TITLE 8 SOCIAL SERVICES
CHAPTER 369 OVERSIGHT OF RESIDENTIAL SHELTER AND MENTAL HEALTH SERVICES AND FACILITIES FOR CHILDREN
PART 3 CERTIFICATION REQUIREMENTS FOR CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

8.369.3.1 ISSUING AGENCY: New Mexico health care authority.
[8.369.3.1 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.2 SCOPE: This policy applies to all child and adolescent behavioral health programs described herein.
[8.369.3.2 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.3 STATUTORY AUTHORITY: The regulations set forth herein have been promulgated pursuant to the general authority granted under Subsection E of Section 9-8-6 NMSA 1978, and Subsection A of Section 24A-1-3 NMSA 1978, as amended, and Sections 32A-12-1 et seq. NMSA 1978.
[8.369.3.3 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.4 DURATION: Permanent.
[8.369.3.4 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.5 EFFECTIVE DATE: xx/xx/2026 unless a later date is cited at the end of a section.
[8.369.3.5 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.6 OBJECTIVES:

A. to establish certification requirements for behavioral health services provided to children and adolescents of New Mexico through the medicaid program (Title XIX of the Social Security Act);

B. to provide for monitoring of agency compliance with these certification requirements to identify any factors that could affect the health, safety, and welfare of the clients and the staff;

C. to assure that the agency establishes and follows written policies and procedures that specify how these certification requirements are met; and

D. to assure that adequate supervision is provided at all times.

[8.369.3.6 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) "Abuse" means any act or failure to act, performed intentionally, knowingly, or negligently that causes or is likely to cause harm to a client including:

(a) physical contact that harms or is likely to harm a client of a facility;

(b) inappropriate use of a physical restraint, isolation, or medication that harms or is likely to harm a client;

(c) inappropriate use of restraint, medication, or isolation as punishment or in conflict with a physician's order;

(d) medically inappropriate conduct that causes or is likely to cause physical harm to a client;

(e) medically inappropriate conduct that causes or is likely to cause great psychological harm to a client;

(f) an unlawful act, a threat, or menacing conduct directed toward a client that results and might reasonably be expected to result in fear or emotional or mental distress to a client;

(g) abuse or neglect as defined in Section 32A-4-2 NMSA 1997, or as amended.

(2) "Accredited" means written acknowledgement from a national organization that an agency or program meets the published standards of the organization issuing the accreditation.

(3) "Accredited residential treatment center for youth (ARTC)" means a facility with 16 beds or less that may be attached to, or housed within, a hospital or other institution; that provides residential treatment services pursuant to these requirements; and that is accredited by JCAHO.

(4) "Active status" means a type of certification or license granted to a program currently

serving clients.

(5) "Administrator" means the person in charge of day-to-day operation of a facility or certified service; may be licensee or authorized representative. For certification the administrator may be the director or operator, and are required to meet to the required qualifications.

(6) "Admissions hold" means restricted admissions or provision of services: The licensing authority may restrict the health facility from providing designated services and from accepting any new patients, residents, or clients until deficiencies are corrected. Voluntary admission holds are acceptable, the agency/facility notifies the HCA of the hold, reasons for and timeframes within 24 hours of the plan for voluntary admission hold.

(7) "Advance directives" means an individual instruction or a power of attorney for health care made, in either case, while the individual has capacity.

(8) "**Advanced practice providers**" are licensed healthcare professionals with advanced education and training who can diagnose, treat, and manage patient care which includes nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs), certified registered nurse anesthetists (CRNAs).

(9) "Agency" means the legally responsible organizational entity administering the facility or program(s) of specific services identified and certified pursuant to these certification requirements.

(10) "Ambulatory" means able to walk without assistance.

(11) "Applicant" means the individual or organization applying for a license or certification.

(12) "Assistance with delivery of medication" means assistance with the method by which the individual(s) take or receive their medication based on clear and concise orders transcribed on the medication administration record.

B. Definitions beginning with "B":

(1) "Bed" means the total assembly on which a child sleeps, including frame, springs, mattress, mattress cover/pad, sheets, pillow, blankets and bedspread.

(2) "Behavioral health assessment" means an assessment by an integrated series of procedures conducted with an individual to provide the basis for the development of an effective, comprehensive and individualized treatment plan.

(3) "Behavioral health services" means a comprehensive array of professional and ancillary services for the treatment, habilitation, prevention and identification of mental illnesses, behavioral symptoms associated with developmental disabilities, substance abuse disorders and trauma spectrum disorders.

(4) "Behavior management" means the use of basic techniques, such as reinforcement, redirection and voluntary time-outs to teach clients skills for managing and improving their own behavior; and the use of verbal de-escalation, therapeutic holds, personal restraint and seclusion in order to maintain a safe and therapeutic environment and to enhance the abilities of clients and care givers to manage client behavior.

(5) "Behavior management skills development services (BMS)" means services provided on a staff-to-child ratio of at least 1:1. Behavior management skills development services are for children and adolescents with psychological, emotional, behavioral, neurobiological or substance use disorder problems in the home, community or school when such problems are of such severity that highly supportive and structured therapeutic behavioral interventions are required. These services are designed to maintain the client in his/her home, community or school setting.

(6) "Behavior management services plan" means a service plan used in behavior management skills development services.

C. Definitions beginning with "C":

(1) "Cancellation" means an HCA action nullifying a program's certification or licensure.

(2) "Capacity" means the maximum number of clients allowed to receive services or the total number of persons or beds for which the facility is licensed at any specified time, also applies to the maximum number of children who can be accommodated in rooms designated for them.

(3) "CARF" means council on accreditation of rehabilitation facilities.

(4) "Certification" means an authorized status conferred by the department on a program that meets these certification requirements for providing service(s) to children and adolescents.

(5) "Certified family specialists (CFS)" means an individual 18 years of age or older who has personal experience navigating any of the child or family-serving systems or advocating for family members who have a knowledge of and are involved with the behavioral health systems and are certified by an approved state of New Mexico certification program.

(6) "Certified peer specialists (CPS)" means a self-identified current or former consumer, 18 years of age or older, of mental health or substance abuse services and has at least one year of mental health or substance abuse recovery and is certified as a CPS by an approved state of New Mexico certification program.

(7) "Chemical restraint" means the administration of a medication(s) which is neither a standard treatment for the client's medical or psychiatric condition nor a part of the client's daily medication regimen, and is used for the primary purpose of controlling a client's behavior or restricting a client's freedom of movement.

(8) "Child/adolescent" means (for the purpose of these regulations), a person under the chronological age of 18 years. Those persons who, are clients receiving certified or licensed services pursuant to these regulations, reach the age of 18 for the purposes of these regulations be considered a child until they complete their course of treatment in the facility.

(9) "Cleared staff member" means an individual approved by CYFD's background check unit for employment in immediate presence of children/adolescents by means of state and federal criminal background clearance as documented by the clearance letter.

(10) "Client" means any child or adolescent who receives treatment from a certified residential agency, a licensed residential agency (to include licensed crisis shelter or multi service home) or both.

(11) "Clinical supervisor" means a staff member who is a licensed independent practitioner and who has responsibility and authority for supervising other clinical staff.

(12) "COA" means council on accreditation for children and family services.

(13) "Community supports" means the coordination of resources to individuals/families necessary for them to implement strategies to promote recovery, rehabilitation and resilience.

(14) "Community support worker (CSW)" means the primary staff responsible for assisting the client and family with implementation of the comprehensive service plan and coordinating or facilitating family and treatment team meetings and is certified by an approved state of New Mexico certification program.

(15) "Comprehensive community support services (CCSS)" means a variety of interventions, primarily face-to-face and in community locations that address barriers that impede the development of skills necessary to independent functioning in the community. It provides assistance with identifying and coordinating services and supports identified in an individual's comprehensive service plan; supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices. The target population for CCSS includes children, youth and adults with significant behavioral health disorders and who meet other criteria as identified by the collaborative.

(16) "Contractor" means an individual who provides direct services to clients through contracts with the agency.

(17) "Corporal punishment" means a form of discipline involving forced exercise or touching a child's body with intent to induce pain; includes shaking, spanking, hitting, etc.; considered abusive.

(18) "Criminal records check (CRC)" means the process of fingerprinting on state and FBI approved cards and submission of the fingerprint cards for the purpose of obtaining the state and federal conviction records of an individual. As defined in 8.8.3. The use of the services of an agency contracted by the department of public safety (DPS) who can access the DPS database in order to obtain state criminal background checks for those applicants who have resided in the state of New Mexico for five years or more may be utilized as a means of obtaining state criminal records checks prior to employment. Federal finger printing is still required. The use of an alternate method to obtain state criminal background checks do not replace the federal fingerprinting requirement.

(19) "Criminal records clearance" means a determination made by CYFD based on the results of the criminal records check, that an individual may work directly and unsupervised with children and adolescents.

(20) "Crisis management services" means those services identified in the individual's crisis plan. Such services are located in the community, include natural supports and are available to the client and family after the agency's normal operating hours.

(21) "Crisis plan" means a component of the comprehensive service plan that clearly identifies the level of intensity and severity of potential crisis events and how they will be managed after normal business hours with specific resources identified for the client, family and natural supports. The crisis plan shall include defined client, family and treatment team roles and activities.

(22) "Cruelty (mental or physical) and indifference to the welfare of children" means a failure to provide a child with the care, supervision, and services to which the child is entitled. Examples of physical and mental cruelty include physical device/chemical restraints, striking, slapping or hitting, withholding food or bathroom privileges as punishment, swearing at or threatening a child, and indifference to the basic needs, including physical and psychosocial, of the child and including any abuse as defined in 32-A-4-2 NMSA 1978.

(23) "Cultural competence" means the involvement, integration and transformation of

knowledge, information and data about individuals and groups of people into specific clinical standards, service approaches, techniques and marketing programs. Cultural competence is illustrated by congruent behaviors, attitudes and policies that match a client's culture to increase the quality and appropriateness of behavioral health care and outcomes.

(24) "Culturally competent assessment" means the relevant cultural considerations in the assessment of the behavioral health needs of a client.

D. Definitions beginning with "D":

(1) "Day treatment services (DTS)" means a coordinated and intensive set of structured individualized therapeutic services, in a school, or a facility licensed by HCA, provided for children, adolescents and their families who are living in the community.

(2) "Deficiency" means violation of or failure to comply with a provision(s) of the licensing or certification requirements.

(3) "Denial" means action by the licensing authority refusing to grant an annual license or certification on the basis of non-compliance with applicable laws and regulations, and specifically under these regulations, nonpayment of the prescribed fee.

(4) "Department" means the New Mexico health care authority.

(5) "Designated agency" means the agency that has the primary responsibility of partnering with the client and family for implementation of the comprehensive service plan.

(6) "Direct care staff" means any person who is employed, contracted or volunteers at a facility that works directly with the clients in the oversite and delivery of care and supervision.

(7) "Directed plan of correction" means a corrective action plan, timeline and monitoring requirements dictated by HCA.

(8) "Discharge criteria" means specific clinically-based indicator(s) used to measure the client's degree of readiness for release from a given level of care stated in terms of achievement of treatment goals or reduction of symptoms; discharge criteria may also include indicators that a given level of care is inappropriate for a client due to such factors as dangerousness or non-responsiveness to treatment.

(9) "Discharge plan" means a written section of a treatment plan/service plan and treatment plan/service plan reviews containing the following elements: behavioral and other clinical criteria that describe the conditions under which discharge will occur, identification of barriers to discharge; the level of care, specific services to be delivered, and the living situation into which discharge is projected to occur; the projected date of discharge, individuals responsible for implementing each action specified in the discharge plan, and, when indicated, revisions.

(10) "Discipline" means non-abusive training that enables a child to develop self-control and orderly conduct in relationship to peers and adults.

E. Definitions beginning with "E":

(1) "Early and periodic, screening, diagnosis and treatment (EPSDT)" means periodic, comprehensive services to persons under 21 years of age; these services are defined in the medicaid program policies.

(2) "Emergency safety intervention" means personal restraint or seclusion.

(3) "Emergency sanction" means an immediate sanction may be imposed on an emergency basis when there exists an immediate threat to human health and safety.

(4) "Emergency service" means unanticipated admission to a hospital or other psychiatric facility; or the provision of emergency services including, but not limited to, treatment for broken bones, cuts requiring sutures, poisoning, contagious diseases requiring quarantine, burns requiring specialized medical treatment, medication under-dose or overdose requiring treatment; or incidents between residents, or between residents and staff resulting in physical or psychological harm or which could result in physical or psychological harm; or other conditions requiring emergency medical services (EMS) specialized treatment at an urgent care center or an emergency room.

(5) "Emergency suspension" means the licensing authority's prohibition of operation of a facility or provide services for a stated period of time by temporary withdrawal of the license, prior to a hearing on the matter, when immediate action is required to protect human health and safety. The emergency suspension is carried out by personal service of an emergency suspension order and notice of a hearing. A hearing must be held within five working days of the effective date of suspension ("five-day hearing"), as noticed in the emergency suspension order and notice of hearing, unless the right to a hearing is waived by the licensee or the right to a five-day hearing is waived and a hearing is requested at a later date by the licensee.

(6) "Employment history" means a verifiable written summary of employment including

names, addresses and telephone numbers of employers, immediate supervisors as well as dates of and explanations for any period(s) of unemployment for a minimum of three years immediately prior to hire for employment by a certified or licensed program.

(7) "Enhanced service" means, in the medicaid managed care system, any and all services beyond the scope of the medicaid (fee-for-service) benefit package available to recipients in the medicaid managed care program.

(8) "Exclusionary criteria" means agency-written criteria that define the diagnoses, behaviors, or conditions that preclude admission to the certified program.

(9) "Exploitation" means the act or process, performed intentionally, knowingly, or recklessly, of using a client's property for another person's profit, advantage or benefit without legal entitlement.

F. Definitions beginning with "F":

(1) "Facility" means publicly or privately owned or operated residence licensed and or certified (to include day treatment services) pursuant to these regulations which provides living accommodations, meals, supervision, care, and in some instances, programmatic services to children.

(2) "Functional level" means a determination of the client and as applicable, his family's, functional skills in multiple domains.

G. Definitions beginning with "G":

(1) "General provisions" means the series of certification requirements found in Sections 9 through 25 of these certification requirements.

(2) "Governing body" means the governing authority of a facility which has the ultimate responsibility for all planning, direction, control, and management of the activities and functions of a facility that is licensed or certified pursuant to these regulations.

(3) "Group home services (GHS)" means mental and behavioral health services offered in a supervised, licensed facility that provides structured therapeutic group living for children/adolescents with moderate behavioral, psychological, neurobiological, or emotional problems, when clinical history and opinion establish that the needs of the client cannot be met in a less restrictive environment.

H. Definitions beginning with "H": "Human services degree" means an approved bachelors or masters degree from an accredited school in one of the following degrees: counseling and therapy, rehabilitation, psychology, criminal justice, social work/social services, or human development. If workforce issues are identified in a region of the state, the some other defined degrees may be considered as human services degrees. However, any experience required in the service definition must be met. In order for an agency to utilize staff with these degrees, they must submit a written waiver request to HCA with documentation supporting the workforce issues. Those alternative degrees may include nursing, sociology, public health, education, occupational therapy, speech and hearing sciences, speech-language pathology, communication sciences and disorders, gerontology, or social sciences.

I. Definitions beginning with "I":

(1) "Inactive status" means a type of certification granted to a program that is not currently serving clients.

(2) "Incident" means any known, alleged or suspected event of abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents.

(3) "Incident report form" means the reporting format issued by the division for the reporting of incidents or complaints.

(4) "Informal dispute review (IDR)" means the facility may request an informal review of survey deficiencies by providing a written request to the licensing authority within 10 calendar days of receipt of the written survey findings. With the request, the facility shall include information or evidence that justifies the disagreement with a cited deficiency.

(a) The licensing authority will review the submitted information and make a determination.

(b) If the deficiency is removed, a new statement of deficiencies will be issued to the facility.

(c) The facility shall provide a new plan of correction for all remaining deficiencies upon receipt of the new statement of deficiencies.

(d) A copy of the "IDR operating rules" is provided with the survey reports, is available upon request or by accessing the DHI website.

(5) "Informed consent" means a document that reflects that a client and the legal guardian(s) are advised of the benefits, risks, and alternatives of a given medication or treatment and agree to the use

of the medication or treatment. Clients age 14 and above may consent to the use of a medication or treatment without the approval of their legal guardian(s).

(6) "Initial certification" means a type of certification granted to a program that has met the minimum requirements to implement a program to provide services pursuant to these requirements.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L":

(1) "License" means the document issued by the licensing authority which authorizes the operation of a facility. The term license may mean an annual license or a time-limited temporary license.

(2) "Licensed independent practitioner" means New Mexico-licensed clinical staff who are authorized to practice at the independent level.

(3) "Licensed independent medical practitioner" means a New Mexico licensed medical doctor (MD), doctor of osteopathy (DO), certified nurse practitioner (CNP), clinical nurse specialist (LCNS), or physician assistant (PA)

(4) "Licensing authority" means the division of health improvement of the New Mexico health care authority.

M. Definitions beginning with "M":

(1) "Maintenance" means keeping the building(s) in a repaired and safe condition and the grounds in a safe, sanitary and presentable condition.

(2) "Mechanical restraint" means any device or material attached or adjacent to the child's body that restricts freedom of movement or normal access to any portion of the child's body and that the child cannot easily remove but does not include mechanical supports or protective devices.

(3) "Medicaid" means Title XIX of the Social Security Act; the joint federal-state program that pays for medical care for low-income persons.

(4) "Mobile non-ambulatory" means unable to walk without assistance but able to move from place to place with the use of devices such as walkers, crutches, wheelchairs, etc.

(5) "Moral turpitude" means conduct contrary to justice, honesty, modesty or good morals including such acts as domestic abuse, drunk driving or other similar convictions and as further specified in 8.8.3 NMAC.

N. Definitions beginning with "N":

(1) "Neglect" by individuals or an agency means:

(a) failure to provide any treatment, service, care, medication or item that is reasonably necessary to maintain the health or safety of a client; or

(b) failure to take any reasonable precaution that is necessary to prevent damage to the health or safety of a client; or

(c) failure to carry out a duty to supervise properly or control the provision of any treatment, care, good service or medication reasonably necessary to maintain the health or safety of a client; or

(d) failure to take any reasonable precaution that would prevent the physical abuse, sexual abuse, or sexual exploitation of a client, as defined in the Children's Code at 32A-4-2 NMSA 1978, or the lack of which causes the client to become an abused child or neglected child as defined in the Children's Code at 32A-4-2 NMSA 1978.

(2) "Non-accredited RTC" means a program that provides residential treatment services pursuant to these requirements that is not accredited by the joint commission.

(3) "Non-mobile" means unable to move without assistance from place to place.

(4) "Non-renewal" means a sanction whereby certification and or licensing is cancelled on or about the date of expiration.

(5) "Non-residential services" means a program that provides certified services other than twenty-four-hour continuous care within the confines of a facility or treatment foster home.

(6) "Notice of contemplated action" means a letter issued by the HCA identifying grounds for sanction of a program.

(7) "Notice of emergency sanction" means a letter issued by the HCA when an emergency sanction is imposed.

(8) "Notice of final action" means a letter issued by the HCA stating that the sanctions proposed in a previous notice of contemplated action are in effect. This letter is issued upon the conclusion of any appeal/informal resolution proceeding or the expiration of the appeal period to the notice of contemplated action.

P. Definitions beginning with "P":

(1) **"Permanency plan"** means the long-term plan for the child/adolescent developed by the protective services division of the department with one of the following outcomes: reunification, permanent guardianship, adoption, permanent placement with a fit and willing relative, or planned permanent living arrangements.

(2) **"Personal restraint"** means the application of physical force without the use of any device, for the purposes of restraining the free movement of a client's body.

(3) **"Physical escort"** means the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purposes of inducing a client who is exhibiting unsafe or potentially unsafe behavior to walk to a safe location.

(4) **"Physician"** means an individual who has received a degree of doctor of medicine or doctor of osteopathic medicine and is licensed to practice medicine in the state of New Mexico.

(5) **"Plan of correction"** means a plan developed by the provider and approved by HCA that describes the actions the facility will take to correct deficiencies and specifies the date by which those deficiencies will be corrected.

(6) **"Policy"** means a statement of principle that guides and determines present and future decisions and actions.

(7) **"Premises"** means all parts of buildings, grounds, vehicles and equipment of a facility.

(8) **"Pre-service training"** means training that is provided to a newly hired employee prior to the employee's provision of direct services.

(9) **"Procedure"** means the action(s) that will be taken to implement a policy; and the written description of such action(s) that serves as instruction to agency staff.

(10) **"Program"** means an agency, or subdivision of an agency, operated with the intent to provide certified services.

(11) **"Programmatic services"** means services provided to children to meet special needs above and beyond living accommodations, meals, care, and routine supervision.

(12) **"Provider"** means an agency or its personnel who have a medicaid provider number and deliver direct services to clients.

(13) **"Psychiatrist"** means a physician who specializes in the treatment of psychiatric disorders, has completed an accredited psychiatric residency program, and holds a current license to practice medicine in the state of New Mexico.

(14) **"Psychological harm"** means harm that causes symptoms of mental or emotional trauma, or that causes distress of sufficient magnitude to cause behavioral change, or physical symptoms that may require psychological or psychiatric evaluation or treatment. A reasonable person standard shall apply when the harmed individual is not able to express their feelings, when there is no discernable response from the harmed individual, when circumstances do not permit a direct evaluation of the individual's psychosocial outcome, or when an individual's reaction to a the harm is markedly incongruent with the level of reaction a reasonable person in the individual's position would have to the harm.

(15) **"Psychologist"** means a doctoral level psychologist who specializes in assessing and treating psychological disorders and holds a current license to practice in the state of New Mexico.

(16) **"Punishment"** means a penalty imposed on a child/adolescent by one in authority for wrongdoing.

Q. Definitions beginning with "Q": [RESERVED]

R. Definitions beginning with "R":

(1) **"Recovery"** means the process, outlook, vision and guiding principle that stresses that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society (adapted from *Mental Health: A Report to the Surgeon General, Chapter 2, 1999*).

(2) **"Recovery/resiliency management plan"** means the foundational component for building the comprehensive service plan. The recovery/resiliency management plan component focuses on strengths and preferences based on identified competencies, the process of autonomy (independence), and developing a system of natural supports (satisfying and supportive social relationships). The recovery/resiliency management plan component shall include:

(a) the client and family's personal choice of service options and priorities in service delivery with a client centered focus;

(b) client driven interventions including attainable objective to address the client's

defined needs;

(c) a clear identification of the environment in which the client lives including: family, school peers, community and home, and how each will play a part in the comprehensive service plan; and

(d) a clear approach to the development of resiliency based on life skills identified by the client and service team.

(3) "Reduction in licensed capacity" means the reduction of licensed capacity of a residential facility until deficiencies are corrected.

(4) "Reference check" means a documented contact with previous employers, supervisors, co-workers, or other sources, initiated by the agency to evaluate a prospective employee prior to hire by establishing the accuracy of his/her employment history and to obtain other information relevant to potential hire.

(5) "Rehabilitation" means a process that enhances the efficacy of clients with functional limitations due to behavioral health disorders to obtain information, develop skills and access resources needed to make decisions and implement strategies to be successful and satisfied in the living, working, learning, and social environments of their choice. Rehabilitation services are driven by the client's desire for recovery and resiliency based outcomes and are individualized, collaborative and person directed.

(6) "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or treatment plan, or any other incident which may evidence abuse, neglect, or exploitation.

(7) "Residential facility" means a facility licensed by HCA, in which 24-hour continuous therapeutic care is provided to a group of children/adolescents in accordance with these certification requirements.

(6) "Residential treatment services" means a program that provides 24-hour therapeutic care to children/adolescents with severe behavioral, psychological, neurobiological, or emotional problems, who are in need of psychosocial rehabilitation in a residential facility.

(8) "Restraint/seclusion clinician" means a New Mexico licensed medical doctor (MD), doctor of osteopathy (DO), certified nurse practitioner (CNP), clinical nurse specialist (LCNS), physician assistant (PA) or doctoral level psychologist (Psy.D., Ph.D., or Ed.D.), who is trained in the use of emergency safety interventions.

(9) "Restricted admissions or provision of services" means the restriction of an agency from providing designated services and from accepting any new clients until deficiencies are corrected.

(10) "Revocation" means a type of sanction making a certification or license null and void through its cancellation.

S. Definitions beginning with "S":

(1) "Sanction" means a measure imposed by the authority on a licensed program, pursuant to these requirements, in response to a finding of deficiency, with the intent of obtaining increased compliance with these requirements.

(2) "Seclusion" means a behavior management technique of Involuntary confinement of a client alone in a room where the individual is physically prevented from leaving, and is limited to those situations with adequate, appropriate clinical justification, requiring policies and procedures with clear criteria. Seclusion is distinct from therapeutic time-out.

(3) "Sexual abuse" means any intentional and uninvited contact, demand or enticement of a sexual nature, including contact with another person's clothed or unclothed genital area, anus, buttocks, or breast(s) if the recipient is female; or, intentional causing of another person to touch any of these areas on one's own or a third party's body; or, consensual contact with any of these areas if the initiator is in a position of significant influence over the recipient by reason of differences in age, physical size, development, intellectual sophistication, sexual sophistication, or position of authority; or, a verbal request, offer, or demand such as would initiate such contact when the initiator of the verbal behavior is in a position of significant influence as described above. Physical contact, as described above, includes contact between clothed or unclothed body parts of individuals, or may be between clothed or unclothed body parts of one person and an object.

(4) "Staff" means a person who has contact with children in a certified program and includes the owner, operator or director of a program, volunteers, full-time, part-time, contract employees, and treatment foster parents.

(5) "Substantial compliance" means that a facility or certified program is found to be without deficiencies.

(6) "Substantiated" means the verification of a complaint based upon a preponderance of reliable evidence obtained from an appropriate investigation.

(7) "Supervision" means one of the following, as indicated by context: the monitoring of clients' whereabouts and activities by the program staff in order to ensure their health, safety, and welfare; or the clinical or managerial oversight of staff.

(8) "Survey" or investigation means an entry into a facility or certified program and examination of the facility premises, inspection of records and interview of staff and clientele to determine compliance with the regulations.

(9) "Suspension" means a type of sanction whereby licensure and or certification is temporarily revoked, pending an appeal hearing for licensure or for certification, during which time the medicaid provider agreement is not in effect.

T. Definitions beginning with "T":

(1) "Therapeutic leave" means a period of time during which a treatment foster care services client is temporarily placed in a different treatment foster home. This affords the primary treatment foster parents a period of authorized leave.

(2) "Therapeutic time-out" means a technique involving individual isolation used as part of a written behavioral plan to prevent or decrease the potential for unsafe behavior and to give the client the opportunity to regain control.

(3) "Therapist" means a person who has a license from an appropriate licensing authority to provide direct clinical care services such as individual, family, or group therapy.

(4) "TJC" The joint commission.

(5) "Treatment foster care services (TFC) level I" means a program that provides therapeutic services to children or adolescents who are psychologically or emotionally disturbed, or behaviorally disordered, in a foster family setting, pursuant to these certification requirements.

(6) "Treatment foster care services level II" means a program that provides therapeutic services to children or adolescents who are psychologically or emotionally disturbed, or behaviorally disordered, in a foster family setting, pursuant to these certification requirements. It is distinct from treatment foster care services level I in that it is provided to children and adolescents who have successfully completed treatment foster care services level I as determined by the treatment team, and are in the process of returning to biological family and community, or who meet other established criteria.

(7) "Treatment foster home" means a licensed residence overseen by a certified program and licensed child placement agency in which treatment foster care services are being provided to agency clients by licensed treatment foster parents.

(8) "Treatment plan" means a plan, based on data gathered during the assessment, that identifies the treatment needs of the client being served, lists the strategies to meet those needs, documents measurable treatment goals and objectives, outlines the criteria and time frame for terminating specified interventions, and, when reviewed, documents the clients progress in meeting the specified goals and objectives.

(9) "Treatment planning" means an ongoing process, based on assessment and regular reassessment of a client's needs, of documenting those needs, the interventions intended to address those needs, and the client's behavioral responses to interventions. Treatment planning includes initial treatment plans, comprehensive treatment plans, treatment plan reviews and discharge plans.

(10) "Treatment team" means the group of individuals that assesses, plans, coordinates, implements, evaluates, reviews, and adjusts all aspects of a client's care over the course of treatment in a certified program. The treatment team includes the client, and as applicable, the client's family or legal guardian(s), therapist, direct service staff, treatment coordinators, treatment foster parents, the department's social worker or juvenile probation/parole officer, case manager, a representative from an educational agency, or other significant individuals in the client's life.

U. Definitions beginning with "U": "Unsubstantiated" means that the complaint or incident could not be verified based upon a preponderance of reliable evidence obtained from an appropriate investigation.

V. Definitions beginning with "V":

(1) "Variance" means a decision that is made at the discretion of HCA to allow a facility to deviate from a portion(s) or to modify a provision of this rule for an unspecified period of time, provided that the health, safety, or welfare of the clients and staff are not in danger.

(2) "Volunteer" means an individual who works without compensation at an agency in the physical presence or proximity of clients.

W. Definitions beginning with "W": "Waive/waiver" means to refrain from pressing or enforcing compliance with a portion or portions of these regulations for a limited period of time provided the health, safety, or welfare of the clients and staff are not in danger. Waivers are issued at the sole discretion of HCA.

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z": [RESERVED]

[8.369.3.7 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.8 RELATED REGULATIONS, LAWS AND CODES: These certification requirements supplement and apply in conjunction with the following regulations laws and codes and any future amendments to such regulations or superseding regulations.

A. Licensing requirements for child and adolescent mental health facilities, health care authority, 8.369.4 NMAC.

B. Health facility sanctions and civil monetary penalties, health care authority, 8.370.4 NMAC.

C. New Mexico Children's Code 32A-1-1 et Seq. NMSA 1978.

D. Specialized behavioral health provider enrollment and reimbursement, health care authority, 8.321.2 NMAC.

E. Governing background checks and employment history verification, children, youth and families department, 8.8.3 NMAC.

F. Adjudicatory hearings for licensed facilities, health care authority, 8.370.2 NMAC.

G. Health facility licensure fees and procedures, health care authority, 8.370.3 NMAC.

H. Health facility sanctions and civil monetary penalties, health care authority, 8.370.4 NMAC.

I. Incident reporting, intake, processing and training requirements, 8.370.9 NMAC.

[8.369.3.8 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.9 ISSUANCE OF CERTIFICATION:

A. Certification is required**:** No person or entity shall provide services outlined in this regulation without first becoming certified by the HCA.

B. Application for initial certification:

(1) Applications for the initial certification of a new program offering comprehensive community support services, behavior management skills development services, day treatment services, group home services, all residential treatment services, or treatment foster care services are submitted to the HCA for review and approval. The application for initial certification of a program includes, but is not limited to, the following:

(a) a letter of intent on agency letterhead naming the service for which the agency is requesting initial certification and describing how and where the proposed service will be delivered;

(b) policies and procedures showing that the agency complies with both the general provisions and the service-specific requirements of the program for which the agency is requesting initial certification; and an index that references each policy and procedure by the applicable certification requirement that the policy is designed to meet;

(c) job descriptions, required qualifications, resumes, current licenses, proof of credentials, and criminal records clearances for professional staff, including designated administrator;

(d) job descriptions, required qualifications and criminal records clearances for direct service staff; and

(e) a complete set of the forms that will be used to document the services being provided.

(2) At the discretion of the HCA, the application process may include interviews with staff, administrators, or program directors.

(3) When applicant agencies have an established in-state or out-of-state history of providing mental health or substance use disorder services for children and adolescents, whether or not the agency is currently providing such services, the agency's record with regulatory compliance will be considered during review of the new application;

(4) Applications will be reviewed by the HCA within 25 business days and a written response will be sent to the agency. The findings of the review will determine which of the following responses will be issued by the HCA:

(a) Complete applications that comply with all the requirements of these certification requirements will be issued an initial certification for a period of up to 120 days.

(b) Incomplete applications will be returned with a letter detailing what elements of the application are missing. initial certification will not be issued.

(c) When an application is complete but fails to show that the agency has fully or

substantially complied with all of these certification requirements, the HCA will issue a letter detailing the findings of the review, with a list of the changes required to show the new program to be in compliance with these certification requirements. An initial certification will not be issued.

(5) If, three months subsequent to the issuance of an HCA letter detailing missing or insufficient elements of an application, the agency has not responded with a completed application or has not achieved compliance with these certification requirements sufficient to warrant initial certification, the application will be considered void. The agency may reapply for certification of the service but will be required to begin a new application process.

(6) COA/CARF/TJC Accreditation does not confer state certification status on a program.

C. Types of certification:

(1) Full certification: Full certification is granted to a program currently serving clients and found by the HCA to be in substantial compliance with these certification requirements. At the discretion of the HCA, the duration of full certification status is 24 months.

(a) The HCA determines the duration of a temporary certification. Temporary certification may be granted for a period of up to 120 days.

(b) At the discretion of the HCA, a second consecutive temporary certificate may be issued for a period of up to 120 days, or certification may be allowed to expire without renewal.

(2) Temporary certification: This certification is granted for a period of 120 days to a program that has met the minimum requirements to provide child and adolescent mental health or substance use disorder services as determined by the application process described in certification requirement 9.A above. If the program has no clients at the end of 120 days, a second 120-day initial certification may be granted. If the program remains without clients beyond 240 days, the program's initial certificate expires and re-application for certification is required; or, at the discretion of the HCA, inactive status may be granted.

(3) Inactive status: This certification is granted to a program not presently serving clients, but which has served clients within the current period of certification. A certificate of inactive status covers a period of time not to exceed 180 days from the date of issue. If the program continues without clients beyond 180 days, a second 180-Day certificate of inactive status may be granted upon request. If the program remains without clients beyond 365 days, the program's inactive status expires and re-application for initial certification is required.

(a) To return to active status from inactive status for a certified service, the program must notify the HCA in writing at least 30 calendar days prior to its intended admission of clients. In addition to the written notice, the agency must submit the following to the HCA: information on any changes in personnel or agency policies and procedures during inactive status; proof of criminal records clearances, qualifications, and, as applicable, licensure for new supervisory and direct service staff of the certified program.

(b) Upon review of the submitted information, the HCA may grant temporary certification. The agency will not admit any client(s) until the HCA issues, and the program receives, temporary certification.

(4) Application for certification renewal: Each agency shall apply for a renewal of the certificate within 30 business days prior to the certification expiration date by submitting an application and the required fee.

(5) Amended certificate: This certification is granted to a program currently serving clients that has had a change of ownership or provider, or that chooses to change its name. The agency submits a written request for an amended certificate to the HCA ten business days prior to the change. A provider must apply to the HCA for an amended certificate when there is a change of administrator/director, location, agency name, or ownership. The agency must notify the HCA 30 calendar days prior to the change.

D. Automatic expirations of a certification: A certificate automatically expires at midnight on the day a certified program discontinues or suspends operation is sold, leased, or otherwise changes ownership or changes location.

E. Waivers and variances: Upon written request of the agency and at the discretion of the HCA, the HCA may issue a waiver or variance

F. In the event that a program's certification is revoked, suspended, denied, or not renewed, the medicaid provider agreement terminates on the date of the revocation, suspension or denial.

[8.369.3.9 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.10 EMERGENCY REVOCATION, SUSPENSION, NON-RENEWAL OF CERTIFICATION OR IMPOSITION OF EMERGENCY SANCTIONS, WITHOUT PRIOR HEARING: In accordance with Subsection H of 24A-1-5 and 24A1-6 NMSA, 1978 of the Health Care Code as amended if immediate action is

required to protect human health and safety, the HCA may immediately suspend or revoke a certification or impose emergency sanctions pending a hearing, provided such hearing is held within five working days of such action, unless waived by the provider.
[8.369.3.10 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.11 GROUNDS FOR IMPOSITION OF SANCTIONS:

A. When the licensing authority determines that it will deny an application for the renewal of a certification or that it will revoke a certification, it shall provide notification to the provider, the residents and the surrogate decision makers for the clients

B. After notice to the provider and an opportunity for a hearing, the authority may deny an initial or renewal application, revoke or suspend the certification of a provider or may impose an intermediate sanction and a civil monetary penalty as provided in accordance with the Health Care Code, Section 24a-1-5.2 NMSA 1978.

C. Grounds for implementing these penalties may be based on the following:

(1) failure to comply with any provision of this rule;

(2) failure to allow a survey by authorized representatives of the licensing authority;

(3) the hiring or retaining of any staff or permitting any private duty attendant or volunteer to work with clients that has a disqualifying conviction under the requirements of the caregiver's criminal history screening program, 8.370.5 NMAC;

(4) the misrepresentation or falsification of any information on the application forms or other documents provided to the licensing authority;

(5) repeat violations of this rule;

(6) failure to maintain or provide services as required by this rule;

(7) exceeding certification capacity;

(8) failure to provide an acceptable plan of correction within the time period established by the licensing authority;

(9) failure to correct deficiencies within the time period established by the licensing authority;

(10) failure to comply with the incident reporting requirements pursuant to incident reporting, intake processing and training requirements, 8.370.9 NMAC;

(11) failure to pay civil monetary penalties pursuant to health facility sanctions and civil monetary penalties, 8.370.4 NMAC.

[8.369.3.11 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.12 APPEALS AND HEARINGS. Hearing procedures for an adverse action taken against a facility by the authority will be conducted in accordance with adjudicatory hearings for licensed facilities, 8.370.2 NMAC.

A. The facility will receive a copy of the hearing procedures at the time that an adverse action is taken or may request a copy by contacting the licensing authority.

B. If immediate action is required to protect human health and safety, the licensing authority may suspend a license or impose an intermediate sanction pending a hearing, provided that the hearing is held within five working days of the suspension or the sanction, unless waived by the facility, in accordance with the Public Health Act, Subsection H of Section 24a-1-5 NMSA**.**

C. A licensee that is subject to an adverse action may request an administrative appeal. Hearing procedures for an administrative appeal of an adverse action taken by the licensing authority against the facility is in accordance with adjudicatory hearings for licensed facilities, 8.370.2 NMAC.

D. A copy of the adjudicatory hearing procedures will be forwarded to the facility when an adverse action is taken against the licensee by the licensing authority.

E. All notices, orders or decisions which the licensing authority issues to a facility prior to a transfer of ownership shall be in effect against both the former owner and the new owner, unless the transfer of penalties to the new owner is rescinded in writing by the authority.

[8.369.3.12 NMAC - Rp, 8.369.3.12 NMAC, xx/xx/xx26]

8.369.2.13 WAIVERS AND VARIANCES. The licensing authority may vary or waive certain certification requirements for providers, provided that it would not adversely affect the health, safety or welfare of the clients or staff.

A. Requests for a variance or waiver may be made at any time, shall be made in writing to the

licensing authority and shall specify the following:

(1) the section of the rule for which the variance or wavier is requested;

(2) the time period for which the waiver is requested;

(3) if the request is for a variance; the specific alternative action that the provider proposes;

(4) the reason(s) for the request and an explanation of why and how the health, safety and welfare of the clients or staff are not endangered by the requested variance or waiver; and

(5) justification that the goal or purpose of the rule would be satisfied with a waiver or variance.

B. The licensing authority may require additional information from the provider prior to acting on the request.

C. The licensing authority may impose conditions on the variance or waiver.

D. The licensing authority may limit the duration of any waiver.

E. Variances and waivers are non-transferable and shall be kept on file and readily available with the provider.

[8.369.3.13 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.14 SURVEY OR MONITORING VISITS:

A. The licensing authority shall perform unannounced on-site surveys or monitoring visits of all providers who require certification under this rule.

B. The provider shall provide the licensing authority with full access to all provider operations, buildings and information related to the operation of the provider. This includes interviews with provider staff. The provider shall develop and implement written policies and procedures that promote a culture of safety, open communication in the work environment, including prohibiting retaliation against an employee who cooperates with the survey process and interviews.

C. The most recent survey inspection reports and related correspondence shall be posted in a conspicuous public place with the provider.

D. Failure by the provider to provide the licensing authority access to the premises or information, including client records and interviews with any party with relevant information, may result in the imposition of sanctions including but not limited to civil monetary penalties, certification revocation or an order to cease and desist, in accordance with 8.370.4 NMAC, as deemed appropriate by the licensing authority. Impeding the survey or investigation includes the following:

(1) Failure of the provider to provide client records, medical records, staff records, or other records necessary for the survey process. The provider must make available a printout of any record or part of a record upon request in a timeframe that does not impede the survey process.

(2) Failure of the provider to provide records. Undue delays in the production of records are unacceptable.

[8.369.3.14 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.15 CRIMINAL RECORDS CHECKS AND CLEARANCES:

A. Every program that provides child/adolescent mental health or substance use disorder services pursuant to these certification requirements, operating in New Mexico, must initiate and provide to CYFD two completed state-and FBI-approved fingerprint cards for each employee must initiate and provide to the background check unit a completed application form and an electronic fingerprint submission receipt for each employee who will have direct clients contact. The agency must have received the criminal records clearance from the background check unit prior to the employee's direct, unsupervised contact with clients of the program.

B. All agencies must comply with 8.8.3 NMAC regulations governing criminal records checks.

C. Student trainees in psychiatry, psychology, social work or nursing, or other related health, social or human-services disciplines who are enrolled in a clinical training program of a New Mexico state accredited institution of higher learning, and who are under the supervision of a cleared licensed independent practitioner, may be allowed to work with children without direct physical supervision during their enrolled student tenure if the trainee signs a sworn affidavit attesting that they have never been convicted of a crime that would disqualify them from providing direct services to children.

D. The certification requirements governing criminal records clearances remain in effect while a program is accredited by COA, CARF or TJC.

E. If a prospective employee has not lived in the United States continuously for the five years previous to hire, the equivalent of a criminal records clearance is required from any country in which they have lived

within the last five years, for a period longer than one year.

F. If the agency receives reliable evidence that indicates that an employee or prospective employee poses a potential risk of child abuse, sexual abuse, exploitation, moral turpitude, cruelty, or indifference to children, the agency is in violation of these certification requirements and subject to sanction up to loss of certification if that individual is hired or retained.

G. Upon request by the HCA, the agency will provide a list of employees who are not required to have a criminal records clearance, and the reason(s) why not.

H. Non-compliance with any certification requirement relating to criminal records checks and clearances may be referred to the background check unit of CYFD.

[8.369.3.15 NMAC - Rp, 8.369.3.15 NMAC, xx/xx/xx26]

8.369.3.16 PERSONNEL:

A. The agency provides personnel who are trained, supervised and in all respects qualified to perform the functions for which they are responsible. Each agency must have a designated Administrator that pursuant to these regulations must have the following minimum qualifications:

(1) Be at least 21 years of age.

(2) Be able to pass a background check as stated in 8.8.3 NMAC.

(3) Possess educational background and experience in the principles and practices of child care, which includes an associate or bachelor's degree in early childhood development or related degree, or documented training related to child development and learning, trauma informed care, health and safety of children, quality improvement and evaluation and licensing requirements.

B. Each position, or group of like positions, is detailed in a written job description that clearly states qualifications, responsibilities and requirements.

C. Each agency employee meets all state registration, licensing and certification requirements applicable to their position and use of professional title(s) and the agency has copies of such licenses, etc. on file.

D. Orientation of personnel:

(1) The agency orients its personnel to the agency's goals, services, policies and procedures, and to the responsibilities of the staff member's position. Initial and ongoing orientation is documented in the personnel record.

(2) Orientation includes training on the establishment and maintenance of appropriate and responsive relationships and boundaries with clients.

E. Personnel training, development, responsibilities and supervision:

(1) The agency provides a training and development program to allow personnel to improve their knowledge, skills and abilities and to promote awareness and appreciation of the cultural background and need of persons served by the agency. This training will be documented in the personnel file.

(2) The agency provides staff development opportunities for personnel, including in-service training.

(3) Staff who require training to qualify for a position in which they are responsible for the care of children do not have sole responsibility for the care of children until after the successful completion of the training.

(4) Staff designated as direct service staff under service-specific certification requirements receive ongoing training related to the age and emotional development of the children for whom they are responsible.

(5) All certified services are provided under supervision of a clinical director who provides clinical oversight of the program, by way of documented supervision and consultation to all agency staff. Supervision may be direct or may occur through a clinical supervisor who is directly supervised by the clinical director.

(6) All clinical supervision/consultation is documented, and documentation includes the theme, date, length of time of supervision and signatures of those participating.

(7) In the event that the therapist and clinical supervisor are the same person, another properly credentialed clinician, either from within the agency or from outside the agency, provides supervision at least one time per month to the clinical supervisor.

(8) The responsibilities of the therapist include providing therapy and participating in the development of a treatment plan. These activities are documented.

(9) When the agency utilizes the services of professionals on a per interview, hourly, part-time, or independent contractor basis, the agency documents regular assessment of the quality of services provided.

F. Accountability:

(1) The agency ensures that the performance of all employees, consultants, contractors, and volunteers is consistent with agency policy and these certification requirements.

(2) At least once a year, written performance reviews are conducted jointly between each staff member, including volunteers, and the person's supervisor.

G. Personnel records:

(1) A personnel record is maintained for each employee, intern and volunteer. Each personnel record is readily accessible to the HCA at each site visit, and contains, at a minimum:

(a) documentation of all orientation and training, including dates, hours or credits, names of trainer and trainee, and written confirmation by trainer or training organization that the training has occurred;

(b) employee's name, current address, telephone number and emergency contact(s);

(c) job title and description;

(d) evidence of licensure for those employees required to be licensed;

(e) date first employed, dates of transfer or changes in position, and date of termination;

(f) documentation of a minimum of three employment reference checks within three weeks prior to employment (if this process yields fewer than three employment reference checks, additional professional or personal references are obtained to achieve the required minimum of three references);

(g) a copy of the employee's current CPR and first aid certificates, and a state approved behavior management training;

(h) for cleared staff, the criminal records clearance letter, or for uncleared staff, a signed statement by the administrator, director, or operator attesting to direct supervision of the uncleared employee by a cleared employee until the clearance is received;

(i) application for employment or resume consistent with agency policy;

(j) performance reviews, as applicable.

(2) The agency's written policies and practices require that an applicant for employment disclose any prior criminal convictions, and employees report any arrests or convictions that occur while employed.

(3) The agency's written policies provide personnel with access to their records and a process to review the record and to make additions and corrections to the record.

H. Schedules of direct service staff in day treatment and residential facilities:

(1) Each facility or licensed unit maintains a written, legible schedule clearly identifying direct service staff responsible for care of clients.

(2) Each uncleared employee is identified on the staff schedule.

(3) The staff schedule is updated daily to reflect actual hours staff are present and changes in attendance as they occur.

(4) Original updated staff schedules are kept on file for at least 12 months.

(5) The updated schedule documents the client census for each unit of a residential treatment services center or group home service on a daily basis.

[8.369.3.16 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.17 REPORTING OF INCIDENTS

A. The provider shall ensure that all suspected cases, allegations or known incidents of abuse, neglect or exploitation are reported in accordance with 8.370.9 NMAC.

B. The provider shall also report any incident immediately upon knowledge of incident but not to exceed 24 hours. The provider shall not delay a report while an internal investigation is conducted. Such incidents may include, but are not limited to:

(1) fire, flood, or other natural disasters which create structural damage to the facility or poses health hazards;

(2) any outbreak of contagious disease dangerous to the public health;

(3) any human act(s) by staff member(s) or client(s) of the facility which presents or poses possible physical, psychological, or both health hazards;

(4) any death of a client;

(5) near fatality (life-threatening injury, organ failure, severe shock, substantial risk of death, life-saving intervention, or ICU admission);

(6) serious injury (requiring utilization of medical attention or hospitalization);

(7) suicide attempt;

(8) allegation of restraint or seclusion;

(9) serious homicidal threat to or by a client;

(10) the use, possession, or distribution of illegal substances by clients or staff;

(11) AMA or emergency discharge;

(12) arrest or detention of a client;

(13) agency knowledge that a staff member has been charged with, or convicted of, a felony or of a misdemeanor involving moral turpitude, including but not limited to convictions referenced in 8.8.3 NMAC;

(14) any suspected client abuse, neglect or exploitation of a client, as defined in these regulations;

(15) incidents that include acts of physical harm to a client by staff or other clients;

(16) absence of clients without permission, including not returning from a pass, for longer than 24 hours past the designated return time;

(17) any non-informational call made to poison control involving potential harm to a client or resulting in treatment of a client;

(18) injury of unknown origin;

(19) falls which cause injury;

(20) medication error which causes or is likely to cause harm;

(21) failure to follow a doctor's order;

(22) any 911 call;

(23) any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the client and staff;

(24) incidents involving minor illnesses or injuries not requiring emergency services do not need to be reported to the HCA. Day treatment services, case management services, and behavioral management skills development services are not required to report serious incidents that do not occur during program hours.

C. The provider is responsible for conducting and documenting the investigation of all incidents within five business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file with the provider. The investigation shall include the following:

(1) a narrative description of the incident;

(2) the result of the provider's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 8.370.9 NMAC; and

(3) plans for further actions in response to the incident.

[8.369.3.17 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.18 AGENCY IN THE COMMUNITY:

A. The agency identifies a defined purpose, uses a multi-disciplinary approach in which services are coordinated within the agency and within the provider community, and collaborates with other agencies in provision of services for its clients.

B. Agency purpose: The agency's statement of purpose includes a description of its primary function as providing services that:

(1) serve those clients in need of treatment who are most vulnerable or at risk;

(2) are habilitative in focus; and

(3) are consistent with the least restrictive means principle.

C. Community access to services:

(1) The agency provides culturally competent services and serves the needs of those clients who are bicultural or who are non-English speaking through the use of:

(a) bilingual/bicultural professional and qualified paraprofessional personnel;

(b) translators to meet the clients' communication needs.

(2) The agency provides public information concerning its services to persons in the community who are non-English-speaking. This information is designed to encourage full participation of non-English speaking clients.

[8.369.3.18 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.19 AGENCY GOVERNANCE AND ADMINISTRATION:

A. The agency is legally authorized to operate, identifies the members of its governing body, and

administers its program in accordance with its own policies, which support compliance with these certification requirements.

B. The agency's governing body is responsible for adopting bylaws and policies and defining the scope of its services. The agency is legally authorized to operate as one of the following:

(1) not-profit agency, incorporated in the state in which it operates, with a charter, constitution, and by-laws;

(2) not-profit agency operated by its own independent governing body, under the aegis of a religious body or other organization recognized under the laws of the state;

(3) public agency authorized and established by statute, or a sub-unit of a public agency with which clear administrative relationship exists;

(4) proprietary agency organized as a legal entity as a corporation, partnership, or association, but excluding therefrom sole proprietors; or

(5) agency of a tribal government, or subdivision thereof.

C. Policies and procedures: The agency maintains current policies and procedures for agency administration, service delivery, and protection of consumer rights.

(1) The agency makes a copy of its policies and procedures available to new personnel upon employment.

(2) The agency documents that it keeps all personnel advised regularly of revisions to its policies and procedures as revisions occur.

(3) The agency conducts annual reviews of its policies and procedures and makes revisions as necessary to maintain compliance with applicable laws, regulations, and these certification requirements.

[8.369.3.19 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.20 QUALITY IMPROVEMENT AND UTILIZATION REVIEW:

A. The agency has a continuous quality improvement process, reviewed annually, through which the agency systematically evaluates the effectiveness of services provided by determining whether its services meet pre-determined quality improvement expectations and outcomes, and corrects any observed deficiencies identified through the quality improvement process.

B. The agency explicitly details the desired expectations and service outcomes for each of its programs and has a written plan to achieve them.

C. The agency establishes a committee or other mechanism for the timely and regular evaluation of serious incidents, complaints, grievances, and related investigations. Committee evaluations include identification of events**,** trends and patterns that may affect client health, safety, and treatment efficacy. Committee evaluation findings and recommendations are documented and submitted to agency management for corrective action. Actions implemented and outcomes are documented, and trends are analyzed over time. The agency has a well-defined plan for correcting problems. When problems (or potential problems) are identified, the facility acts as soon as possible to avoid any risks to clients by taking corrective steps that may include, but are not limited to:

(1) changes in policies or procedures;

(2) staffing and assignment changes;

(3) additional education or training for staff;

(4) addition or deletion of services.

D. The agency develops a system to utilize its collected data regarding the outcome of its activities for delivering continuously improving services.

E. Formal and informal feedback from consumers of services and other collateral sources is aggregated and used to improve management strategies and service delivery practices.

F. The agency collects and maintains information necessary to plan, manage, and evaluate its programs effectively. The outcomes are evaluated on a quarterly basis, the results of which are used continuously to improve performance and maintain documentation for review at time of survey.

G. The agency implements and maintains ongoing utilization review processes.

[8.369.3.20 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.21 LEGAL, REGULATORY, AND ACCREDITATION COMPLIANCE FOR PROGRAM OPERATION, INCLUDING HEALTH, SAFETY AND PHYSICAL PLANT REQUIREMENTS:

A. The agency promotes and protects the health and safety of its clients, demonstrates compliance with all applicable laws and regulations, adheres to the requirements of its accrediting bodies, if any, and possesses all applicable licenses required by law and departmental policy.

(1) License(s) required: The agency possesses a license(s) and complies with applicable licensing requirements for each service required by state and local law and departmental regulation including, but not limited to the following:

(a) Each treatment foster care child placement agency is licensed by the protective services division of the New Mexico children, youth and families department as a child placement agency.

(b) All residential facilities are licensed by the department. Each maintains a separate license.

(2) Residential treatment services and group home services are certified only when provided in a facility licensed by the HCA for 16 beds or fewer per unit.

B. An agency accredited by an accrediting organization recognized by the HCA complies with the current requirements of the accrediting organization. The accrediting organizations recognized by the HCA are:

(1) council on accreditation for children and family services (COA);

(2) the joint commission and;

(3) council on accreditation of rehabilitation facilities (CARF).

[8.369.3.21 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.22 CLIENT PARTICIPATION, PROTECTION, AND CASE REVIEW:

A. The agency takes all reasonable action(s) to protect the health, safety, confidentiality, and rights of its clients. The agency informs the client of their rights and responsibilities and develops and implements policies and procedures that support and facilitate the client's full participation in treatment and related agency activities. The agency protects the confidentiality of client records through adherence to its own set of policies and procedures governing access to, and release of, confidential information.

B. Materials describing services offered, eligibility requirements and client rights and responsibilities are provided in a form understandable to the client and client's legal guardian(s) with consideration of the client's/guardian's primary language, and the mode of communication best understood by persons with visual or hearing impairments.

(1) If the client is unable to understand the materials for any reason, every effort is made to explain their rights and responsibilities in a manner understandable to the client. These efforts will be documented in the client's record.

(2) Materials are available or posted in the agency's reception area and handed to potential clients during their initial contact with the agency.

C. The agency explains to each client what their legal rights are in a manner consistent with the client's ability to understand and makes this information available to the client in writing, or in any other medium appropriate to the client's level of development. A written explanation of these rights is given to the parent/legal guardian upon admission.

(1) A client who receives residential treatment services has the rights enumerated in the New Mexico children's mental health and developmental disabilities code, Sections 32A-6-1 et seq. NMSA 1978. Explanation of rights to the client and parents/legal guardian is documented in the client's record.

(2) The agency maintains and follows written policy affirming that clients may refuse any treatment or medication, unless the right to refuse treatment(s) has been limited by law or court order. The agency informs the individual of the risks of such refusal. Client refusal of treatment and advisement of risks of the refusal is documented in the client's record.

(3) The agency specifies in written policies and procedures the conditions under which it serves minors without parental/legal guardian consent, and when parental/legal guardian consent is not possible, designates who is authorized to give consent to treat the minor.

(a) The client record contains all applicable consents for treatment, including 8.369.3 NMAC consent for emergency medical treatment and informed consent for all prescription medication.

(b) Exception: Day treatment services, behavioral management skills development services and case management services programs are not required to file consents for prescription medications that are not taken during program hours unless the medications are prescribed by a program physician.

(c) Consent forms must contain the information identifying the specific treatment, prescription medication, medication indication, information release, or event for which consent is being given prior to being signed by a client or guardian.

(4) Upon admission, each client receives an orientation to the agency's services that includes the basic expectations of the clients, the hours during which services are available, and any rules established by the agency regarding client conduct, with specific reference to behavior that could result in discontinuation of a service.

Orientation of the client and parents/legal guardians is documented in the client's record.

(5) The agency maintains a written grievance/complaint procedure that is reviewed with the client and parent/legal guardian upon admission. The client's record contains documentation of the agency's explanation of the grievance procedure to the client and the parent/legal guardian.

(6) Financial arrangements are fully explained to the client and their parent/legal guardian upon admission, and at the time of any change in the financial arrangements.

(7) Procedures for protecting client assets: The agency establishes and follows written policies and procedures to identify how it manages, protects, and maintains accountability for client assets, including the segregation of client funds when an agency assumes fiduciary responsibility for a client's assets or disburses funds such as maintenance or allowance funds to clients.

(8) The agency establishes written procedures for providing client access to emergency medical services.

(9) Written agency policy specifies clinically appropriate and legally permissible methods of behavior management and discipline and provides training in their use to all direct service staff. The agency prohibits in policy and practice the following:

(a) degrading punishment;

(b) corporal or other physical punishment;

(c) group punishment for one individual's behavior;

(d) deprivation of an individual's rights and needs (e.g., food, phone contacts, etc.) when not based on documented clinical rationale;

(e) aversive stimuli used in behavior modification;

(f) punitive work assignments;

(g) isolation or seclusion, except as delineated in Section 24;

(h) harassment; and

(i) chemical or mechanical restraints, and therapeutic holds except as delineated in Section 24.I.

(10) The agency establishes and follows written policies and procedures for the use of therapeutic time-out in accordance with these certification requirements, including the following directives:

(a) therapeutic time-out can only be used for the length of time necessary for the client to resume self-control and to prevent harm to the client or others;

(b) therapeutic time-out is not used as a means of punishment;

(c) therapeutic time-out is not used for the convenience of staff; and

(d) therapeutic time-out is monitored closely and frequently to ensure the client's safety.

D. Client information and case review: The agency maintains records and follows policies and procedures governing the access to, and release of, confidential information. The agency provides adequate facilities for the storage, processing and handling of clinical records, including suitably locked and secured rooms.

(1) The agency's written policies govern the retention, maintenance, and destruction of board administrative records, and records of former clients and personnel. These policies address:

(a) protection of the privacy of former clients and personnel; and

(b) legitimate future requests by former personnel or clients for information, particularly information that may not be available elsewhere.

(2) The agency has policies governing the disposition of records, security of records and timely access and retrieval of records in case of the agency's dissolution. The retention of records is required for the later of:

(a) four years after the client is released from treatment; or

(b) two years after the client reaches age 18; or

(c) two years after a client has been released from most recent legal guardianship, and is no longer under legal guardianship.

(3) The agency specifies in written policies and procedures how it releases information. Any release is in accordance with applicable state and federal laws. The agency does not request or use any information release form that has been signed by a client, parent, guardian or other party prior to pertinent information being completed on the form.

(4) In the event of a medical emergency that warrants immediate intervention in order to protect the life or safety of the client, access to information regarding the client's diagnoses and treatment plan/service plan may be provided to medical personnel.

E. Contents of the client record:

(1) Agency policy defines information to be contained in the client record. At the time of admission, the client's date of admission to each and any certified service is documented in a consistent location in the client record.

(2) Agency policy and practice provide that entries in the client record are made in an accurate, objective, factual, legible, contemporaneous, and clinically-based manner.

(a) Entries made in the client record pursuant to these certification requirements clearly identify the person completing the entry and their credentials.

(b) Late entries are identified as such; late entries include the actual date of the entry and the signature of the person completing the entry.

F. When prescribing medication or other treatments, the prescribing professional documents the indication for any medical procedures and prescription medications.

(1) When a client is seen by the prescribing professional, subsequent to a medical prescription or treatment, the professional documents the response to the prescription or treatment and any observed side effects.

(2) Medication, including non-prescription medication that is administered by a nurse or is self-administered, is documented by the agency staff with the date and time of administration, the name and dosage and any side effects observed.

G. A written discharge summary is placed in the client's record within 15 days of termination of services and includes:

(1) clinical and safety status;

(2) medications being taken at discharge*;*

(3) documentation of notification to primary care physician;

(4) specification of referrals/appointments made with specific names*;*

(5) target behaviors addressed;

(6) services provided;

(7) progress attained, or lack thereof;

(8) description of interventions to which the client did and did not respond, including medications;

(9) recommendations for continued treatment and services.

H. Client review of case record:

(1) An individual may review their case record in the presence of a therapist or licensed independent practitioner of the agency on the agency's premises unless to do so would not be clinically indicated. The reasons why review is not clinically indicated are documented in the client's record. The confidentiality of other individuals is protected.

(2) The agency's policies and procedures allow the client to insert a statement into the record about their needs or about services they are receiving or may wish to receive. Any agency statements or responses are documented with evidence that the client was informed of insertion of such responses.

[8.369.3.22 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.23 INTAKE, ASSESSMENT, TREATMENT PLANNING, DISCHARGE PLANNING, AND DISCHARGE:

A. The agency establishes criteria for admission, conducts ongoing clinical assessments, and develops, reviews, revises treatment plans and provides ongoing discharge planning with the full participation of the treatment team.

B. Clinical decisions are made only by qualified clinical personnel.

C. Intake and screening:

(1) The agency establishes and follows written criteria for admission to its program(s) and service(s), including exclusionary criteria.

(2) The agency establishes and follows written intake procedures to address clinical appropriateness for admission.

(3) The agency's eligibility criteria are consistent with EPSDT requirements and licensing requirements for child and adolescent mental health facilities, 8.369.4 NMAC.

D. Assessments: The following applies to all certified services, except case management services. Each client is assessed at admission and reassessed at regularly specified times to evaluate their response to treatment, and specifically when significant changes occur in their condition or diagnosis. The assessment process

is multidisciplinary, involves active participation of the family or guardian, whenever possible, and includes documented consideration of the client's and family's perceptions of treatment needs and priorities. Assessment processes include consideration of the client's physical, emotional, cognitive, educational, nutritional, and social development, as applicable. At a minimum, the following assessments are conducted and documented:

(1) An initial screening, conducted at admission, of physical, psychological, and social functioning, to determine the client's need for treatment, care, or services, and the need for further assessment; and assessment of risk of behavior that is life-threatening or otherwise dangerous to the client or others, including the need for special supervision or intervention.

(2) A full EPSDT screen (tot-to-teen health check) within 30 calendar days of the initiation of services, unless such an examination has taken place and is documented within the 12 months prior to admission. The documented content of the history and physical examination must meet EPSDT requirements.

(3) The agency conducts a comprehensive assessment of each client's clinical needs. The comprehensive assessment is completed prior to writing the comprehensive treatment plan, and includes the following:

(a) Assessment of the client's personal, family, medical and social history, including:

(i) relevant previous records and collateral information;

(ii) relevant family and custodial history, including non-familial custody and guardianship;

(iii) client and family abuse of substances;

(iv) medical history, including medications;

(v) history, if available, as a victim of physical abuse, sexual abuse, neglect, or other trauma;

(vi) history as a perpetrator of physical or sexual abuse;

(vii) the individual's and family's perception of their current need for services;

(viii) identification of the individual's and family's strengths and resources; and

(ix) evaluation of current mental status.

(b) A psychosocial evaluation of the client's status and needs relevant to the following areas, as applicable:

(i) psychological functioning;

(ii) intellectual functioning;

(iii) educational/vocational functioning;

(iv) social functioning;

(v) developmental functioning;

(vi) past and current substance use;

(vii) culture; and

(viii) leisure and recreation.

(c) Evaluation of high-risk behaviors including a risk assessment and past and current suicidal and homicidal ideation or potential for such;

(d) A summary of information gathered in the clinical assessment process, in a clinical formulation that includes identification of underlying dynamics that contribute to identified problems and service needs.

(4) If the comprehensive assessment is completed prior to admission, it is updated at the time of admission to each certified service. If the comprehensive assessment is current and no changes are required, documentation should reflect review date and independent clinician signature with no changes required.

(5) Assessment processes include the following:

(a) within 30 days of admission, an educational evaluation or current, age-appropriate individualized educational plan (IEP), or documented evidence that the client is performing satisfactorily at school;

(b) when indicated by clinical severity, a psychiatric evaluation;

(c) a psychological evaluation, when specialized psychological testing is indicated;

(d) monthly updates on mental status and current level of functioning, performed by a New Mexico licensed master's or doctoral level behavioral health practitioner.

(6) Assessment information is reviewed and updated as clinically indicated and is

documented in the client's record. For clients who have been in the service for one year or longer, an annual mental status exam and psychosocial assessment are conducted and documented in the client's record as an addendum to previous assessment(s). The agency makes every effort to obtain all significant collateral information and documents its efforts to do so. As collateral information becomes available, the comprehensive assessment is amended.

E. Treatment planning and discharge planning: The treatment planning process is individualized and ongoing, and includes initial treatment planning, comprehensive treatment planning, discharge planning, and regular re-evaluation of treatment plans and discharge criteria.

(1) For certified services other than CCSS and behavior management skills development services, an initial treatment plan is developed and documented within 72 hours of admission to each service. Based on information available at the time, the initial treatment plan contains the treatment planning elements identified in Subsection E of 8.369.3.23 NMAC, with the exception that individualized treatment goals and objectives are targeted the first 14 days of treatment.

(2) For certified services other than CCSS and behavior management skills development services, a comprehensive treatment plan based on the comprehensive assessment is developed within 14 days of admission. The comprehensive treatment plan contains the treatment planning elements identified in Subsection E of 8.369.3.23 NMAC.

(3) Each initial and comprehensive treatment plans fulfill the following functions:

(a) involves the full participation of treatment team members, including the client and their parents/legal guardian, who are involved to the maximum extent possible; reasons for nonparticipation of client or family/legal guardian are documented in the client's record;

(b) is conducted in a language the client and family members can understand, and is explained to the client in language that invites full participation;

(c) is designed to improve the client's motivation and progress, and strengthen appropriate family relationships;

(d) is designed to improve the client's self-determination and personal responsibility;

(e) utilizes the client's strengths;

(f) is conducted under the direction of a person who has the authority to effect change and who possesses the experience and qualifications to enable them to conduct treatment planning; treatment plans meet the provisions of the Children's Code, Sections 32A-6-10 NMSA 1978, as amended, and are otherwise implemented in accordance with the provisions of Article 6 of the Children's Code;

(g) documents in measurable terms the specific behavioral changes targeted, including potential high-risk behaviors; corresponding time-limited intermediate and long-range treatment goals and objectives; frequency and duration of program-specific intervention(s) to be used, including medications, behavior management practices, and specific safety measures; the staff responsible for each intervention; projected timetables for the attainment of each treatment goal; a statement of the nature of the specific problem(s) and needs of the client; and a statement and rationale for the plan for achieving treatment goals;

(h) specifies and incorporates the client's permanency plan, for clients in the custody of CYFD;

(i) provides that clients with known or alleged history of sexually inappropriate behavior, sexual aggression or sexual perpetration are adequately supervised so as to ensure their safety and that of others; and

(j) documents a discharge plan that:

(i) requires that the client has achieved the objectives of the treatment plan;

(ii) requires that the discharge is safe and clinically appropriate for the client;

(iii) evaluates high risk behaviors or the potential for such;

(iv) explores options for alternative or additional services that may better meet the client's needs;

(v) establishes specific criteria for discharge to a less restrictive setting; and

(vi) establishes a projected discharge date, which is updated as clinically indicated.

(4) For residential treatment services and group home services, the comprehensive treatment

plan also includes the following elements: a statement of the least restrictive conditions necessary to achieve the purposes of treatment, and an evaluation of the client's cultural needs and provision for access to cultural practices, including culturally traditional treatment.

(5) For CCSS, a service plan is developed and written within 30 days of the initiation of services.

(6) For behavior management skills development services, a service plan is developed within 14 days of initiation of services.

F. The treatment plan is reviewed by the treatment team at intervals not to exceed 30 days and is revised as indicated by changes in the child's behavior or situation, the child's progress, or lack thereof.

(1) Each treatment plan review documents assessment of the following, in measurable terms:

(a) progress, or lack thereof, toward each treatment goal and objective;

(b) progress toward and identification of barriers to discharge;

(c) the client's response to all interventions, including specific behavioral interventions;

(d) the client's response to medications;

(e) consideration of significant events, incidents, and safety issues occurring in the period under review;

(f) revisions of goals, objectives, and interventions, if applicable;

(g) any change(s) or updates in diagnosis, mental status or level of functioning;

(h) the results of any referrals or the need for additional consultation;

(i) the effectiveness of behavior-management techniques used in the period under review.

(2) Some or all of the required elements of a treatment planning document may be recorded in a document other than the treatment plan/review, such as a clinical review form or format provided by, or to a payor, when the following conditions are met:

(a) all required elements are performed and documented contemporaneously in a timely manner by qualified clinical personnel;

(b) the client's record contains evidence of participation of treatment team members in each phase of the treatment planning process.

G. When aftercare is indicated at the time of non-emergency discharge, the agency involves the client, case manager (if applicable), the parent, legal guardian, or guardian ad litem, if applicable; and assists the client, family, or guardian in arranging appointments, obtaining medication (if applicable), transportation and meeting other identified needs as documented in the treatment/discharge plan.

H. Prevention, planning, and processing of emergency discharge:

(1) The agency establishes policies and procedures for management of a child who is a danger to themself or others or presents a likelihood of serious harm to themself or others. The agency acts immediately to prevent such harm. At a minimum, the policies and procedures provide that the following be documented in the client's file:

(a) that the agency makes all appropriate efforts to manage the child's behavior prior to proposing emergency discharge; and

(b) that the agency takes all appropriate action to protect the health and safety of other children and staff who are endangered.

(2) In the event of a proposed emergency discharge, the agency provides, at a minimum, procedural due process including written notice to the family/legal guardian, guardian ad litem and department, if applicable, and provision to stop the discharge action until the parent/legal guardian, guardian ad litem or the department exhausts any other legal remedy they wish to pursue. The agency documents the following in the client record:

(a) provision for participation of the parent/legal guardian, and guardian ad litem in the discharge process, whenever possible; and

(b) arrangement for a conference to be held including all interested persons or parties to discuss the proposed discharge, whenever possible.

(3) If the child's parent/legal guardian is unavailable to take custody of the child and immediate discharge of the child endangers the child, the agency does not discharge the child until a safe and orderly discharge is affected. If the child's family refuses to take physical custody of the child, the agency refers the case to CYFD.

I. Discharge: Non-emergency discharge occurs in accordance with the client's discharge plan, unless

precipitated by a client's or guardian's refusal to consent to further treatment, or other unforeseen circumstances. Prior to discharge, the agency:

(1) evaluates the appropriateness of release of the client to the parent/legal guardian;

(2) provides that any discharge of the client occurs in a manner that provides for a safe and orderly transition; and

(3) provides for adequate pre-discharge notice, including specific reason for discharge.

[8.369.3.23 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.24 BEHAVIOR MANAGEMENT, PERSONAL RESTRAINT, AND SECLUSION PRACTICES: Certain provisions of this section are included to implement regulations of the federal centers for medicare and medicaid services (CMS) and may be amended when appropriate to reflect subsequent changes in the federal CMS regulations. These provisions are intended to implement, and to be consistent with the Child Health Act of 2000 and the CMS interim final rule issued May 22, 2001, and are subject to further modifications as dictated by CMS.

A. The agency protects and promotes the rights of each client in the program, including the right to be free from physical or mental abuse, corporal punishment, and any personal restraint or seclusion imposed for purposes of discipline or convenience. The agency establishes and follows policies and procedures governing the use of behavior management practices including personal restraint and seclusion (when allowed as delineated below). This will include documentation of each personal restraint and seclusion in the client's record.

B. For those behavior management practices that are allowed for each type of program and are described above, the program supports their limited and justified use through:

(1) staff orientation and education that create a culture emphasizing prevention of the need for personal restraint and seclusion and their appropriate use;

(2) assessment processes that identify and prevent potential behavioral risk factors; and

(3) the development and promotion of preventive strategies and use of less restrictive alternatives.

(4) Any child/resident that has more than 3 episodes total of restraint, both mechanical or chemical, or seclusion must have a care team review that is documented in the record of the child. This documentation should include actions taken to reduce the use of episodes of restraint and seclusion. This should be done for 3 episodes of any combination of use of these methods.

C. Agency policy and procedures identify qualified staff authorized to approve the protocols and apply the criteria for use of personal restraint and seclusion.

D. Performance-improvement processes identify opportunities to reduce or eliminate the use of personal restraint or seclusion.

E. The agency establishes and follows policies and procedures for the safe, effective, limited, and least restrictive use of behavior management practices. The policies and procedures include measures to ensure that treatment planning includes regular review of the necessity for, type and frequency of behavior management practices used in individual cases. When restraints or seclusion is initiated, documentation of less restrictive interventions must be present before using restraints or seclusion. The agency policy and procedures must include a glossary of definitions related to restraint and seclusion practices.

F. When behavior management practices are used, the agency protects the safety, dignity, and privacy of clients to the maximum extent possible at all times during each procedure.

G. Treatment plans document the use of seclusion, and personal restraint treatment plans are expected include: consideration of the client's medical condition(s); the role of the client's history of trauma in their behavioral patterns; and the treatment team's solicitation and consideration of specific suggestions from the client regarding prevention of future physical interventions.

H. Seclusion and personal restraints are implemented only by staff who have been trained and certified by a state recognized body in the prevention and use of personal restraint and seclusion. This training emphasizes de-escalation techniques and alternatives to physical contact with clients as a means of managing behavior. Clients do not participate in the personal restraint or seclusion of other clients.

I. Mechanical and chemical restraints are prohibited in all programs except the program created under the Adolescent Treatment Hospital Act, which has been mandated by Sections 23-9-1 et.seq. NMSA 1978, to serve adolescents who are violent or have a history of violence, and which provides 24-hour on-site professional medical services in accordance with Section 3207 of the Children's Health Act of 2000.

J. Personal restraint and seclusion, as defined in these certification requirements, are used in the joint commission-accredited and non-joint commission-accredited residential treatment centers and group homes in

emergency circumstances to ensure the immediate physical safety of the client, other clients, staff member(s) or others, and when less restrictive interventions have been determined to be ineffective. Personal restraint and seclusion are used in accordance with these provisions and with federal law, rule or regulation which may supersede state or accreditation regulations. Personal restraint and seclusion are imposed only by an individual trained and certified by a state-recognized body in the prevention and use of personal restraint and seclusion and in the curriculum that may be set forth in federal regulations to be promulgated under Title V of the Public Health Service Act (42 U.S.C. 290aa et seq. as amended by section 3208, Part I, section 595). When federal regulations are promulgated under Title V as described above, the curriculum set forth there shall be included in the training.

K. Physical escort is allowed as a safe means of moving a client to a safe location.

L. Personal restraint or seclusion are not to be used for staff convenience or as coercion, discipline, or retaliation by staff.

M. This sub-section (M) applies, for personal restraint, to facilities accredited by TJC and to all residential treatment centers for seclusion. These entities require orders that are consistent with department regulation, agency policy, and regulations of the centers for medicare and medicaid services (CMS) 42 CFR, Parts 441 and 483. These orders are issued by a restraint/seclusion clinician within one hour of initiation of personal restraint or seclusion, and include documented clinical justification for the use of personal restraint or seclusion.

(1) If the client has a treatment team physician and the physician is available, only the physician can order personal restraint or seclusion.

(2) If personal restraint or seclusion is ordered by someone other than the client's treatment team physician, the restraint/seclusion clinician will consult with the client's treatment team physician as soon as possible but no later than within 48 hours and inform them of the situation requiring the client to be restrained or placed in seclusion and document in the client's record the date and time the treatment team physician was consulted and the information imparted.

(3) The restraint/seclusion clinician must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the situation.

(4) If the order for personal restraint is verbal, the verbal order must be received by a restraint/seclusion clinician or a New Mexico licensed registered nurse (RN) or practical nurse (LPN). The restraint/seclusion clinician must verify the verbal order in a signed, written form placed in the client's record within 24 hours after the order is issued. The ordering physician must review and sign off on the verbal order form within 48 hours.

(5) A restraint/seclusion clinician's order must be obtained by a restraint/seclusion clinician or New Mexico licensed RN or LPN prior to or while the personal restraint or seclusion is being initiated by staff, or immediately after the situation ends. There are no standing orders or prn orders for restraint use allowed. If the clinician removed the episode of restraints and then feels there is a continued need for additional restraints, a new order must be obtained.

(6) Each order for personal restraint or seclusion must be documented in the client's record and will include:

(a) the name of the restraint/seclusion clinician ordering the personal restraint or seclusion;

(b) the date and time the order was obtained;

(c) the emergency safety intervention ordered, including the length of time;

(d) the time the emergency safety intervention actually began and ended;

(e) the time and results of any one-hour assessment(s) required; and

(f) the emergency safety situation that required the client to be restrained or put in seclusion; and

(g) the name, title, and credentials of staff involved in the emergency safety intervention.

(7) Supervision and assessment of personal restraint or seclusion

(a) The restraint/seclusion clinician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(b) A New Mexico registered nurse or a restraint/seclusion clinician other than a doctoral level psychologist, must conduct a face-to-face assessment of the physical well-being of the client within one hour of the initiation of the emergency safety intervention and immediately after the personal restraint is removed or the client is removed from seclusion. A restraint/seclusion clinician or a New Mexico registered nurse must conduct a face-to-face assessment of the psychological well being of the client within one hour of the initiation of the emergency safety intervention and immediately after the personal restraint is removed or the client is removed

from seclusion. When the personal restraint or seclusion is less than one hour in duration, and the restraint/seclusion clinician is not immediately available at the end of the period of restraint or seclusion, the restraint/seclusion clinician will evaluate the client's well-being as soon as possible after the conclusion of the restraint/seclusion, but in no case later than one hour after its initiation.

(c) If the situation requiring emergency safety intervention continues beyond the time limit of the order for the use of personal restraint or seclusion, the New Mexico RN or LPN must immediately contact the ordering restraint/seclusion clinician or the client's treatment team physician to receive further instructions. If clinical circumstances justify renewal of personal restraint or seclusion, then the renewal order must be obtained within the time frames outlined below.

N. This Subsection N applies to personal restraint in residential treatment services not accredited by the joint commission. In these residential treatment services, personal restraint requires the following, which is consistent with department regulation and agency policy.

(1) An independently licensed practitioner working within the scope of their license must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(2) An independently licensed practitioner working within the scope of their license or a non-independently licensed practitioner working under the supervision of an independently licensed practitioner trained in the use of emergency safety interventions must conduct a face-to-face assessment of the well-being of the client within one hour of the initiation of the emergency safety intervention and immediately after the personal restraint is removed or the client is removed from seclusion. When the personal restraint or seclusion is less than one hour in duration, and the restraint/seclusion clinician is not immediately available at the end of the period of restraint or seclusion, the restraint/seclusion clinician will evaluate the client's well-being as soon as possible after the conclusion of the restraint/seclusion, but in no case later than one hour after its initiation.

O. This Subsection O applies to all residential treatment centers and group homes.

(1) The personal restraint or seclusion is limited to a maximum of two hours for clients age 9 to of 17 and one hour for clients under nine years of age.

(2) Post-intervention debriefings with the client will take place after each emergency safety intervention and the staff will document in the client's record that the debriefing sessions took place.

(3) The agency will have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the medicaid program that reasonably ensure that:

(a) A client will be transferred from the facility to the hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;

(b) Medical and other information needed for care of the client in light of such transfer will be exchanged between the organizations in accordance with state medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and

(c) Services will be available to each client 24 hours a day, seven days a week.

(4) The agency will document in the client's record all client injuries that occur as a result of an emergency safety intervention.

(5) All agencies will attest in writing that the facility is in compliance with CMS standards governing the use of personal restraint and seclusion. This attestation will be signed by the agency director.

(6) If the client is a minor, the agency will notify the parent(s) or legal guardian(s) that personal restraint or seclusion has been ordered as soon as possible after the initiation of each emergency safety intervention. This will be documented in the client's record, including the date and time of any attempt to contact for notification, the name of the staff person providing the notification, and who was notified.

(7) Agencies will provide for client health and safety by requiring direct service staff to demonstrate competencies related to the use of emergency safety interventions on a semiannual basis. This education at a minimum will include de-escalation training, restraint and seclusion protocol and demonstration of placement of any mechanical restraints used. Documentation and notification requirements should also be included. Direct service staff will demonstrate, on an annual basis, their competency in the use of cardiopulmonary resuscitation and maintain a national CPR certification. The agency will document in the staff personnel records that the training required was successfully completed.

(8) The agency must maintain an aggregate record of all situations requiring emergency safety intervention, the interventions used and their outcomes.

(9) Programs must report the death of any client to the CMS regional office by no later than close of business the next business day after the client's death. The report must include the name of the client and the name, street address and telephone number of the agency. The parent or legal guardian will also be notified. Staff must document in the client's record that the death was reported to the CMS regional office.

[8.369.3.24 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.25 MEDICATIONS:

A. The agency establishes and follows policies and procedures governing the storage, handling, use, administration and disposal of all medications that are consistent with applicable laws, regulations, and accepted professional practices.

B. Prescription orders are verified and individuals are identified before medications are administered or self-administered by using two unique patient identifiers such as name and date of birth.

C. Medications are administered only by qualified, licensed medical staff, or are self-administered by the client with supervision of staff who have been trained in assisting with self-administration.

D. PRN medications can be self-administered by the child if they can verbalize the reason for needing the PRN medication. If the child cannot verbalize this, an RN is required to assess the child and identify the symptoms exhibited that would require the prn medications. The reason for the prn medication should be documented in the record of the child.

E. Policies and procedures support self-administration of medications. Staff trained in these procedures provide supervision of self-administration of medications and document the time the medications are taken, the side effects observed, and client response, as well as any medications refused or held. When medications are self-administered by clients, a staff member may hold the container for the client and assist with opening the container, but may not place the medication in the client's hand or mouth.

F. The agency has controls in place for locked storage of medication and for access by authorized personnel.

G. The agency has controls in place to ensure that medications are properly labeled with name of person served, dosage, name of medication, name of prescribing physician, and number or code identifying the written order.

H. The agency has controls in place for the destruction of out-of-date medications and proper disposal of unused medication and syringes.

I. When adverse or unusual conditions are observed, appropriate consultation and medical response must be sought in a timely manner.

J. Medication monitoring may include input from various disciplines and the client and family. This information is used to maintain and improve the outcomes of medication therapy while minimizing any drug-related problems or adverse effects.

K. When medications that require periodic testing of drug levels are used, such laboratory test results are accurately recorded in the client record, as applicable.

L. The physician documents in the client record the indication for, response to, and the potential and observed side effects of any prescription medication(s).

[8.369.3.25 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.26 COMPREHENSIVE COMMUNITY SUPPORT SERVICES:

A. The purpose of CCSS is to provide an eligible recipient and their family with the services and resources necessary to promote recovery, rehabilitation, and resiliency. Community support services address goals specifically in the following areas of the eligible recipient's activities: independent living; learning; working; socializing and recreation. CCSS consists of a variety of interventions, based on coaching and addressing barriers that impeded the development of skills necessary for independent functioning in the community. Community support services also include assistance with identifying and coordinating services and supports identified in an individual's treatment plan; supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices.

B. An assessment of baseline functioning shall be performed within 10 working days of the client's admission into CCSS services. The assessment shall evaluate and document the client's specific functional effectiveness in multiple skill domains based on the desired outcomes of the client or family.

(1) Functional level determination shall identify domains in which functional limitations precipitated by the behavioral health disorder are present. The diagnoses and assessments shall be the basis for the comprehensive client or family-driven goal-directed, measurable service plan.

(2) CCSS eligible clients shall have one designated agency that will have the primary responsibility of partnering with the client and family for the purpose of implementing the comprehensive service plan.

C. Within the CCSS agency, a primary community support worker (CSW), under the documented

supervision of the CCSS supervisor, shall be identified on the comprehensive service plan and shall partner with the client and family for the purpose of coordinating and facilitating recovery and resiliency directed team meetings. The CCSS supervisor shall sign, with name, credentials, and date, the initial service plan indicating that he has reviewed and approved the comprehensive service plan and each revision as it occurs.

D. Community support activities and relevant providers shall be clearly identified in the comprehensive service plan. The primary CSW shall coordinate the service plan without duplication by the other service providers. The CCSS comprehensive service plan shall be completed no later than 30 calendar days of the client's admission into CCSS services and specify recovery and resiliency strategies to include:

(1) the community support(s) and any other rehabilitative and treatment interventions needed for the client to achieve their specified service goals and to meet recovery and resiliency outcomes;

(2) the CCSS staff responsible for each recovery and resiliency intervention and the frequency of the planned interventions;

(3) the client's relevant diagnoses and other risk factors that place them at risk of further diagnoses;

(4) measurable goals and objectives identified by the client and family as their comprehensive service plan priorities to meet desired recovery and resiliency outcomes;

(5) a recovery/ resiliency management plan;

(6) a crisis management plan to address after-hours crisis situations including actions to be taken by client, family and natural supports;

(7) potential service plan barriers and applicable strategies; and

(8) if requested, advanced directives related to client's behavioral healthcare.

E. CCSS shall include the development of crisis plan interventions, as defined in an individual crisis plan, as a component of overall CCSS comprehensive service plan. If the client has or requests an advance directive, the crisis plan may be incorporated into the advance directive. The individualized crisis plan shall support the client and family in the management of crisis situations outside of regular business hours to develop or enhance the client's ability to make informed and independent choices.

(1) The crisis plan shall include the following requirements, which shall be formulated on admission to CCSS by the CCSS team, client, family, legal guardian and other interested parties:

(a) Risk assessment: Specify a process to assess potential risk and specify an algorithm of community resources to address by risk level that ranges from immediate (i.e. 911 or first responders) to intermediate (e.g. call to crisis line) to moderate (call for a clinic appointment). Specify a process to identify benchmarks that indicate when a crisis is appropriate reconciled.

(b) Client/family education: Provide the client and family education on community resources to be accessed during crisis situations. Each family and client shall be provided basic verbal communication techniques to help de-escalate a potential crisis situation.

(c) Internal communication: Crisis events are discussed in the CCSS team meeting to ensure all risk factors are identified and known by all team members.

(d) Face-to-face assessment: CCSS team member shall make a face-to-face visit as soon as possible, but no more than 48 hours after notification of a crisis and complete an updated assessment for presentation to the team.

(e) Research past crisis situations for antecedent, precipitant, and consequent behaviors and discuss with the client or family to identify strategies or objectives likely to prevent crises.

(f) Identify alternative interventions that may be initiated during crisis situations, including pre-crisis or crisis instructions identified by the client or family.

(g) Incorporate client and family outcomes as benchmarks or measures of when the crisis is over.

(h) Revise the crisis plan over time based on newly identified triggers and what is known to be effective.

(i) Document behavioral benchmarks (e.g., number of runs, self-injury, assaults, etc., and what worked).

(2) The negotiated crisis plan shall triage for differing levels of intensity and severity of crisis events and may identify other types of interventions that may include:

(a) residential services for stabilization;

(b) crisis respite services;

(c) wrap around services;

(d) increased family and community support specialist capacity to manage crisis

situations;

(e) activation of advance directive instruction; and

(f) utilization of emergency room (ER) and other emergency response supports.

F. Every 90 days after implementation of the comprehensive service plan, the CCSS team, in partnership with the client and family, shall track and provide detailed documentation demonstrating progress made over time relating to the CCSS service goals, objectives and client/family designated recovery or resiliency outcomes. These shall be documented in the service plan updates with modifications made based upon barriers identified or redefined goals and objectives and future needs.

G. The follow up assessment shall document the current status of the client and family designated measurable recovery or resiliency functional outcomes.

H. Individualized CCSS interventions shall address the following objectives, as indicated in the assessment and comprehensive service plan:

(1) community services and resources available to support the client's achievement of their functional CCSS service goals and objectives;

(2) assistance in the development of interpersonal, community coping and functional skills (i.e., adaptation to home, school and work environments), utilizing evidence-based practices to support the skills development in the following domains:

(a) socialization skills;

(b) developmental issues as identified in the assessment;

(c) daily living skills;

(d) school and work readiness activities; and

(e) education and management of co-occurring illness;

(3) facilitating the development and eventual succession of natural supports in the workplace, housing/home, and social and school environments;

(4) provision of client and family education as appropriate regarding:

(a) self-management of symptom monitoring, illness management, and recovery and resiliency skills;

(b) relapse prevention skills;

(c) knowledge of medication and potential side effects;

(d) motivational and skill development in taking medication as prescribed;

(e) ability to identify and minimize the negative effects of symptoms which potentially interfere with the client's activities of daily living; and

(f) as indicated, supports to the client to maintain employment and school or community tenure;

(5) facilitating the client's abilities to obtain and maintain stable housing;

(6) any necessary follow-up by the CSW to determine if the services accessed have adequately met the client's needs.

I. Cultural competence shall be demonstrated by the CCSS provider through the agency's policies, procedures, training, outreach and advocacy efforts, and throughout the array of service delivery framework.

J. The CSW shall provide routine follow-up to determine if the services accessed have adequately met the client's rehabilitative, recovery, resiliency, and treatment needs and document findings.

K. When CCSS is provided by a certified peer or family specialist, CCSS functions shall be performed with a special emphasis on recovery and resiliency values and process, such as:

(1) empowering the client to have hope for, and participate in, their own recovery;

(2) assisting the client to identify strengths and needs related to attainment of independence in terms of skills, resources and supports, and to use available strengths, resources and supports to achieve independence;

(3) assisting the client to identify and achieve their personalized recovery and resiliency goals; and

(4) promoting the client's responsibility related to illness self-management.

L. CCSS shall be subject to the limitations and coverage restrictions as defined by 8.321.2 NMAC, comprehensive community support services.

M. Behavior management skills development service (BMS) interventions are distinct and different from CCSS and shall not be considered to be CCSS.

N. Eligible providers and practitioners:

(1) See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements.

To provide CCSS services, a provider must receive CCSS training through the state or state approved trainer. The children, youth and families department (CYFD) will provide background checks for CCSS direct service and clinical staff for child/youth CCSS programs.

(2) Clinical services and supervision by licensed behavioral health practitioners must be in accord with their respective licensing board regulations:

(a) minimum staff qualifications for the community support worker (CSW):

(i) must be at least 18 years of age; and

(ii) hold a bachelor's degree in a human services field from an accredited university and have one year of relevant experience with the target population; or

(iii) hold an associate's degree and a minimum of two years of experience working with the target population; or

(iv) hold an associate's degree in approved curriculum in behavioral health coaching; no experience necessary; or

(v) have a high school diploma or equivalent and a minimum of three years of experience working with the target population; or

(vi) hold a valid certification in good standing from the NM credentialing board as a certified peer support worker (CPSW), a certified family peer support worker (CFPSW) or a certified youth peer support specialist (CYPSS); and

(b) minimum staff qualifications for certified peer support workers:

(i) must hold a valid certification in good standing from the NM credentialing board for behavioral health professionals; and

(ii) meet all qualifications defined in 8.321.2.42 NMAC.

(c) minimum staff qualifications for the CCSS program supervisor:

(i) must hold a bachelor's degree in a human services field from an accredited university; and

(ii) have four years relevant experience in the delivery of case management or CCSS with the target population; and

(iii) have one year demonstrated supervisory experience.

(d) minimum staff qualifications for the clinical supervisor:

(i) must be RLD board approved clinical supervisor;

(ii) provide documented clinical supervision on a regular basis to the CSW, CPSW, CFPSW, and CYPSS; and

(iii) obtain a continuing education unit (CEU) training certificate related to providing clinical supervision of non-clinical staff.

(3) The clinical supervisor and the CCSS program supervisor may be the same individual.

(4) Documentation requirements: In addition to the standard client record documentation requirements for all services, the following is required for CCSS:

(a) case notes identifying all activities and location of services;

(b) duration of service span; and

(c) description of the service provided with reference to the CCSS treatment plan and related goals.

O. Staff training requirements:

(1) CSW staff must also complete 20 hours of initial training within the first 90 days of employment, and 20 hours of education every subsequent year. Training and education topics include:

(a) Clinical and psychosocial needs of the target population.

(b) Managing side effects of psychiatric medication and communicating with your clinician.

(c) Principles of states of change.

(d) Principles of motivational interviewing.

(e) Crisis management.

(f) Behavioral management.

(g) Principles of recovery, resiliency, and empowerment.

(h) Cultural considerations with regard to race, religion, national origin, sex, physical disability and other.

(i) community- specific characteristics.

(j) Ethics and professionalism.

(k) Enhancing interpersonal supports.

(l) Mental health/developmental disabilities.

(m) Children's Code.

(n) Client/family-centered practice.

(o) Treatment and discharge planning with an emphasis on recovery and crisis planning.

(p) Psychiatric advance directive.

(q) Strategies for engagement in services.

(2) documentation of ongoing training is required and maintained in the personnel record and comprised of 20 hours per year, commencing after the first year of hire, with content of the education based upon agency assessment of staff's needs. Such assessment shall be monitored and documented through the agency's continuous quality improvement program and annual plan.

(3) The CCSS program supervisor and RLD board-approved clinical supervisor can be the same individual, but minimum qualifications vary for each position. Supervisors must complete must also complete 20 hours of initial training within the first 90 days of employment, and 20 hours of education every subsequent year. Content of the education is based upon agency assessment of staff's needs. Such assessment shall be monitored and documented through the agency's continuous quality improvement functions.

(4) CCSS program supervisor must have the following minimum qualifications:

(**a**) A bachelor's degree in a human services field from an accredited university;

(b) Four years relevant experience in the delivery of case management or CCSS with the target population; and

(c) One year demonstrated supervisory experience.

P. Caseloads:

(1) Caseloads, on average, shall not exceed a ratio of one CSW to 20 clients receiving CCSS.

(2) Clients participating in medication management as the primary focus of service are not subject to the client-staff ratio.

(3) CSW caseloads, of client to staff ratio of one CSW to 20 clients on average, shall be monitored and documented through the agency's internal continuous quality improvement program through defined periodic review activities such as peer chart reviews to ensure the agency is in caseload compliance. The agency will implement timely corrective action when it is identified that staff ratio averages are not in compliance.

(4) Detailed case notes document all CCSS service intervention activities and locations of services provided for each service span delivered and include the CCSS worker's name, credential and date of the service delivery.

Q. Documentation requirement:

(1) The CCSS provider shall be responsible for consistent documentation of all service delivery. Each service delivery case note shall include but not be limited to:

(a) date of service;

(b) service location;

(c) duration of service span (e.g., 1:00-2:00 pm);

(d) description of the service provided with reference to the comprehensive service plan and related service goal and objective; and

(e) the client's name, and signature and credential of the individual delivering the service.

(i) All CCSS file documentation shall be legible.

(ii) All CCSS service delivery shall be consistent with the service definition requirements.

(2) CCSS comprehensive service plan and service delivery documentation shall be internally monitored through the agency's continuous quality improvement functions at least quarterly to ensure compliance with all of the certification requirements.

[8.369.3.26 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.27 DAY TREATMENT SERVICES:

A. Day treatment services as defined herein are provided in a school or other community setting and are distinct from partial hospitalization services provided in a psychiatric hospital. Education services are provided through the public school system or through a New Mexico accredited private school in coordination with the day treatment services.

B. Personnel:

(1) Direct service staff may be unlicensed or uncertified paraprofessionals such as teacher aides, mental health workers, psychiatric technicians or similar direct service workers. At least one staff member who has received all training required in Subsection B of 8.369.3.27 NMAC is present during program hours. The direct service staff receives documented clinical supervision for a minimum of two hours per month. The agency's direct service staff must have at least a high school education or GED and 20 hours of documented pre-service training, including, but not limited to crisis management, prevention and intervention, behavior management, and emergency procedures, that include current CPR and first aid certificates. Within 90 days of hire, the staff will receive an additional 20 hours of documented training, including but not be limited to:

(a) etiology and symptoms of emotional disturbances and neurobiological disorders;

(b) family systems;

(c) basic communication and problem-solving skills;

(d) child and adolescent development;

(e) issues related to ethnic and cultural considerations of the clients served; and

(f) action and potential side effects of medications.

(2) Clinical director:

(a) Clinical director qualifications: The clinical director possesses one of the following New Mexico licenses; physician (physicians must be board-certified in psychiatry or eligible to attain such certification), psychologist, licensed independent social worker (LISW), licensed master social worker (LMSW), clinical nurse specialist in child psychiatric nursing, registered nurse (RN) with a master's degree in psychiatric nursing, licensed professional clinical mental health counselor (LPCC), licensed marriage and family therapist (LMFT), or licensed independent school psychologist.

(b) In addition to having one of the above licenses, the clinical director is required to have a minimum of two years of experience in clinical practice with children, adolescents and families.

(c) Clinical director responsibilities: The responsibilities of the clinical director are to provide clinical oversight of the services, as well as to provide supervision, support, and consultation to all agency direct service staff.

(d) The clinical director may also serve as the clinical supervisor, if approved by the New Mexico regulation and licensing department.

(3) Clinical supervisor is defined in 16.27.19 NMAC and 16.63.1 NMAC. Supervision by RLD board approved clinical supervisors must be in accordance with their respective licensing regulations.

(4) Therapist/social worker/counselor: clinical services and supervision by licensed behavioral health practitioners must be in accord with their respective licensing board regulations.

C. Services:

(1) Assessment and treatment planning conform to Section 23 of these certification requirements.

(2) The agency provides adequate care and continuous supervision of the client at all times in accordance with the client's developmental and clinical needs.

(3) The structured program of care is scheduled for a minimum of four hours per day, two to five days per week based on the acuity and the clinical needs of the client and family. The agency provides the following, pursuant to the client's treatment plan:

(a) individual, family, group or other therapy, in whatever combination is appropriate to meet the needs of the client;

(b) other services as provided in the treatment plan;

(c) development of life skills activities;

(d) crisis intervention;

(e) therapeutic recreation, when indicated by the child's needs;

(f) documentation of services provided, and of the client's progress or lack thereof on each day that service is provided.

(4) The agency documents that:

(a) the child has access to the appropriate educational services;

(b) the child has opportunities for involvement in community, social, athletic and recreational programs;

(c) the child has opportunities to pursue personal, ethnic or cultural interests; and

(d) advance schedules are posted for structured and supervised activities which include individual, group and family therapy, and other planned activities appropriate to the age, behavioral and

emotional needs of the client pursuant to the treatment plan.

(5) The agency maintains a written agreement with the public school district or private school so that appropriate educational services are provided to clients in the day treatment services program.

[8.369.3.27 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.28 BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES:

A. Behavior management skill development services are delivered through an individualized behavior management skills development service plan designed to develop, restore, or maintain skills and behaviors that result in improved function or which prevent deterioration of function. Behavior management skills development services are delivered to clients up to age 21 who:

(1) are in need of behavior management skills development intervention to avoid inpatient hospitalization, residential treatment or separation from their family; or

(2) require continued intensive or supportive services following hospitalization or out-of-home placement as a transition to maintain the client in the least restrictive environment possible.

B. Personnel:

(1) The behavior management skills development specialist meets the following criteria:

(a) is at least 21 years of age; and

(b) demonstrates the ability to independently implement and document the outcome of the goals, measurable objectives and interventions as defined in a behavioral management skills development service plan.

(2) The behavior management skills development specialist receives 20 hours of documented pre-service training, to include, but not limited to:

(a) crisis management/intervention;

(b) behavior management;

(c) emergency procedures, which include current CPR and first aid certificates.

(3) Within 90 days of hire, the behavior management skills development specialist receives an additional 20 documented hours of training, including but not limited to:

(a) etiology and symptoms of emotional disturbances and neurobiological disorders;

(b) family systems;

(c) basic communication and problem solving skills;

(d) child and adolescent development;

(e) issues related to ethnic and cultural interests of the clients served;

(f) action and potential side effects of medications.

(g) trauma informed care.

(4) Behavior management skills development specialists receive supervision by a New Mexico licensed practitioner with a doctoral or master's degree from an accredited institution in a human service related field who has at least two years experience working with children, adolescents and families. Exception: If a supervisor with the above qualifications cannot be recruited, the supervisor must possess, at a minimum, a B.S.W., B.A., B.S., or B.U.S. in a human service related field plus four years experience working with seriously emotionally disturbed or neurobiological disordered children and adolescents.

(5) Supervisory requirements are met consistent with the practitioner's licensing board within their scope of practice and dependent upon the complexity of the needs presented by clients and the supervisory needs of the behavior management skills development specialist. Supervision is documented with dates, times, and content of contacts.

C. Services:

(1) Behavior management skills development services focus on acquisition of skills and improvement of the client and family's performance related to targeted behaviors. The agency:

(a) conducts a clinical assessment, or acquires clinical information that guides the development of the behavior management skills development services plan;

(b) documents clinical review of information that enables the agency to complete the behavior management skills development service plan;

(c) develops a behavior management skills development service plan, including: client needs, measurable goals, interventions, discharge criteria, and a discharge plan, within 14 days of admission to the service;

(d) reviews the behavior management skills development service plan every 30 days and revises as necessary; and

(e) works in partnership with other agencies or individuals involved in the client's care to implement the discharge plan and link the client to aftercare, as indicated;

(f) provides services to one or more child(ren) from the same or different home(s), provided that a staff-to-client ratio of one-to-one is maintained at all times.

(2) The behavior management skills development specialist provides the following services:

(a) participation in the development, review and revision of the behavior management service plan;

(b) implementation of the behavior management skills development service plan to include teaching of behavior enhancing skills;

(c) documentation of each client contact, including date, time, duration, location, and the client's progress and response to the interventions each day service is provided, stated in terms of service plan goals and objectives; and

(d) coordinating with the family and school personnel, if appropriate, to assist the client to achieve or to maintain appropriate behavior management.

[8.369.3.28 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.29 TREATMENT FOSTER CARE SERVICES:

A. Treatment foster care services, Level I and Level II, are specifically designed to accommodate the needs of psychologically or emotionally disturbed or behaviorally disordered clients. Eligible clients are those who are at risk for failure or have failed in regular foster homes, are unable to live with their own families, or are going through a transitional period from residential care as part of the process of return to family and community.

(1) Treatment foster care services, level I and II, are targeted to children who meet the following criteria:

(a) are at risk for placement in a higher level of care or are returning from a higher level of care and are appropriate for a lower level of care; or

(b) have complex and difficult psychiatric, psychological, neurobiological, behavioral, psychosocial problems; and

(c) require, and would optimally benefit from, the behavioral health services and supervision provided in a treatment foster home setting.

(2) Treatment foster care services level II (TFC II) services are targeted to children who also meet one of the following additional criteria:

(a) have successfully completed treatment foster care services level I (TFC I), as indicated by the treatment team; or

(b) require the initiation or continuity of the treatment and support of the treatment foster family to secure or maintain therapeutic gains; or

(c) require this treatment modality as an appropriate entry level service from which the client will optimally benefit.

(3) A client eligible for treatment foster care services, level I or level II, may change treatment foster homes only under the following circumstances:

(a) an effort is being made to reunite siblings; or

(b) a change of treatment foster home is clinically indicated, as documented in the client's record by the treatment team.

B. Personnel qualifications and responsibilities:

(1) Treatment coordinator qualifications: The treatment coordinator possesses one of the following: a master's degree from an accredited program in social work or another human-services field; or a bachelor's degree in social work or another related human-service field and two years experience with this population.

(2) Treatment coordinator responsibilities:

(a) Treatment planning: Under supervision, and in coordination with the rest of the treatment team, the treatment coordinator:

(i) prepares the initial and comprehensive treatment plans in accordance with the timelines established in these certification requirements;

(ii) coordinates the implementation of the treatment plan;

(iii) monitors the client and their progress for events related to the treatment plan or otherwise significant to provision of treatment;

(iv) documents revisions to the treatment plan;

(v) assures that all members of the treatment team, including the client as clinically indicated, participate in the treatment planning process, as documented by the signatures of treatment team members on the treatment planning documents; and

(vi) involves the client's parents or legal guardians in treatment team meetings and in all plans and decisions affecting the client and keeps them informed of the client's progress in the program unless prohibited by the court or otherwise contraindicated according to documentation in the client's record.

(b) Contact with client: The treatment coordinator has a private face-to-face visit with the client within the first two weeks of placement, and at least twice monthly thereafter for TFC I clients and once monthly for TFC II clients. These contacts are conducted both in-home and out-of-home.

(c) Contact with treatment foster parent(s): The treatment coordinator has a face-to-face interview with the client's treatment foster parents within the first two weeks of placement and at least twice monthly thereafter TFC I clients and once monthly for TFC II clients. The treatment coordinator has a minimum of one phone contact with the treatment foster parent(s) weekly. Phone contact is not necessary in the same week that face-to-face contact has been made.

(d) All contacts are documented in the client's record and include a summary related to the treatment plan, significant events and the communications between treatment coordinator, client, treatment parent(s) and the biological/adoptive family. All documentation includes the date, time, location of the contact, and names of persons present.

(e) Support of the client's relationship with their biological/adoptive family: The treatment coordinator supports and enhances the client's relationship with their family to the extent determined by the treatment team. The treatment team reviews any restrictions at the time of the writing of the comprehensive treatment plan or at the time the restriction is imposed. The treatment coordinator documents in the client's treatment plan the reason(s) for any restriction, and the treatment team's involvement. Thereafter, the restriction is reviewed at least every 30 days and documented in the treatment plan review.

(f) Assistance to treatment foster parents: The treatment coordinator assists the treatment foster parents in the implementation and development of treatment strategies, including goal-setting and planned interventions. This assistance is done through the following:

(i) the provision of ongoing client-specific training and problem solving;

(ii) facilitation of professional development training for the treatment foster parents as described in Section 29.B(10) of these certification requirements*;*

(iii) observation/assessment of family interactions;

(iv) assessment of safety issues involving the client(s) in the home.

(g) Community liaison and advocacy: Based upon an assessment of the client's and biological/adaptive family's needs, the treatment coordinator advocates for and coordinates the provision of community-based services*,* as related to identified goals*,* and provides technical assistance to community providers as needed to maximize the utilization of services by the client and family.

(h) A treatment coordinator is physically available within 60 minutes of a treatment foster home so that quality of care, appropriate supervision and timely responsiveness to the treatment foster family are possible.

(3) Clinical supervisor qualifications: are defined in 16.27.19 NMAC and 16.63.1 NMAC. Supervision by RLD board approved clinical supervisors must be in accordance with their respective licensing regulations.

(4) Clinical supervisor responsibilities: The role of the clinical supervisor is to provide support, consultation and oversight to the treatment coordinator(s) and therapist(s) in accordance with their respective board requirements. Additionally, the clinical supervisor provides supervision each month based on the needs of program and staff needs.

(5) Supervision/consultation: Both independently licensed [therapist] therapists and non-independently licensed therapists consult with the supervisor as deemed per 16.63.1 NMAC. All consultation/supervision is documented with the date, time, duration, and topics discussed.

(6) Staff training:

(a) Therapists, treatment coordinators, and other professional staff participate in knowledge/skill based pre-service training relevant to the services provided including:

(i) child and adolescent development;

(ii) prevention and de-escalation of aggressive behavior;

(iii) crisis management and intervention;

(iv) grief and loss issues for client(s) in foster care;

(v) cultural competence and knowledge of the means for obtaining and providing culturally responsive services;

(vi) specific agency policies and procedures including documentation;

(vii) recognition of abuse/neglect symptoms and state abuse/neglect/exploitation reporting requirements;

(viii) actions and potential side-effects of medications;

(ix) certification in emergency first aid and CPR; and

(x) behavior management.

(b) Professional staff who can provide verifiable documentation of previous training in one or more of the above areas are not required to repeat the training if the staff and the clinical supervisor agree in writing as to which specific training is equivalent and therefore not required. This exception does not apply to training regarding an agency's policies and procedures.

(c) All professional staff attend annual, ongoing professional development/ training relevant to the agency's treatment foster care model and to their individual job responsibilities.

(7) Treatment parent qualifications/requirements: Prior to hiring or contracting with prospective treatment foster parents, the agency documents that each prospective treatment foster parent, including those who provide therapeutic leave, meets and conforms to the certification requirements set forth in 8.369.3 NMAC as well as the following qualifications and requirements:

(a) hold a current and valid license as treatment foster parent issued by an agency licensed by CYFD as a child placement agency. No home can be licensed for treatment foster care services until any previous foster care license is surrendered to the issuing agency;

(b) have signed a release to allow the agency to read prior foster home and prior treatment foster home records that exist through any previous foster home licensure or certification;

(c) understand the placement in treatment foster care services as temporary, except when adoption by the treatment foster parents has become the permanency plan;

(d) have access to reliable transportation, and when driving a car have a valid New Mexico driver's license and liability insurance;

(e) have read, expressed understanding of, and agreed in writing to fulfill the requirements and responsibilities of a treatment foster parent;

(f) prior to hiring or contracting with prospective treatment foster parent(s), the agency documents that it has requested and reviewed the prospective parent(s)' substantiated reports of abuse/neglect, if any, and previous foster-parent records, if any, and determined that such history does not disqualify the prospective parent(s) from becoming treatment foster parent(s); the agency will inquire about any previous treatment foster care services or regular foster care experience applicant families may have had.

(8) Treatment parent training: The training of treatment foster parents is systematic, planned, documented and may include modalities other than didactic instruction. Training is consistent with the program's treatment philosophy and methods and equips treatment foster parents with the skills to carry out their responsibilities as agents of the treatment process. Prospective treatment foster parents are provided with a written list of duties clearly detailing their responsibilities prior to their approval by the program. The written professional development plan is placed in the treatment foster parent(s) record.

(a) All treatment foster parents receive 40 hours of training, at least 30 hours of which are completed prior to placement of client(s). Any remaining hours are completed within two months of first placement. The training, at a minimum, includes:

(i) first aid and CPR training, provided by a certified instructor before receiving a client for placement;

(ii) child and adolescent development;

(iii) behavioral management;

(iv) prevention and de-escalation of aggressive behavior;

(v) crisis management/intervention;

(vi) grief and loss issues for client(s) in foster care;

(vii) cultural competence and culturally responsive services;

(viii) specific agency policies and procedures including documentation,

(ix) recognition of abuse/neglect symptoms, and state abuse/neglect/exploitation reporting requirements;

(x) side-effects of psychotropic medication; and

(xi) role of treatment foster parent in treatment planning.

(b) Treatment foster parents who can provide verifiable documentation of previous training in one or more of the above areas are not required to repeat the training if the staff and the clinical supervisor agree in writing which specific training is equivalent and therefore not required. This exception does not apply to training regarding an agency's policies and procedures.

(c) Twenty-four hours of in-service training is required annually after receiving a client for placement. The 24 hours may include:

(i) up to four hours of video when supplemented by discussion in a classroom or clinical training setting;

(ii) up to four hours of supplemental reading may be part of the 24 hour annual in-service training when supplemented by discussion in a classroom or clinical training setting.

(9) Treatment foster parent responsibilities: The treatment foster parent works with the treatment team and with agency supervision to develop and implement the treatment plan. Treatment foster parents provide front-line treatment interventions. The family living experience is the basic service to which individualized treatment interventions are added. Treatment foster parents are responsible for meeting the client's basic needs and providing daily care and supervision. In addition to their basic foster parenting responsibilities, treatment foster parents perform the following tasks and functions:

(a) Treatment planning: Treatment foster parents actively participate in the treatment planning process and implement specified provisions of the treatment plan.

(b) Treatment foster parents work with the treatment team to maximize the likelihood that all services are provided in a culturally competent and culturally proficient manner.

(c) Contact with the client's family: Unless contraindicated in the client's treatment plan, or by court order, treatment foster parents assist the client in maintaining contact with their family and actively work to support and enhance those relationships. When reunification with the client's family is planned, the treatment foster parents work in conjunction with the treatment team toward the accomplishment of the reunification objectives outlined in the treatment plan.

(d) Permanency planning assistance: The treatment foster parents assist with efforts specified in the treatment plan to meet the client's permanency planning goal(s).

(e) Record keeping: The treatment foster parents systematically record information and document client behaviors/activities and significant events related to the treatment plan. Documentation occurs on a daily basis.

(f) Agency contact: The treatment foster parents keep the agency informed of the occurrence of significant events within 24 hours.

(g) Confidentiality: Treatment foster parents maintain agency standards of confidentiality.

(h) Incident reporting: Treatment foster parents report all serious incidents to the agency, consistent with agency policy and certification requirements.

(i) Availability: At least one treatment foster parent is readily accessible at all times and is able to be physically present, if necessary, to meet the client's emotional and behavioral needs; e.g., a treatment foster parent responds if the school requires immediate parental attention. A single treatment foster parent may not schedule work hours when a client is normally at home.

(j) Care and supervision: Treatment foster parents ensure that proper and adequate supervision is provided at all times. Guardians ad litem, court-appointed special advocates, and court-appointed guardians may meet privately with clients as necessary. Clients are not left in the care or unsupervised presence of friends, relatives, neighbors, or others who have not received both criminal records clearance and training. Treatment teams determine that all out-of-home activities are appropriate for the client's level of need, including the need and plan for supervision.

(k) Community-based resources: The treatment foster parents work with all appropriate and available community-based resources to secure services for and advocate for the client(s).

C. Assessment, pre-placement, and placement: Prior to placement of any treatment foster care client in any home, including therapeutic leave or interim placement, the agency will determine that the placement is therapeutically appropriate. The placement process includes documented consideration of the home and all residents.

(1) The comprehensive assessment includes face-to-face interviews with the client; with the client's biological or adoptive family whenever possible and when not contraindicated; and contact with any previous care providers. The comprehensive assessment meets the following requirements, in addition to those

listed in the general provisions:

(a) the client's and their family's priorities and concerns, as appropriate, are documented; and

(b) if the client is in CYFD (court-appointed legal) custody**,** the agency requests information from the client's social worker, including the permanency plan, collateral assessment(s), and any known or suspected history of abuse/neglect.

(2) Placement does not occur until after a comprehensive assessment of how the prospective treatment foster family can meet the client's needs and preferences, and a documented determination by the agency that the prospective placement is a reasonable "match" for the client.

(3) A documented match assessment includes, but is not limited to:

(a) the identified needs of the client;

(b) the strengths of the treatment foster parents to implement the client's specific services and treatment plan;

(c) composition of the treatment foster family; including the name, age, and gender of each person residing in the home or visiting on a regular basis;

(d) treatment foster parents' specific knowledge, skills, abilities and attitudes as related to the specific needs of each client including high risk behaviors or the potential for such;

(e) treatment foster family's ability to speak the primary language of the client;

(f) treatment foster family's willingness and ability to work with the client's family;

(g) proximity of the treatment foster parent to the client's family, friends and school. If the client is placed more than an hour's driving time from the family, the justification is documented in the client's record;

(h) client and client's family's (if applicable) preference for placement;

(i) availability of, and access to, community resources required to meet the client's needs; and

(j) a summary/rationale of the client's placement in the particular treatment foster home chosen; the clinical rationale includes consideration of all residents of the home, including anticipated effects of the placement on all clients present and potential health and safety risks, and is documented in each client record prior to the placement.

(4) Pre-placement processes:

(a) Prior to placement**,** the client's family of origin meets with their child's prospective treatment foster parent(s) unless clinically contraindicated, prohibited by court order, or prevented by refusal or unavailability**.** If a pre-placement meeting does not occur, the reasons are documented in the client's record.

(b) Following completion of the match assessment, the client visits with the treatment foster family for a full 72 hours. The dates and times of the visit are documented in the client's record. At the end of the 72 hours, the treatment coordinator documents an assessment of the visit and the therapeutic appropriateness of the match, including the client's reaction and the treatment foster parent(s) response. When it is clinically indicated, the client may remain in the placement at the end of the 72 hour visitation, provided that the clinically based reasons are documented in the client's record.

(c) All information that the treatment foster care services agency receives concerning a client waiting for placement is explained to the prospective treatment foster family prior to placement. Prospective treatment foster parents are responsible for maintaining agency standards of confidentiality regarding such information.

(d) For all clients in CYFD (court- appointed legal) custody, the treatment foster care services agency shares the home study of a prospective licensed treatment foster family with the client's legal guardian and invites the legal guardian to meetings in which the prospective placement is discussed.

(e) The treatment foster parent(s) can refuse placement of any treatment foster client whom they consider inappropriate for the home or to protect the safety of any children currently in the home.

(f) Treatment home composition and capacity, including capacity for therapeutic leave: Prior to any placement, the agency determines that the match is consistent with the following limits:

(i) A treatment foster family is eligible to care for level I and level II treatment foster clients, non-treatment siblings of treatment clients, and children who were previously treatment foster clients in the same home but are no longer qualified for TFC. Non-treatment regular foster or shelter care children may be temporarily placed in the home for therapeutic leave or shelter care for up to 30 days, after the agency assesses and documents that such a temporary placement will not compromise the treatment of any current

client. Regular foster care children who were in the home previously or foster children who are siblings or children of treatment foster clients currently in the treatment foster home may be placed without the 30 day limit pertaining to therapeutic leave or shelter care clients. Arrangements pertaining to placement of regular foster children are made with court-appointed legal guardian.

(ii) The total number of children in a treatment foster care services home, including treatment foster care clients, therapeutic leave children, and any other children, may not exceed six, except in rare circumstances such as placing sibling groups together. Such exceptions are approved in advance by the treatment teams, guardians of all children, and by the agency's clinical director. The clinical rationale for the exception is documented in each client's record.

(iii) The total number of treatment foster clients placed in a two-parent treatment foster care home is limited to three. At no time may more than three TFC I children be placed in the same home, except when they are siblings. In the case of multiple treatment foster care children placements, at least one treatment foster care parent will not be employed outside the home.

(iv) The total number of treatment foster care clients placed in a single-parent treatment foster care home cannot exceed two. No more than one level I treatment foster care client may be placed in a single-parent treatment foster care home, unless both are siblings.

(g) The agency obtains written agreement of the treatment team, including Guardians ad Litem (GALs), and legal guardians, for all placements.

(h) Any deviation from the requirements for two-parent and single parent treatment foster care homes require a waiver request from HCA as defined in NMAC 8.369.3.7 Definitions.

(i) A client with a history of more than one incident of substantiated sexual aggression may not be placed in a home with any other client, including client(s) temporarily present for therapeutic leave or shelter purposes, without prior written approval by the treatment teams of all treatment clients in the home. In the case of non-treatment minors, written permission must be obtained from the legal guardian(s) prior to such placement. The rationale for such placement will distinguish the sexually reactive from the sexually aggressive client. The sexually reactive child may have presented with a history of symptoms such as public masturbation, sex play or developmentally incongruent preoccupation with sexual matters or topics. This behavior by itself should not present a barrier to the placement of other children. The sexually aggressive child has had more than one incident of using force or intimidation to make another child comply with a sexual activity. The treatment team is responsible for evaluating all collateral information, evaluating any high-risk behaviors or the potential for such, regardless of when it occurred or when an evaluation was performed**,** and the severity of the force or intimidation, regardless of how recently it occurred, prior to placing the child in a home where there are other children.

(j) The agency trains the treatment foster family in cultural and physical care issues related to the client's race and culture prior to the client's placement.

(5) Therapeutic leave: Agency policy and practice provide for treatment foster parent(s)' access to therapeutic leave, both planned and crisis based.

(a) Treatment foster parents providing therapeutic leave placements are licensed and trained by the agency, are given a copy of the client's treatment plan, and are supervised by the treatment coordinator in the implementation of the in-home strategies.

(b) Therapeutic leave placements may be provided by a licensed and appropriately trained treatment foster family from another licensed and certified treatment foster care services agency, provided that the placing agency ensures the client's treatment plan is implemented appropriately.

(c) It is the treatment foster care services agency's responsibility to determine that treatment foster parents into whose home a therapeutic leave client has been placed are sufficiently skilled to work with the mix of treatment clients in their home, and document this determination in their records prior to placement.

(d) If a treatment foster care services agency cannot secure a trained and licensed treatment foster care family to provide therapeutic leave for a client, the agency may place the client in a licensed residential treatment services or licensed group home services, if clinically appropriate and documented, for a period not to exceed seven days. The residential treatment services or group home services program must adhere to the client's treatment plan and document the services provided and the client's behavior, consistent with these certification requirements for treatment foster parent documentation.

(e) Therapeutic leave placements comply with all certification requirements stated herein, including capacity limits. The agency documents assessment of treatment home/family composition, physical and sexual safety issues, and language(s) spoken, prior to therapeutic leave placement.

D. Service planning and provision:

(1) All treatment foster care services, as described in these certification requirements, are the

responsibility of the treatment foster care services agency. Services are furnished either through agency staff or contracted persons.

(2) The treatment foster care services agency provides intensive support, technical assistance, and supervision of all treatment foster parents.

(3) The agency provides clinically appropriate therapy services to the client and involves the treatment foster parents and the client's family to achieve the goals of the treatment plan. Each treatment client receives regularly scheduled therapy, including family therapy, as clinically indicated and specified in the client's treatment plan. Family involvement in treatment, including family therapy is not required when contraindicated by court order, or temporarily contraindicated by the clinical judgement of the department's legal guardian or treatment team.

(a) Therapy cannot be suspended or terminated unless there is concurrence by the treatment team that therapy is not presently indicated.

(b) All efforts are made to place a client in close enough proximity to biological/adoptive family so that family therapy will not be hindered.

(c) Family therapy is required when reunification is the goal.

(d) In cases where family involvement is contraindicated, the agency documents the clinical or legal basis for that determination and documents regular review of the determination.

(4) The professional/clinical staff provide or locate resources most suited to the individual needs of the client in treatment foster care services and helps the client, their parent(s) and the treatment foster families to make effective use of them.

(5) Client's access to agency staff: An agency staff person, who is a member of the client's treatment team, is designated as a contact person for each client. The client has direct access to that staff member. The client is informed of their designated staff person and how to reach that person. The means for such communication is available to the client for their use at all times. This is documented in the client's record at admission, and each time a change is made.

(6) Crisis on call: The treatment coordinator, or another professional clinical staff member or contractor who meets the qualifications for treatment coordinator, is on-call for treatment foster parents, client(s) and their families on a 24 hour, seven-day-per-week basis.

(7) The agency works with the local school district to access for the client the most appropriate educational services in the least restrictive setting.

(8) The agency facilitates the creation of formal and informal support networks for its treatment foster parents through coordination of parent support groups and other systems.

(9) Documentation:

(a) All contacts between agency staff and clients' biological/adoptive parents, and treatment foster parent(s) are documented in the client's records.

(b) All therapy notes are documented and placed in the client's record within one week of the session date.

(c) Therapy notes explicitly address the goals/objectives identified in the treatment plan.

(10) The treatment foster care services agency provides intensive support, technical assistance and supervision to all treatment foster parents. The agency trains the treatment foster family in cultural and physical care issues related to the client's race and culture prior to placement and throughout its duration, with the intention of the treatment foster family becoming culturally competent.

(11) The agency is responsible for determining that the treatment foster parent(s) effectively manage the individual treatment needs, acuity-based safety needs, and cultural needs of all clients placed in the home.

(12) The agency develops and implements a plan to connect the treatment foster client with other children and adults in the community who share the same culture, race and ethnicity.

(13) Services are provided to each client as determined by the treatment team. No one member of the treatment team has veto power except for those provisions set forth in the Children's Code regarding change of placement notification. No services are terminated or suspended without the review and concurrence of the team. This certification requirement does not limit a managed care entity's right to determine, or the agency's or legal guardian's right to appeal, based on medical necessity criteria, the authorization of continued placement of a treatment foster care services client.

(14) The treatment plan is developed through a process that utilizes a treatment team comprised of the following individuals, as applicable and appropriate: the client, the client's family, treatment foster

parent(s), treatment coordinator, department social worker, juvenile probation/parole officer, education agency, guardian ad litem and other significant individuals in the client's life.

(15) The agency ensures that all treatment plans adhere to the treatment planning requirements contained in the general provisions section of these certification requirements.

(16) The initial treatment plan includes specific tasks to be carried out by the treatment team within the first 14 days of placement.

(17) The initial and comprehensive treatment plans address strategies to ease the client's adjustment to the treatment home and to assess directly the client's strengths, skills, interests and needs for treatment within the home.

(18) The treatment plan reviews address discharge planning and strategies to prepare for the client's return to the biological, or adoptive, regular foster care home or independent living as appropriate.

(19) The treatment plan is reviewed every 30 days by the treatment team, in accordance with the general provisions, and revised when clinically indicated. The review occurs face-to-face, telephonically or through teleconference.

E. Agency oversight:

(1) Except in emergencies, a client is removed from a treatment foster care services home only after the treatment team has documented that the move is in the client's best interest. When such a move is necessary, the agency complies with pre-placement, placement and treatment planning requirements.

(2) In the event that the treatment foster parents request that a treatment foster client be removed from their home, a treatment team meeting is held and there is agreement that a move is in the best interest of the involved client. Any treatment foster parent(s) who demands removal of a treatment foster client from their home without first discussing with and obtaining consensus of the treatment team will have their license revoked.

(3) If treatment foster parent(s) wish to transfer between agencies, there must be written documentation from both agencies that the transfer is in the best interest of any client(s) currently in the home, including consideration of change of treatment team members, and a written statement from the previous agency that the transferring treatment foster family is in good standing.

(a) If any clients are currently placed in the transferring treatment home, the receiving agency will evaluate the appropriateness of the match and update the treatment plan.

(b) The receiving agency completes a new home study, or an addendum to the original home study reflecting any changes that have occurred in the composition of the home since the date of the client's admission.

(c) The receiving agency notifies the previous agency that the treatment foster parent(s) has been hired, and the previous agency, upon receipt of that notice, cancels its previous license.

(4) At the time of new licensure of a treatment foster care home, if non-treatment foster care client(s) placed through prior licensing arrangements must be removed, the process is conducted through an orderly and purposeful plan which is approved in writing by the previous licensing agency as meeting the best interests of the clients.

F. Property damage and liability:

(1) Written plan: The agency providing treatment foster care services has a written policy concerning compensation for damages to a treatment foster family's property by client(s) placed in their care. A copy of the written plan is provided and explained to the prospective treatment foster parents during the pre-service training.

(2) Liability insurance: Treatment foster parent(s) document and verify on a regular basis that they continuously maintain liability insurance for automobiles, home and persons, including owner and occupants of the home.

(3) Property damage caused by client(s) in court-appointed legal custody may be reimbursed by the protective services division of the New Mexico children, youth and families department.

G. Transition to independent living:

(1) Older adolescents in treatment foster care are provided with a series of developmental activities and supportive services designed to enable them to prepare to lead self-sufficient adult lives, in accord with their treatment plan. For those clients 16 to 20 years old for whom family reunification, placement with extended family or with previous caretakers, or adoption has been found to be infeasible or inappropriate, the agency provides or arranges for a set of service components to be delivered which are designed to enable the client to prepare for a successful transition to independent living.

(2) The services provided or coordinated address the client's identified needs for:

(a) life skills training;

(b) education with regard to health concerns including human sexuality;
(c) vocational and technical training;
(d) housing needs during transition and after discharge;
(e) legal services;
(f) arrangements for support services, aftercare services and socialization, and
(g) cultural, religious and recreational activities, as appropriate to the client's needs.

[8.369.3.29 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.30 RESIDENTIAL TREATMENT SERVICES AND GROUP HOME SERVICES:

A. Residential treatment services are provided to children/adolescents with severe behavioral, psychological, neurobiological, or emotional problems, who are in need of psychosocial rehabilitation in a residential setting. They require active residential psychotherapeutic intervention and a 24-hour therapeutic group living setting to meet their developmental, psychological, social, and emotional needs.

B. Group home services are provided to children/adolescents with moderate behavioral, psychological, neurobiological, or emotional problems, who are in need of active psychotherapeutic intervention, who require a 24 hour therapeutic group living setting to meet their developmental, social and emotional needs, or who are in transition from a higher level of care to a lower level of care.

C. The agency maintains and follows policies and procedures for emergency and non-emergency admissions. Admission policies and criteria are based on the client's identified need for residential treatment services or group home services.

D. At the time of admission or transfer to residential treatment services or group home services, the client is informed of the reasons for the placement/transfer and their treatment options. This discussion with the client is documented in the client's record by the admitting professional.

E. Personnel:

(1) Direct service staff providing residential treatment services or group home services receive a minimum of 20 hours of pre-service training, including training in:

(a) crisis management/intervention, behavioral management, personal restraint and seclusion;

(b) the agency's emergency procedures, which include CPR and first aid.

(2) The direct service staff possess a high school diploma or G.E.D and one or more of the following:

(a) two years experience working with clients and adolescents with severe psychological/ emotional disturbances/neurobiological disorders; or

(b) two years of post-secondary education in a human service related field; or

(c) a minimum of 40 hours of documented training, including the 20 hours of pre-service training described in E above, and 20 additional hours including the following topics:

(i) etiology and symptoms of emotional disturbances and neurobiological disorders;

(ii) family systems;
(iii) basic communication and problem solving;
(iv) child and adolescent development;
(v) ethnic and cultural considerations related to the clients served; and
(vi) action and potential side effects of medications.

(3) The training specified above, when required, must be provided within three months of hire.

(4) Those direct service staff who, prior to beginning direct service work, can provide documentation of a current certificate of training in one or more of these specified areas are not required to repeat that training; their training requirements may be adjusted as justified and documented by the clinical director or designee.

(5) Clinical director:

(a) Clinical director qualifications: The clinical director possesses one of the following New Mexico licenses: physician (physicians must be board-certified in psychiatry or eligible to attain such certification); psychologist; licensed independent social worker (LISW); clinical nurse specialist in child psychiatric nursing; registered nurse (RN) with a master's in psychiatric nursing; licensed professional clinical mental health counselor (LPCC); and licensed marriage and family therapist (LMFT);

(b) In addition to having one of the above licenses, the clinical director is required

to have a minimum of two years of experience in clinical practice with clients, adolescents, and families.

(c) Clinical director responsibilities: The responsibilities of the clinical director are to provide clinical oversight of the services, as well as to provide supervision, support, and consultation to all agency staff.

(6) Clinical supervisor qualifications: as defined in 16.27.19 NMAC and 16.63.1 NMAC. Supervision by RLD board approved clinical supervisors must be in accordance with ther respective licensing regulations.

(7) Therapists qualifications: Therapists providing individual, family or group therapy must meet either the necessary licensed requirements as listed for clinical supervisor or possess one of the following New Mexico licenses: licensed professional mental health counselor (LPC); licensed master's social worker (LMSW); licensed art therapist (LAT); or licensed mental health counselor **(**LMHC).

F. Services:

(1) Residential treatment services are provided through a treatment team approach and the roles, responsibilities and leadership of the team are clearly defined.

(2) The agency provides a daily structured program that meets clients' needs as identified in the comprehensive assessment and as prescribed in the treatment plan. The following services are provided:

(a) individual, family, and group therapy, at the level of frequency documented in the treatment plan;

(b) access to timely and necessary medical care;

(c) supervision of self-administered medication, if appropriate;

(d) crisis intervention;

(e) educational services;

(f) activities of daily living;

(g) recreation, leisure time and other planned therapeutic activities; and

(h) planning of discharge and aftercare services; to facilitate timely and appropriate post discharge care, regular assessments are conducted to support discharge planning and effect successful discharge with clinically appropriate aftercare services; this discharge planning begins when the client is admitted to residential treatment services and is updated and documented in the client's record at every treatment plan review, or more frequently as needed.

(3) The agency provides services, care, and supervision at all times, including:

(a) the provision of, or access to, medical services on a 24-hour basis;

(b) maintenance of a staff-to-client ratio appropriate to the documented level of acuity, care and needs of the clients.

(i) for residential treatment services, the minimum ratios are one to six during the day and evening shifts and one awake staff to 12 clients during the night shift.

(ii) for group home services, the minimum ratios are one to eight during the day and evening shifts and one awake staff to 12 clients during the night shift.

(iii) additional staff must be provided if the clinical needs of the client population are high.

(iv) a written schedule must be maintained by the agency to document the staffing ratios.

(c) arrangements for, and provision of, documented supervision for off-grounds activities, including transportation, in accordance with minimum and need-based ratios; and

(d) arrangements for, and provision of responses to significant life events that may affect the client's treatment when out of the facility.

(4) Services and activities are appropriate to the age, behavioral, and emotional development level of the client.

(5) When not therapeutically or legally contraindicated, the agency encourages parent/client contact and makes efforts at family reunification. Such contacts and efforts are documented as they occur. If reunification is contraindicated, the reason is documented in the client's record at the time that determination is made, and the issue is reconsidered when indicated.

(6) The following factors will be considered and documented in determining the appropriate level of services and supervision.

(a) risk of victimizing others;

(b) risk of inappropriate consensual activity;

(c) risk of being victimized by others;

(7) The treatment plans contain all the elements outlined in Section 23 of these certification requirements.

[8.369.3.30 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.31 JOINT COMMISSION ACCREDITED RESIDENTIAL TREATMENT SERVICES: Residential treatment services programs that are accredited by the joint commission comply with the general provisions and residential treatment services sections of these requirements, and the following standards:

A. The agency provides services, care, and supervision at all times, including maintenance of a minimum staff-to-child ratio of one to five during the day and evening shifts and one awake staff to 10 clients during the night shift. Additional staff is provided when warranted by level of acuity, care, and needs of the clients.

B. A physical examination is completed by a licensed independent medical practitioner within one week of admission, and includes medical history, physical examination, assessment of pain, motor and sensorimotor functioning, speech, hearing, and language functioning, vision, immunizations, oral health, history of psychotropic medication use, and, when indicated an AIMS test. If a comprehensive medical history and physical examination have been completed within 30 days before admission, a durable, legible copy of this report may be used in the clinical record as a physical examination, but any subsequent changes must be recorded at the time of admission.

C. The agency evaluates the need for the following assessments, and when such assessments are indicated, they are completed in a thorough and timely manner: psychological, psychiatric, educational, vocational, legal, nutritional, developmental disabilities, and substance use disorder~~.~~

D. The agency has a written plan to provide all necessary medical histories, physical examinations, and laboratory tests that the agency does not directly provide.

E. Infection control.

(1) The agency has a comprehensive and functioning infection-control program based on proven epidemiological methods for surveillance and prevention of adverse outcomes related to infection.

(2) The agency uses preventive processes such as universal precautions to reduce risks for endemic and epidemic infections in clients and staff.

(3) Infection control policies, procedures, and practices include surveillance, identification, and control of infection, and required reporting to staff and public health authorities.

(4) A current certification stating that the employee is free from tuberculosis in a transmissible form, obtained prior to the first date of direct service.

[8.369.3.31 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.32 CORRECTIVE ACTION: If violations of this rule are cited, the facility will be provided with an official statement of deficiencies within 10 business days following the survey.

A. Informal dispute review (IDR): The facility may request an informal review of survey deficiencies by providing a written request to the licensing authority within 10 calendar days of receipt of the written survey findings. With the request, the facility shall include information or evidence that justifies the disagreement with a cited deficiency.

(1) The licensing authority will review the submitted information and make a determination.

(2) If the deficiency is removed, a new statement of deficiencies will be issued to the facility.

(3) The facility shall provide a new plan of correction for all remaining deficiencies upon receipt of the new statement of deficiencies.

(4) A copy of the "IDR operating rules" is available upon request or by accessing the DHI website.

B. Plan of correction (POC): The facility shall submit a plan of correction within 10 calendar days of receipt of the statement of deficiencies and after receipt of a revised statement of deficiencies, when the findings are changed pursuant to an IDR.

(1) The licensing authority may either accept, direct or reject a plan of correction (POC).

(2) If the first POC is rejected by the licensing authority, the facility will be sent a second copy of the statement of deficiencies. The facility shall complete and return the second copy of the statement of deficiencies with an acceptable plan of correction within three business days. The process will repeat until an acceptable plan of correction is received by the authority.

(3) Failure to provide an acceptable plan of correction within a reasonable period of time may lead to civil monetary penalties or other sanctions.

(4) The plan of correction shall:

(a) address how all violations identified in the official statement of deficiencies will

be corrected;

(b) address how the facility will monitor the corrective action and ensure ongoing compliance; and

(c) specify the date that the corrective action will be completed.

(5) All cited violations shall be corrected within 30 calendar days from the date of the survey; unless the licensing authority approves an extended date.

(6) Failure to submit an acceptable plan of correction may result in sanctions, including but not limited to civil monetary penalties, suspension or non-renewal of the facility license.

[8.369.3.32 NMAC - N/E, 5/26/2026; N, xx/xx/2026]

8.369.3.33 [RESERVED]

History of 8.369.3 NMAC: [RESERVED]

History of Repealed Material: 8.369.3 NMAC, Certification Requirements for Child and Adolescent Mental Health filed 5/26/2026 Repealed effective xx/xx/2026.

Other: 7.20.11 NMAC, Certification Requirements for Child and Adolescent Mental Health Services filed 2/19/2022 Replaced by 8.369.3 NMAC, Certification Requirements for Child and Adolescent Mental Health Services effective 7/1/2026.
8.369.3 NMAC, Certification Requirements for Child and Adolescent Mental Health filed 5/26/2026 as an emergency rule Replaced by 8.369.3 NMAC, Certification Requirements for Child and Adolescent Mental Health effective xx/xx/2026.