may be accomplished by doctoral level psychologists. We have added language which allows clinical directors to be physicians or, where permitted by law and by the facility, doctoral level psychologists who meet CHAMPUS requirements for individual professional providers.

4. Admitting Privileges for Nonphysician Providers. A number of commenters objected to proposed language which limited admitting privileges to physicians. They argued that such limitations on certain nonphysician mental health professionals, for example, master's level clinical social workers, were unnecessarily restrictive and counter to legislative and industry trends toward an expanded scope of practice for these providers.

*Response.* We are aware of these changes and agree that, where permitted by law and by the facility, individuals who meet the CHAMPUS definition of individual professional mental health provider should be allowed to refer patients for admission. We have included language in the final rule which reflects this position.

5. *Qualifications for CEOs.* We received a number of comments suggesting that upgraded CEO requirements should not apply to individuals who, although they do not meet these standards, are currently serving in that capacity successfully.

*Response.* We believe the proposed standards for CEOs are appropriate, given the level and scope of responsibility attached to this position. However, we have included language which makes CEO qualification standards effective October 1, 1997. This should provide sufficient time for CEOs currently serving to undertake appropriate education and/or training to meet increased requirements.

5. Upgraded Standards are Costly and May Limit Treatment Options for CHAMPUS Beneficiaries. A number of commenters suggested that standards in the proposed rule were costly to implement. They argued that the increased cost of doing business, in addition to potential reductions in reimbursement caused by the rule's payment reforms, may cause some providers to drop participation in CHAMPUS programs. Commenters viewed this as a particular problem for providers with limited CHAMPUS volume and those in rural areas. Some commenters argued that treatment methods not relying upon a medical model should be expanded, rather than changed to conform.

*Response.* Standards in this final rule are based upon accepted standards of practice, requirements of the Joint

Commission on Accreditation of Healthcare Organizations, and input from Department consultants and the provider community. Although we have made significant progress in addressing quality issues raised by GAO's study and highlighted in various forms, rapidly evolving practice patterns and treatment settings require CHAMPUS standards which reflect the character and pace of these changes. We believe these updated standards are necessary minimums which ensure CHAMPUS beneficiaries receive high quality care by appropriately trained professionals and staff. We believe the cost of upgraded standards will be accommodated within projected reimbursement rates. Facilities unable or unwilling to comply with these standards are not in a position to provide a proper standard of care.

6. Implementation of Seclusion and *Restraint.* We received a large number of comments objecting to standards which restricted implementation of seclusion and restraint to qualified mental health professionals. Additionally, the proposed rule excluded seclusion and restraint as behavior management devices in substance use disorder rehabilitation facilities. Commenters argued that these restrictions were unworkable, that they may pose safety issues when professional staff are not immediately available, and that facility staff are trained to use these techniques for behavior management.

Response. Seclusion and restraint imply a severity of dysfunction and need for treatment beyond the scope of care settings addressed in this rule. If seclusion and/or restraint is frequently required for behavior management in RTCs, PHPs, or SUDRFs, this suggests patients who require a more intense level of care. Facilities should evaluate policies and practices to determine their effectiveness in identifying patients who have not been assigned to the appropriate level of care. All facility staff should be trained in temporary holds which provide immediate intervention for safety of the patient and others. Also, facilities should have clear emergency response procedures which define appropriate intervention in crisis situations.

With the exception of brief physical holds and time outs, use of seclusion and restraint is excluded in SUDRFs, as patients who require this level of intervention are not appropriate to this treatment setting. The use of time out or physical holds should be infrequent, since behavior routinely requiring this type of intervention suggests a need for care at a higher level of intensity. We do agree that proposed rule language may have restricted appropriate response to emergency situations. We have added clarifying language which requires a qualified mental health professional to be responsible for implementation of seclusion and restraint, but allows actual implementation by facility staff under supervision of the responsible provider.

7. Inclusion of Spiritual and Skills Assessments. A number of commenters questioned inclusion of new requirements for spiritual and skills assessments in the proposed standards and requested more detailed description of this requirement.

Response. Spiritual assessments are part of a comprehensive, multidisciplinary assessment which should address the full range of a patient's clinical needs, including the impact of religious, ethnic and cultural influences upon the patient or family. Spiritual assessments, which occur in the context of obtaining a social history, are not new to the CHAMPUS standards and are included specifically in standards of other widely recognized accrediting bodies. A skills assessment is an important component of patient evaluation and includes activities of daily living, perceptual-motor skills, sensory integration factors, cognitive skills, communication skills, social interaction skills, creative abilities, vocational skills, and the impact of physical limitations. Activity services related to this assessment should be part of the therapeutic plan and should be supervised by a qualified mental health professional.

8. *Requirement for Clinical Formulation.* Several commenters questioned the need for clinical formulation in addition to development of a treatment plan. Additionally, several comments pointed out the standards allowed less time for completion of a treatment plan (10 days) than for development of the clinical formulation (14 days) which forms the basis of the treatment plan.

Response. The clinical formulation summarizes significant clinical interpretations from each of the multidisciplinary assessments, forming the basis for development of a master treatment plan. Interrelating findings from all assessments, the clinical formulation should clearly describe problems to be addressed in the treatment plan and indicate appropriate focus for the treatment strategies. We view this as a necessary, and not redundant, part of the process for developing a plan of care responsive to the unique requirements of each patient. We agree the proposed time requirements were not consistent with