**Section 380.320 Recovery and Rehabilitation Supports Centers**

a) Recovery and rehabilitation supports centers shall facilitate *a consumer's longer-term symptom management and stabilization while preparing the consumer for transitional living units* or transition to the community *by improving living skills and community socialization. The duration of stay in* this *setting shall be* based on the clinical needs of the consumer, as determined by the consumer's interdisciplinary team. (Section 1-102 of the Act)

b) Consumers admitted to an RRS center shall be in need of RRS care as determined by State-authorized assessment, level of service determination, and authorization criteria.

c) A consumer shall not be admitted to an RRS center without authorization and without undergoing the authorization and background check requirements of Sections 380.170 and 380.180.

d) RRS centers shall not accept for admission:

1) Anyone younger than 18 years of age;

2) Anyone with a primary diagnosis of substance use disorder;

3) Anyone who has one of the medical conditions in Section 380.120(n), requiring active intervention or treatment and a higher level of medical care beyond the capabilities of the RRS center;

4) Anyone diagnosed with a traumatic brain injury or diagnosed with dementia;

5) Consumers who are non-ambulatory;

6) Anyone who presents an imminent risk of harm to himself or to herself, or to others and is eligible for involuntary commitment under the Mental Health and Developmental Disabilities Code; or

7) Anyone who falls under any other restrictions in the Act and this Part, including exclusions from the definition of "consumer" in Section 380.100.

e) The determination that a consumer meets the requirements of subsections (d)(2) through (d)(6) shall be made by the center's LPHA. The determination shall be in writing, shall be kept on file at the center for no less than three years, and shall be made available to the Department or to DHS-DMH upon request.

f) Service Requirements

The recovery and rehabilitation supports center shall ensure that:

1) Treatment planning is conducted in accordance with Section 380.210;

2) The continued stay of all consumers is subject to demonstrated medical necessity as substantiated by regular authorization reviews pursuant to the assessment timetables in Section 380.210(b);

3) The facility is capable of performing dual diagnosis services for consumers, including the engagement of services appropriate for the pre-contemplative state of recovery;

4) The facility provides consumers with assistance in identifying and developing natural supports in the community;

5) Consumers receive an initial assessment of their mental health treatment and training needs as required in Section 380.200(d). The initial assessment shall occur within the first two weeks after admission and shall be updated no less than quarterly;

6) Consumers receive adequate case management, including discharge planning and linkage, referral and follow-up to all necessary supports needed to live safely in the community;

7) Consumers receive appropriate therapeutic interventions, including evidence-based practices of IMR, WRAP, motivational interviewing, cognitive training, and wellness and resilience support development.

8) Consumers are provided training in ADLs and IADLs, as clinically appropriate;

9) Consumers receive regular psychiatric and medical evaluations as indicated by changing conditions in their treatment plans, or as a part of other authorization processes;

10) Consumers receive 15 hours of treatment programming per week, and that the care is documented in the consumer's medical record and is part of the consumer's treatment plan; and

11) Consumers receive adequate medication services, pursuant to Section 380.630.

g) Staffing Requirements

*In no case shall the staffing ratios in* a *recovery and rehabilitation supports* center *be less than* *a staffing ratio of 1.8 hours of direct care* *for* each consumer. (Section 2-102(2) of the Act) For the purposes of this Section, "on site" means being present in the RRS unit within a facility. For the purpose of computing staff-to-resident ratios, direct care staff shall include the following:

1) An LPHA, to provide clinical supervision of the program. The LPHA shall spend at least 25% of each work week on site at the RRS center;

2) For each consumer, a minimum of 15 minutes of nursing care per day by a registered nurse or licensed practical nurse;

3) At least one CRSS, on site eight hours per day, five days per week, to provide recovery support services. Each consumer shall have at least one individual face-to-face discussion with a CRSS within the first week after admission to the RRS center, at least one additional individual, face-to-face discussion prior to discharge or transfer, and the opportunity for participation in group and individual meetings to develop a wellness recovery action plan;

4) MHPs, on site and available to provide mental health services to consumers 24 hours per day, seven days per week. The ratio of consumers to MHPs shall not exceed 32 to one;

5) RSAs, on site and available to provide support and assistance to consumers, as needed, 24 hours per day. The ratio of consumers to RSAs shall not exceed 16 to one;

6) An LPHA, QMHP or MHP to provide clinical services, e.g., treatment planning and therapy, for 60 minutes per consumer per week; and

7) An LPHA, QMHP, MHP, RSA or occupational therapy assistant, to provide group recreational and rehabilitative services for 60 minutes per consumer per week.

h) The RRS center shall ensure that a psychiatrist makes monthly visits to each consumer. In addition, the psychiatrist shall be on call each day and shall be available to respond on site within 24 hours after being contacted by the center when considered necessary by staff.

i) The staff of an RRS center also shall include a dietetic service supervisor, who shall not be considered part of the facility's direct care staff.

j) An RSS center shall maintain collaborative agreements with community mental health agencies to facilitate discharge planning.

k) Discharge Planning

1) In conjunction with the consumer or any individual acting on behalf of the consumer at the consumer's request, a minimum of a QMHP shall develop, or supervise the development of, the discharge plan.

2) Discharge planning shall be conducted in conjunction with a community mental health center or other service provider selected by the consumer, and shall commence as early in the admission as practicable.

3) The RSS unit shall facilitate connection to the community-based behavioral health provider or community-based provider in order to begin discharge planning. Discharge planning shall be part of, and based on, the initial assessment that is conducted when the consumer is admitted to the RSS unit.

4) The discharge plan shall be reviewed at least quarterly with the consumer and any individual acting on behalf of the consumer at the consumer's request, and revised as progress indicates.