receptacle outlets and lighting outlet requirements.

**210.4 Multiwire Branch Circuits.** The conductor grouping requirements for multiwire branch circuits now mirror similar rules contained in 200.4(B).

**210.5 Identification for Branch Circuits.** Existing wiring systems are now addressed in the requirement of marking and posting the identification of conductors when more than one voltage systems present on the premises wiring systems.

**210.7 Multiple Branch Circuits.** The rule requiring simultaneous disconnect for multiple branch circuits was editorially revised.

**210.8 GFCI Protection.** New informational note added, the methods used for measuring GFCI requirements are now addressed, some three-phase circuits now require protection, and new requirements for crawl spaces have been added.

**210.11 Branch Circuits Required.** The rules for the circuiting of dwelling unit garages have been relocated, and an exception was added.

**210.12 Arc-Fault Circuit-Interrupter Protection.** The AFCI requirements have been greatly expanded.

**210.52 Dwelling Unit Receptacle Outlet Requirements.** Many changes have been made to dwelling unit receptacle location rules, most having to do with countertops and work surfaces.

**210.64 Electrical Service Areas.** The rule requiring a convenience receptacle near the service disconnect was revised.

**210.70 Lighting Outlet Requirements.** Wall switch lighting outlet rules include adding wall switches for kitchens lighting, the use of dimmers for stairway lighting, and lighting in underfloor areas attics, equipment spaces, and similar areas of other than dwelling units.

**210.71 Meeting Rooms.** New rules require receptacle outlets for meeting rooms in commercial occupancies.

### Article 215—Feeders

**215.2 Minimum Rating.** A new rule clarifies the application of smaller feeder conductors sizing when using separate 90°C terminations in accordance with 110.14(C)(2).

### Article 220—Branch-Circuit, Feeder, and Service Load Calculations

**220.12 General Lighting.** A new exception for calculating lighting loads might result in designers dancing in the streets.

**220.87 Determining Existing Loads.** The allowance for using real world data when determining load calculations of existing installation was clarified.

### Article 225—Outside Branch Circuits and Feeders

**225.17 Masts as Supports.** The rules for overhead masts were editorially revised.

**225.22 Raceways on Exterior Surfaces.** This section was revised to use more accurate terms.

**225.27 Raceway Seals.** The requirements for sealing of raceways entering buildings from the outside have been expanded.

**225.30 Number of Feeder Supplies.** An additional feeder supply is now allowed for one- or two-family dwellings.

### Article 230—Services

**230.10 Vegetation as Support.** Trees are no longer allowed to support service equipment.

**230.29 Supports over Buildings.** A new section for overhead conductor support above buildings was added.

**230.42 Size and Rating.** The sizing requirements for service conductors have been revised for consistency with similar rules elsewhere in the *NEC*.

**230.53 Raceways on Exterior Surfaces.** This section was revised to use more accurate terms.

**230.54 Overhead Service Locations.** A clarification to the rules on service heads was made.

**230.66 Listed as Suitable for Service Equipment.** The rules requiring service equipment to be listed have been revised to include field labeled equipment, and a new requirement for meter socket enclosures was added.

**230.82 Connected on Supply Side of the Service Disconnect.** Wind and energy storage systems can now be installed on the supply side of the service disconnect.

**230.91 Location.** A new requirement for fused disconnects was added.

### Article 240—Overcurrent Protection

**240.24 Location of Overcurrent Devices.** The accessibility of overcurrent devices was clarified.

### Article 250—Grounding and Bonding

**250.4 General Requirements for Grounding and Bonding.** New Informational notes to inform *Code* user of NFPA 780, *Standard of Lightning Protection Systems*.

**250.24 Service Equipment—Grounding and Bonding.** Sizing the service neutral conductor when using a cable wiring methods is now addressed.

**250.30 Separately Derived Systems—Grounding and Bonding.** The requirement to use either structural metal or water piping as the preferred grounding electrodes was removed. Metal water piping can now be used for multiple separately derived systems, and the dimensions of the busbar used to splice grounding electrode conductors was clarified.

## Summary of the Changes – 2017 National Electrical Code®

**250.52 Grounding Electrode Types.** The description of what used to be known as structural metal was revised...again, coatings for plate electrodes must be electrically conductive, and swimming pools can't be used as a grounding electrode now.

**250.53 Grounding Electrode Installation Requirements.** The installation requirements for ground ring electrodes were revised for consistency with other rules and it was clarified that coatings on plate electrodes must be electrically conductive.

**250.60 Lightning protection Electrode.** The informational notes regarding lightning protection electrodes were both revised.

**250.66 Sizing Grounding Electrode Conductor.** The text of "sole connection" for rods, pipes, plates, rings, and concrete encased electrodes was clarified.

**250.68 Termination to the Grounding Electrode.** The five feet rule for underground water piping electrodes was clarified, the methods of connecting structural metal to the grounding electrode system have been relocated here, and rebar outside of the concrete was clarified.

**250.80 Service Raceways and Enclosures.** The items that aren't required to be bonded in underground service raceways have been expanded.

**250.86 Other Enclosures.** The items that aren't required to be bonded in underground raceways containing branch circuits and feeders have been expanded beyond just metal elbows.

**250.94 Bonding for Communications Systems.** The title of this section, which requires a bonding mechanism for limited energy systems, was revised for accuracy, options have been added, and a new exception was added.

**250.102 Grounded Conductor, Bonding Conductors, and Jumpers.** Several changes to this section including adding "Grounded Conductor" to the title that improves the accuracy and usability of this section.

**250.104 Bonding of Piping Systems and Exposed Structural Metal.** The requirements for bonding piping systems and structural metal have been editorially revised.

**250.118 Types of Equipment Grounding Conductors.** The allowance for using flexible metal conduit as an equipment grounding conductor are being restricted once again.

**250.122 Sizing Equipment Grounding Conductor.** The requirements for sizing EGCs for voltage drop and for feeder circuits have been clarified.

**250.148 Continuity and Attachment of Equipment Grounding Conductors to Boxes.** The requirements for splicing equipment grounding conductors in boxes have been edited to replace the word any with the word all. This has been no change in the meaning.

### Chapter 3—Wiring Methods and Materials

#### Article 300—General Requirements for Wiring Methods and Materials

**300.3 Conductors.** The exception allowing for parallel isolated phase installations was clarified.

**300.4 Protection Against Physical Damage.** An Informational Note was added to address superficial damage of cables or conduits.

## Summary of the Changes – 2017 National Electrical Code®

**300.5 Underground Installations.** Several changes have been made to the rules for underground installations including added footnotes in table 300.5, clarifications to requirements for parallel conductors, burial warning ribbons, sealing underground raceways, and backfill materials.

**300.7 Raceways Exposed to Different Temperatures.** The requirements for raceway expansion fittings now apply to other fittings as well.

**300.11 Securing and Supporting.** The rules for securing and supporting wiring methods were editorially revised to clarify it is a general rule.

**300.12 Mechanical Continuity.** The text about “metallic and nonmetallic” raceways was removed from the rule relating to mechanical continuity.

**300.19 Supporting Conductors in Vertical Raceways.** The rule about supporting conductors in vertical installations was clarified.

**300.22 Wiring in Ducts and Plenums Spaces.** Greater restrictions were added to the installation of limited-energy cables inside a physically constructed air movement duct.

### Article 310—Conductors for General Wiring

**310.15 Conductor Ampacity.** As always, many changes to the rules for establishing conductor ampacities have been made including requirements for cable bundling, rooftop temperature correction, and dwelling service conductor sizing.

### Article 312—Cabinet and Cutout Boxes

**312.8 Switch and Overcurrent Device Enclosures.** The rules for sufficient conductor space within cabinets have been revised to deal with power monitoring equipment.

### Article 314—Outlet, Device, Pull, and Junction Boxes; Conduit Bodies; and Handhole Enclosures

**314.15 Damp or Wet Locations.** Field-installed drainage holes now have a 1/8" minimum size.

**314.16 Number of Conductors in Boxes and Conduit Bodies.** The conductor fill calculation for boxes with a barrier is now addressed.

**314.17 Conductors That Enter Boxes or Conduit Bodies.** Nonmetallic-sheathed cables installed in metal boxes must now meet the ¼ in. cable sheath rule.

**314.20 Flush-Mounted Box Installations.** The rules for flush-mounted boxes have been expanded and clarified to cover all installations.

**314.27 Outlet Box.** New text addresses “receptacles” that support stuff...like luminaires and paddle fans.

**314.28 Sizing Boxes and Conduit Bodies—Conductors 4 AWG and Larger.** The allowance for using conduit bodies smaller than generally required was clarified, and power distribution blocks on the supply side of the service are now allowed if listed for the location.

### **Article 320—Armored Cable (Type AC)**

**320.6 Listing Requirement.** Type AC Cable and its associated fittings must now be listed.

**320.30 Securing and Supporting.** Cable ties for securing and supporting must now be listed.

### **Article 330—Metal-Clad Cable (Type MC)**

**330.6 Listing Requirements.** Type MC Cable and its associated fittings must now be listed.

**330.15 Exposed Work.** New requirements for the installation of exposed Type MC Cables have been added.

**330.30 Securing and Supporting.** Cable ties for securing and supporting must now be listed.

### **Article 334—Nonmetallic-Sheathed Cable (Types NM and NMC)**

**334.6 Listing Requirements.** Type NM Cable fittings must now be listed.

**334.12 Uses Not Permitted.** An editorial change was made to the language regarding ceilings.

**334.30 Securing and Supporting.** Cable ties for securing and supporting must now be listed.

### **Article 336—Power and Control Tray Cable: Type TC**

**336.6 Listing Requirements.** Type TC Cable fittings must now be listed.

### **Article 338—Service-Entrance Cable (Types SE and USE)**

**338.6 Listing Requirements.** Type SE Cable and its associated fittings must now be listed.

**338.10 Uses Permitted.** The conductor ampacity correction and adjustment rules for Type SE Cable have changed...again.

### **Article 340—Underground Feeder and Branch-Circuit Cable (Type UF)**

**340.6 Listing Requirements.** Type UF Cable fittings must now be listed.

### **Article 342—Intermediate Metal Conduit (Type IMC)**

**342.10 Uses Permitted.** IMC in corrosive environments must now be approved for the location.



### Article 344—Rigid Metal Conduit (Type RMC)

**344.10 Uses Permitted.** RMC in corrosive environments must now be approved for the location.

**344.14 Dissimilar Metals.** The rules for using fittings of dissimilar metal than the metal raceway have been clarified.

### Article 348—Flexible Metal Conduit (Type FMC)

**348.30 Securing and Supporting.** Cable ties for securing and supporting must now be listed.

### Article 350—Liquidtight Flexible Metal Conduit (Type LFMC)

**350.28 Trimming.** A new rule requires the cut edges of liquidtight flexible metal conduit to be trimmed.

**350.30 Securing and Supporting.** Cable ties for securing and supporting must now be listed.

### Article 356—Liquidtight Flexible Nonmetallic Conduit (Type LFNC)

**356.30 Securing and Supporting.** Cable ties for securing and supporting must now be listed.

### Article 358—Electrical Metallic Tubing (Type EMT)

**358.10 Uses Permitted.** The permitted uses list for electrical metallic tubing (EMT) was greatly expanded.

### Article 362—Electrical Nonmetallic Tubing (Type ENT)

**362.30 Securing and Supporting.** Cable ties for securing and supporting must now be listed.

### Article 376—Metal Wireways

**376.20 Conductors Connected in Parallel.** A new requirement for grouping parallel conductors was added.

**376.22 Number of Conductors and Ampacity.** The conductor fill rules for wireway sizing now include requirements for cables installed in wireways.

**376.56 Splices, Taps, and Power Distribution Blocks.** An allowance has been added for the use of power distribution blocks on the supply side of the service disconnect.

## Article 392—Cable Trays

**392.22 Number of Conductors or Cables.** The cable tray conductor fill sizing calculations have been clarified.

**392.80 Ampacity of Conductors.** An Informational Note was added to remind the *Code* user of the conductor termination temperature rules.

## Chapter 4—Equipment for General Use

### Article 400—Flexible Cords and Flexible Cables

The title of this article was changed to more clearly address its application.

**400.1 Scope.** A new Informational Note was added to try to clear up the scope of Article 400.

**400.12 Uses Not Permitted.** Changes attempt to clarify the restriction on cord use above a suspended ceiling.

### Article 404—Switches

**404.2 Switch Connections.** An attempt was made to clarify the rule on when you need a neutral wire at switches.

**404.9 Switch Faceplates.** A new requirement for metal faceplates to be “grounded” was added.

**404.22 Electronic Lighting Switches.** A new rule requires electronic switch manufacturers to use a neutral for return current, not the equipment grounding conductor.

### Article 406—Receptacles, Cord Connectors, and Attachment Plugs (Caps)

**406.2 Definitions.** A new definition for “outlet box hoods” was added.

**406.3 Receptacle Rating and Type.** The rules on automatically controlled receptacles have been revised, and new text regarding receptacles with USB outlets was added.

**406.4 General Installation Requirements.** Two Informational Notes about replacing nongrounding type receptacles have been added, and the rule for providing AFCI protection at replacement receptacles was clarified.

**406.5 Receptacle Mounting.** The rules governing the installation of receptacles in countertops and work surfaces have been clarified.

**406.6 Receptacle Faceplates.** A new rule requiring cover plates with USB ports or with night lights to be listed was added.

**406.12 Tamper-Resistant Receptacles.** The locations requiring tamper-resistant receptacles have been expanded, as have the types of receptacles requiring such protection.

### Article 408—Switchboards, Switchgear, and Panelboards

**408.4 Field Identification.** The requirement for marking other than dwelling unit panels was expanded.

### Article 411—Low Voltage Lighting

**411.1 Scope.** The title of this article, as well as its scope, has been changed to more accurately describe the allowable voltages of these systems.

### Article 422—Appliances

**422.5 Ground-Fault Circuit-Interrupter (GFCI) Protection for Personnel.** The rules for providing GFCI protection for specific appliances found throughout Article 422 have been relocated to this section, the voltage and current ratings for equipment requiring GFCI's have been specified, and the options for protection methods have been expanded.

**422.6 Listing Required.** A new rule requires most appliances to be listed.

**422.16 Flexible Cords.** The cord requirements for dishwashers and trash compactors have been revised to reflect product standards.

**422.18 Support of Ceiling Paddle Fans.** This section was edited to include listed outlet box systems, SQL receptacles meeting 314.27(E) requirements.

**422.21 Covering of Combustible Material at Outlet Boxes.** The requirement for covering noncombustible finishes inside the fan canopy has been greatly reduced.

**422.31 Permanently Connected Appliance Disconnects.** The disconnect rules for appliances are now all the same, regardless of VA or HP rating.

### Article 424—Fixed Electric Space-Heating Equipment

**424.38 Area Restrictions.** The allowable locations for space-heating cables have been extensively revised.

**424.39 Clearance from Other Objects and Openings.** The rules for heating cables near lights have been clarified.

### Article 430—Motors, Motor Circuits, and Controllers

**430.99 Available Fault Current.** A new rule requiring motor control centers to be marked with the available fault current was added.

### Article 440—Air-Conditioning and Refrigeration Equipment

**440.9 Grounding and Bonding.** A wire-type equipment grounding conductor is now required for some air-conditioning installations.

### Article 445—Generators

**445.18 Disconnecting Means and Shutdown of Prime Mover.** The rules for a generator disconnecting means have been clarified. And this time we mean it!

**445.20 GFCI for Receptacles on 15 kW or Smaller Portable Generators.** The rules for GFCI protection of generators is now different for bonded neutral and floating neutral generators.

### Article 480—Storage Batteries

**480.3 Listing Requirement.** Most batteries must now be listed.

**480.4 Battery and Cell Terminations.** The requirement for using anti-oxidizing compounds on terminations was clarified.

**480.9 Battery Support Systems.** The requirements for battery support systems have been decreased.

## Chapter 5—Special Occupancies

### Article 500—Hazardous (Classified) Locations

**500.2 Definitions.** Section 500.2 (definitions) has been deleted and relocated to Article 100.

### Article 501—Class I Hazardous (Classified) Locations

**501.10 Wiring Methods.** Threadless intermediate metal conduit and rigid metal conduit fittings will now be permitted in Class I, Division 2 locations.

**501.15 Raceway and Cable Seals.** Clarifications for factory-sealed equipment were made, and provisions for sealing equipment in accordance with manufacturer's instructions were added.

**501.115 Enclosures.** The types of equipment not requiring a seal have been clarified.

**501.145 Receptacles and Attachment Plugs.** The allowance for using attachment plugs in Class I locations has been changed.

### Article 511—Commercial Garages, Repair, and Storage

**511.3 Classification of Hazardous Areas.** This section of the *NEC*, used to determine area classifications in commercial garages, has been turned into a table.

**511.8 Underground Wiring.** A new section was added detailing the requirements for wiring beneath commercial garage floors.

### Article 514—Motor Fuel Dispensing Facilities

**514.8 Underground Wiring.** The allowance for underground nonmetallic raceways was expanded to permit HDPE conduit.

**514.9 Raceway Seal.** The installation requirement for raceway seal fittings now matches 501.15 for boundary seals.

**514.11 Circuit Disconnect.** The requirements for emergency electrical shutoff devices for fuel dispensers have been (somewhat) clarified and a new requirement was added for unattended dispensing facilities.

### Article 517—Health Care Facilities

**517.2 Definitions.** New definitions for Governing Body and Medical Office (Dental Office) have been added, and existing definitions for Health Care Facility and Patient Care Space have been clarified.

**517.13 Grounding of Equipment in Patient Care Spaces.** Some requirements for equipment grounding conductors (EGCs) in patient care spaces have been expanded while others are now reduced. Exception 2 of 517.13(B) was clarified and isolated ground receptacles are no longer a black hole in this rule.

**517.16 Isolated Ground Receptacles.** The allowances for isolated ground receptacles in health care facilities now make sense.

### Article 525—Carnivals, Circuses, Fairs, and Similar Events

**525.23 GFCI-Protected Receptacles and Equipment.** GFCI devices that are part of portable cords must now be listed for portable use.

### Article 547—Agricultural Buildings

**547.2 Definitions.** The definition of equipotential plane was revised for accuracy.

### Article 550—Mobile Homes, Manufactured Homes, and Mobile Home Parks

**550.13 Receptacle Outlets.** Dishwashers in mobile and manufactured homes must now be GFCI protected.

**550.25 AFCI Protection.** The AFCI protection requirements for manufactured and mobile homes now mirror the rules for dwellings in 210.12.

### Article 555—Marinas, Boatyards, and Commercial and Noncommercial Docking Facilities

**555.1 Scope.** The title of this article, its scope, and many of its provisions were changed to include residential installations.

**555.3 Ground-Fault Protection.** The trip setting requirements of the ground-fault protection device required in this article were changed.

**555.24 Electric Shock Hazard Sign.** A new warning sign is required at boat docks or marinas.

### Article 590—Temporary Installations

**590.4 General.** Changes to this section expand allowable wiring methods to include SE cable and revises rules relating to open splices on temporary wiring.

**590.6 Ground-fault Protection for Personnel.** “Special Purpose GFCIs” are now permitted for receptacles other than those rated 15A, 20A, and 30A, 125V.

## Chapter 6—Special Equipment

### Article 600—Electric Signs and Outline Lighting

**600.1 Scope.** Retrofit kits for signs are now covered by this article.

**600.2 Definitions.** A new definition for “Photovoltaic (PV) Powered Sign” was added.

**600.4 Markings.** A new requirement for marking of retrofitted signs was added.

**600.6 Disconnecting Means.** Several changes have been made to the disconnect requirement for signs, including adding an Informational Note to express the intent of the rule, clarifying which conductors require disconnection, adding an exception for signs that contain a panelboard, indicating the location and type of warning sign in instances where the disconnect is remote, and adding an exception for the controller disconnect.

**600.24 Class 2 Power Sources.** A clarification to requirements for the grounding and bonding of Class 2 power sources has been made.

## Summary of the Changes – 2017 National Electrical Code®

**600.33 Class 2 Sign Illumination Systems, Secondary Wiring.** A new table was added to discuss the cable types that can be used for Class 2 signs circuits.

**600.34 Photovoltaic (PV) Powered Sign.** A new section for PV powered signs was added.

### Article 604—Manufactured Wiring Systems

**604.6 Listing Requirements.** Manufactured wiring systems must now be listed.

### Article 620—Elevators, Escalators, and Moving Walks

**620.16 Short-Circuit Current Rating.** Elevator control panels must now be marked with the short-circuit current rating.

**620.23 Branch Circuit for Machine Room/Machinery Space.** The circuiting requirements for lighting and receptacles in the equipment machine room/machinery space have been expanded.

**620.24 Branch Circuit for Hoistway Pit Lighting and Receptacles.** The circuiting requirements for lighting and receptacles in a hoistway pit area have been expanded, and a new Informational Note was added.

**620.51 Disconnecting Means.** The equipment that requires a disconnecting means is now clear.

**620.85 GFCI-Protected Receptacles.** The receptacle GFCI rules for elevators and similar equipment were expanded.

### Article 625—Electric Vehicle Charging System

**625.2 Definitions.** A new definition for “Wireless Power Transfer Equipment (WPTE)” was added.

**625.5 Listed.** The equipment required to be listed was clarified.

**625.40 Electric Vehicle Branch Circuit.** The circuiting requirement for electric vehicle charging systems has been relocated from 210.17 to 625.40.

### Article 630—Welders

**630.6 Listing.** A new requirement for the listing of welding and cutting equipment was added.

**630.31 Ampacity of Supply Conductors.** The language regarding voltage drop for resistance welders has been relegated to an Informational Note.

### Article 640—Audio Signal Processing, Amplification, and Reproduction Equipment

**640.3 Locations and Other Articles.** The “requirements” for audio cables in ducts, plenums, and air-handling spaces are now really “requirements.”



## Summary of the Changes – 2017 National Electrical Code®

**640.25 Loudspeakers in Fire-Resistance-Rated Partitions, Walls, and Ceilings.** The rules for loudspeakers in fire-resistance-rated assemblies have been lessened.

### Article 645—Information Technology Equipment

**645.3 Other Articles.** The wiring methods permitted in plenum spaces above information technology rooms are more clearly stated.

**645.4 Special Requirements.** The applicability of Article 645 has been clarified, again.

**645.5 Supply Circuits and Interconnecting Cables.** The permitted wiring methods under raised floors in IT equipment rooms are now contained in an even bigger list than before and a new Informational Note was added about securing and supporting.

### Article 680—Swimming Pools, Spas, Hot Tubs, Fountains, and Similar Installations

**680.2 Definitions.** A new definition for “electrically powered pool lift” was added and the definition for storable pools (and other storable features) was revised.

**680.4 Approval of Equipment.** A new rule requires electrical equipment associated with pools to be listed.

**680.7 Grounding and Bonding Terminals.** Grounding and bonding terminals now have specific location-driven requirements.

**680.11 Underground Wiring.** The cover (burial depth) requirements for pools and similar installations are now no different than those for other installations.

**680.12 Equipment Rooms and Pits.** A reminder that pools and similar installations are in corrosive environments was added.

**680.14 Corrosive Environment.** A new section provides the requirements for equipment subject to corrosion.

**680.21 Motors.** The allowable methods for wiring a pool motor have been greatly simplified.

**680.22 Lighting, Receptacles, and Equipment.** The requirements for receptacles supplying circulation pumps were lessened, and new provisions for “low-voltage gas fired” equipment were added.

**680.23 Underwater Luminaires.** Some unenforceable language about GFCI protection has been removed, and the allowable wiring methods for underwater luminaires have been simplified.

**680.25 Feeders.** The wiring methods for feeders supplying pools and similar installations were changed into a reasonable requirement.

**680.26 Equipotential Bonding.** Changes to the bonding requirements of perimeter surfaces (decking) were made for accuracy and logic.

**680.28 Gas-Fired Water Heaters.** New GFCI provisions for gas-fired water heaters were added.

**680.42 Outdoor Installations.** The rules for the interior wiring supplying outdoor spas and hot tubs were simplified.

**680.74 Equipotential Bonding.** The rules for bonding hydromassage tubs have been revised, again.

**680.80 General.** A new Part VIII, covering electrically powered pool lifts, was added to this article.

### Article 695—Fire Pumps

**695.14 Control Wiring.** The fire pump control wiring methods have been expanded.

**695.15 Surge Protection.** Fire pump controllers must now have surge protection.

### Chapter 7—Special Conditions

#### Article 700—Emergency Systems

**700.3 Tests and Maintenance.** The equipment that might require maintenance is no longer limited to just batteries.

**700.5 Transfer Equipment.** Transfer equipment must now be marked by the installer to indicate its short-circuit current rating.

**700.10 Wiring.** Raceways and cables, as well as receptacles, for emergency systems must now be marked, and the exception regarding selective coordination for breakers feeding a common bus was turned into positive *Code* language.

**700.12 General Requirements.** The requirements for batteries permitted for emergency power have been revised.

#### Article 701—Legally Required Standby Systems

**701.3 Tests and Maintenance.** The equipment that may require maintenance is no longer limited to just batteries.

**701.5 Transfer Equipment.** Transfer equipment must now be marked by the installer to indicate its short-circuit current rating.

#### Article 702—Optional Standby Systems

**702.5 Transfer Equipment.** Transfer equipment must now be marked by the installer to indicate its short-circuit current rating.

#### Article 725—Remote-Control, Signaling, and Power-Limited Circuits

**725.1 Scope.** The scope of this article was revised for accuracy to include circuits that are part of utilization equipment.

**725.3 Other Articles.** This article now contains provisions for cable routing assemblies and communications raceways.

**725.121 Power Sources for Class 2 and Class 3 Circuits.** Some of the Class 2 power sources will require a label, effective January 1st, 2018.

**725.144 Transmission of Power and Data.** A new section and table were added to address cables that transmit power and data.

**725.179 Listing and Marking of Class 2 and Class 3 Cables.** Type LP (limited power) cable was added.

### Article 760—Fire Alarm Systems

**760.3 Other Articles.** This article now contains provisions for cable routing assemblies and for communications raceways.

**760.179 Listing and Marking of Power-Limited Fire Alarm Cables (PLFA).** Power-limited fire alarm cables must now have a temperature rating of at least 60°C.

### Article 770—Optical Fiber Cables and Raceways

**770.2 Definitions.** Many definitions have been relocated to Article 100.

**770.24 Mechanical Execution of Work.** A new Informational Note was added to warn people about the effect paint, cleaners, and similar contaminants might have on cable jackets.

## Chapter 8—Communications Systems

### Article 800—Communications Circuits

**800.2 Definitions.** The definition of “point of entrance” was revised.

**800.24 Mechanical Execution of Work.** A new Informational Note was added to warn people about the effect of paint, cleaners, and similar contaminants might have on cable jackets.

**800.100 Cable and Primary Protector Bonding and Grounding.** This section was revised to clarify that installing an intersystem bonding terminal is always okay.

**800.133 Installation of Communications Wires, Cables, and Equipment.** The types of circuits that can share a raceway or other enclosure with communications cables were increased.

### Article 810—Radio and Television Satellite Equipment

**810.15 Metal Antenna Supports—Grounding.** The requirement to ground antennas was reduced.

### Article 820—Community Antenna Television (CATV) and Radio Distribution Systems (Coaxial Cable)

**820.2 Definitions.** The definition of “point of entrance” was revised to be consistent with similar sections of the *NEC*.

**820.24 Mechanical Execution of Work.** A new Informational Note was added to warn people about the effect of paint, cleaners, and similar contaminants might have on cable jackets.

**820.100 Bonding and Grounding Methods.** This section was revised to clarify that installing an intersystem bonding terminal is always okay.

**820.133 Installation of Coaxial Cables and Equipment.** The types of circuits that can share a raceway or other enclosure with coaxial cable were increased.